Patient Quality, Safety & Outcomes Committee

Tue 07 June 2022, 09:30 - 12:30

Microsoft Teams

Agenda

09:30 - 09:45
15 min

1. Preliminary Matters

1.1. Welcome and Introductions

Verbal *Chair*

1.2. Apologies for Absence

Verbal *Chair*

1.3. Declarations of Interest

Verbal *Chair*

1.4. For Approval: Draft Minutes of the Committee Meeting held on 5th April 2022

Attachment *Chair*

1.4 Draft PQSOC Minutes 5th April 2022 Chair approved.pdf (15 pages)

1.5. For Review: Committee Action Log

Attachment *Chair*

1.5 PQSOC Action Log June 2022.pdf (9 pages)

09:45 - 12:25
160 min

2. Items for Presentation and Discussion

2.1. Audit Wales review of ABUHB's Quality Governance Arrangements and Management Response

Attachment *Audit Wales/Clinical Executive Directors*

2.1 Audit Wales Quality Governance Arrangement for PQSOC.pdf (5 pages)
2.1a 2861A2022_abuhb_quality_governance_report_final.pdf (44 pages)

2.2. Theatres Safety Programme Updates

Presentation- to follow *Clinical Executive Directors/Directorate Manager, Theatre Service*

2.3. Covid-19 Concerns and Claims: The National Framework & Investigative Process

Presentation *Executive Director of Nursing*

2.3 Covid-19 Concerns and Claims Presentation for PQSOC - June 2022.pdf (7 pages)

2.4. Learning from Death Report

Attachment *Medical Director*

2.4 Learning from Death 20211115 v2 (1).pdf (22 pages)

2.4.1. 10 MINUTE COMFORT BREAK

2.5. HIW Unannounced Visit to the Grange University Hospital (November 2021)

Attachment *Executive Director of Nursing*

2.5 HIW Unannounced Visit to the Grange University Hospital 1-3 November 2021.pdf (7 pages)
2.5a 21034 - The Grange Hospital - Letter to ABUHB - Update on Improvement Plan - The Grange ED.pdf (1 pages)
2.5b Immediate Improvement Plan Update May 2022.pdf (14 pages)
2.5c Improvement Plan Update 2022.pdf (28 pages)
2.5d Published HIW Report - GUH 1-3 Nov 2021.pdf (114 pages)

2.6. The Independent review of Maternity Services at SATH (The Ockenden Review)

Attachment *Executive Director of Nursing*

2.6 Ockenden Report May 22.pdf (8 pages)
2.6a Independent Review of SaTH Maternity Services 7 Point Briefing - May 2022.pdf (1 pages)
2.6b Ockenden Report.pdf (250 pages)

2.7. Patient Quality, Safety & Outcomes Performance Report

Attachment *Clinical Executive Directors*

2.7 PQSOC Performance Report - June 2022.pdf (43 pages)

2.8. Operation Jasmine and the Coronors Inquests- further Reflection and Learning

Attachment *Executive Director of Nursing*

2.8 Operation Jasmine and the Coroner's Inquests - further reflection and learning - PQSOC June 2022.pdf (5 pages)
2.8a Operation Jasmine-Coroner Inquests - Actions for Improvement - Update May 2022.pdf (7 pages)

2.9. PQSO Committee Risk Report

Attachment *Director of Corporate Governance*

2.9 PQSO Committee Risk Report Jun2022 V1(1).pdf (7 pages)
2.9a Appendix 1 Master June 2022.pdf (23 pages)

2.10. Committee Priorities 2022/23

Presentation- to follow *Director of Corporate Governance*

12:25 - 12:25
0 min

3. Items to be Received for Information

3.1. Highlight Assurance Reports:

3.1.1. Maternity and Neonatal Services Assurance Group

Attachment *Executive Director of Nursing*

3.1.1 Maternity Services Assurance Group Highlight Report- May 2022.pdf (4 pages)

3.1.2. Report from the Chair of the WHSSC Quality & Patient Safety Committee

Attachment *Executive Director of Nursing*

3.1.2 QPS Chairs Report March 2022.pdf (14 pages)

3.2. An Overview of 'Enhanced Care': linking provision, cost & outcome

Attachment *Executive Director of Nursing*

3.2 Enhanced Care Report_Board_ April 22.pdf (8 pages)

3.3. Internal Audit Report: Facilities (Care After Death) Report- Reasonable Assurance

Attachment *Director of Operations*

3.3 AB 2122-24- FINAL Internal Audit Report Facilities for Client v2.pdf (13 pages)

12:25 - 12:25
0 min

4. Other Matters

4.1. To confirm any key risks and issues for reporting/escalation to Board and/or other Committees

Verbal *Chair*

12:25 - 12:25
0 min

5. Date of Next Meeting is Thursday 16th August 2022

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of Patient Quality, Safety & Outcomes Committee held on Tuesday 5th April 2022 at 9.30am via Teams

Present:

Pippa Britton	-	Vice Chair (Chair of Committee)
Shelly Bosson	-	Independent Member
Louise Wright	-	Independent Member
Paul Deneen	-	Independent Member

In attendance:

Glyn Jones	-	Interim Chief Executive
Rani Mallison	-	Director of Corporate Governance
Rhiannon Jones	-	Director of Nursing
Tanya Strange	-	Head of Person-Centred Care (for agenda item PQSO 0504/08)
Chris O'Connor	-	Interim Executive Director of Primary Care, Community and Mental Health (for agenda item: PQSO 0504/13)
James Calvert	-	Medical Director (part of the meeting and for agenda item: PQSO 0504/06)
Karen Hatch	-	Assistant Director of Therapies and Health Sciences (representing DoTH)
Alexandra Scott	-	Assistant Director for Quality and Patient Safety (representing MD)
Kathryn Smith	-	Associate Director of Operations (for agenda item: PQSO 0504/07)
Gareth Hughes	-	Divisional Director of Facilities (for agenda item PQSO 0504/07)
Victoria Taylor	-	Head of Primary Care (for agenda item PQSO 0504/13)
Emma Guscott	-	Committee Secretariat

Observers:

Laura Howells	-	Principle Auditor, NWSSP
Tracey Partridge Wilson	-	Assistant Director of Nursing, Quality, Safety & Patient Experience

Apologies:

Leanne Watkins	-	Director of Operations
Helen Sweetland	-	Independent Member
Peter Carr	-	Director of Therapies & Health Science

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1	**Preliminary Matters**
PQSO 0504/01	**Welcome and Introductions** The Chair welcomed those present to the meeting and thanked individuals for their attendance, noting the Medical Director needed to leave the meeting following the agenda item for Clinical Audit.
PQSO 0504/02	**Apologies for Absence** Apologies for absence were noted as above.
PQSO 0504/03	**Declarations of Interest** There were no Declarations of Interest raised in relation to items on the agenda.
PQSO 0504/04	**Draft Minutes of the Committee held on 8th February 2022**

	The minutes of the meeting held on the 8th February 2022 were agreed as a true and accurate record. Agenda Item 0802/04 contained an explanation of the term *moral injury.* A more detailed explanation has been shared with Shelley Bosson, Independent Member, by Rhiannon Jones.
PQSO 0504/05	**Action Sheet of the Committee held on the 8th February 2022** The Committee reviewed those actions outstanding as recorded in the action log and noted the following: **1910/13 Annual Assurance Report on Health & Care Standards: Nutrition and Hydration** *Update the Equality Impact Assessment and recirculate the paper.* **2112/04 Annual Assurance Report on Health & Care Standards: Nutrition and Hydration** *Peter Carr informed members that the Health Board is not meeting NICE best practice model regarding a dedicated nutritional support team to include specialist nurses. A business case for a dedicated nutritional support team is being developed and would be presented to the Executive Team for consideration, with an update to the Committee.* Karen Hatch, Assistant Director of Therapies and Health Sciences, informed the Committee that a timeline on when *1910/13* and *2112/04* would be shared with the Independent Members. **Karen Hatch to address with Peter Carr** **2112/07 Minor Injuries Units eLGHs** *The Chair requested further information on patient transfers and any challenges to come back to a future meeting.* Information on Urgent Care recruitment and improved staffing numbers has been shared with Independent Members by Rhiannon Jones outside of the meeting. The recruitment picture is very positive. **2112/13 WCCIS Implementation:** *A strategic review was underway by WG of WCCIS national programme. The results of the report will influence how the Health Board utilises the system. A draft report would be completed by WG in January 2022. Draft report to be shared with Independent Members once published.* Rani Mallison, Director of Corporate Governance, informed the Committee that an update would be shared outside of the meeting. **Rani Mallison**

2	**Items for Presentation and Discussion**
PQSO 0504/06	**Assurance Report: National Clinical Audit and Local Clinical Audit Arrangements** James Calvert, Medical Director, provided the Committee with an overview of the report and an update on the Health Boards compliance and performance against National and Local Audit reports. The report provided oversight of results from Clinical Audits, Confidential Inquiries and Peer reviews, giving oversight of the improvements underway to address performance. It was noted that the Health Board participates in all available National Audits. All Health Board actions, particularly arising from Audits, could now be tracked and recorded through the newly purchased specialist software AMAT, further strengthening assurance mechanisms. Paul Deneen, Independent Member, discussed recently highlighted national maternity service issues, and requested assurance around the Ethnic Socio-Economic factors included in the report. James Calvert informed members that the Health Boards model of care, focusing on prevention and public health, with models such as the Gap and Grow programme, provided tailored intervention, enhanced monitoring and support all, including 'at risk' mothers. Rhiannon Jones, Director of Nursing, identified that regular reporting was rooted through the Health Boards Maternity Services Assurance Group, with Highlight reports to the PQSOC. Additionally, the Chief Nursing Officer for Wales had recently secured funding for a new national Maternity and Neonatal Board, with clear expectations of an improvement methodology and approach against a range of indicators for maternity and neonatal services, including self-assessments and learning from other Health Board reviews. Terms of Reference had been drafted for the Maternity and Neonatal Board and all Health Boards in Wales would be members. The Health Board was currently undertaking a review based on recent findings and recommendations from the Ockenden Review regarding Maternity Services at Shrewsbury & Telford NHS Trust. A report will be added to a future agenda for PQSOC **Action:** Maternity Overview to come back to a future Committee. **Rhiannon Jones** The Chair requested yearly reviews of high-risk areas, including Maternity and Mental Health Services. **Action:** To be added to Committee Forward Work Programme. **Secretariat** Shelley Bosson requested assurance around the following areas; • How the Health Board triangulates clinical audit outcomes with other reports, for example Community Health Council (CHC)

	reviews such as the recent Diabetes Review. Alexandra Scott, Assistant Director of Quality and Patient Safety, informed members that this would be an additional piece of work which required strengthening and would be explored. • In terms of Mental Health services, what are the Health Board plans to support Children and Young adults with psychosis. **Action:** A detailed response to identified gaps in the Psychosis Audit to come back to a future meeting. **James Calvert** • Further information on how the Health Board intended to provide Cognitive Behavioural Therapy (CBT) to all patients who require the treatments. Alexandra Scott informed members that the Health Boards delivery of CBT services was above the current National rate and plans to develop the service for at risk groups were in progress. Members were informed that the Health Board was in the process of re-framing its Clinical Audit Strategy and policies. Divisions would be developing measurable, local audit plans with the support of the newly purchased AMAT software. **Action:** The Chair requested that a high-level overview of the Health Boards Local Clinical Audit plan to come back to the Committee. **James Calvert** Shelley Bosson discussed the Neonatal business case outlined in the report and requested a timeline for action. Members were informed that the business case has been finalised and was awaiting funding allocation. It has been flagged by the Family and Therapies Division through their IMTP contribution. Committee Members discussed the results detailed in the paper whilst recognising more work was required to provide assurance on the gaps identified and with the management of ABUHB Clinical Audit.
PQSO 0504/07	**Assurance Report: Compliance with Cleaning Standards, including Benchmarking Data, and Actions underway to address associated issues and risks** Gareth Hughes, Divisional Director of Facilities, provided an update on the organisational compliance with cleaning standards, requested in light of the increasing rates of Clostridium Difficile. The report outlined the workforce challenges impacting compliance with standards and the mitigating actions. The following points were highlighted:

	• Through the Innovation Capital programme, the Health Board had purchased and successfully piloted an additional robot, totalling four, utilised for cleaning out of hours. • In relation to recruitment, the Health Board were utilising 172 additional staff to support the surge at present. The total requirement equates to 127 WTE to meet the standards. • The Division had identified new ways of providing services and embracing new technology to assist in the delivery of improved cleaning. • ABUHB had further increased its Audit team to ensure regular and timely auditing of cleaning standards. • In relation to recruitment, the Health Board had recruited 38 out of the 51 intended fixed term contract positions, however, recruitment remained a challenge. The facilities team had appointed a Recruitment and Retention Officer to facilitate the recruitment process and avoid any unnecessary delays in start dates. • The report highlighted an element of staff turnover; this was noted as part of the Divisions plan as it indicated successful staff development and career progression pathways. • The Health Board was showing an improved cleaning score with 19 areas receiving 100% compliance. The Estates & Facilities Division were working alongside the Infection Prevention and Control Team (IPAC) and nursing teams to ensure compliance. The ABUHB RAG rating builds in a more robust internal governance than the current Welsh Government requirements, allowing areas below 93% to be highlighted earlier, enabling risk mitigation. Shelley Bosson, Independent Member, queried if there would be a change in the All-Wales Cleaning standards post-pandemic and if not, would funding continue to be available to facilitate the current standards going forward. Gareth Hughes informed the Committee that the Welsh Government are reviewing the All-Wales Cleaning Standards. Welsh Government funding had been confirmed up until March 2022 but there was confidence funding would continue. A review of any changes in standards would take place where necessary, in line with current Covid guidance. The Chair thanked Gareth Hughes and the teams. The Committee received the report for assurance and noted the plans in place to overcome the workforce supply challenges, which are critical to maintaining cleaning standards compliance.
PQSO 0504/08	**Dementia Standards Update, including a patient story**

	Rhiannon Jones, Director of Nursing, supported by Tanya Strange, Head of Person-Centred Care, provided the Committee with an overview of the new Dementia Standards and the launch, on the 6th April 2022, of the All-Wales Hospital Dementia Charter. The following was discussed: • Dementia Standards Framework was developed by Improvement Cymru, with the Outcomes Framework element currently under development. • The development of the standards incorporated patients, families, and carers feedback to inform best practice and care for patients. • ABUHB has revised its Regional Dementia Action Plan to embed the new standards. 100 standards had been condensed to 20, containing four main themes. **Action:** A document outlining standards to be shared with Committee Members. **Rhiannon Jones** • Health Board staff were undergoing training, working alongside Citizens UK, to maximise community engagement. • The Dementia Friendly Hospital Charter will be embraced, with regular review of outcomes and impact. • ABUHB aim to support patients with planning for the future within 12 weeks of diagnosis, to include end of life care. • ABUHB is working alongside the Community Health Council (CHC) to gather patient feedback on accessibility of services during the pandemic. Any learning will be taken forward to further improve services. • Existing ABUHB Regional Workstreams have been mapped against the 7 National Workstreams. Further work is required on the respective Terms of Reference for each workstream subgroup. A patient story, outlining the importance of adhering to standards and the impact the pandemic has had on patients and their families, was shared with the Committee members. The Committee were assured that the significant and complex complaint involving the patient was being addressed through Putting Things Right processes. The Committee acknowledged the power of the patient story and the courage of the story-teller. Paul Deneen, Independent Member, queried how the staff on wards identified vulnerable patients with Dementia. Rhiannon Jones informed the Committee that patients with Dementia are assessed on admission and the 'Dementia Daisy' symbol is used on the 'patient status at a glance' boards, indicating that patient has a diagnosis. In addition, patients undergo a capacity assessment, which highlights individual

	and often complex patient needs. Staff training is taking place to further strengthen Dementia care. The Health Boards Action Plan was discussed. The Dementia Charter starts on the 6th April 2022, with four ABUHB wards piloting a VIPS tool to rate progress in patient centred care. The Chair discussed the importance of improving quality throughout the system, with particular focus on consistent reporting during patient transfers and the ability for family members and carers to have regular contact with patients and wards. It was recognised there is significant work required nationally, regionally, and locally to improve care of people living with dementia. The Committee thanked Tanya Strange and the Person-Centred Care Team for the work regarding Dementia and also offered congratulations on their receipt of the CHC Award for Person Centred Care at the recent ABUHB Staff Recognition Awards.
PQSO 0504/09	**Committee Annual Workplan and Priorities 2022/23** Further communication to take place outside of the meeting. **Action: Rani Mallison** Paul Deneen, Independent Member, requested plans to reinstate visits for Independent Members (IM). Rhiannon Jones, Director of Nursing, assured members that, alongside other lead Executives, the reinstatement of IM visits was being discussed and a timetable would be produced, with alignment with the Health Boards Integrated Medium Term Plan (IMTP) priorities.
PQSO 0504/10	**Healthcare Inspectorate Wales: Inspections Update** Rhiannon Jones, Director of Nursing, provided the Committee with an update on progress against the Healthcare Inspectorate Wales (HIW) inspections and ABUHB' response. The update covered inspections that have taken place since 2018 to the present day, noting that inspections prior to 2018 have previously been reviewed and closed. An area of ongoing attention was noted to be the Divisional responses to recommendations made following a review. The Health Boards' aim is to ensure the recommendations are addressed and ensure proportionate and appropriate responses, ensuring Divisional actions address the recommendations. The following was highlighted and discussed:

	• 23 reviews and inspections have been undertaken since 2018, with 234 recommendations, including three internal audit requirements. • Against the 23 reviews undertaken there were a total of 192 actions identified by the Health Board, with 60 actions outstanding at present. • The three 'Immediate Assurance' issues were noted as ligature risk and management at Ty Lafant at Llanfrechfa Grange Hospital, concerns regarding the length of stay of a patient on Adferiad Ward, St Cadocs Hospital and the regular checking of Resuscitation trolleys in the Emergency Department. All recommendations made have been addressed to HIW satisfaction. • An area to note within the report was the 'Discharge Review', a national review undertaken in 2018. An update on ABUHB actions had been provided to HIW in March 2022. Two actions were outstanding. The first action related to the auditing of 'tablets to take home', which will be completed by the Pharmacy teams by June 2022; the second related to E-Discharge summaries, which was delayed due to issues with WCCIS system implementation. The Committee was informed that the awaited Grange University Hospital (GUH) report had been published by HIW, week commencing 28th March 2022, which will be presented to the next PQSOC. **Action: Rhiannon Jones** The next steps are to strengthen the identification of themes from the HIW reviews, enabling the targeting of improvements across the Health Board as opposed to just addressing the issues within the service inspected. The Chair suggested amending the tracker to include due dates for outstanding actions. Action: **Rhiannon Jones** The Committee thanked Rhiannon Jones for the update, noting the volume of actions closed and improvement in overall compliance and assurance to HIW.
PQSO 0504/11	**Patient Quality and Safety Outcomes Report** Rhiannon Jones, Director of Nursing, provided an overview of the Outcomes report. Reporting continues to adopt a proportionate approach due to Health Board challenges, focusing on high-risk matters.

	The Committee was informed that two areas continued to be 'red' RAG rating: Stroke Services and Urgent Care. Infection Prevention and Control (IPAC) has reduced from 'red' to 'amber' RAG rating, due to overall performance against the six Welsh Government reportable expectations, with some improvement in Clostridium Difficile and reductions in Covid impact and hospital outbreaks. An Internal Audit review on the management of inpatient falls has been conducted, eliciting a 'reasonable assurance' rating. The Health Board has received a Regulation 28 from the Gwent Coroner relating to management of falls and is preparing a comprehensive response, to be included in the next PQSO report. In response to increased death from suicide in children and young people, a Self-Harm and Suicide Prevention Task and Finish Group has established by the Health Board, aligning to a national piece work being undertaken due to an increase in the number of suicides in children and young people during the Covid period. The Committee requested a future update on this area at a future meeting. **Action: Secretariat** The Committee was informed of the current challenges within the Stroke pathway and how this linked to system pressures on the Urgent Care pathway, which is mirrored across NHS Wales. Quality metrics were discussed; over the past 6 months, patients arriving in the Emergency Department (ED) with suspected stroke, having a CT scan within the first hour has been at 50%. This was partly explained by a very congested ED. Patients with confirmed stroke being admitted to a Stroke Unit within 4 hours remained low, 14% in February 2022, with a similar performance of 17.6% across Wales. In February 2022, the Health Board recovered its 'best in Wales' performance, with 93% of patients assessed by a Stroke Consultant within 24 hours, in comparison to an All-Wales average of 73%. The proportion of patients assessed by a therapist within 24 hours has improved from 28.6% in January 2022 to 53.55 in February 2022. The lack of capacity within the Hyper Acute Stroke Unit (HASU) was largely attributed to system pressures and the need for HASU beds to be used to accommodate non-stroke patients. The unavailability of this assessment facility influenced to ability to undertake the required level of therapy assessment for stroke patients. The Stroke Directorate were working alongside 'Getting It Right First Time', who were conducting an external review. Recommendations from this exercise will support the Health Board in improving future Stroke services. This review was ongoing and overseen by the Stroke Recovery Group.

	The Committee was informed that the Urgent Care system remained under sustained and continued pressure. Urgent Care performance was flagged as a national issue, with the Health Board implementing a recent 'two-week reset' to mitigate risk, alongside all Health Boards. The impact of the reset was being completed and an update would be presented to Board. Contextual issues impacting urgent care were summarised for the Committee. The system pressures had resulted in detrimental impact on patient experience, with some patient safety risks with long delays for ambulance handovers and long waits in the ED, together with delayed ambulance response times in the community. Patient experience relating to waiting times had been highlighted by the CHC, HIW and social media feedback, with most of the feedback praising the professionalism of staff and the Health Boards ability to provide continued dignified care. Committee members had previously requested information around the numbers of inappropriate attendances to ED and Minor Injury Units; this was included within the report. Concerns were outlined in the report. The following points were discussed: • 491 complaints had been received during January and February 2022. The top themes were noted as clinical treatment, appointments, and communication. • There were 32 Public Service Ombudsman for Wales cases open at the time of the meeting. • Patient Safety Incidents - there had been 40 classified as serious incidents during Jan-Feb 2022, inpatient falls being the highest category. • No 'Never Events' were recorded for Jan-Feb 2022. However, some 'Never Events' have been identified in March. The Committee were assured that Clinical Executives were meeting to discuss key themes and determine actions to mitigate further risk. The Heath Board had received three reports from the Community Health Council (CHC), as outlined in the report. A key theme flagged in each report was nutrition, this will be included in the Health Boards' nutrition review. The Committee noted the outcome of an Internal Audit report relating to the management of the Mental Capacity Act, which secured a reasonable assurance rating. From this report, a number of actions were to be taken forward by the Health Board and further work was required, aligning with the new Liberty Protection Safeguarding Standards, currently out for consultation as well as the Dementia agenda.

	Paul Deneen, Independent Member, queried the inability to use the Therapies room for stroke services and its availability for stroke patients. Rhiannon Jones informed members that the Executive Team are in full support that the Stroke Therapies Room should be used to deliver stroke patient care. However, due to system pressures and demands, there is a 'Hospital Full' protocol in place that enables the use of identified areas to accommodate patient demand and facilitate additional capacity. All areas identified in the Health Boards 'Hospital Full' protocol have been risk assessed for patient placement. The Stroke Programme Board are reviewing options to identify alternative temporary rooms during increased demand and capacity to mitigate this risk. Shelley Bosson, Independent Member, requested a conversation outside of the meeting to further understand the Stroke Pathway **Action: Peter Carr to contact Shelley Bosson** Committee members discussed the terminology 'self-presenter' and 'inappropriate attender' and queried the possibility of a different use of language. Rhiannon Jones informed the Committee that the terminology is a coding category and recognised descriptor but that for the purposes of the Outcomes Report alternative language could be explored. Committee members requested the following changes to the report: • For the RAG rating - include arrows to illustrate improvement status. • A table at the back of the report describing acronyms, to avoid repetition in the main document. **Action: Clinical Executives** The Chair thanked Rhiannon Jones for the overview and the Committee noted the high risks and actions being taken to mitigate the position. The Urgent Care pressure is the subject of an in-committee discussion.
PQSO 0504/12	**Patient Safety, Quality and Outcomes Committee Risk Report** Rani Mallison, Director of Corporate Governance, presented the previously circulated risk report to the Committee. The Committee were advised that the report included risks that had recently been reported to the Board as part of the Corporate Risk Register. The report was used to inform the Committee agenda.

	The risk report would continue to inform the Committee workplan and priorities going forward.
PQSO 0504/13	**Assurance Report: Access to Primary Care Services** Chris O'Connor, Interim Executive Director of Primary Care, Community and Mental Health, supported by Victoria Taylor, Head of Primary Care, provided an update of progress following the initial presentation in September 2021 of the review of Access Arrangements in General Medical Services (GMS) undertaken in June 2021. The Health Board undertook an in-depth review of Access arrangements across all 72 GP practices, to determine the impact of new ways of working in response to the pandemic, and to seek assurance in respect of access to services for patients, an issue raised by the Community Health Council. A further review of the initial report was undertaken and identified three key areas for improvement; these were face to face consultations, number of clinical sessions available and availability of telephone lines to contact GP surgeries. The actions taken by the Health Board since the initial review and next steps, as outlined in the report, were discussed. Victoria Taylor informed the Committee that funding received through Restart & Recovery supported the backlog of appointments and improvement in capacity due to address increased demand. Paul Deneen, Independent member, queried if the required access was available in areas of deprivation. Victoria Taylor informed the Committee that of three of the practices identified in the review that fall into a deprived catchment area, one practice identified access issues based upon workforce and recruitment issues however this has since been resolved. A Primary Care Sustainability Framework is in place to support practices with recruitment issues and the Primary Care Team were looking to repeat the Sustainability Review, alongside the continuation of the GMS Access review. Chris O'Connor informed the Committee that challenges around workforce availability were an ongoing issue in Primary Care and further work, alongside clinicians, was needed to strengthen and develop the Primary Care multi-disciplinary team. Development of the Neighbourhood Care Networks and Accelerated Cluster Developments would further support the improvement of Primary Care. Shelley Bosson, Independent Member, discussed the Community Health Council (CHC) patient surveys and requested that there was an option to include the name of the GP surgery, which may help identify any areas needing further support. Victoria Taylor informed members that the previous Welsh Access Standards set out a requirement for

	practices to undertake individual patient surveys. This was suspended during Covid but will resume. The Health Board will repeat the exercise to continue to actively monitor and support GMS access in line with contractual requirements. The Committee received the report for assurance and thanked Chris O'Connor and Victoria Taylor for the work and improvements.
3	**Items to be Received for Information**
PQSO 0504/14	**Highlight Assurance Reports:** **a) Quality, Patient Safety and Outcomes Group** Report received for assurance. **b) Children's Rights & Participation Forum** Report received for assurance. The Committee supported the request for a Board Development session. **c) Welsh Health Specialised Services Committee (WHSSC) Quality & Patient Safety Committee Chair's Report** Report received for assurance.
PQSO 0504/15	**Transition and handover- Children's and Adults Health Care Services** Letter noted by the Committee.
PQSO 0504/16	**Investigating and Learning from Cases of Nosocomial Covid-19** Report received by the Committee, noting a detailed update on the ABUHB approach would be presented at a future Committee.
PQSO 0504/17	**Internal Audit Reports:** **a) GUH Quality Assurance Report** **b) Falls Management Report** The above reports were to be discussed further at the upcoming Audit Risk and Assurance Committee.
PQSO 0504/18	**Committee Terms of Reference** Committee Terms of reference were previously approved by the Board.
4	**Other Matters**
PQSO 0504/19	**To Confirm any Key Risks and Issues for Reporting/Escalation to Board and/or other Committees**

	The continued pressures in Urgent Care, noting a paper was being prepared for the Board in May 2022.
5	**Date of Next Meeting is Tuesday 7th June 2022 at 09:30 via Microsoft Teams**

Patient Quality, Safety & Outcomes Committee

Action Log - June 2022

Agreed Actions:

Overdue	Not yet due	Due	Transferred	Complete

Action Ref	Action Description	Due	Lead	Progress at 07 June 2022	Status
1304/05	A Matrix of Committee Duties to come to a future meeting (1102/17)	April 2022	**Director of Corporate Governance**	At its meeting in March 2022, the Board approved a revised committee structure which included terms of reference and committee assurance map. This action is therefore deemed closed.	Complete
1910/13	**Annual Assurance Report on Health & Care Standards: Nutrition and Hydration**		**Director of Therapies & HS / Secretariat**	Updated document shared with Committee members. (Secretariat on behalf of Peter Carr)	Complete

Action Ref	Action Description	Due	Lead	Progress at 07 June 2022	Status
	Update the Equality Impact Assessment and recirculate the paper				
	An update inclusive of a map of where the facilities are to be received following the review	July 2022	**Director of Therapies & HS / Secretariat**	**21/12/21** Catering Review: Peter Carr informed the Committee that meetings had taken place with facilities with the view to start immediately. There was an expectation that the duration of the Health Board wide review would be 6 months with the plan to present findings to the Executive Team in Summer 2022.	Not yet due
2112/04	**Annual Assurance Report on Health & Care Standards: Nutrition and Hydration** **Shelley Bosson requested the following be added as an action (PQSOC 1910/13)** Peter Carr informed members that the Health Board is not meeting NICE best practice model regarding a dedicated nutritional	**TBC**	**Director of Therapies & HS**	**21/12/21** Peter Carr updated the Committee that the Divisions were working on the Nutrition Standards paper, and this would be presented to the Executive Team, with an update to the Committee to follow. **30/5/2022** Peter Carr to seek an update from the Division.	In progress

Action Ref	Action Description	Due	Lead	Progress at 07 June 2022	Status
	support team to include specialist nurses. A business case for a dedicated nutritional support team is being developed and would be presented to the Executive Team for consideration, with an update to the Committee.				
2112/07	**Minor Injuries Units eLGHs** The Chair requested further information on patient transfers and any challenges to come back to a future meeting.		**Director of Nursing/ Medical Director**	Information on Urgent Care recruitment and improved staffing numbers has been shared with Independent Members by Rhiannon Jones outside of the meeting. The recruitment picture is very positive.	Complete
2112/13	**WCCIS Implementation** A strategic review was underway by WG of WCCIS national programme. The results of the report will influence how the Health	Feb 2022	**Director of Corporate Governance**	A Board Briefing paper on WCCIS, including the Strategic Review, was issued to members by email on 3rd May 2022. This action is therefore deemed closed.	Complete

Action Ref	Action Description	Due	Lead	Progress at 07 June 2022	Status
	Board utilises the system. A draft report would be completed by WG in January 2022. Draft report to be shared with Independent Members once published				
0802/09	**Patient Safety, Quality and Outcomes Committee Risk Report** Shelley Bosson requested that the threat cause of the risk *Inadequate surge capacity to meet surge demand, pg.66* be reviewed to ensure the threat cause of *Increase in pandemic levels* was still relevant. **Action:** Board Secretary to look into request.		**Director of Corporate Governance**	This risk has been reframed and the committee will receive the updated risk as part of its strategic risk paper for the next meeting. This action is therefore deemed closed.	Complete
PQSO 0504/06	**Assurance Report: National Clinical Audit and Local Clinical Audit Arrangements** The Health Board was currently undertaking a review based on recent	**June 2022**	**Director of Nursing**	Included on the Committee's agenda for 7th June 2022 – agenda item 2.6 This action is therefore deemed closed.	Complete

Action Ref	Action Description	Due	Lead	Progress at 07 June 2022	Status
	findings and recommendations from the Ockenden Review regarding Maternity Services at Shrewsbury & Telford NHS Trust. A report will be added to a future agenda for PQSOC **Action:** Maternity Overview to come back to a future Committee.				
PQSO 0504/06.2	**Assurance Report: National Clinical Audit and Local Clinical Audit Arrangements** The Chair requested yearly reviews of high-risk areas, including Maternity and Mental Health Services. **Action:** To be added to Committee Forward Work Programme.		**Secretariat**	Added to Forward Work Plan	Complete
PQSO 0504/06.3	**Assurance Report: National Clinical Audit and Local Clinical Audit Arrangements** In terms of Mental Health services, what are the	**TBC**	**Medical Director**	To be scheduled for a future agenda. Date TBC	In Progress

Action Ref	Action Description	Due	Lead	Progress at 07 June 2022	Status
	Health Board plans to support Children and Young adults with psychosis. **Action:** A detailed response to identified gaps in the Psychosis Audit to come back to a future meeting.				
PQSO 0504/06.4	**Assurance Report: National Clinical Audit and Local Clinical Audit Arrangements** Divisions would be developing measurable, local audit plans with the support of the newly purchased AMAT software. **Action:** The Chair requested that a high-level overview of the Health Boards Local Clinical Audit plan to come back to the Committee.	TBC	**Medical Director**	To be scheduled for a future agenda. Date TBC	In Progress
PQSO 0504/08	**Dementia Standards Update, including a patient story**		**Director of Nursing**	The Director of Corporate Governance shared the standards with Board Members via email.	Complete

Action Ref	Action Description	Due	Lead	Progress at 07 June 2022	Status
	ABUHB has revised its Regional Dementia Action Plan to embed the new standards. 100 standards had been condensed to 20, containing four main themes. **Action:** A document outlining standards to be shared with Committee Members.				
PQSO 0504/10	**Healthcare Inspectorate Wales: Inspections Update** The Committee was informed that the awaited Grange University Hospital (GUH) report had been published by HIW, week commencing 28th March 2022, which will be presented to the next PQSOC.	**June 2022**	**Director of Nursing**	Received by Committee in April 2022.	Complete
PQSO 0504/10.2	**Healthcare Inspectorate Wales: Inspections Update** The Chair suggested amending the tracker to		**Director of Nursing**	Action complete.	Complete

Action Ref	Action Description	Due	Lead	Progress at 07 June 2022	Status
	include due dates for outstanding actions.				
PQSO 0504/11	**Patient Quality and Safety Outcomes Report** In response to increased death from suicide in children and young people, a Self-Harm and Suicide Prevention Task and Finish Group has established by the Health Board, aligning to a national piece work being undertaken due to an increase in the number of suicides in children and young people during the Covid period. The Committee requested a future update on this area at a future meeting.		**Secretariat**	Added to Forward Work Plan	Complete
PQSO 0504/11.2	**Patient Quality and Safety Outcomes Report** Shelley Bosson, Independent Member, requested a conversation outside of the meeting to further understand the Stroke Pathway.		**Director of Therapies & HS**	Meeting scheduled between Peter Carr and Shelley Bosson for 13th June 2022.	Complete

Action Ref	Action Description	Due	Lead	Progress at 07 June 2022	Status
PQSO 0504/11.3	**Patient Quality and Safety Outcomes Report** Committee members requested the following changes to the report: For the RAG rating - include arrows to illustrate improvement status. A table at the back of the report describing acronyms, to avoid repetition in the main document.		**Clinical Executives**	Action complete.	Complete

Committee:	Patient Quality, Safety & Outcomes Committee
Date:	7 June 2022
Agenda Item:	2.1
Document Title:	Audit Wales: Review of Quality Governance Arrangements – Aneurin Bevan University Health Board (May 2022)

Aneurin Bevan University Health Board

Patient Quality, Safety and Outcomes Committee

Audit Wales: Review of Quality Governance Arrangements

Summary

Audit Wales has undertaken a review of the organisations' governance arrangements that support the delivery of high quality, safe and effective services focusing on the operational and corporate approach to quality governance from 'floor to board', with a specific review of General Surgery.

The review was conducted between June and October 2021, with the final report published in May 2022.

8 recommendations have been made by Audit Wales for which ABUHB has submitted a management response, which can be found in Appendix 1 of the main report.

Purpose: **Patient Quality, Safety and Outcomes Committee is asked to:**	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	

Author: Rhiannon Jones – Executive Director of Nursing

Report Received consideration and supported by:

Executive Team	X	**Sub-Committee**	

Date of the Report: 24 May 2022

Supplementary Papers Attached:

- Audit Wales Final Report

Background

Quality should be at the heart of all aspects of health care and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales. Poor quality care can be costly in terms of harm, waste and variation and sound governance plays a fundamental part in ensuring the delivery of high quality health care. It is important that NHS Boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality, not least in response to Covid-19.

Assessment

The key message following the comprehensive review is that the Health Board has clearly articulated the corporate arrangements for quality governance and its key areas of focus for quality and safety but there are some identified weaknesses at Division and Directorate level impacting on flows of assurance from floor to board.

The audit has covered the following areas:

- Risk Management
- Clinical Audit
- Values and Behaviours
- Patient Experience
- Putting Things Right
- Quality and Safety Framework
- Resources to support quality governance
- Coverage of quality and safety matters

From a corporate perspective there is acknowledgement that the Patient Quality, Safety and Outcomes Committee is stronger with greater breadth and depth of reporting together with good scrutiny and challenge. The improvements in Putting Things Right policy compliance is recognised as is the enhanced Clinical Audit arrangements but the need to improve how the organisation captures patient experience is identified. In terms of the Scheduled Care Division and Surgical Directorate there is an identified need to improve the scrutiny of patient quality and safety at Leadership Team meetings, with a standardised agenda and clear metrics. In addition, the need to feedback to staff regarding the outcome of patient reviews and concerns requires strengthening and a recommendation is also made regarding the capacity of staff and champions to undertake their role effectively.

The following provides a summary of the key recommendations:

- Risk Management – strengthen the maintenance and oversight of the Divisional Risk Register;
- Clinical Audit – complete work on the organisational clinical audit strategy, policy and plan;
- Values and Behaviours – undertake work to understand why some staff feel they are not treated fairly or given feedback when reporting errors/near-misses or incidents;
- Patient Experience – ensure there are systematic arrangements for collating and acting upon patient experience;
- Putting Things Right – ensure the policy is rapidly reviewed and updated;
- Quality and Safety Framework – complete a review of the Quality Assurance Framework and ensure coverage of operational flows;
- Resources to support governance – undertake an assessment of resources in place for quality and safety across Divisions and determine the capacity of staff to undertake their role effectively;
- Coverage of quality and safety matters – ensure operational meetings provide coverage for quality and safety alongside finance and performance.

The management actions have implementation dates from May to October 2022, with ownership amongst the Clinical Executives.

Conclusion

Audit Wales are thanked for the review and comprehensive report, which has been received at the Executive Team. Our assessment is that it is a reasonable report which provides some assurance whilst identifying areas for improvement, to strengthen floor to board reporting and assurance flows.

A summary of progress against actions will be provided for the Committee at its October 2022 meeting.

Recommendations:

The Patient Quality, Safety and Outcomes Committee is asked to:

- **NOTE** the final report of the review of quality governance arrangements in Aneurin Bevan University Health Board.
- **RECIEVE** the summary and action plan for assurance.
- **NOTE** the plan to provide an update on progress in October 2022.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring, recommendations and actions within this report will provide a mechanism for strengthened assurance
Financial Assessment, including Value for Money	Direct or indirect impact on finance.
Quality, Safety and Patient Experience Assessment	This report highlights key learning to improve the safety and quality of care provided.
Equality and Diversity Impact Assessment (including child impact assessment)	Not applicable for the purpose of this summary report
Health and Care Standards	This report provides information around standards 1.1, 2.1, 3.1,3.2, 3.3, 3.5, 4.1, 4.2, 6.1, 6.3 and 7.1
Link to Integrated Medium Term Plan/Corporate Objectives	Aligned to all IMTP Priorities through the life course.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –**Improving the quality and safety of the services will help meet the long term needs of the population and the organisation
	Integration – The quality and patient safety improvements described work across directorates and divisions
	Involvement –Improvement initiatives are developed using feedback from staff.
	Collaboration – The quality and patient safety described work across directorates, Divisions and Health Board.
	Prevention – Improving patient safety will prevent patient harm within our services and improve public confidence.
Glossary of Terms	
Public Interest	Written in the public interest

Archwilio Cymru
Audit Wales

Review of Quality Governance Arrangements – Aneurin Bevan University Health Board

Audit year: 2019

Date issued: May 2022

Document reference: 2861A2022

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Contents

Summary report

About this report

1 Quality should be at the 'heart' of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these 'quality governance' arrangements is to help organisations and their staff both monitor and where necessary improve standards of care.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users. The Act comes into effect in 2023.

3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.

4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the COVID-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at Aneurin Bevan University Health Board (the Health Board carried out between June and October 2021. To test the 'floor to board' perspective, we examined the arrangements for general surgical services.

Key messages

6 Overall, we found that **the Health Board has clearly articulated the corporate arrangements for quality governance and its key areas of focus for quality and safety. However, there remain weaknesses at a divisional and directorate level which could impact the flow of assurance from floor to board.**

7 The Health Board has articulated its annual key areas of focus for quality and safety and there are reasonable corporate and divisional arrangements for monitoring risk with good scrutiny and challenge by the Patient Quality, Safety and Outcomes committee on quality and safety risks it has been assigned. Arrangements for monitoring mortality and morbidity and national clinical audit are developing and performance in relation to responding to complaints, and arrangements for learning lessons are improving. The Health Board has a well-established values and behaviours framework, it encourages staff to raise concerns and there is collective responsibility for quality and safety amongst Executive Leadership. Corporate quality and safety structures and processes are clearly articulated and arrangements for monitoring quality and safety information are improving.

8 However, we found some gaps in flows of assurance on healthcare standards between operational and corporate structures. This indicates a need to ensure that the quality assurance framework provides clarity around how a 'floor to board' quality and safety assurance system operates in practice. There is also a need to review the extent that operational staff and management have sufficient capacity to effectively support quality governance. At a corporate level, the Patient Quality, Safety and Outcomes committee provides limited scrutiny on risks that have a clear quality and safety impact but are assigned to other committees. At a directorate level, arrangements for monitoring and reporting on key areas of focus for quality and safety are yet to be finalised and the monitoring and escalation of risk is not always effective. Whilst there are dedicated resources for quality improvement, the capacity of the team has decreased and was further affected by COVID-19. The arrangements for Health Board-wide and local clinical audit also require improvement. The Health Boards Putting Things Right policy is out-of-date and needs reviewing. There are opportunities for the Health Board to improve how it captures and learns from patient experience in respect of services it provides and services it commissions from other providers and more to do to ensure that staff feel comfortable to report concerns, and they receive feedback on actions taken.

Recommendations

9 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

Recommendations
Risk management R1 Divisional risks are presented to Quality and Patient Safety Operational Group, but there was limited evidence of in-depth analysis and discussion. There is also limited evidence that the General Surgery directorate maintain risk registers that adequately identify quality and safety risks and mitigating actions. The Health Board should: • ensure there is appropriate scrutiny, challenge, cross divisional discussion and sharing of good practice around divisional risks at the Quality and Patient Safety Operational Group. • ensure that risk registers are completed and maintained across all directorates that identify quality and safety risks and mitigating actions and there are appropriate risk escalation arrangements.
Clinical audit R2 During our review, the Health Board was updating its clinical audit strategy and policy and developing a standalone clinical audit plan. The Health Board's Clinical Effectiveness and Standards group terms of reference were in draft and contained out-of-date information. At an operational level, clinical audit capacity is limited and systems to share learning and good practice are not embedded or systematic. The Health Board should: • complete the work on its clinical audit strategy, policy, and plan. The plan should cover mandated national audits, corporate-wide and local audits informed by areas of risk. This plan should be approved by the Patient Quality, Safety and Outcomes Committee and progress of its delivery monitored routinely. • update and finalise the terms of reference for the Clinical Effectiveness and Standards Committee. • ensure there is sufficient resource and capacity for clinical audit at an operational level. • ensure systems for learning and good practice from clinical audit are embedded across the organisation.

Recommendations

Values and behaviours

R3 The Health Board has a well-established values and behaviours framework which sets out its vision for a quality and patient safety focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns and the action taken by the Health Board to address them. The Health Board should undertake work to understand why some staff feel:

- they are not treated fairly or given feedback when reporting errors, near misses or incidents.
- that the Health Board does not act on concerns they raise or take action to minimise future of occurrence errors, near misses or incidents.

Patient experience

R4 Whilst the Health Board uses a range of methods to capture patient experience information, regular patient feedback updates are not always provided to work areas or departments and arrangements are not systematic across the organisation or the services it commissions. The Health Board should:

- undertake work to understand why patient feedback updates are not regularly provided to work areas or departments.
- ensure there are systematic arrangements for collating and action upon patient experience information across the organisation and the services it commissions.

Putting Things Right

R5 The Health Boards Putting Things Right Policy was due to be reviewed in 2018 and contains out of date information. The Health Board should review and update the Putting Things Right Policy as a priority.

Quality and safety framework

R6 The Health Boards quality assurance framework includes a range of committees and groups aligned to Health and Care Standards. The framework is assisting the Health Board in identifying areas which previously had not provided assurance. However, there are still gaps in the flows of assurance from some sub-groups and in relation to elements of the Health and Care Standards. Whilst the framework is reasonably comprehensive at a corporate level, it doesn't fully articulate the operational structure and processes for quality and safety. The Health Board should:

Recommendations

- complete its review of the quality and safety framework to ensure that flows of assurance are appropriate, and that the framework functions as intended.
- articulate the operational structures and processes for quality and safety within the quality assurance framework and how they align with the corporate structure to provide 'floor to board' assurance.

Resources to support quality governance

R7 The Scheduled Care division and General Surgery directorate have designated leads for many keys aspects of quality and safety. However, we found that some designated leads do not have protected time for these roles. The Health Board should ensure operational staff have sufficient time and capacity to effectively fulfil these roles.

Coverage of quality and safety matters

R8 The General Surgery directorate has recently established its own patient safety and quality group. However, the group does not have a terms of reference, standardised agenda, or report templates and minutes of meetings are not taken. Whilst quality and safety did feature in bi-annual reviews with the Executive Team and monthly assurance meetings with the Director of Operations. We note the monthly assurance meetings stopped in March 2021. We found limited focus on quality and safety at Scheduled Care Divisional Management Team meetings. The Health Board should:

- review the operational patient safety and quality groups to ensure they are effectively supporting the Health Boards quality governance arrangements.
- ensure that other operational meetings / forums provide sufficient focus on quality and safety alongside finance, performance, and operational matters.

Detailed report

Organisational strategy for quality and patient safety

10 Our work considered the extent to which there are clearly defined priorities for quality and patient safety and effective mitigation of the risks to achieving them.

11 We found that **the Health Board has articulated its annual quality and safety priorities, but it needs to improve how it monitors the delivery of these. Quality risks are appropriately managed at corporate and divisional levels but requires strengthening at directorate levels.**

Quality and patient safety priorities

12 **The Health Board has articulated its annual quality and safety priorities but there needs to be better alignment between operational quality priorities to the strategic quality aims. Monitoring and reporting on the delivery of those priorities need strengthening.**

13 The Health Board has articulated its approach to quality and safety through its Integrated Medium-Term Plan (IMTP) 2019-20 to 2021-22, Annual Plan 2021-22, and Quality Assurance Framework 2020-23. The Health Board's Annual Plan 2021-22 outlines its commitment to ensure that every individual 'has a positive experience'. To achieve this, the Experience, Quality and Safety element of the Annual Plan incorporates five key aims which replace the previous IMTP's quality priorities:

- enabling a safety culture
- a learning organisation
- a just culture
- data for quality and improvement
- a safe environment.

14 As part of its corporate planning cycle, the Health Board engages external partners, including the Community Health Council on priorities and challenges. Our discussions with staff suggest limited involvement from operational areas to help shape the Experience, Quality and Safety element of the plan.

15 The Health Board's delivery actions are designed to support achievement of its five quality aims. These delivery actions, however, lack clear target dates or milestones. Furthermore, there is no monitoring and reporting framework in place. We also found limited scrutiny and assurance by the Board and Patient Quality, Safety and Outcomes Committee (PQSO committee) on the key areas of delivery. This creates a risk that the committee might not be sighted on aspects where quality delivery aims aren't achieved or where progress is limited. Our 2021 Structured Assessment report also highlights weaknesses and made a

recommendation on the Health Board's arrangements for monitoring progress on the 2021-22 Annual Plan[1].

16 Both the General Surgery directorate and Scheduled Care division identify quality and patient safety priorities and monitor progress. The directorate and division revised their priorities in response to COVID-19. However, they haven't aligned their operational priorities with the Health Board's key delivery actions for quality and safety outlined in its Annual Plan for 2021-22.

Risk management

17 **The Health Board has defined its risk appetite for patient safety and experience and regularly reviews risks at Board, committee, and divisional levels. However, directorate level risk management arrangements need strengthening.**

18 The Health Board revised its risk management strategy, approach, and Board Assurance Framework (BAF) during 2021. This provides a greater focus on risk escalation and how it assists in achieving the Health Board's strategic objectives. It also places additional responsibility on operational areas to take greater ownership for managing risks to the delivery of local objectives.

19 The Health Board has defined its risk appetite and tolerance for patient safety and patient and experience as level 1 indicating a low risk appetite in this area. Ten of the twelve principal risks to the Health Board relate to quality and patient safety. Quality risks in the BAF and corporate risk register are appropriately assigned to the PQSO committee designated lead Executive Director.

20 Our observations of the PQSO committee indicates good discussion and scrutiny on the quality and safety risks. The Health Board's Quality and Patient Safety Operational group is a key forum in the quality and safety assurance framework. It provides assurance and advice to the PQSO committee and coordinates the management of quality risks across the organisation. Risk is a standing item on the group's agenda. This provides a platform for each division to escalate their highest risks and concerns in relation to quality and safety. In practice however, our review found limited scrutiny, challenge, cross divisional discussion or sharing of good practice around the risks discussed.

21 At an operational level, the Health Board's Scheduled Care division maintains and actively manages its divisional risk register. Quality and safety risks at this level are clearly articulated and scored with appropriate controls and risk owners identified. However, our work found gaps in the risk management arrangements at directorate level. A risk register for the general surgery directorate was not available for review during our fieldwork. Discussions with staff suggest that completion of directorate risk registers is inconsistent. This may impact on the quality of the divisional risk

[1] audit.wales/sites/default/files/publications/aneurin_bevan_health_board_structured_assessment_2021_english_0.pdf

register because it is reliant on risks escalated from the directorate level. We understand that the Scheduled Care division has recently established a quarterly meeting to review directorate risks, to improve the quality of these arrangements (**Recommendation 1).**

Organisational culture and quality improvement

22 NHS organisations should be focused on continually improving the quality of care and using finite resources to achieve better outcomes and experiences for patients and service users. Our work considered the extent to which the Health Board is promoting a quality and patient-safety-focused culture, compliance with statutory and mandatory training and wider quality improvement processes.

23 We found that **the Health Board has maintained a reasonable focus on quality improvement over the course of the pandemic. However, there are a number of areas that should be strengthened including clinical audit, addressing staff concerns and approaches for capturing and sharing patient experience.**

Quality improvement

24 **The Health Board's dedicated Quality Improvement team capacity has decreased over the past three years, being further affected by COVID-19. The Health Board has worked hard to develop its arrangements for monitoring mortality and morbidity and national clinical audit. However, local, and corporate clinical audit programmes require improvement.**

Resources to support quality improvement

25 The Health Board's Aneurin Bevan Continuous Improvement team (ABCi) currently consists of 9.79 whole time equivalent (WTE) staff (12 headcount). But compared to three years ago, resources have been reduced. The pandemic further impacted the capacity of the ABCi team with some staff redeployed to other roles within the Health Board.

26 The ABCi team provides training and support to operational teams. The pandemic is limiting usual training activity, but the team has continued to deliver in virtual settings where possible. The team deliver a range of quality improvement, analytics, modelling, and leadership training, such as 'Pocket Quality Improvement' and 'PocED Quality Improvement'. The IQT training has been superseded by the Improvement Cymru Improvement Practitioner Programme. Over the past three years however, the Health Board has provided an alternative to the bronze and silver IQT. The latest Health Board figures show that 4.7% of staff to have completed its IQT equivalent training.

Clinical Audit

27 Clinical audit is an important way of providing assurance about the quality and safety of services. At the time of our review the Health Board was updating its Clinical Audit Strategy and Policy. This will include requirements for divisions to develop their own clinical audit plans upon which a Health Board clinical audit plan will be based. At present though the clinical audit plan is not in place.

28 Positively, the Health Board has continued to deliver all mandated national clinical audits and provide regular progress updates to the PQSO committee. These updates identify learning and actions to be taken to address issues arising from the reviews. The Health Board's Medical Directors Support team (MDS team) comprises of 7 WTE (9 headcount) staff. The team supports divisions and directorates, by facilitating data collection, on national clinical audit, outcome reviews and local clinical audit. The team also support divisions with their development of data outputs, presentations, and improvement plans.
These improvement plans are then overseen by the Clinical Effectiveness and Standards Group. The Health Board is currently reviewing the effectiveness of its MDS team to maximise the support it provides to operational areas.

29 Arrangements to support sharing of clinical audit learning and good practice at an operational level are not yet effectively embedded or systematic. We also identified limited operational clinical audit resources to undertake corporate and local clinical audit work effectively and consistently.

30 In January 2020, the Health Board established the bi-monthly Clinical Effectiveness and Standards Group (CES group). This group provides a forum for senior clinicians to monitor outcome data relating to clinical effectiveness, patient safety and to monitor national and Health Board wide clinical audit activity.
The CES group's multi-disciplinary membership includes all divisions and is chaired by the Assistant Medical Director for Clinical Effectiveness. However, the pandemic has meant this group has been unable to meet as planned and there is variable participation. At the meeting we observed, there were no representatives from Scheduled or Unscheduled Care.

31 In addition, at the time of our review the CES group terms of reference were draft and there was some confusion about which version was in use. We were also informed that some elements required updating to reflect changes to the group's remit **(Recommendation 2).** CES group meeting agendas are well-structured with good presentations focussing on national clinical audits and other quality and safety related issues. There are discussions on some agenda items that lead to a focus on actions and solutions to address issues. However, there are opportunities to strengthen this further by encouraging this 'actions focussed' practice across all agenda items. Where actions are identified, it is unclear if the CES group regularly seeks further assurance from divisions to understand if the actions are delivered and sustained.

Mortality and morbidity reviews

32 Mortality and morbidity meetings provide a systematic approach for peer review of adverse events, complications, or mortality to learn from and improve patient care. In November 2020, universal mortality reviews were superseded by the Medical Examiner function. The Health Board anticipates that by May 2022, all inpatient and community deaths will be subject to Medical Examiner scrutiny.

33 The Health Board established a Mortality Review Screening panel in July 2021. This has multi-disciplinary and cross-division representation. The panel considers the need for further investigation to Medical Examiner referrals. If needed, the panel determines an investigation terms of reference and appoints an investigating officer. The panel reports investigation outcomes to the Health Board's Mortality Review Group and has recently published its first bi-annual Learning from Death report.

34 Shared learning is a crucial element of the five levels of mortality management. The Health Board's Learning from Death report demonstrates how the organisation is learning and improving its arrangements following investigation.
The improvements in prevention of COVID-19 nosocomial infection using a Rapid Assessment Tool provides a good example of this. Other learning following investigations include lessons from inter-site transfers, steroid prescribing, and advanced care planning. The Learning from Death report identifies communication as a commonly recurring theme and outlines several improvement actions. The Health Board now intends to introduce a systematic process for reporting outcomes of mortality and morbidity reviews to different Health Board forums.

35 The Health Board is planning on developing a Learning from Death Framework during 2022. This will bring together information from numerous sources including inquests, mortality and morbidity reviews, Putting Things Right complaints processes, and Medical Examiner scrutiny. It will focus on outcomes and improvements and further strengthen the assurance provided to PQSO committee.

36 Together, the Mortality Review Group, CES group and Deteriorating Patient and Resuscitation Group prepare a joint annual report. The aim of this is to provide collective assurance to the Quality and Patient Safety Operational group and PQSO committee on the arrangements for safe and clinically effective care.
Our review of the report found it to provide sufficient information for assurance and decision-making, demonstrating levels of compliance with healthcare standards and improvement actions for the next 12 months.

Values and behaviours

37 **While there is a well-established values and behaviours framework, the Health Board needs to ensure that staff feel listened to when they report errors or concerns.**

38 The Health Board's values and behaviours framework sets out its vision of a quality and patient-safety-focussed culture. It focuses on continuous improvement, openness, transparency and learning when things go wrong. Values and behaviours are embedded in workforce processes, such as recruitment, induction and performance appraisal and development reviews. They are also regularly publicised and referenced during meetings.

39 Our work revealed a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns. We undertook a survey of operational staff working across the Scheduled Care Division[2] (see results in **Appendix 2).** Of those responding, we found that 58 out of 83 staff agreed or strongly agreed that the organisation encourages staff to report errors, near misses or incidents. However, 39 out of 83 staff agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly by the organisation (**Recommendation 3**).

40 The most recent NHS Wales Staff Survey[3] showed a minority but significant proportion of concerns relating to bullying, harassment, or abuse over the past year (16.6%, 15.2% and 9.6% respectively). Fewer than half agreed or strongly agreed that the organisation takes effective action if staff are bullied or harassed by members of staff or a member of the public (42.2%).

41 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. November 2021 figures show a 76%[4] overall organisation compliance with mandatory training requirements. This level has remained consistent since November 2020. Our survey of staff in the Scheduled Care division found that 42 out of 83 staff disagreed or strongly disagreed that they have enough time at work to complete any statutory and mandatory training.
The Scheduled Care division and General Surgery directorate have indicated that they are developing plans to ensure staff have access to training and time to

[2] We invited operational staff working across the Scheduled Care division to take part in our online attitude survey about quality and patient safety arrangements. The Health Board publicised the survey on our behalf. We had a response rate of 83 staff. Although the findings are unlikely to be representative of the views of all staff across the Scheduled Care division, we have used them to illustrate particular issues.

[3] The NHS Wales staff survey ran during February 2021 at the same time as the second surge in COVID-19 transmission and rising numbers of hospital admissions. The survey response rate was 19%, compared to an all-Wales average of 20%.

[4] The Health Board is required to report compliance to the Welsh Government on a monthly basis. The target for compliance for all health boards is 85%.

complete online modules. Despite this, the Health Board remains concerned and is establishing a working group to further support mandatory training compliance.

42 Performance appraisal and development reviews aim to help staff understand what is expected of them and take responsibility of their own performance and development. Against a national target of 85%, the Health Board's compliance rate for appraisals in November 2021 was 59%. This is also broadly consistent with the compliance rate reported by the Scheduled Care division during our fieldwork of 50%. The Health Board is seeking to improve through its PADR strategic meetings and shared learning. The pressure on services may continue to affect PADR rates for some time.

Listening and learning from feedback

43 **Building on the lessons learnt from the pandemic, the Health Board now needs to reinvigorate its efforts to capture and learn from patient experience, staff feedback and independent review.**

Patient experience

44 Information on patient experience can provide a valuable insight into the quality of services received. Our work has found that the arrangements for obtaining feedback have been impacted by the pandemic.

45 It has not been possible for the Health Board's Person-Centred Care team to support divisions in capturing patient experience in the same way they would have prior to the pandemic. The Health Board has instead relied on patient experience surveys and third-party feedback. In August 2020, 96 patients provided feedback through a pilot scheme. While small in terms of numbers contacted, this innovative scheme enabled virtual inpatient 'buddying', where two members of the Person-Centred Care team would attend wards and connect patients to Community Health Council officers.

46 The Scheduled Care division and General Surgery directorate use questionnaires, complaints, and compliments, critical care follow-up clinics and patient stories to capture information. The division and directorate indicated to us that they seek feedback from patients and share learning. However, our survey found that 38 out of 83 staff disagreed or strongly disagreed that they receive regular updates on patient feedback for their work area or department.

47 The Health Board has arrangements for collating and acting upon patient experience information. However, our discussions with Health Board staff reveal that these arrangements are not systematic across the organisation or the services it commissions. A business case is being developed for the Health Board to procure the Once for Wales Concerns Management System. Its aim is to provide real-time feedback and 'ward to board' reporting functionality **(Recommendation 4)**.

48 At a corporate level, reports provided to both the Quality and Patient Safety Operational group and PQSO committee provide a good overview of patient experience activity alongside areas for improvement. The Health Board does not intend to update its Patient, Family and Carer Experience Strategic Framework which expired in 2019. However, it uses the 'what matters' principles and is awaiting the refreshed national approach to patient experience which aligns to the Quality and Engagement Act.

Concerns and complaints

49 The Health Board's Putting Things Right Policy outlines its arrangements for complaints, claims and patient safety incidents. The policy applies to all staff employed by or working with the Health Board and outlines their roles and responsibilities for dealing with concerns. The policy was due to be reviewed in 2018 and now contains out of date information **(Recommendation 5)**.

50 Against a national target of 75% of complaints responded to within 30 days, the Health Board achieved 69% compliance during 2020-21. This represents a year-on-year improvement from 2018 to 2021 and we understand that performance is continuing to improve. We were told, however, that the impact of the pandemic is resulting in growing complaints within the Scheduled Care division. The numbers of complaints are steadily rising due to service pressures and lengthy waits.

51 Staff training on 'putting things right' is well attended and receives positive feedback. The Health Board has also introduced a Complaints Co-ordinator Network meeting and a tracking system to monitor progress with corporate complaints. The Health Board uses learning from concerns, complaints, incidents, and redress to identify required improvements. These are reported in the annual Putting Things Right and Patient Quality Safety and Outcomes reports. For example, the latest report highlights aspects of clinical treatment, assessment, communication issues, and timeliness of appointments as the main themes arising from concerns and complaints.

Listening to staff concerns

52 The Health Board uses the all-Wales incident reporting policy, procedure and the Datix system for staff to raise concerns and support learning from staff experiences. This includes guidance on the responsibilities of all staff and the process for raising concerns, including whistleblowing. All staff have access to the system, however there are inconsistencies at corporate and operational levels around the levels of training provided on reporting concerns or near misses.

53 Our review found that there was an 'open door' policy amongst senior Health Board staff where staff concerns are confidentially brought to their attention. We were also informed of various other methods to understand staff concerns such as bespoke surveys, exit meetings, staff forums and the 'ask the Chief Executive' on the intranet. But our work suggests there is more to do to address staff

concerns and demonstrate where improvement action has been taken, or act to minimise future occurrence of errors, near misses or incidents. Our survey found that only 30 out of 83 staff agreed or strongly agreed that the organisation acts on concerns raised by staff and just over half of respondents (44 out of 83) agreed or strongly agreed that the organisation acts to minimise future occurrence of errors, near misses or incidents **(Recommendation 3)**.

Patient stories

54 Patient stories are used by the organisation at Board meetings, PQSO committee and various learning events. Patient stories featured regularly at Board prior to the pandemic. Since April 2021, patient experience and public engagement is a standing agenda item. While there have been difficulties in collating patient experience information needed over the last two years, there is an opportunity to return the frequency of patient story use to pre-pandemic levels. When used, patient stories are linked to agenda items.

55 The PQSO committee receives specific examples of patient stories as part of its assurance reporting in relation to listening and learning from feedback. Health Board staff have completed several digital patient stories. These include a patient's experience of COVID-19 in the Intensive Care Unit, and the experience of a patient within cancer services. However, it is unclear where these stories are presented. We also found limited evidence to indicate if patient stories are considered at divisional and directorate Patient Safety and Quality group meetings.

Patient safety walkarounds

56 Patient safety walkarounds provide independent members with an understanding of the reality for staff and patients, making data more meaningful and provide assurance from more than one source. The Health Board has recommenced the programme of walkarounds having paused them due to the pandemic. Independent Members commented positively on the walkarounds. They indicate that the walkarounds help to triangulate information, gain a sense of staff morale and an understanding of the day-to-day issues affecting staff.

Internal and external inspections

57 Our work indicates that the number of outstanding HIW recommendations has reduced over the last three years. The Health Board has made good progress in developing its arrangements for monitoring and disseminating findings and recommendations from Health Inspectorate Wales (HIW) reports. It maintains a detailed tracker which it uses to monitor progress in implementing the required improvements arising from HIW inspections across the organisation.

58 The Executive Team reviews the tracker quarterly prior to the PQSO committee meeting. The detailed tracker is not shared with the PQSO committee but doing so might help provide a greater level of assurance. The committee does however

receive updates on HIW inspections as part of its assurance reporting. Updates provide details of HIW inspections completed during the year, and both positive findings and areas for improvement.

59 The PQSO committee receives quality and safety related reports which may reference findings from Internal Audit reviews where these are relevant. At present though, Internal Audit reports that focus on quality and safety issues are not included on the committee agenda in their own right. This could leave some members less than fully sighted on quality and safety risks and limits opportunities to provide scrutiny and assurance.

Governance structures and processes

60 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.

61 We found **collective responsibility for quality governance amongst the Executive Leadership of the Health Board and corporate structures and processes are working well. However, there are gaps in flows of assurance with a need to strengthen 'floor to board' quality and safety assurance.**

Organisational design to support effective governance

62 There is collective responsibility for quality and safety amongst the Executive Leadership of the Health Board. The Health Board's Clinical Executives have a collegiate and robust approach to quality and safety supported by the Assistant Director of Nursing for Quality and Safety, Assistant Director for Quality and Patient Safety and Assistant Director for Person-Centred Care. Together they provide additional senior capacity and focus from medical, nursing, and patient perspectives. The Health Boards' Director of Nursing will be retiring in July 2022 and therefore the Health Board will need to recruit to this role.

63 The Health Board's clinical executives and their teams attend weekly 'clinical huddle' meetings to discuss quality and patient safety matters. The executive team receive regular reports identifying issues and risks from these huddle meetings during its standing agenda item on quality and patient safety.

Quality and safety framework

64 In March 2020, the Board approved the Health Board's quality assurance framework. The purpose of the framework is to inform and support the Board and the PQSO committee in its focus on quality and quality improvement. The framework is mapped to Health and Care Standards and outlines the Health Board's quality assurance structure. The approval and implementation of the framework coincided with the COVID-19 pandemic which had an impact on progress to embed the approach across the Health Board.

65 The quality assurance framework articulates a structure which includes a range of committees and groups focussing on specific aspects of quality and safety. For example, the Health and Care Standard for 'safe care' structure includes overarching committees, such as the Health and Safety Committee supported by sub-groups including the Strategic Fire Safety Committee and Manual Handling Group. Each group is required to provide assurance to the Quality and Patient Safety Operational group and ultimately the PQSO committee and Board. The framework helpfully identifies areas which previously had not provided assurance. However, there are gaps in the flows of assurance from some sub-groups and in relation to some elements of the Health and Care Standards, for example, Communicating Effectively (Health and Care Standard 3.2).

66 The framework is reasonably comprehensive at a corporate level. But it doesn't fully articulate the operational structure and processes for quality and safety and how those align with the corporate structures to provide 'floor to board' quality and safety assurance. The Health Board recognises that elements of the framework and structure are not functioning as intended and have identified this as a key area for delivery in its annual plan **(Recommendation 6)**.

Patient Quality, Safety and Outcomes Committee

67 The Health Board's PQSO committee is responsible for providing assurance and advice to the Board in relation to quality and safety. The terms of reference for the PQSO committee were revised in April 2021 in response to changes made to the Health Board's governance structure. The changes aim to achieve a person-centred approach to care and recognise the need to become more outcomes focussed.

68 Our work found the committee is becoming more effective. We noted clear and concise papers and an increased focus on risk and outcomes. Independent Members commented positively on the quality of the committee meetings and were generally satisfied with the level and quality of assurance they receive. As part of our audit, we observed the committee on several occasions. We found good quality discussion, scrutiny, and challenge from independent members. There is multi-disciplinary involvement at agenda setting meetings ensuring transparency and balance in the coverage of quality and safety matters at the meeting.

Quality and Patient Safety Operational Group

69 The Health Board's Quality and Patient Safety Operational group is responsible for providing assurance and advice to the PQSO committee in relation to quality and safety. The group's bi-monthly meetings precede the PQSO committee. The group is chaired by the Director for Families and Therapies with representation from across all Health Board operational divisions and corporate departments. Health Board staff informed us that operational participation at the meeting has improved following the introduction of virtual meeting arrangements during the pandemic.

The Health Board intends to review the role of the Quality and Patient Safety Operational group within the Health Boards quality assurance structure to ensure that it is receiving and providing appropriate quality and safety assurance.

Divisional / Directorate Patient Safety and Quality Group(s)

70 The Scheduled Care Divisional Patient Safety and Quality group (DPSQ group) terms of reference indicates a responsibility to provide assurance on quality and safety to the Health Board's corporate groups and committees. However, our work found that the group does not provide a dedicated assurance report and there is a lack of clarity around the flows of assurance from divisional to corporate levels.

71 The DPSQ group meets monthly and is chaired by the Divisional Director for Scheduled Care. The groups terms of reference outline a multi-disciplinary membership. This includes both the divisional director and divisional nurse, medical and nursing leads for patient safety and quality, and senior representatives for Putting Things Right, Health and Safety. Whilst the proposed membership is appropriate, our work identified instances where certain members, for example a Health and Safety representative had not attended a meeting or provided an update for some time, leaving a gap in assurance. It was also unclear whether representatives from all directorates attend this meeting. Health Board staff indicate that meeting dates for the group are being revised to align with directorate audit days to improve attendance.

Resources and expertise to support quality governance

72 Corporately there are several teams working to support quality and safety issues in the Health Board. The Person-Centred Care Team and Putting Things Right Team, report to the Assistant Directors of Nursing for Person-Centred Care and Quality and Safety respectively. This is in addition to ABCi, Medical Director's Support Team, and Infection Prevention and Control Teams referred to earlier this report.

73 The Person-Centred Care Team (9.8 WTE, 12 headcount) provides a range of training and support to operational areas on patient surveys, developing patient experience metrics and digital patient stories. The team has expanded over the last three years through recruitment of an End-of-Life Companion Co-ordinator and Clinical Skills Trainer on fixed term contracts.

74 The Putting Things Right Team (11.9 WTE staff, 14 headcount) role is to provide training and support to operational staff, for example effective complaints handling and investigating officer training. The Health Board informed us that 150 staff are trained to investigate complaints and 101 staff trained to investigate incidents across the Health Board. There are currently no vacancies within the team and its size and composition has remained relatively constant over the last three years. However, there have been some changes to its structure resulting in recruitment and changes in personnel.

75 There is a dedicated team for Infection Prevention and Control (14.8 WTE staff, 17 headcount). They provide training and support to operational staff in line with the Health Board's infection prevention training strategy and has adapted in response to the COVID-19 pandemic. Recently, the Infection Prevention and Control Team has received funding to enhance the primary care aspect of its role. The pandemic has placed significant additional demands on the team, and this limits the amount of proactive infection and prevention control work it undertakes.

76 At an operational level, the Scheduled Care division and General Surgery directorate have designated leads for many keys aspects of quality and safety. This includes managing concerns, risk management, infection prevention and control, quality improvement, Datix and health and safety. They also have designated leads for quality and safety. They assist with serious incidents investigations, support wards and departments in relation to the Datix system, attend quality improvement meetings and represent the division at meetings where there is a quality and safety focus. However, we found that some designated leads do not have protected time to fulfil several of these roles. **(Recommendation 7)**. In addition, the Health Board does not have designated leads for patient experience or a dedicated patient experience team such as a Patient Advice and Liaison Service (PALS). This contrasts with some other Health Boards in Wales. However, we understand that the Health Board is currently considering a model for the introduction of this service.

Arrangements for monitoring and reporting

77 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

78 We found that **the Health Board arrangements for monitoring quality and safety at a corporate level are improving, but the Health Board needs to review arrangements at an operational level to ensure it is receiving appropriate assurance on the quality and safety of its services**.

Information for scrutiny and assurance

79 The Board performance report and integrated performance dashboard provides performance information against the NHS Wales Delivery Framework measures including complaints and healthcare acquired infections. The redesigned Patient Quality, Safety and Outcomes report is more succinct, and outcome focussed. It includes quality metrics, including healthcare-associated infections, COVID-19, pressure damage and inpatient falls. It also provides greater clarity around emerging themes, areas of concern, mitigation, and good practice. Whilst the report is predominantly secondary care focussed, it includes wider areas of the Health Board's business such as Child and Adult Mental Health Services (CAMHS)

and Primary Care Mental Health. However, opportunities exist to strengthen reporting on the services the Health Board directly commissions.

80 At an operational level, the Divisional Patient Safety and Quality group receives presentations and reviews performance reports and dashboards with infection control, incident reports, concerns data and health and safety information. Some supporting papers are available in advance and attached to meeting agendas, but several are not. This may limit opportunity for attendees to review information in advance and provide sufficient scrutiny and challenge at meetings.

81 The four harms associated with COVID-19 remain a key consideration on the Health Board's BAF and information is routinely reported and escalated via a safety dashboard report to the PQSO committee. Whilst COVID-19 issues are included in various reports and papers for the Board, the removal of COVID-19 updates as a standing item on the Board agenda may limit opportunities to provide assurance.

82 The Health Board's annual plan includes requirements to refine its quality and safety dashboard quality indicators and increase the capacity and capability of divisions and its corporate teams to utilise data to support quality and safety.

Coverage of quality and patient safety matters

83 The PQSO committee's remit is clear in relation to oversight for quality and safety and its agendas are aligned to the main quality and safety risks within the Health Board. Agenda includes regular information around patient feedback within services and reports on external inspections and reviews. Health Board senior leadership are responsive to requests from the committee for additional information resulting from concerns identified at previous meetings. The chair of the Quality and Patient Safety Operational group presents assurances to the PQSO committee on the group's activities. Our review of the update reports found them to provide information on divisional quality and safety risks, and a summary of key matters arising from other items considered during the meeting. This is supplemented with additional information by the Quality and Patient Safety Operational group chair and senior Health Board officers as part of its presentation and discussion during committee meetings.

84 Operationally, the Divisional Patient Safety and Quality group uses a standardised agenda which covers key aspects of quality and safety. This includes infection prevention and control, serious incidents, safety alerts, complaints and concerns, divisional risks and Datix feedback to staff. The group also focuses on wider quality improvements. An example of this is its regular oversight of the theatre improvement programme which was established in response to 'never events' occurring within the General Surgery directorate. The Divisional Patient Safety and Quality group actively manages its action log which provides details on actions, completion dates, lead officers and progress updates.

85 The General Surgery directorate has recently established its own Patient Safety and Quality group, but it is in the early stages. At the time of our review, the group

did not have a terms of reference, standardised agenda, or report templates and whilst an action log is maintained, minutes of meetings are not taken.
The Divisional Patient Safety and Quality group is considering the introduction of standardised agendas, reporting templates and patient safety and quality plans and gaps in the flow of quality and safety information across its directorates. This should help to address some the inconsistencies in directorate approaches.

86 Our review of agendas and papers for the monthly assurance meetings with the Director of Operations indicate a focus on quality and safety, particularly around concerns, serious incidents, and infection control. However, these meetings stopped in March 2021 and have not resumed. We also note a focus on quality and safety at bi-annual reviews with the Executive Team. However, we found limited focus on quality and safety at the Scheduled Care divisional management team meetings with some meetings mainly focussing on finance, performance, and operational matters **(Recommendation 8)**.

Appendix 1

Management response to audit recommendations

Exhibit 1: management response

Recommendation	Management response	Completion date	Responsible officer
Risk Management R1 Divisional risks are presented to Quality and Patient Safety Operational Group, but there was limited evidence of in-depth analysis and discussion. There is also limited evidence that the General Surgery directorate maintain risk registers that adequately identify quality and safety risks and mitigating actions. The Health Board should: • ensure there is appropriate scrutiny, challenge, cross			

Recommendation	Management response	Completion date	Responsible officer
divisional discussion and sharing of good practice around divisional risks at the Quality and Patient Safety Operational Group. • ensure that risk registers are completed and maintained across all directorates that identify quality and safety risks and mitigating actions and there are appropriate risk escalation arrangements.	The form and function of Quality Patient Safety Operational Group is currently being reviewed, with the aim of strengthening oversight of Risk. ABUHB are in the process of introducing the OFWCMS with the Risk module part of a future phase of roll-out. This will be a driver for improving Divisional ownership of risk management and mitigation. A programme of Divisional awareness raising will be introduced across ABUHB to strengthen risk management processes. The responsibility of Divisional Directors will be reinforced in terms of maintaining registers and ensuring appropriate mitigation.	June 2022 October 2022 May 2022	Executive Director of Therapies and Health Sciences Director of Clinical Governance Director of Clinical Governance

Recommendation	Management response	Completion date	Responsible officer
Clinical audit R2 During our review, the Health Board was updating its clinical audit strategy and policy and developing a standalone clinical audit plan. The Health Board's Clinical Effectiveness and Standards group terms of reference were in draft and contained out-of-date information. At an operational level, clinical audit capacity is limited and systems to share learning and good practice are not embedded or systematic. The Health Board should: • complete the work on its clinical audit strategy, policy, and plan. The plan should cover mandated national audits, corporate-wide and local audits informed by areas of risk. This	The Clinical Audit strategy and policy are currently under review and will be ratified by June 2022. A Digital Clinical Audit Platform has been procured to support the delivery of Divisional, Directorate and Corporate Clinical audit plans designed to provide assurance around areas of high priority.	June 2022	Executive Medical Director

Recommendation	Management response	Completion date	Responsible officer
plan should be approved by the Patient Quality, Safety and Outcomes Committee and progress of its delivery monitored routinely. • update and finalise the terms of reference for the Clinical Effectiveness and Standards Committee. • ensure there is sufficient resource and capacity for clinical audit at an operational level • ensure systems for learning and good practice from clinical audit are embedded across the organisation.	Complete ABUHB will undertake a review of resources and capacity available to support the completion of the National Clinical Audit programme. The Clinical Standards and Effectiveness Group is the forum where Clinical audit is discussed and presented to ensure scrutiny and assurance. Bi-annual reporting to the PQSOC takes place to provide assurance of clinical performance and the development of action plans to address requisite improvements. A review of the	N/A August 2022 June 2022	N/A Executive Medical Director Executive Medical Director

Recommendation	Management response	Completion date	Responsible officer
	membership of the group will be undertaken to support improved Divisional representation.		

Recommendation	Management response	Completion date	Responsible officer
Values and behaviours R3 The Health Board has a well-established values and behaviours framework which sets out its vision for a quality and patient safety focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns and the action taken by the Health Board to address them. The Health Board should undertake work to understand why some staff feel: • they are not treated fairly or given feedback when reporting errors, near misses or incidents.	The ABUHB Value Framework has been refreshed recently. There is clearly a need to remind managers and leaders to ensure feedback to staff who have raised concerns and this will be reinforced through Divisional Triumvirates for cascade.	October 2022	Executive Director of Workforce and Organisational Development

Recommendation	Management response	Completion date	Responsible officer
• that the Health Board does not act on concerns they raise or take action to minimise future occurrence of errors, near misses or incidents	A review of concerns raised by staff and the actions taken will be conducted to provide assurance.	October 2022	Executive Director of Workforce and Organisational Development

Recommendation	Management response	Completion date	Responsible officer
Patient experience R4 Whilst the Health Board uses a range of methods to capture patient experience information, regular patient feedback updates are not always provided to work areas or departments and arrangements are not systematic across the organisation or the services it commissions. The Health Board should: • undertake work to understand why patient feedback updates are not regularly provided to work areas or departments. • ensure there are systematic arrangements for collating and acting upon patient experience	A business case is in-development for the procurement of 'Civica' as part of the OFWCMS. If supported this will strengthen the ability to capture live patient experience which Divisions and Directorates will own, strengthening feedback. (As per response above)	September 2022	Executive Director of Nursing

Recommendation	Management response	Completion date	Responsible officer
information across the organisation and the services it commissions.			

Recommendation	Management response	Completion date	Responsible officer
Putting Things Right R5 The Health Boards Putting Things Right Policy was due to be reviewed in 2018 and contains out of date information. The Health Board should review and update the Putting Things Right Policy as a priority.	The PTR policy will be updated with an extension to the date in light Welsh Government are reviewing the PTR policy aligned to the Quality & Engagement Act implementation.	June 2022	Executive Director of Nursing

Quality and safety framework R6 The Health Boards quality assurance framework includes a range of committees and groups aligned to Health and Care Standards. The framework is assisting the Health Board in identifying areas which previously had not provided assurance. However, there are still gaps in the flows of assurance from some sub-groups and in relation to elements of the Health and Care Standards. Whilst the framework is reasonably comprehensive at a corporate level, it doesn't fully articulate the operational structure and processes for quality and safety. The Health Board should: • complete its review of the quality and safety framework to ensure that flows of assurance are appropriate, and that the	The Quality Assurance Framework will be reviewed to assess fitness for purpose and alignment to the BAF.	October 2022	Clinical Executives

Recommendation	Management response	Completion date	Responsible officer
• framework functions as intended. • articulate the operational structures and processes for quality and safety within the quality assurance framework and how they align with the corporate structure to provide a 'floor to board' assurance.	The revised Quality Assurance Framework will include the operational structures and processes.	October 2022	Clinical Executives

Recommendation	Management response	Completion date	Responsible officer
Resources to support quality governance R7 The Scheduled Care division and General Surgery directorate have designated leads for many keys aspects of quality and safety. However, we found that some designated leads do not have protected time for these roles. The Health Board should ensure operational staff have sufficient time and capacity to effectively fulfil these roles.	A review of roles for QPS across Divisions will be undertaken with the aim of implementing a consistent approach (this will include time for leads to undertake their role effectively).	October 2022	Clinical Executives

Recommendation	Management response	Completion date	Responsible officer
Coverage of quality and safety matters R8 The General Surgery directorate has recently established its own patient safety and quality group. However, the group does not have a terms of reference, standardised agenda, or report templates and minutes of meetings are not taken. Whilst quality and safety did feature in bi-annual reviews with the Executive Team and monthly assurance meetings with the Director of Operations. We note the monthly assurance meetings stopped in March 2021. We found limited focus on quality and safety at Scheduled Care Divisional			

Recommendation	Management response	Completion date	Responsible officer
Management Team meetings. The Health Board should: • review the operational patient safety and quality groups to ensure they are effectively supporting the Health Boards quality governance arrangements. • ensure that other operational meetings / forums provide sufficient focus on quality and safety alongside finance, performance, and operational matters.	The patient, quality and safety structures for each Division will be reviewed and outlined in the revised Quality Assurance Framework (see R6). Divisions will be reminded to ensure a robust focus on patient quality and Safety through Divisional and Directorate meetings.	October 2022 May 2022	Clinical Executives Clinical Executives

Appendix 2

Staff survey findings

Exhibit 2: staff survey findings

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't Know	
Delivering safe and effective care							
1. Care of patients is my organisation's top priority	19	32	12	11	8	-	82
2. I am satisfied with the quality of care I give to patients	25	28	10	12	6	2	83
3. There are enough staff within my work area/department to support the delivery of safe and effective care	5	17	16	18	27	-	83
4. My working environment supports safe and effective care	15	25	11	16	15	1	83

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
Delivering safe and effective care							
5. I receive regular updates on patient feedback for my work area / department	11	21	13	18	17	3	83
Managing patient and staff concerns							
6. My organisation acts on concerns raised by patients	14	35	18	4	5	7	83
7. My organisation acts on concerns raised by staff	7	23	16	16	17	4	83
8. My organisation encourages staff to report errors, near misses or incidents	18	40	13	6	5	1	83
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation	11	28	24	9	4	7	83

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't Know	
Managing patient and staff concerns							
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	11	33	20	10	5	4	83
11. We are given feedback about changes made in response to reported errors, near misses and incidents	8	26	17	18	10	4	83
12. I would feel confident raising concerns about unsafe clinical practice	18	31	15	10	7	2	83
13. I am confident that my organisation acts on concerns about unsafe clinical practice	12	32	21	11	6	1	83

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't Know	
Working in my organisation							
14. Communication between senior management and staff is effective	2	27	16	18	20	-	83
15. My organisation encourages teamwork	7	35	22	11	8	-	83
16. I have enough time at work to complete any statutory and mandatory training	4	25	12	25	17	-	83
17. Induction arrangements for new and temporary staff (e.g. agency/locum/bank/re-deployed staff) in my work area/department support safe and effective care	7	31	23	5	10	7	83

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Presentation for PQSOC – June 2022

Covid-19 Concerns and Claims:

The National Framework & Investigative Process

Deb Jackson – Assistant Director of Nursing, IPAC

Covid-19 Investigation Framework

- A national framework for Covid investigations is in place.
- The Minister for Health and Social Care has pledged all incidents of nosocomial Covid-19 will be investigated.
- Lessons will be learned to reduce the chances of reoccurrence.
- Health Boards and Trusts have received money to set up a Covid Investigation Team to investigate hospital-acquired infections (with a 2 year timeframe).

Expectations:

- Put in place the necessary resource and infrastructure to deliver the programme of investigation work in relation to patient safety incidents of nosocomial Covid-19.
- Establish relevant internal assurance mechanisms such as scrutiny panels.
- Proactively engage with patients and families who have been affected by incidents of nosocomial Covid-19, including advocacy through the Community Health Council.
- Put in place the necessary infrastructure to provide a dedicated point of contact for supporting families for five days a week.
- Develop robust governance structures.
- Engage with colleagues in the Delivery Unit who will have overall responsibility for national leadership and oversight in relation to implementation and application of the national framework.
- Work with the Delivery Unit to develop the national learning plan which will incorporate the lessons learned throughout the pandemic and identified through investigative process.

3 stage approach to standardise Covid-19 investigation

01 IDENTIFICATION

The identification of patients who meet the criteria of nosocomial Covid including those patients who have subsequently been discharged.

02 ASSESSMENT

The clinical assessment of each patient to determine the level of harm. Where moderate or severe harm is identified, the process will progress to stage 3 of the investigation tool kit and the patient, their family or representatives are contacted by the Health Board to advise them of the investigation and to allow them an opportunity to contribute to the investigation.

03 INVESTIGATION

The Health Board will undertake a proportionate investigation; it is recognised that this approach will vary according to each case investigated and therefore no standardised investigation tool is being mandated. As part of this process the investigation will consider the level of harm. Scrutiny Panel to be set up to review level of harm with clear Executive Lead.

Number of Covid-19 Health acquired incidents recorded for ABUHB

	Wave 1 (27/2/2020 - 26/7/2020)	Wave 2 (27/07/2020 - 16/05/2021)	Wave 3 (17/05/2021 - 19/12/2021)	Wave 4 (20/12/2021 - 30/04/2022) **
Total Incidents	252	837	439	990

- A handful of formal complaints
- No legal claims as yet
- Some cases where solicitors have requested copies of records

Requirements

It is anticipated the Health Board will require 15.2 WTE multi-disciplinary staff to conduct approximately 2317 investigations from Waves 1-4 (and likely to climb).

WTE	Role
1	To Head Covid investigation (HOCI) Team (line managed by the IPAC in collaboration with PTR).
3	To undertake the notes reviews/investigations – need to be clinical, lead the patient/family meetings and oversee Covid concerns.
3	Delivering the patient contact and running the helpline plus completion of timelines
1	Business/Performance Manager
1	Medic to undertake complex reviews of clinical care
1	To develop the epi curves for each of the clusters (Epidemiologist)
1	Infection Prevention & Control lead (knowledge of daily outbreak decision making)
1	Administrative support
0.2	To lead on the ABUHB comms/media and patient/family engagement
2	Claims and Redress cross-cover
1	Admin for the Redress Team

ABUHB approach to investigations

1. Outbreaks on wards for nosocomial cases to be reviewed. Working through outbreaks, during each wave of the pandemic.

2. Prioritisation of all deceased patients who contracted Covid-19 in hospital.

3. The investigation team will use the nosocomial Covid-19 Patient Safety Incident investigation decision tool, to consider the circumstances of the outbreak, whether potential failings in care, and whether a case for further scrutiny/referral for legal advice. These identified cases will be reviewed through the Scrutiny Panel – the panel may determine that care was deemed reasonable, at that time, and for no further action.

4. If Panel identify/agree that a case might give rise to a legal liability, to then refer the case to Legal & Risk as per current WRP mandatory requirement.

NB. Commencement July 2022, based on successful recruitment.

Committee:	**Patient Quality, Safety & Outcomes Committee**
Date:	**7th June 2022**
Agenda Item:	**2.4**
Document Title: Learning From Death	

Aneurin Bevan University Health Board

Patient Quality, Safety and Outcomes Committee

Learning From Death

Summary

- RAMI for March 2022 was 97.44 (e.g. 2.56% below that expected after control for case mix)
- 30 day inpatient stroke mortality is 9.562% the lowest in Wales
- 30 day MI inpatient mortality is 4.425%
- Hip Fracture mortality is below the UK national level
- 169 Medical Examiner referrals have been received between 1st December 2021 and 1st May 2022
- The most common reason for referral remains communication issues
- There has been an increase in ME referrals associated with interventional procedures in the past 4 months
- Elective and Non elective 30 day mortality is below the Welsh average
- ED mortality per 10 000 attendances is in line with Wales ED mortality rates
- The ABUHB Learning Disability Steering group has reconvened in response to several ME referrals
- A thematic review of all vancomycin incidents in the past 12 months is being undertaken by pharmacy is response to 2 recent ME referrals

Purpose: **Patient Quality, Safety and Outcomes Committee is asked to:**	
Discuss and Provide Views	x
Receive the Report for Assurance/Compliance	x
Note the Report for Information Only	
Executive Sponsor: Dr James Calvert Medical Director	
Author(s):Alexandra Scott – Assistant Director of Quality and Patient Safety	
Report Received consideration and supported by:	

Executive Team		**Sub-Committee**	
Date of the Report: June 2022			

Supplementary Papers Attached: Nil

Situation

Weekly multidisciplinary Mortality Screening Panels continue to review all referrals from the Medical Examiner and to commission, where required further investigation.

The emerging themes have been combined with information from clinical coded data, and national audits to support learning from death and will be reported to the committee on a bi annual basis.

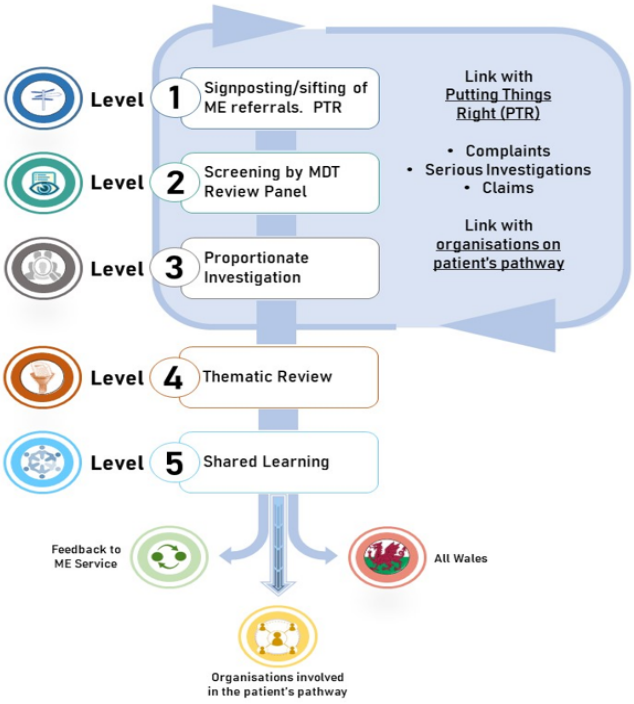
Background and Context

Health organisations across Wales use a number of measures to consider mortality. The Risk Adjusted Mortality Index (RAMI) adjusts for individual patient risk factors and co morbidities and therefore allows comparison between organisations. The accuracy of RAMI is dependent on the completion and accuracy of clinical coding, 11.77% of finished consultant episodes in February 2022 were un-coded and this increased to 13.76% in March 2022. In 2014 Professor Palmer published an independent review of the use of RAMI and the extent to which it provides valid data and recommended a blended approach that considers numerous sources of information, in addition to RAMI, including that from mortality reviews and national audit.

There will be a statutory requirement for an independent review of all deaths in Wales by a Medical Examiner (ME) service by late 2022. There has been a phased approach across ABUHB to implement this system since November 2020 with inpatient deaths in YYF, GUH and RGH now subject to independent scrutiny by the ME. The National Mortality Framework illustrated in figure 1, describes 5 levels of mortality management

Figure 1

5.5 Mortality Review 5 Levels of management



Assessment and Conclusion

RAMI

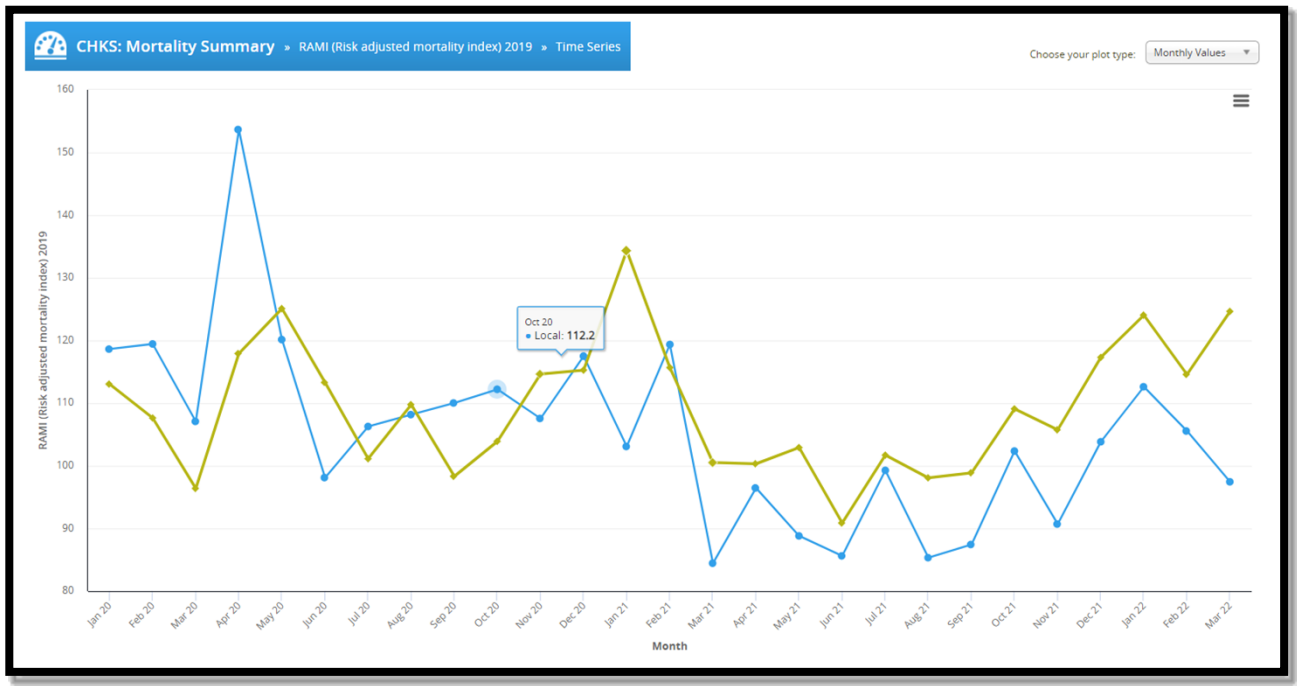
The Risk Adjusted Mortality Index (RAMI) is a statistical tool which estimates the probability of death for all admitted patients, taking into account factors such as age, sex, diagnoses, procedure, clinical grouping and admission type. Where the predicted mortality rate equates to the actual mortality rate, RAMI will be reported as 100, where actual mortality exceeds the predicted rate, RAMI will be reported as a figure exceeding 100.

Figure 2 shows the ABUHB RAMI of 97.44, compared with Welsh peers to March 2022 . Since March 2021 the ABUHB RAMI has been tracking below the Welsh Median.

Figure 2 Risk Adjusted Mortality Index

ABUHB Blue

Wales Green

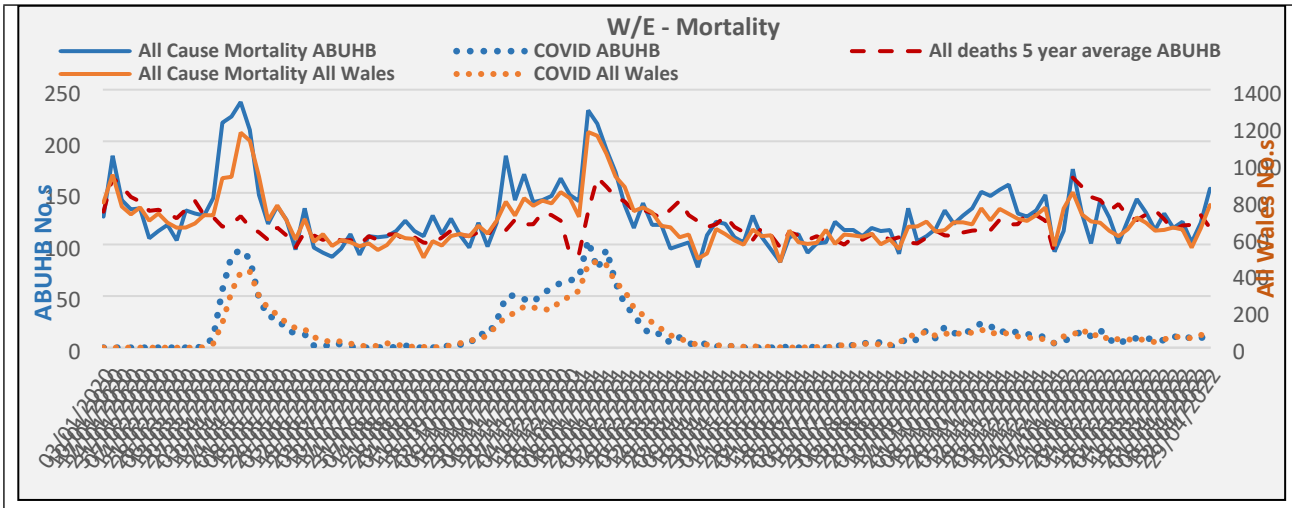


All-Cause Mortality

Figure 3 illustrates ABUHB all-cause mortality, including combined inpatient and community deaths. The chart compares ABUHB mortality since March 2020 compared with the Health Board 5 year average and also compares it to the All Wales mortality rate for the same period and the All Wales 5 year average.

Where Welsh and ABUHB mortality rates have risen above the 5 year average this correlates with deaths in patients who have been diagnosed with Covid, defined as patients who had any Covid-19 identified in their inpatient notes or included anywhere in the death certificate. Excess mortality (above the 5 year average) was significantly reduced in the most recent wave of covid when compared with wave 1 and 2.

Figure 3 All-Cause Mortality

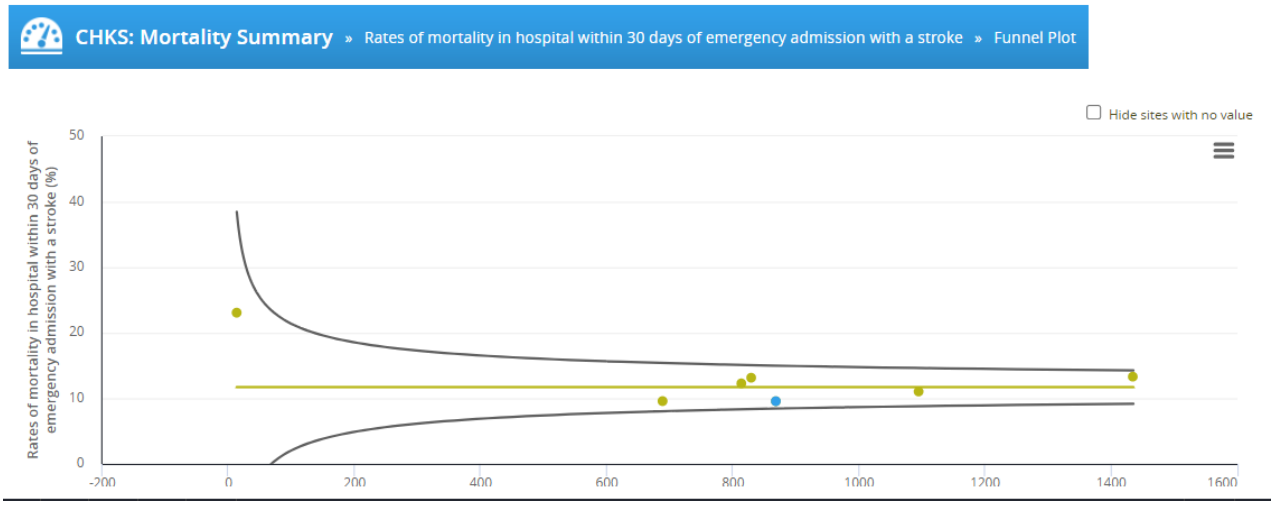


Condition Specific Mortality

Stroke

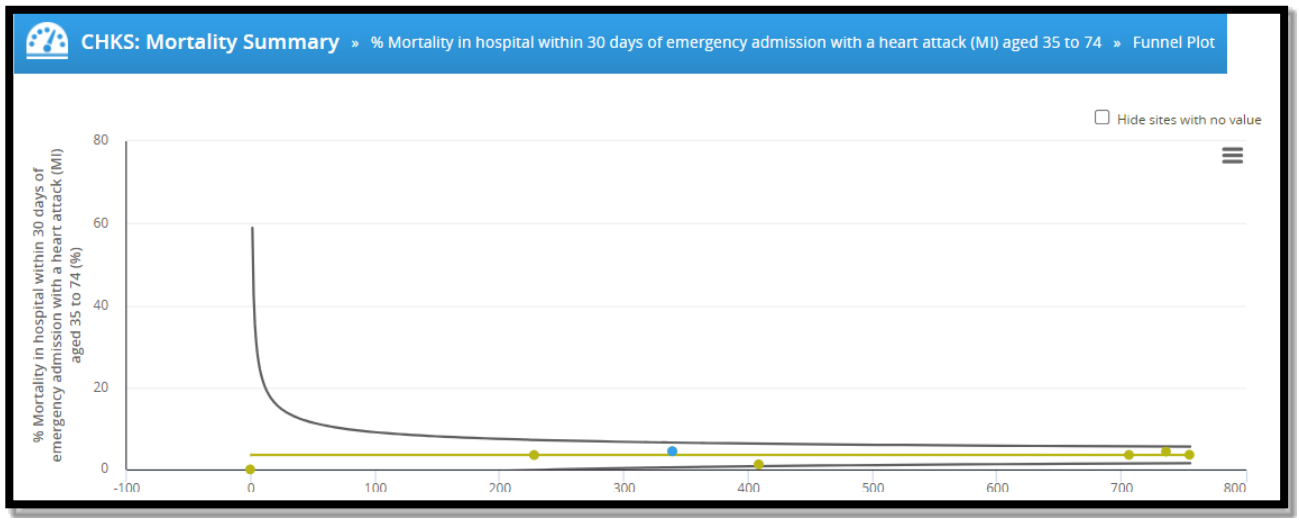
ABUHB 30 day inpatient mortality following admission with a stroke is 9.562% below the national mean and the lowest mortality rate for any Health Board in Wales for the period January 2021-March 2022.

Figure 4 30 Day Inpatient Mortality following a Stroke (Jan 21-Mar 22)



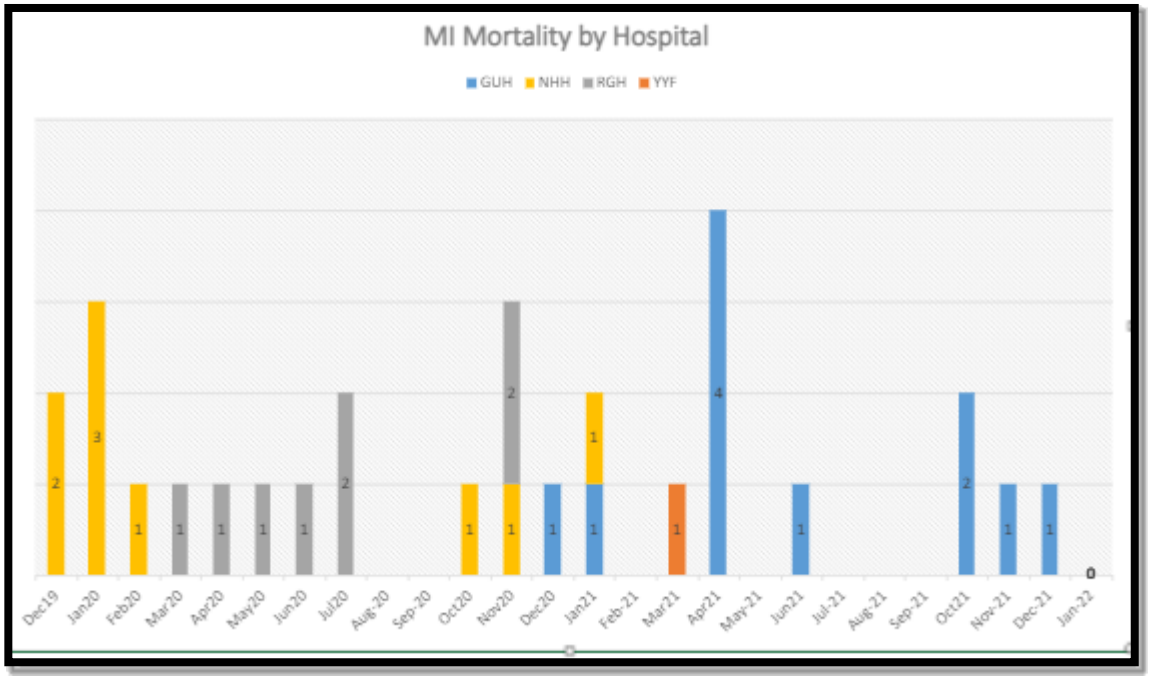
Myocardial Infarction (MI)

Figure 5 **30 Day Inpatient Mortality following An MI (age 35-74) (Jan 21-Mar 22)**



ABUHB MI mortality in January 2022 was 4.425%, lying within the control limits describing all Welsh Health Boards. The data does account for variation in the caseload between Health Boards, with much smaller numbers of patients with ST elevation MIs treated in ABUHB. Figure 6 shows the actual numbers of MI associated deaths per site since December 2019. A previous thematic review of MI cases reported to PQSOC in December 2021 identified that the majority of deaths were in patients who experienced an out of hospital cardiac arrest or patients who had significant comorbidities and were diagnosed with a non ST elevation MI.

Figure 6 ABUHB MI deaths per site



Hip Fracture

Figure 7 illustrates the ABUHB mortality rate compared with Welsh health Organisations, with a rate of 4.539% for January 2021-March 2022, while figure 8 illustrates the improvement in hip fracture mortality since March 2019 with ABUHB adjusted rate now below the UK national rate.

Figure 7 30 day inpatient Mortality post Hip Fracture

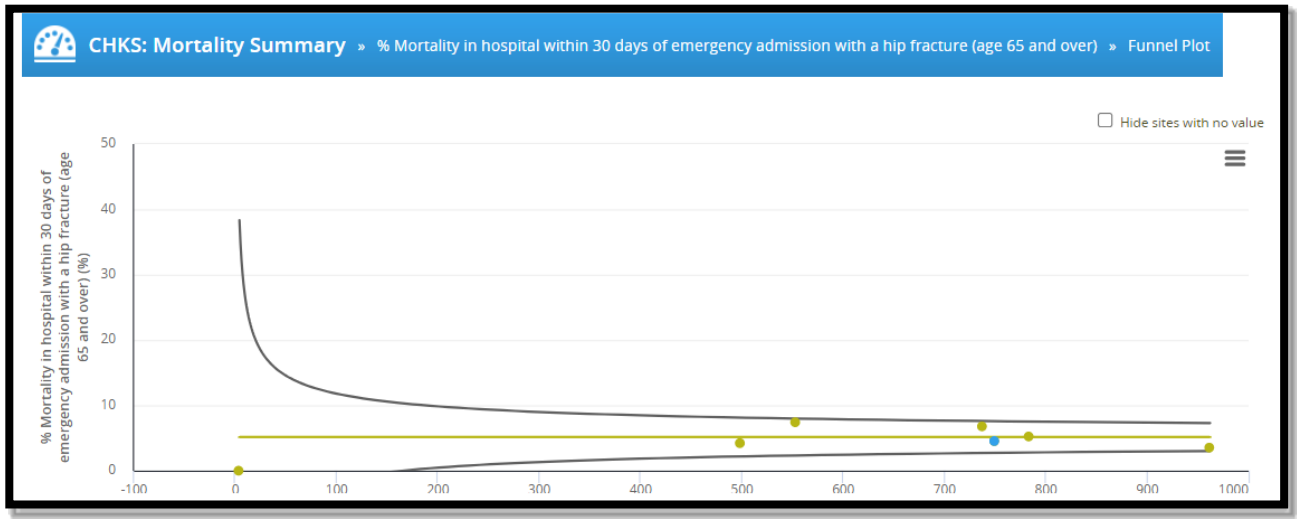
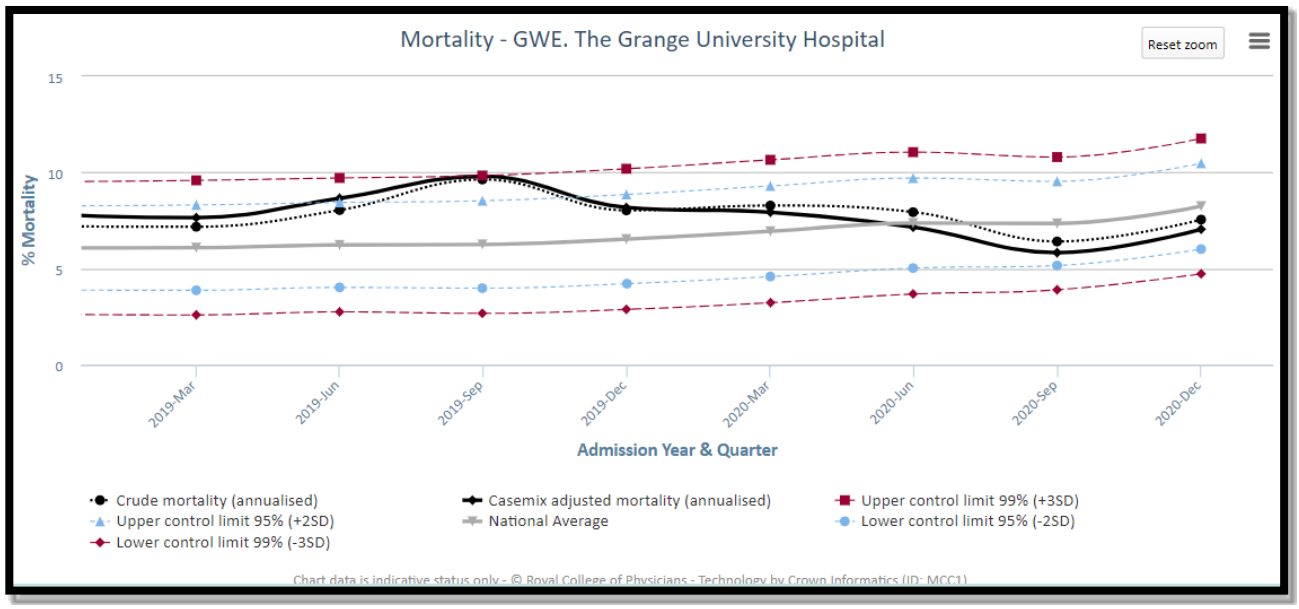


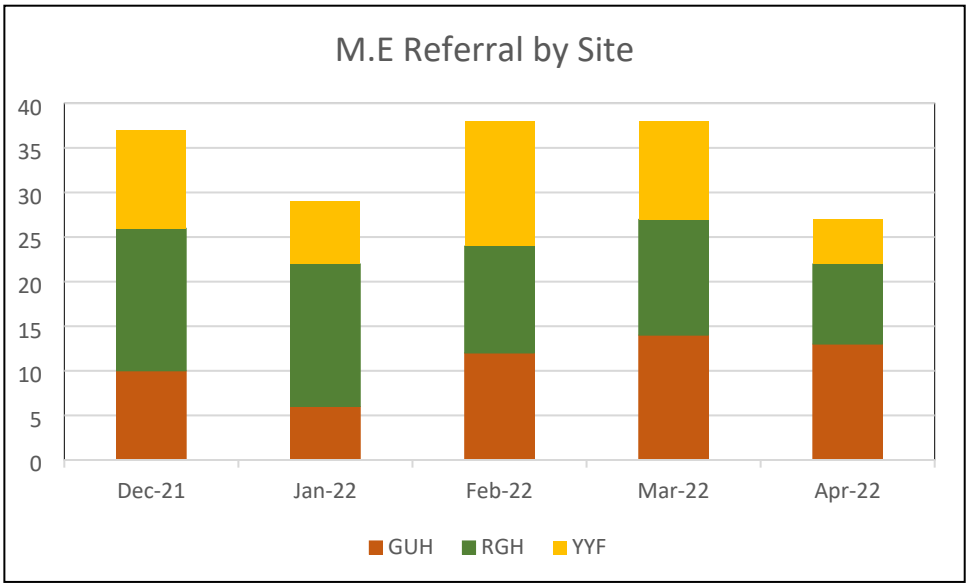
Figure 8 ABUHB Adjusted Mortality – Hip Fracture (NHFD)



Medical Examiner

The Health Board received 169 referrals from the Medical Examiner between 1st December 2021 and 1 May 2022 with monthly referrals varying between 27 and 38 and the largest number of deaths occurring in RGH.

Figure 9 ME Referrals by Site



Reasons for Medical Examiner referral vary but figure 10 demonstrates the commonly recurring words in the reason for referral as identified through a thematic synthesis of all referrals. The most common concerns highlighted by the ME relate to communication and the trend remains unchanged for the previous learning from death report in December 2021. Concerns have been exacerbated by the ongoing visiting restrictions imposed as a result of Covid.

Figure 10 Reasons for Referral

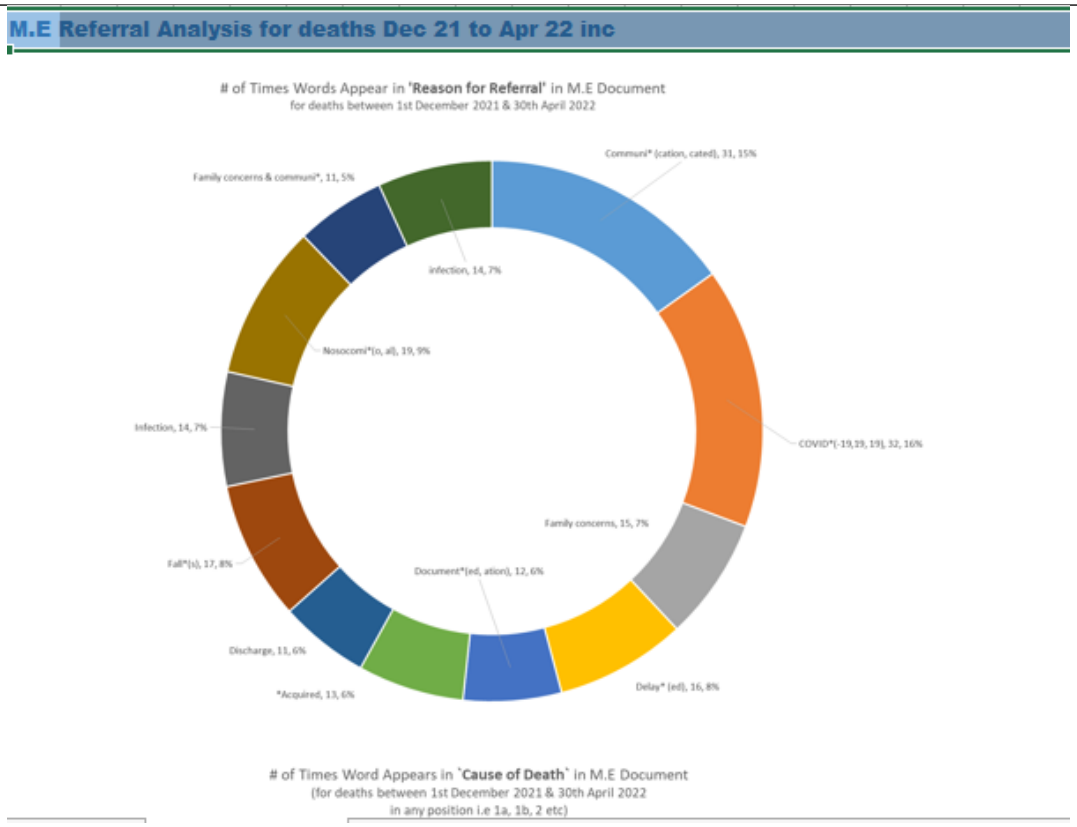
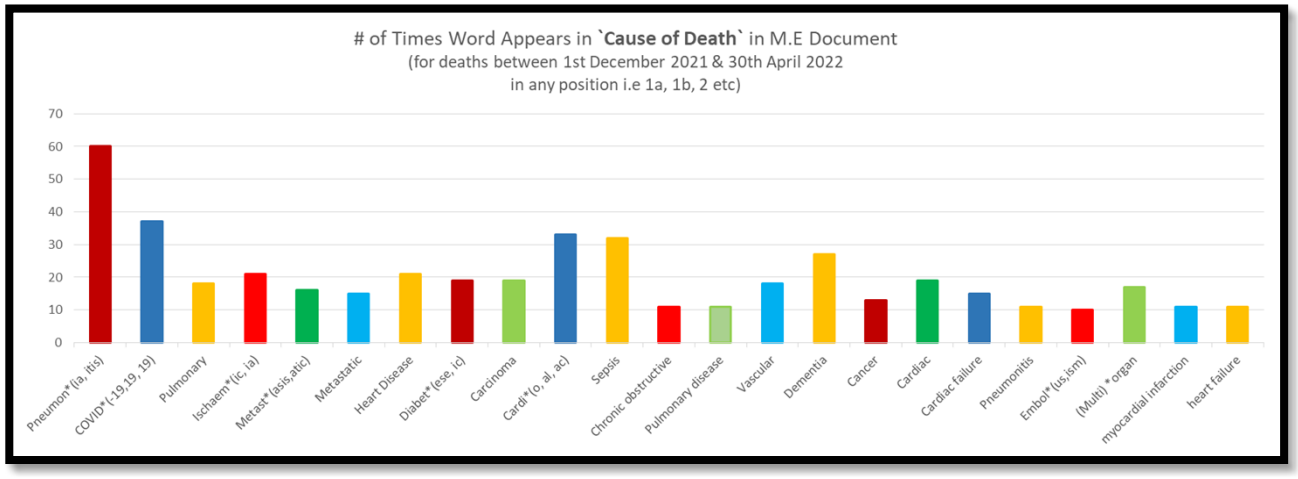


Figure 11 Illustrates a thematic review of the agreed cause of death recorded in ME referrals. Pneumonia, Pneumonitis, Covid and Pulmonary remain the most commonly recurring words in the cause of death in referrals from the Medical Examiner

Figure 11 Cause of Death.



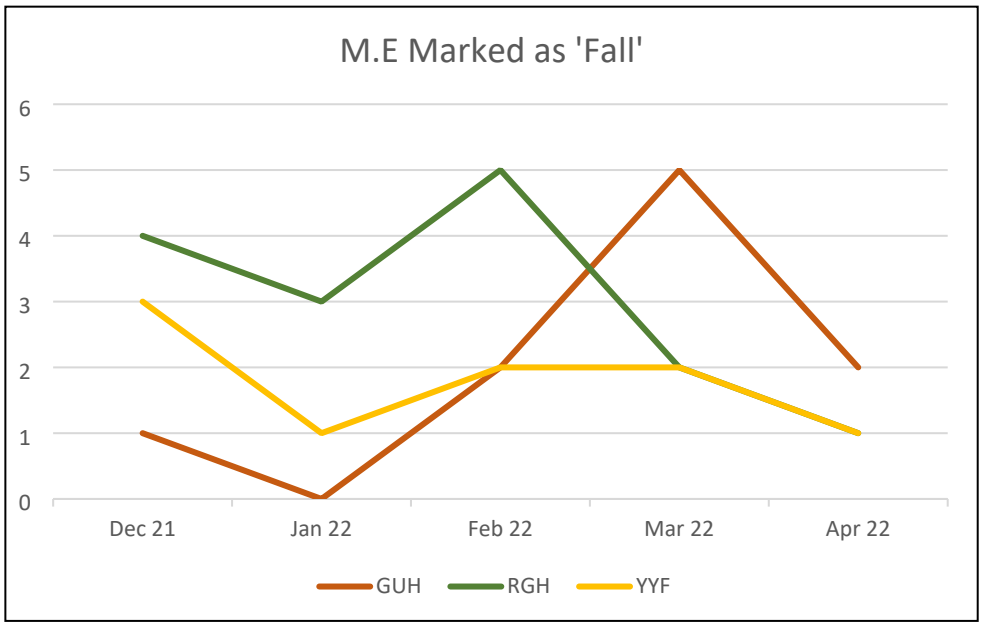
The Medical Examiners considers a number of factors in each mortality review undertaken. These include:

- Recent interventional procedure following which death was not expected as the outcome?
- Was the death due to the pre-existing condition or the known chronic condition?
- Was there a major change in diagnosis or development of an additional condition?
- Delay in recognition of deterioration, diagnosis and or treatment?
- Incorrect diagnosis or treatment?
- Failure of communication and or documentation?
- Did the patient fall and sustain any injuries during the last illness or acute admission?
- Did pressure ulcers develop during the last illness or acute admission?
- Did the patient develop an infection during last illness or acute admission?
- Was the patient admitted to ITU/HDU?
- Was there a complication of treatment?
- Was there a clinically significant change in blood results, out with that expected as part of the expected course of illness?
- Is there any indication of concerns from family or carers about the care this patient received?
- Is there any evidence of documented concerns about this patient's care raised by other health professionals?
- Was the patient under any safeguarding order or state custody (e.g. DOLS,POVA,MHA)?

Falls

Figure 12 illustrates all ME referrals between December 2021 and May 2022 where the patient had either fallen, as an inpatient or in the community prior to their admission.

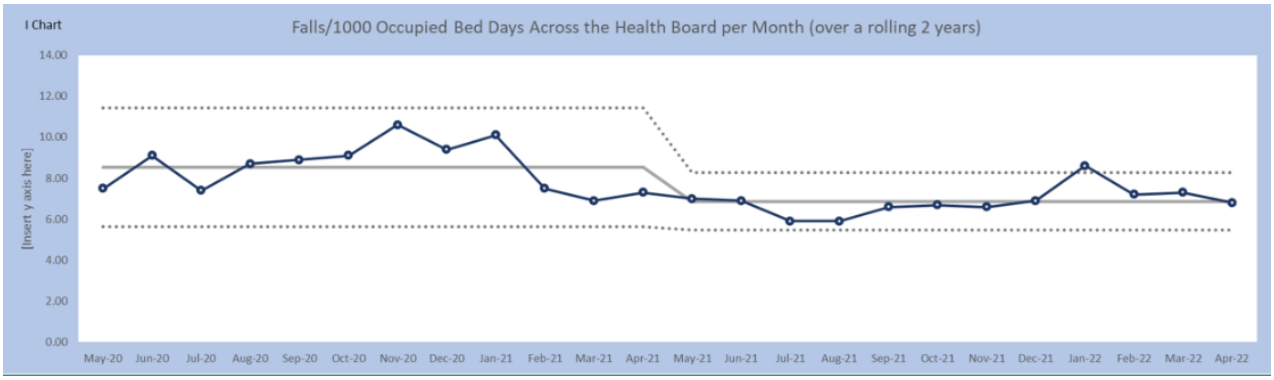
Figure 12 Medical Examiner Referrals with Falls



Work to reduce incidents of inpatient falls has contributed to a significant reduction in the numbers of inpatients falls per 1000 occupied bed days since May 2021 as illustrated in figure 13. All inpatient falls that result in a fracture are considered at the inpatient Falls Review Panel to identify and share learning. An All-Wales inpatient falls network was established in 2022 to support national learning including a review of the evidence relating to falls sensors to understand the efficacy of this equipment and to standardise the use nationally.

The recent implementation of a community Falls Network will support quality improvement work designed to reduce community incidents of falls and harm.

Figure 13 Inpatient falls per 1000 Occupied Bed Days

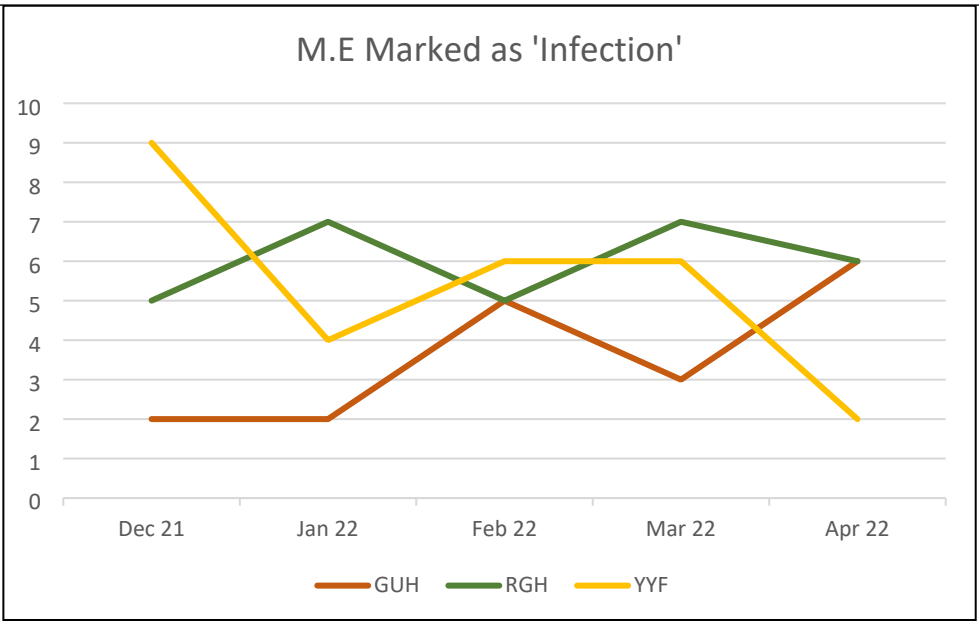


Infection

The Medical Examiner includes details of all infections that occur in the final admission or illness and include patients admitted with a community acquired infection.

The predominant theme relating to infections has been covid, including patients admitted with covid and nosocomial transmission. All cases of nosocomial covid identified by the ME will be subject to a review by IP&C and further investigation through the national nosocomial investigation framework and themes and trends are reported to the Regional Nosocomial Transmission Group.

Figure 14 ME Referrals with Infection

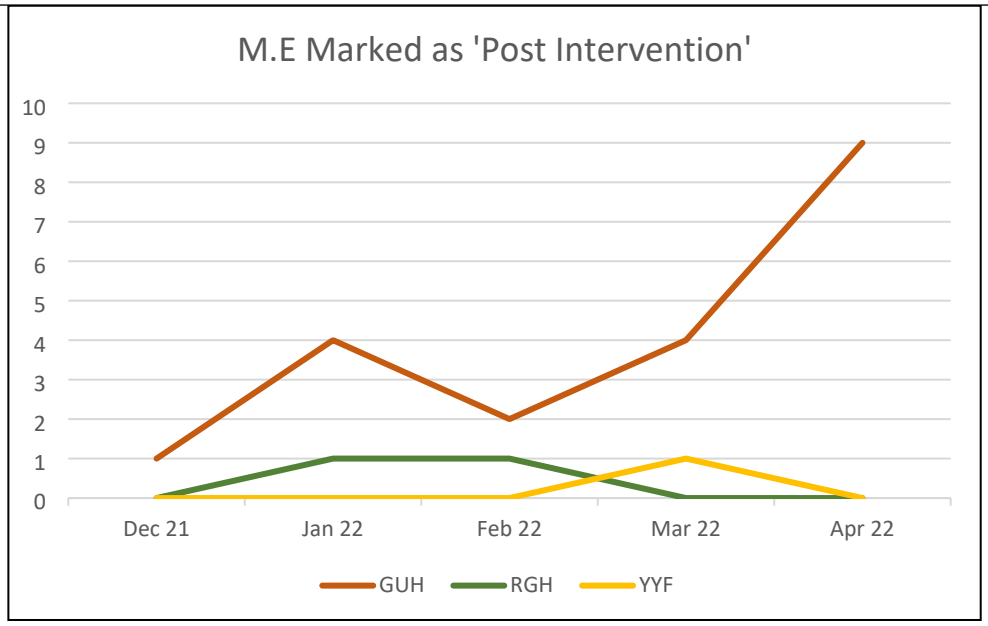


Interventional procedures

Referrals associated with recent interventional procedures have increased over the past four months, reflective of the increasing elective surgical activity.

All referrals are subject to review by a multidisciplinary panel that includes both physicians, surgeons and anaesthetists to support further scrutiny and to commission additional investigation or action.

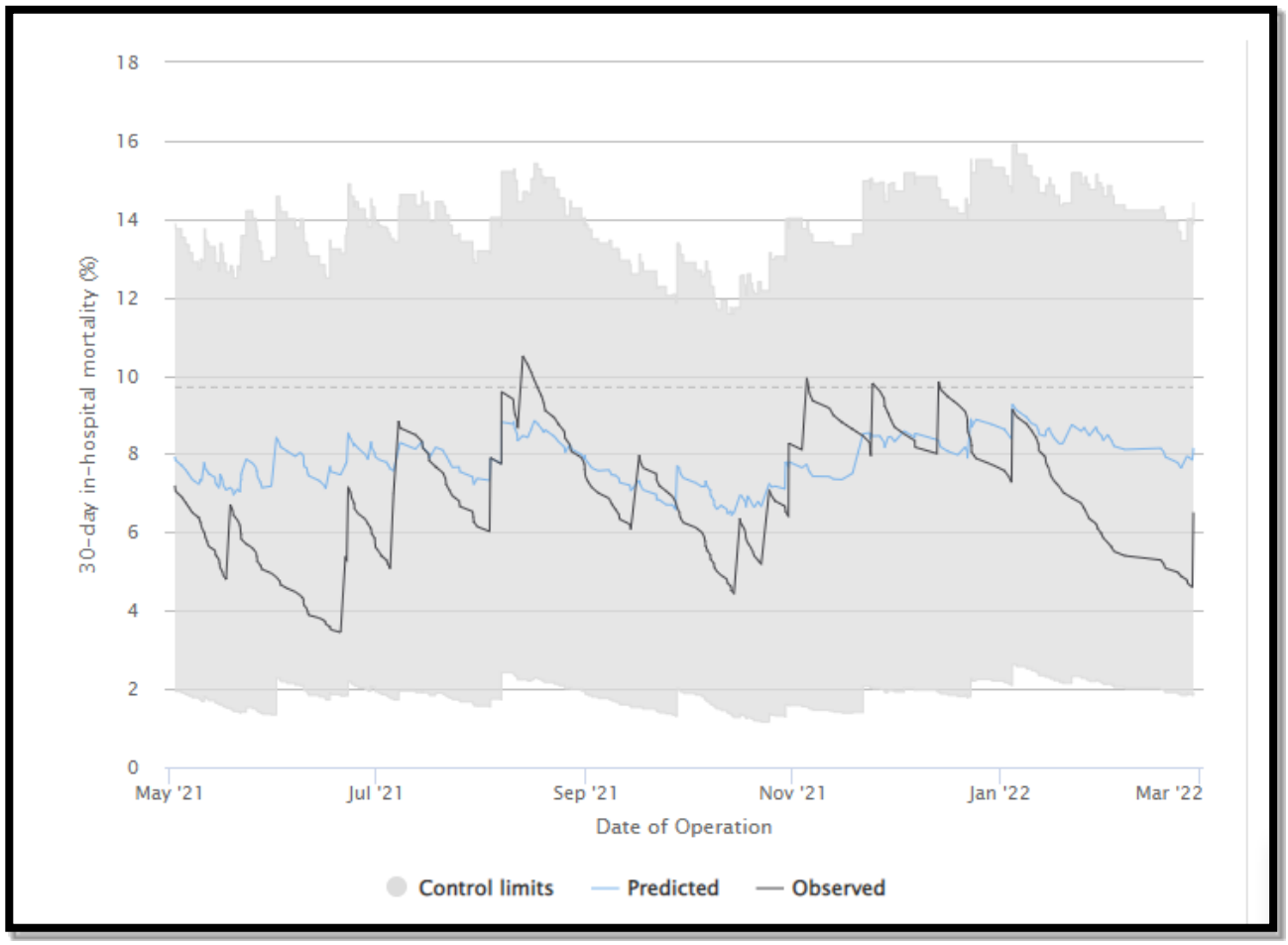
Figure 15 ME Referral Associated with Post Intervention Procedure



The National Emergency Laparotomy Audit (NELA) identified Royal Gwent Hospital as a mortality rate outlier in 2019-2020 with an adjusted mortality rate of 14.4% compared to a mortality rate of 9.5% in NHH and 8.7% nationally. Future NELA reports will reflect the opening of GUH and relocation of surgery to this site. There is an ongoing programme of improvement focusing on increasing the presence of consultant anaesthetists and surgeons in theatres, reducing delays to theatre and improving multi-disciplinary decision making around post-operative admission to ITU.

NELA produce Exponentially Weighted Moving Average (EWMA) mortality charts to provide near real-time 30 day unadjusted in-hospital mortality. The EWMA chart displays the expected range of mortality given the hospitals casemix, and the hospital's actual mortality. The unadjusted data in Figure 16 suggests an improvement in mortality in the past 14 months.

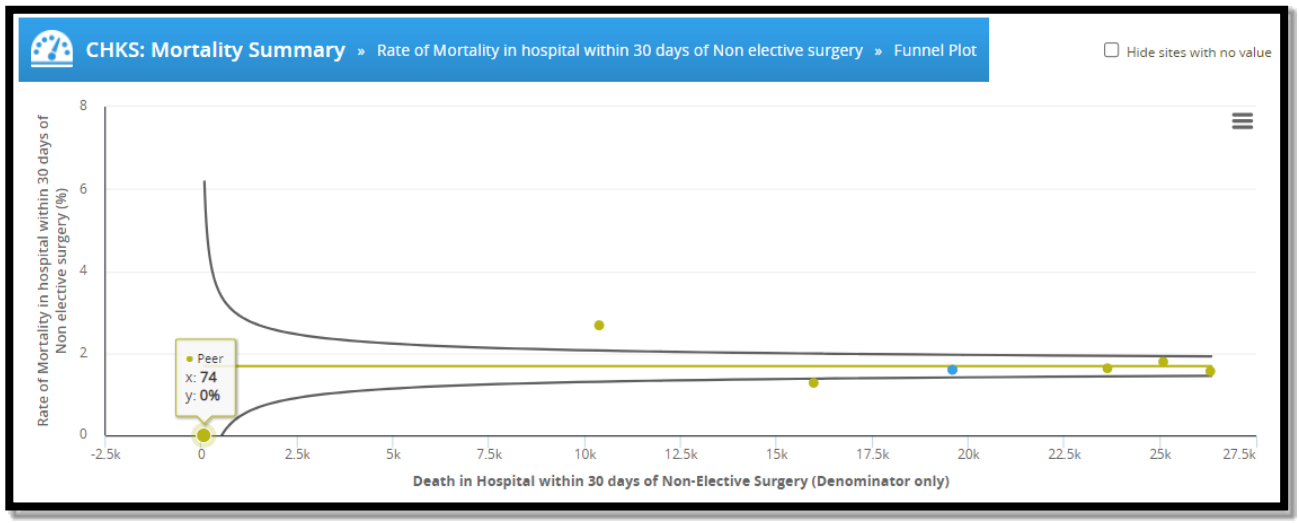
Figure 16 Real Time ABUHB NELA Mortality (EWMA)



Non elective Surgery Mortality

30 day mortality associated with non-elective procedures is recorded as a percentage of total surgical cases and is illustrated in the Figure 17 compared with Welsh Health Organisations. ABUHB performance is below the national mean and was 1.42% for January 2020-march 2022 compared with the Welsh peer average of 1.79%.

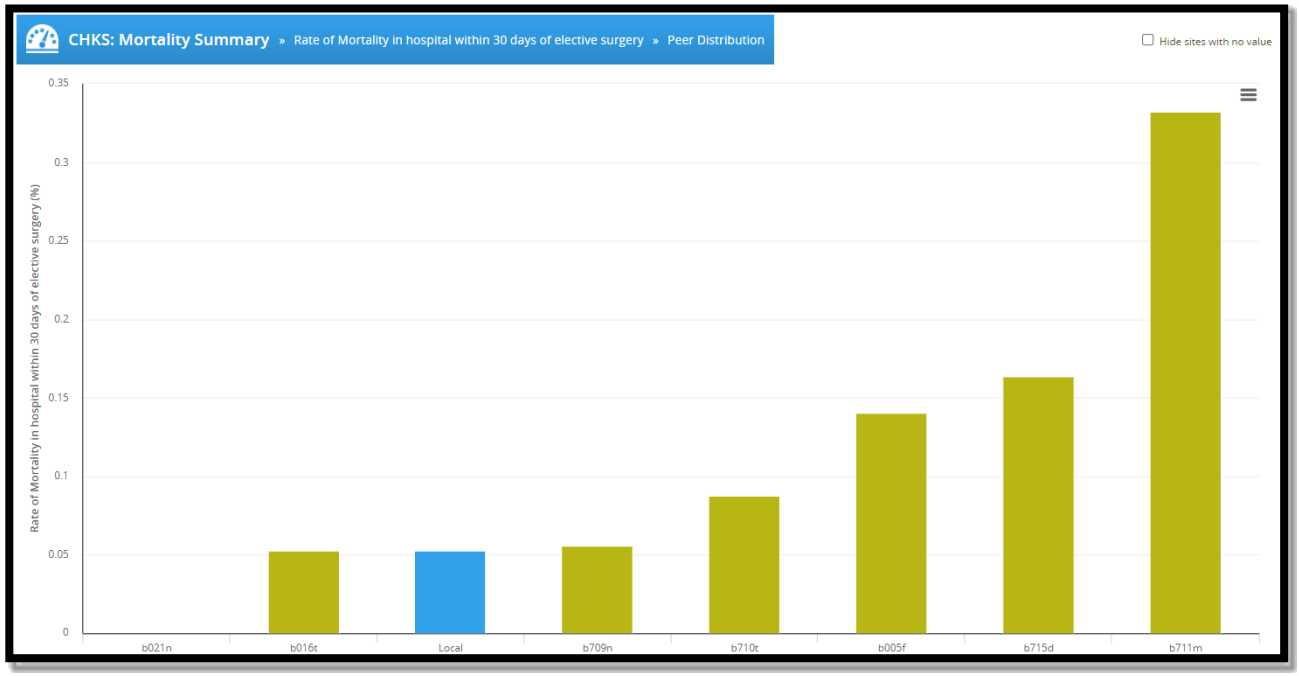
Figure 17 Non elective 30 day inpatient mortality



Elective Surgery Mortality

Figure 18 illustrated the ABUHB performance relating to 30 day inpatient associated with elective procedures. ABUHB have a 0.05% 30 day inpatient post elective surgery mortality rate for January 2020-March 2022 and report the second lowest rate in Wales.

Figure 18 Elective Surgery 30 day Inpatient Mortality



Following consideration at the ABUHB Mortality Review Panel, the Mortality and Morbidity (M&M) groups have been asked to provide assurance relating to questions raised by the Medical Examiner, for example the process of informed consent and the communication of risks and benefits of interventional

procedures to patients and their families. The outcome of the reviews are pending and will be reported in the next Learning from Death report.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)

Several referrals received from the Medical Examiner have noted delays in completion of a DNACPR decision and in two cases there has been poor documentation relating to the reasons for the decision. Discussion at the All Wales Mortality Review Steering Group suggest that this is a theme observed in a number of Health Organisations in Wales.

Two Grand Round development session have been undertaken to raise awareness of the DNACPR process and the importance of undertaking and documenting a mental capacity assessment. In addition an educational video has been developed to support wide reaching education.

Consideration is being given to an All wales DNACPR learning event facilitated by the Delivery Unit in response to the national trend.

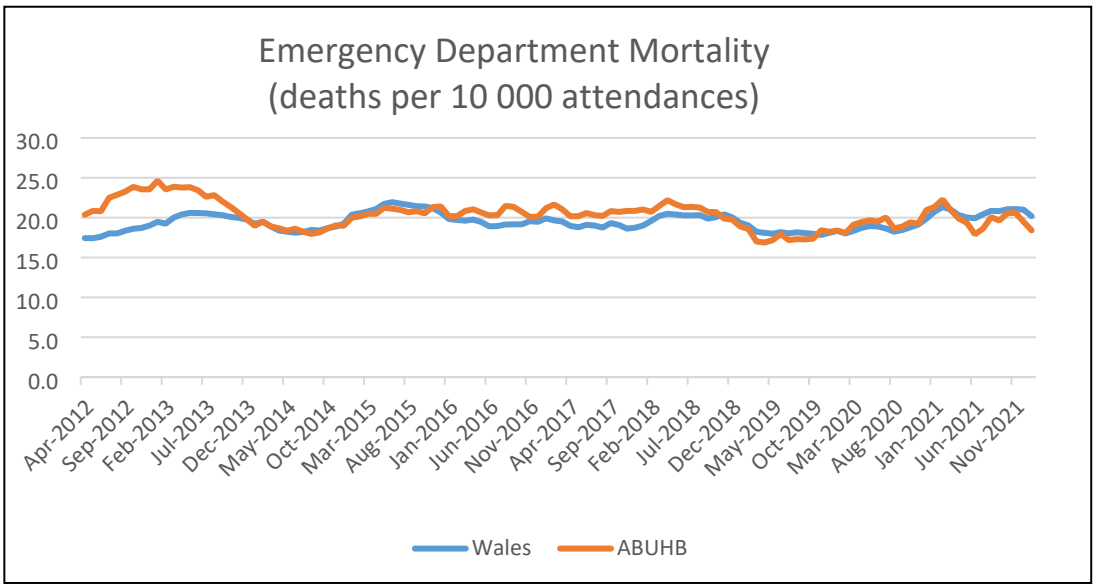
In March 2022 Health Boards in Wales received correspondence from Welsh Government reminding them of their responsibility to undertake two yearly Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) audits reviewing a minimum of 50 cases in each audit. In 2021 ABUHB undertook a retrospective audit of DNACPR forms completed during the first and second Waves of Covid. 124 forms completed between March and June 2020 (wave 1) and 95 form completed between October 20 and January 21 (wave 2) were reviewed and an additional 30 cases were reviewed prospectively. The results demonstrate good documentation of the reasons for the DNACPR decision with 98% compliance in the first wave and 91% in the second wave. 94% of forms recorded the patients mental capacity status and 84% of the forms completed during the second wave. There was poor completion of the existence of a Lasting Power of Attorney or an Advanced Decision Document in both waves, when these documents existed.

An audit of DNACPR is currently underway and a Treatment Escalation Plan audit is currently planned and will be undertaken by August 2022. Both results will be shared with the All Wales Advance and Future Care Planning Strategy Group.

Emergency Department Mortality

Welsh Government provide all health boards in wales with data relating to Emergency Department (ED) Deaths per 10000 attendances. Making direct comparisons between health board mortality rates is difficult due to variation in the configuration of accident and emergency departments across wales and the inclusion of minor injuries services in some EDs. Figure 19 illustrates ABUHB ED mortality compared to All Wales mortality rate per 10 000 attendances.

Figure 19 Emergency Mortality Rate per 10 000 attendance



A thematic review of deaths occurring in GUH emergency department between September and December 2021 identified 85 deaths.

The majority of patients that died within the ED received conservative medical treatment and palliative care from assessment onwards or were admitted following an out of hospital cardiac arrest.

Six patients had been subject to delays in being admitted into the department and four of these were delays in conveyance to GUH. Two patients experienced delays in ambulance handover. One of these patients experienced delay at an ELGH and were subsequently transferred to ED. The second patient experienced a 6.5 hour delay in handover from the Welsh Ambulance Service Trust (WAST) to the ED - although this delay did not contribute to the patient's outcome.

Notable themes included the sub optimal completion of Treatment Escalation Plans (TEP) and communication between clinicians in the ED, ITU and anaesthetics. A TEP audit is planned by August 2022 to inform work which will support improved compliance with the TEP process. An operational group has been formed to support safer and more effective transfers of patients between sites to support improved communication.

Acute Care of Patients with a Learning Disability

The Health Board have received five referrals from the Medical Examiner relating to care received in the acute secondary care setting of individuals with a learning disability.

Four cases highlighted potential learning, including improvements in communication and timely medical review and monitoring.

Two cases are being further investigated as serious incidents with consideration given to reporting nationally and one of these will be considered at an Inquest.

All deaths of patients with learning disabilities have traditionally undergone additional scrutiny at mortality review and there is a low threshold for triggering further examination of care.

In each of the four cases the Medical Examiner has identified areas that required additional consideration, either to confirm the patients cause of death, to establish if an acute hospital setting was the most appropriate place to provide care or because of communication issues, details of the cases have not been provided to avoid the risk of patients being personally identifiable".

The 1000 lives work "Improving General Hospital Care of Patients who have a Learning Disability" included a care bundle which aimed to improve:

- Early recognition of patients with learning disabilities.
- Effective communication with patients, carers, family members and clinicians.
- Dignified, person-centred care and treatment
- Effective review and discharge planning.

The bundle includes steps to be undertaken within 4 hours of admission, within 24 hours of admission and within 7 days of admission. These actions are designed to support patient centred care , involving next of kin or carer and the Learning Disability Team. These standards were previously monitored through the ABUHB Learning Disability Steering Group. This group did not meet during the pandemic. In response to the ME referrals the group has reconvened and the membership is being reviewed.

A thematic review of four of the ME cases will be undertaken with terms of reference agreed with the Clinical Director for Learning Disabilities and the MHLD Division and the results will be presented back to the Learning Disability Steering Group.

Non Contrast CT Scan

A recent Medical Examiner referral identified a patient who developed post-operative complications. A non-contrast CT scan was undertaken, which did not pick up bowel ischaemia and a thrombus. A repeat contrast CT scan undertaken 12 hours later identified the pathology and prompted a laparotomy. Non contrast CT scans are sometimes undertaken to prevent acute kidney injury (AKI) however in this case the risk of not identifying the bowel pathology outweighed the potential risk of AKI.

The presentation at panel triggered further discussion around similar cases where non contrast CT scan had been undertaken.

In response, this case will be considered jointly between General Surgery and Radiology to understand the contributory factors and to consider the development of a protocol to support decision making around the use of non-contrast CT scans.

Vancomycin Prescribing and Administration

Two recent Medical Examiner referrals highlighted errors in Vancomycin prescribing, administration and monitoring. In one case there was a failure to use a vancomycin chart and both cases resulted in failure to monitor Vancomycin blood levels. These omissions in care were not contributory factors in either patient's death, however both have quality and safety implications.

Both cases were presented at the ABUHB Medicines Safety Group where it was agreed that a thematic review of all Vancomycin medication errors reported in the past 12 months would be undertaken and reported back to the medicines Safety Group along with recommendations for any necessary improvements and actions.

Recommendation
The Committee isasked to: **NOTE** the assurance provided by the ABUHB process for reviewing and scrutinising standards of care through monitoring of inpatient and 30 day mortality **Discuss** the learning and improvements being implemented where required

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report reviews high level data in order to highlight learning from death. The quality improvement initiatives in this report are being undertaken to improve patient safety and therefore reduce the risk of harm to our Patients. Improved patient safety also reduced the risk of litigation Issues are part of Divisional risk registers where they are seen as a particular risk for the Division and a number of areas are also included within the Covid and Corporate Risk Registers.

Financial Assessment, including Value for Money	Some issues highlighted within the report will require additional resources to support further improvement. These will be subject to individual business cases which will contain the full financial assessment. In many cases, improving the quality will reduce harm to patients and/or waste, but this will also be highlighted in the business cases.
Quality, Safety and Patient Experience Assessment	The report is focussed on improving quality and safety and therefore the overall patient experience.
Equality and Diversity Impact Assessment (including child impact assessment)	NA
Health and Care Standards	Health and Care Standards form the quality framework for healthcare services in Wales. The issues focussed on in the report are therefore all within the Health and Care Standards themes, particularly safe care, effective care and dignified care. Many of the themes reported in the paper have been discussed and presented at ABUHB groups that from part of the quality assurance framework
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP and the quality improvements highlighted here are within the Plan.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being Objectives and should also indicate to which Objective(s) this area of activity is linked.*
	Long Term – Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Involvement –Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.

	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	
Public Interest	Report has been written for the public domain.

Committee:	Patient Quality, Safety & Outcomes Committee
Date:	**7th June 2022**
Agenda Item:	**2.5**
Document Title:	**HIW – Unannounced Visit to the Grange University Hospital (1-3 November 2021)**

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality Safety and Outcomes Committee Tuesday 7th June 2022 Agenda Item:2.5

Aneurin Bevan University Health Board

Patient Quality, Safety and Outcomes Committee

HIW – Unannounced Visit to the Grange University Hospital (1-3 November 2021)

Summary

Health Inspectorate Wales (HIW) undertook an unannounced visit to the Grange University Hospital (specifically the Emergency Department, Children's Assessment Unit and Surgical Assessment Unit) on the 1-3 November 2021. Their final report was published on the 29th March 2022 (114 pages).

This paper provides an overview of the findings and an update on progress against the recommendations.

Purpose: **Patient Quality, Safety and Outcomes Committee is asked to:**	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	
Author: Rhiannon Jones – Executive Director of Nursing	
Report Received consideration and supported by:	

Executive Team		**Sub-Committee**	

Date of the Report: 23 May 2022

Supplementary Papers Attached:

- Letter from HIW
- Immediate Improvement Plan – Update May 2022
- Improvement Plan – Update 2022

Situation

Health Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales. They inspect NHS services and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. They essentially check that healthcare services are provided in a way which maximises the health and wellbeing of people. They are: -

- Independent
- Objective
- Decisive
- Inclusive
- Proportionate

Background

The following areas were visited by the team of inspectors over a 3 day period: -

- The Waiting Room
- Triage
- Majors
- Resuscitation
- Rapid Assessment Unit
- Childrens Emergency Assessment Unit
- Paediatric Emergency
- Covid Corridor
- Surgical Assessment Unit

Overall HIW were not assured that all systems and processes in place were sufficient to ensure patients consistently received an acceptable standard of safe and effective care, despite hard working staff.

They identified that until the flow of patients into and through the Emergency Department (ED) can be improved, the Health Board may find it difficult to address a number of concerns.

They observed staff striving to deliver good quality, safe and effective care to patients within very busy units, albeit some staff indicated that could not deliver the care they wanted to (as indicated in the staff survey results).

HIW had some immediate concerns about patient safety which resulted in an "Immediate Assurance" letter to the Chief Executive following the visit. The issues included: -

- Patients in the waiting area not overseen by staff at all times.
- Infection control issues in the Covid corridor.
- Poor staff survey results.
- Resuscitation trolley checks not signed as completed.

The immediate improvement needed and the Health Board response can be found in the Appendix B of the final report. It consists of 12 recommendations and progress has been made against all elements.

HIW have identified 59 recommendations as part of the improvement plan, which can be found in Appendix C of the final report. Reasonable progress has been made in addressing actions.

Assessment

In the final report HIW have summarised what they found the service was doing well, as follows: -

- Patients, including those on ambulances were provided with food and drinks.
- Internal signage was found to be very good and was bi-lingual.
- Paediatric patients were seen in a timely manner.
- Aspects of medicines management were positive.
- They were designated specialist training rooms.
- Patients felt the ED was clean and Covid compliant.
- Patient were triaged for Covid-19 outside the ED.
- Controlled drugs checks were completed in full.
- Good multi-disciplinary team working.
- Management and leadership was focussed and robust.
- Practice Educators were in place with more being recruited.
- The preceptorship and mentorship programme in the SAU.
- Patients were generally complimentary about care in the ED and SAU.

HIW also identified areas they felt required improvement, as follows: -

- The ED waiting area is a major concern with compromised privacy, dignity and comfort due to size and demand.
- Flow through ED.
- Robust completion of patient records to ensure a full record of treatment, observation and medication.
- Patients being offered hand-wipes before and after meals.
- Redirecting the reliance on bank and agency staff.
- Patient flow from ambulance to ED through to wards (or discharge).

- Increasing mandatory training compliance.
- All staff to receive an annual appraisal.

It is usual for the Health Board to provide an update on actions within 3 months of publication of the final report, which would be the end of June 2022. HIW wrote to the Chief Executive on the 9th May 2022, requesting an update against the Immediate Improvement Plan (Appendix B) and the improvement plan (Appendix C) within 7 working days. Their letter was triggered by "concerns" regarding the Emergency Department and ongoing pressures. They requested specific detail regarding the improvements to the waiting area together with an update on flow improvements, with evidence. The updated plans have been provided, together with progress on urgent care transformation and the GUH – one year on report to illustrate impact and outcomes associated with GUH, as discussed at Board. 25 pieces of evidence were submitted.

The following table summarises the number of recommendations, actions completed and the number outstanding (not yet due), together with dates for completion.

Number of improvements identified by HIW	**71**
Number of actions identified by ABUHB	**112**
Total number of outstanding actions	**15**
Dates for outstanding actions	**June 2022 = 3** **July 2022 = 7** **September 2022 = 1** **October 2022 = 4**

Conclusion
Reasonable progress has been made against the HIW recommendations for improvement. As indicated by HIW it will be difficult to address some recommendations, such as improvements in flow, due to the significant demand and capacity challenges which are issues being experienced across NHS Wales and indeed the UK. A revised programme of actions are being undertaken following the recent publication of the national 6 goals for urgent and emergency care. The plan for which is being presented to an extraordinary meeting of the Board mid-June 2022. During the inspection patient views were sought and 84% rated their experience as very good or good.

Recommendations
The Patient Quality, Safety and Outcomes Committee are asked to **NOTE** the HIW Report, the Health Board response and progress against actions and receive the report for assurance

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of inspections, reviews and actions are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	Direct or indirect impact on finance.
Quality, Safety and Patient Experience Assessment	This report is central to the safety and quality of care provided to patients and it provides an update of HIW (Healthcare Inspectorate Wales) inspection of Grange Hospital Emergency Department inspections, reports, and outstanding actions.
Equality and Diversity Impact Assessment (including child impact assessment)	Not applicable to the purpose of this summary report.
Health and Care Standards	This report provides information around standard 2.1, 3.1,3.2, 3.3, 3.5,4.2,5.1, 6.3 and 7.1
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP. This report refers to the work of Healthcare Inspectorate Wales (HIW) in unplanned work which is referenced in the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Long Term – Improving the safety and quality of the services will help meet the long term needs of the population and the organisation
	Integration – The quality and patient safety improvements described work across directorates and Divisions within the Health Board.
	Involvement – Many improvement initiatives are developed using feedback from the population using the service.
	Collaboration – The quality and patient safety described work across directorates and divisions within the Health Board.

	Prevention – Improving patient safety will prevent. Patient harm within our services.
Glossary of New Terms	
Public Interest	The HIW report has been published on their website and is in the public domain.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Chief Executive
Aneurin Bevan University Health Board
Email: Glyn.Jones7@wales.nhs.uk

09 May 2022

Dear Mr Jones,

RE: Action plan from The Grange ED Inspection

As you will be aware, Healthcare Inspectorate Wales (HIW) undertook an unannounced inspection of The Grange Hospital Emergency Department (ED) on 1-3 November 2021. As part of our inspection process, we ask health boards to provide us with an update on the agreed improvement plan three months after the report has been published. As the report was published on 29 March 2022, we would ordinarily not expect this update until 29 June 2022. However, as we have received a number of concerns regarding patient experience at The Grange ED, we are requesting an earlier update. Whilst we are requesting a full update on the action plan (Annex B and Annex C within the report), we would ask that specific attention is given to the ongoing work to improve the space within the waiting room and majors area of the ED, which has a completion date of May 2022. For ease, I have attached a link to the report: 20220329TheGrangeHospitalEDEN.pdf (hiw.org.uk) and enclose word copies of the action plans.

Please can you provide an update against each action contained within the Immediate Assurance action plan (Annex B) and the Improvement Plan (Annex C), and associated evidence to support this, to the Objective Connect workspace by 18 May 2022. If you wish to discuss the above, then please do not hesitate to contact me further.

Yours sincerely

S. Brooks

Sam Brooks
Head of Corporate Services and Relationship Manager for ABUHB

Immediate improvement plan

Service: The Grange Hospital

Area: Emergency Department, including Paediatrics, Majors and Resuscitation, and the Surgical Assessment Unit

Date of Inspection: 1 – 3 November 2021

Quality of patient experience

The arrangements for oversight of the waiting room in the main emergency department, the waiting room in the Children's Assessment Unit and areas within the surgical assessment unit (SAU), placed patients at risk of harm through unobserved deterioration.

EVIDENCE

The main waiting room in the emergency department had treatment rooms to one side where staff would triage patients from the waiting room. There was limited visibility of the waiting room from the reception area, and the staff who sat in this area also had limited knowledge of first aid. There was CCTV in the waiting room, this was monitored on an ad hoc basis from a monitor in an area known as the rapid assessment unit (RAU).

If the condition of a patient deteriorated, the unit were reliant on:

- Reception staff informing staff in the RAU if they saw anything relating to a patients' condition

- Patients informing reception staff
- Triage staff noticing anything when they went into reception to call out the names of the next patient
- A staff member seeing an incident on the CCTV monitor.

The Director of Planning told us that there were both short terms plans (by January 2022) and longer term plans (by mid-year 2022) to move the waiting area, to ensure better patient visibility.

Children's Assessment Unit - The waiting area is closed off from the ward and requires a swipe card to access. We were told that there was a receptionist there most of the time, but not all the time. As child health can be unpredictable and deteriorate quickly, relying on parents is not acceptable. Whilst staff observe the children often, if the ward is busy it may not be as regular as required. Staff should be able to observe all the children in the department.

The Director of Planning also told us that plans were in place to extend this assessment unit, but this is unlikely to be completed before August 2022.

SAU – We were told that patients sitting in the chairs along the corridor wall were allocated a qualified member of staff who undertook all their nursing duties, reviewing their care regularly. However, the unit were aware that the patients did not have a call bell. Staff sitting in the reception area had limited visibility of the majority of the patients sitting in the chairs and staff were not present in this area at all times. During the visit, one HIW Inspector noticed a patient in some distress who said they were having a panic attack. There were no nursing staff visible in the area at that time. The Inspector asked a healthcare support worker (HCSW) in a nearby room to assist the patient.

If the condition of a patient deteriorated, the unit were reliant on:

- Reception staff informing staff in the SAU if they saw anything relating to a patients' condition
- Patients informing reception staff

- Staff noticing anything when they attended to another patient.

HIW is not fully assured that the unwell patients, in the various waiting areas, were being sufficiently monitored at all times.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
HIW requires details of how the health board will ensure that there are measures in place to ensure that:				
1. All patients accommodated in the waiting room are observed and monitored to ensure their safety, at all times.	**Standard 2.1** Managing Risk and Promoting Health and Safety	**1)** CCTV cameras covering all areas of the main waiting area have been installed. Monitors are in place within the triage area, assessment area and office within majors monitoring this area. These areas are manned 24hrs a day	Service Lead / Clinical Director / Senior Nurse / Divisional Nurse	Completed
2. All patients accommodated in the children's assessment unit waiting room are observed and monitored to ensure their safety, at all times.		**2)** CCTV cameras have also been installed within the paediatric waiting area. **3)** May '22 - Additional Health Care Support Workers in place to observe children and for general		Completed

		rounding to support children and families.		
3. All patients accommodated in the surgical assessment unit chairs are observed and monitored to ensure their safety, at all times.		**4)** The chairs within the back corridor have been removed and these patients are now managed within the main unit **5)** The remaining chairs and waiting area are monitored by one registered nurse, one Health Care Support Worker and the ward clerk	Scheduled Care Service Lead / Clinical Director / Senior Nurse / Divisional Nurse	Completed

Delivery of safe and effective care

The location of the area known as the COVID-19 corridor has created a risk of cross infection and a failure in infection prevention and control. There was also on occasions insufficient staff available to monitor patients.

EVIDENCE

Patients were triaged for COVID-19 symptoms before entering the emergency department. Patients with symptoms of COVID-19 would be streamed down a corridor known as the COVID corridor. Approximately 15 metres down this corridor there was an area with equipment for a patient to be briefly triaged and tested for COVID. The patients would then sit in soft chairs, with screens between each patient, along this corridor. At the end of the corridor, approximately 80 metres long, was the COVID-19 ward known as A1. The area was not a public thoroughfare, other than the other patients in the corridor passing each other. There would normally be two members of staff on duty, one qualified and one healthcare support worker. Staff would wear the appropriate PPE with patients (apron, mask and gloves).

We noted the following points:

- There was no wash hand basin for patients or staff in this area, although there was sanitising gel available
- The staff manning this station would have to go into the non-COVID paediatric area to print off the “casualty cards” for each patient and then return to the COVID-19 corridor
- Staff from other areas, such as resuscitation, the main emergency department or the paediatric area would pass this area from time to time if they needed to walk between these areas creating additional footfall and risk of cross infection
- The staff on duty in addition to testing the patients, would also have to monitor the patients in case their condition deteriorated, view patients in an ambulance with suspected COVID-19, from time to time, as well as the testing in the corridor. If the staff in this area needed additional support because of the number of patients, they would escalate to the nurse in charge of ED. We were told this would then be risk assessed to see whether another member of staff should be sent to assist this area, but there was not always someone available.

HIW consider that this provided a risk of cross contamination, a failure in infection prevention and control and of being unable to appropriately manage the patients in this area. We were told by the director of nursing that as a result of our observations, there will be a rapid installation of a sink, but that infection control considered that the wearing of PPE provided sufficient mitigation.

Resuscitation equipment was not being checked to ensure that the contents were complete, serviceable and in date

EVIDENCE

We considered the arrangements for the checking of the contents of resuscitation trollies in the various areas of the department. The records in the Resuscitation and Majors areas showed there were a number of gaps in the record of checks completed in October 2021 on both units. This demonstrated that the resuscitation equipment had not always been checked daily. We reviewed the contents and we found the items to be in date and serviceable.

HIW consider that the lack of regular checks meant that there was a risk to patient safety, as the resuscitation trollies in both units may not be sufficiently stocked, or equipment / medication may not be in-date and ready for use, in the event of a patient emergency. We were told by the director of nursing that as a result of this and a previous failing in another inspection, the health board have now issued an organisational-wide alert. This is to ensure that these checks are carried out daily and evidenced. The health board will be carrying out a health board wide audit to ensure compliance with these checks.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action it will take to ensure that:				
4. The risk of cross contamination is reduced in the area known as the COVID corridor.	**Standard 2.4** Infection prevention and Control (IPC) and De-contamination	**6)** A Portacabin for the management of suspected COVID 19 patients has been delivered and is currently being commissioned for a July 2022 opening. This will result in the current COVID 19 corridor being decommissioned	Service Lead / Clinical Director / Senior Nurse / Divisional Nurse	July 2022 **(1)**
5. Suitable hand washing facilities are provided.		**7)** A sink was installed during the inspection (5 November 2021)		Completed
6. Printing facilities are available within the corridor.		**8)** A dedicated printer is now available within the corridor		Completed

7. Risk are mitigated in the corridor care when the number of patients is greater than can be managed by the normal staffing level.	**Standard 2.1** Managing Risk and Promoting Health and Safety.	**9)** A Portacabin for the management of suspected COVID 19 patients has been delivered and is currently being commissioned for a July 2022 opening. This will result in the current COVID 19 corridor being decommissioned	Service Lead / Clinical Director / Senior Nurse / Divisional Nurse	July 2022 **(2)**
		10) Patients presenting with COVID 19 symptoms is reducing. When there is a peak in demand this is escalated to the Nurse in Charge and where possible and appropriate extra staffing provided to support		
8. Resuscitation equipment and medication is always available and safe to use in the event of a patient emergency within the emergency department and within all other wards and departments across the health board.	**Standard 2.6** Medicines Management and **Standard 2.9** Medical Devices, Equipment and Diagnostic Systems	**11)** Daily audit of checking all emergency trollies in place **12)** Included in daily Safety Briefing **13)** Health Board wide alert sent to all areas **14)** Internal comms within ED via Nursing Newsletter and secure social media groups	Service Lead / Clinical Director / Senior Nurse / Divisional Nurse	Completed

Quality of management and leadership

The HIW online survey indicated that staff were feeling overworked, due to understaffing, the volume of patients, shortage of emergency department experience and insufficient space in the department, hospital and the community to cope with the patient numbers.

EVIDENCE

We made arrangements for staff to be able to complete an online survey relating to their experience at the various areas within the emergency department at the Grange University Hospital. The survey is open until Friday 5 November 2021 and the comments below are based on a download taken at 10.00am on Wednesday, 3 November 2021, with 78 responses.

Based on the responses received there were a number of tick replies to various statements. Whilst the majority of these were not negative, the number of 'sometimes' and 'never' or similar less positive replies, were considerably worse than has been previously noted on inspections. There were also a number of negative and possibly passionate comments made by staff.

From what we saw during the inspection, and the comments made to HIW inspectors, the management and leadership was good. We also noted the environment was quiet and calm, with staff going about their work efficiently, treating patients with respect. However, based on the survey comments, staff clearly feel that:

- There are insufficient staff to deal with the number of patients presenting, in a timely manner
- There is insufficient space to treat patients in a timely manner
- Some staff may not have sufficient experience in the emergency department

- General frustrations with patient flow as a whole
- Not being able to provide the level of care that patients deserve based on the above.

We also spoke to medical staff who had similar concerns regarding the availability of beds to move patients into, outside of the department and being unable to treat patients because there were no treatment rooms available.

The negative comments, as written, included:

"Lots of feedback been given about department not being safe and fit for purpose and feeling dangerous to patient care. Constantly short staffed or not staffed with appropriate experience"

"60+ patients in the waiting room being looked after by 2-3 nurses isn't safe, especially when you don't have eyes on them. I feel every shift In the dept is a near miss. Also looking after unwell patients with COVID in a corridor isn't safe when often they require oxygen, iv therapy, bloods and cannulation. Then if the triage nurse is outside triaging an ambulance and NO HCSW or they are in A1 performing ECG etc who looks after the corridor?"

"The job in general is now detrimental to my health xxx and with the lack of space in the department, space in the hospital as a whole and the lack of staff. Some agency staff have commented that they would not come back to the department due to the above reasons. Stress levels are at an all-time high, anxiety levels are constantly raised both in and out of shift due to the worry of being unable to complete my work to my high standards with the situation of the department and worrying about what I have missed or the pressures on other staff members. Breaks are often missed due to demands within the department. Lack of staff and the acuity of patients mean that things cannot wait and staff regularly end up going late for breaks sometimes going up to 6/ 7 hours without a break or even a drink. Senior nurses try their best to support breaks and move staff to help but unable to do so resulting in long waits when short staffed."

"Work is very stressful and everyone is finding it hard. Senior managers help when needed but sometimes I feel I don't want to bother them because they have so much more going on trying to make the department safe. It is hard not to let work affect your health as you constantly go home exhausted. Thinking about what care you have given and how it isn't to the standard you would like."

“I’m exhausted on my days off. I often can’t sleep when I get from home because of the stress.”

“They know it’s overcrowded and under staffed. Even offering extra pay for doing bank staff won't do it. It's too much soul destroying working there. Staff are just leaving all the time.”

“My manager has always been good with me. However I feel at the beginning when we first opened and before we opened at the Grange there was no support we wasn't prepared for our new job role. We should of had training and been told what would be expected from us so we could been prepared instead being put in a new environment not having a clue.”

“The emergency department and acute medical take of this hospital is frankly unsafe. The number of near misses every single day is shocking (and too numerous to incident report constantly). The model of care to step-down patients is an error and there is not enough capacity at GUH. The physical footprint of the building is inadequate for a new 'super-hospital' - not enough space and not enough flow as well as not enough provisions for staff. Patients are constantly let down and put at risk by long waiting times, numerous transfers (especially the frail and elderly). The amount of clinical risk healthcare professionals encounter every day is vast. Wellbeing of the workforce is not a product of wellbeing measures but actually the everyday work environment.

I would strongly recommend that no-one should work in ABUHB and especially GUH. I would certainly not recommend it patients and would feel afraid if my family needed to attend.”

The percentages of replies to various comments or statements included:

- 27 percent of staff said they had faced discrimination at work within the last 12 months (on grounds of nine protected characteristics, other and prefer not to say)
- 50 percent of staff said they ‘disagreed’ or ‘strongly disagreed’ with the statement ‘I would be happy with the standard of care provided by this organisation for myself or friends / family’ and 29 percent neither agreeing or disagreeing
- 66 percent of staff were only ‘sometimes’ able to meet all the conflicting demands of their time at work

- 56 percent of staff were only ‘sometimes’ satisfied with the quality of care given to patients
- 93 percent of staff answered with ‘sometimes’ or ‘never’ to the statement, ‘There are enough staff working in the department to allow me to do my job properly’.
- 100 percent replied ‘no’ to the question, ‘From your time spent within the ED, do you feel the ED staff are able to perform their duties in line with patient’s needs?’ (only 12 staff replied to this question)
- 92 percent replied ‘no’ to the question, ‘Are patients able to access your service from the ED in a timely way?’ (only 12 staff replied to this question).

The draft and final report will include details of all the questions and answers but only a sample of comments, which will include comments that are generally less negative. We were also told of a number of initiatives within the areas covered that have been introduced including the weekly nursing news and that 19.44 whole time equivalent staff are being recruited.

HIW believes that, whilst the above is a snapshot of the full survey and does not include all the areas whether negative or otherwise, there is a need to ensure that the issues and concerns raised by staff are addressed.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action it will take to ensure that:				
9. The areas of dissatisfaction shown by staff are addressed.	**Standard 7.1** Workforce	**15)** Nursing Newsletter sent every Friday which contains relevant departmental information (e.g.	Senior Nurse / Divisional	Completed

		good news, bad news, plans for development).	Nurse	
10. Staff are updated regularly on the action taken to address the issues raised.		**16)** A social media broadcast group in place for nursing staff which shares messages from the Band 7 team. This is then re-enforced via email		Completed
		17) Quarterly staff meetings in place		
		18) Wellbeing link nurses in place. Open forum in place		
11. A similar exercise is carried out to establish the improvements in the actions taken by the health board.		**19)** Two Staff Engagement sessions for Urgent Care have been undertaken using Appreciative Inquiry methodology for improvement focussing on 'Schwartz Rounds'. This has engaged c.40 individuals on "Our experiences during COVID and working in GUH'. Feedback from staff has been positive including:	Assistant. Director WOD	Completed

		"It was lovely to hear everyone's feedback to know that I am not alone in feeling overwhelmed. It was a very powerful session". *"Good to share experience and support one another".* *"Facilitated well, ensuring a safe space to openly share feelings and experiences"* *"I loved my time here today. I found this day to be very helpful and gave me the opportunity to vent on what needs to be aired".* **20)** A series of 'People First – staff reconnection' Exec site Walkarounds have also been undertaken at the GUH site (three in Q3, 4 2021/22). The visits have promoted reconnection between Exec team, Divisional Management teams and Staff members, with time and space for staff to discuss their experience of working directly with operational and executive leadership.		
12. On-going support is provided to staff, to promote and maintain staff well-being.		**21)** Open door availability to meet with Senior Nurse	Service Lead / Clinical	Completed

		22) x2 wellbeing Consultants and x2 Band 7 nurses in place	Director / Senior Nurse / Divisional Nurse	
		23) Regular staff wellbeing sessions are available		

Service / health board Representative:

Name (print): Penny Gordon

Role: Head of Nursing, Urgent Care

Date: 18/05/22

Appendix C – Improvement plan – update for HIW (May ’22)

Hospital: The Grange Hospital

Ward/department: Emergency Department and Surgical Assessment Unit

Date of inspection: 1 – 3 November 2022

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that: 1. More leaflets or posters are available in all areas of the Emergency Department (ED) relating to support groups 2. Where applicable patients should be questioned about how they are looking after their health and this should be documented on patient notes 3. The Right Place message is advertised further throughout the health board area, including in health centres, clinics and GP practices.	1.1 Health promotion, protection and improvement	1) A selection of Health promotion and awareness/support posters are now in place (E1)	Service Lead / Clinical Director / Senior Nurse / Communications Team	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
Health board must ensure that: 4. Staff are reminded of the need to consider any communication issues with patients when speaking with patients 5. Staff are reminded about the need to ensure privacy and dignity and confidentiality when speaking to patients in areas where they can be overheard 6. The communications with patients in the waiting room are improved	4.1 Dignified Care	2) Within the medical clerking proforma the assessing clinician will ascertain a number of social, health and wellbeing information including home circumstances, weight, BP, smoking, drugs and alcohol. Where necessary appropriate referrals will take place.	Service Lead / Clinical Director / Senior Nurse / Nurse in Charge	Completed
		3) When patients are admitted the Patient Care Record is completed.		Completed
		4) Choose Well has been reinforced to service users and Health Care Professionals via the Health Board's website and social media platforms.		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
to ensure confidentiality, including the hearing loop 7. More room is made available in the main reception area and for the triage area for patients 8. They consider the comments raised by staff who do not work in the ED and provide HIW with the work they are carrying out to address these issues 9. The section on the patients' notes in relation to capacity, comfort and dignity is completed in full 10. That patients are not required to wait on chairs overnight		5) The intercom/hearing loop on the main reception has now been moved which has improved communication /confidentiality during the booking in process.		Completed
		6) Staff have been reminded of the importance of maintaining patient privacy throughout the department. Private rooms are available if required. (E2)		Completed
		7) There is ongoing work to improve the space within the waiting room. In July 2022 a temporary structure will be commissioned which will house a larger waiting area and assessment rooms whilst a permanent solution is developed to improve the waiting area long term.		July 2022 **(1)**

Improvement needed	Standard	Service action	Responsible officer	Timescale
11. The chairs used in the corridors are changed to reclining chairs to ensure patients can wait comfortably for their treatment, especially when having to wait long periods 12. The use of alternative pathways for cancer palliative patients to avoid attending the ED 13. A secure soundproof confidential area be provided where ambulance staff can exchange information and handover patients away from a public corridor.		8) Weekly meetings with WAST colleagues continue with a focus on quality, safety and experience. (E3)		Completed
		9) There is continued work across the Health Board to improve the flow of patient, to reduce pressure in the ED and assessment areas, aligned to the new 6 Goals national programme.		Completed
		10) All staff have been reminded of the importance of completing documentation fully.		Completed
		11) Daily one patient one day audits will continue to monitor completion of documentation and compliance. (E4)		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		12) Monthly Dignity & Essential Care Inspections are undertaken by Senior Nurse and Deputy Head of Nursing, with actions taken to secure improvement. (E5)		Completed
		13) Comfortable chairs are now in place to improve patients comfort within sub wait, Red corridor and A1.		Completed
		14) Fit to sit criteria in place and all patients in chairs are assessed with appropriate escalation to the site ops team in the event of concerns. To note there are discussions to consider a national “Fit to Sit” policy. (E6)		July 2022 **(2)**

Improvement needed	Standard	Service action	Responsible officer	Timescale
		15) An ED escalation process is in place, with ongoing review to align to the new national Escalation Plan.		Completed
		16) Cancer pathways are in place, there can be however occasions when speciality areas are full with no bed capacity.		Completed
		17) There is a dedicated ambulance triage area. A private room is available as required.		Completed
		18) Where crews are held the ambulance triage nurse will go to each ambulance to undertake timely triage.		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		19) Crews' handover at the patient's bedside to promote confidentiality.		Completed
14. The health board must ensure that all signage is in an area that can be seen and that patients, including those with sight difficulties, can see the signs.	4.2 Patient Information	20) All signage on the first floor has been reviewed. (E7)	Estates Manager	Completed
		21) A plan is in place to remove and install new signage where the font was assessed as being too small.		June 2022 **(3)**
15. The health board must consider ways of ensuring that communication with patients waiting for care or triage is effective, on the initial call to avoid delays in treatment.	3.2 Communicating effectively	22) Patient information screens have been installed in the ED waiting area to include Choosing Well, Health promotion, support groups, which is being finalised.	Service Lead / Clinical Director / Senior Nurse	July 2022 **(4)**

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is to provide HIW with the update on the actions taken to: 16. Introduce an electronic waiting time board 17. Reduce the waiting times for patients 18. Ensure a system wide solution to poor flow and overcrowding at the ED waiting rooms. 19. The health board must ensure that staff in the ED and WAST staff are all aware of their responsibilities for the patients when in the ambulance until they have been	5.1 Timely access	23) The ED is working towards an automated display of live waiting times for triage and wait to be seen by a clinician in keeping with accepted good practice as recommended by the Royal College of Emergency Medicine.	Service Lead / Clinical Director / Senior Nurse	October 2022 **(5)**
		24) The ED medical staff rotas are matched to attendances to ensure staffing is maximised at the busier times of the day to improve wait times.		Completed
		25) The ED and assessment units have invested in alternative roles to support medical staff and reduce the wait to be seen time (Nurse Practitioner's / Physician Assistants / Acute Care Practitioners).		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
offloaded into the ED, including for pressure relief.		26) There is continued work across the Health Board to improve the flow of patients through the ED and assessment units, via the Urgent Care Transformation Programme.		October 2022 **(6)**
		27) There are agreed policies with the ED and WAST in place, with roles and responsibilities outlined.		Completed
The health board must ensure that: 20. Patient records are completed in full including clear evidence of a transfer of care and discharge planning.	6.1 Planning Care to promote independence	28) Nursing staff will ensure appropriate discharge arrangements and transport is in place to ensure a safe, effective and timely discharge. A discharge checklist is available within the nursing documentation and will be completed.	Band 7's / Senior Nurse / Nurse in Charge	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
21. The necessary arrangements are in place to ensure that transport had been ordered and community support had been requested.		29) Staff have been reminded about the importance of completing a timely and safe discharge. (E8)		Completed
		30) Daily one patient one day audits will continue to monitor completion of documentation and compliance.		Completed
		31) Monthly Dignity & Essential Care Inspections undertaken by Senior Nurse and Deputy Head of Nursing, with actions taken to address any deficits.		Completed
The health board must ensure that:	6.2 Peoples rights	32) Patients deemed end of life will be transferred to a cubicle where possible.	Service Lead / Clinical Director /	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
22. The location of the room for patients at end of life should be reconsidered to ensure that the patient and relatives are able to spend their remaining time together at peace in a secluded or quiet area 23. Further arrangements are put in place to ensure that all patients are made to feel that they can		33) ED End of Life nursing document is being implemented to improve the management of this patient group.	Senior Nurse	June 2022 **(7)**
		34) Choose Well has been reinforced to service users and Health Care Professionals via the Health Board's website and social media platforms.		Completed
		35) A redirection policy in place within GUH and is constantly being re-enforced. (E9)		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
access the right healthcare at the right time.		36) Right Place Right Time is part of the ongoing transformation work led by Director of Operations and Director of Primary Care & Community, through 6 Goals workstream.	Director of Ops / Director of Primary Care & Community	October 2022 **(8)**
The health board must ensure that: 24. A system is put in place to ensure that patients are made aware of the actions being taken as a result of their feedback 25. They address the staff perception that no action is taken on patient feedback	6.3 Listening and Learning from feedback	37) All informal concerns raised are addressed contemporaneously.	Service Lead / Clinical Director / Senior Nurse / Nurse in Charge	Completed
		38) In line with PTR guidance, all complaints / concerns are followed up with a telephone call from a senior member of staff. If unable to resolve the concerns verbally a formal response will be provided from the Chief Executive, as per policy.		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
26. Staff are all made aware of the results of the feedback and of the actions they are taking to address the comments made.		39) Concerns and actions will be discussed with staff members and feedback provided of actions taken, via staff meetings.		Completed
		40) The minutes from Quality and Patient Safety meetings are shared with all staff, with any themes discussed for action. (E10)		Completed
Delivery of safe and effective care				
27. The Health Board must ensure that a procedure is put in place for the management of patients in custody that ensure that their dignity and safety is maintained,	2.1 Managing risk and promoting	41) Patients in custody will be cared for in a private, discreet area.	Service Lead/Clinical Director/Senior Nurse for	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
should their condition be liable to deteriorate. This procedure should be agreed with the local constabulary to ensure they are aware of the procedure. 28. The Health Board must inform patients of the current plans in place to change the design of the ED, including the changes to the waiting rooms and any plans for an additional minor injuries area.	health and safety	42) ED have an agreed process in place to manage patients in custody. (E11)	Surgical Assessment Unit	Completed
		43) Communications team have informed the public of planned developments via social media. (E12)	Communications team	Completed
The Health Board needs to ensure that: 29. Pressure risk assessments are completed in full for all patients	2.2 Preventing pressure and tissue damage	44) Pressure area risk assessments will be completed in full for all patients. (E13)	Service Lead / Clinical Director / Senior Nurse / Nurse in Charge	Completed
		45) Patients identified at risk will receive the appropriate pressure relieving devices.		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
30. Sufficient pressure relieving mattress are available for patients at risk.		46) The importance of pressure area care has been shared via the nursing Newsletter in ED.		Completed
		47) Equipment is available for use based on patient risk assessment.		Completed
		48) All pressure ulcer Datix are reviewed by the Band 7's and appropriate actions implemented.		Completed
31. The Health Board must ensure that patients in beds have easy access to the call bells.	2.3 Falls Prevention	49) Patients within trolley/bed spaces will have a call bell within reach	Senior Nurse/ Nurse in Charge	Completed
		50) The importance of call bells within reach has been reinforced through ED Nursing News. (E14)		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		51) Daily one patient one day audits will continue, which includes checking call bells are within reach.		Completed
		52) Monthly Dignity & Essential Care Inspections are undertaken by the Senior Nurse and Deputy Head of Nursing.		Completed
The Health Board must ensure that: 32. Assessments are carried out on patients about their ability to eat and drink	2.5 Nutrition and Hydration	53) Patients are assessed on their clinical presentation which includes eating and drinking.	Senior Nurse/ Clinical Director	Completed
		54) Patients will be repositioned to ensure they are in a safe position for feeding.		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
33. That appropriate support is given to those patients who needed support 34. Patients are repositioned prior to eating, to ensure that they are able to eat and drink the food 35. Patients are offered hand washing or hand wipes prior to or after eating and that they are encourage to use these facilities before and after meals 36. Nutrition and fluids are recorded appropriately on the relevant documentation		55) Patients will be offered hand wipes prior to mealtime. This will be supported by all staff, including Red Cross and the department assistants.		Completed
		56) The ED will ensure intravenous fluids are recorded on the All Wales medication charts.		Completed
		57) Fluid balance is recorded within the ED Patient Care Record which is a mirror image of the All Wales Fluid Balance Chart.		Completed
		58) The All Wales Nutrition chart has been introduced into ED.		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
37. All staff are trained on the use of the All Wales Nutrition charts.		59) Training is included within induction for new staff. (E15)		Completed
The Health Board must ensure that: 38. Staff on a medication round, wear the appropriate tabard and are not disturbed when dispensing medication 39. Further attempts are made to maintain patient privacy when asking patients to confirm their information during the dispensing of medication.	2.6 Medicines Management	60) Tabards are not used within the ED and assessment units due to the variability of timing of admissions and need for medication.	Senior Nurse	Completed
		61) The correct medication administration process has been reinforced to all nursing staff.		Completed
		62) Staff have been reminded of the importance of confidentiality when checking patient's demographics prior to administering medication. (E16)		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The Health Board must ensure that: 40. Additional training is given to staff to raise their awareness and knowledge of DoLS 41. Documentation is completed in full on the capacity of patients in their notes.	2.7 Safeguarding children and adults at risk	63) Additional safeguarding and DoLS training will be undertaken and cascaded through the department. (E17)	Clinical Director/Senior Nurse	July 2022 **(9)**
		64) Medical notes will include a full overview of a patient's cognition and plan of care.		Completed
		65) All staff are being reminded of the importance of completing documentation in full.		Completed
		66) Daily one patient one day audits will continue to assess compliance.		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		67) Monthly Dignity & Essential Care Inspections are undertaken by Senior Nurse and Deputy Head of Nursing to monitor documentation and actions taken to address any deficits.		Completed
42. The Health Board must ensure that all staff are made aware of Serious Hazards of Transfusion (SHOT) and the importance of reporting any instances.	2.8 Blood management	68) SHOT awareness forms part of the IV training package.	Clinical Director / Senior Nurse	Completed
		69) SHOT awareness re-enforced via Nursing Newsletter. (E18)		Completed
		70) Any infusion incidents are reported on Datix. The blood transfusion service report these incidents to SHOT.		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The Health Board must ensure that: 43. All entries in patient's records are completed in full, signed, dated and timed 44. Paper records are appropriately stored away from patient view 45. All medication is appropriately prescribed and signed 46. Patient information is made available on handover and takeover.	3.5 Record keeping	71) The ED Leadership Team will ensure patient records are completed fully and all medication signed for correctly, with a schedule of Audits to assess concordance. (E19)	Senior Nurse/ Clinical Director	Completed
		72) The ED will ensure all medication is prescribed correctly, assessed through auditing.		Completed
		73) Pharmacy will undertake medicines reconciliation.		Completed
		74) Scanned notes currently stored securely within appropriate boxes in the reception area are removed in a timely manner.		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		75) Staff have been reminded of the importance of a thorough and comprehensive handover of patients during the transfer process.		Completed
Quality of management and leadership				
47. The Health Board must ensure that staff are reminded of the need to complete a Datix report in every instance that met the relevant criteria. 48. The Health Board should consider the separate reporting arrangements in the CEAU and	Governance, Leadership and Accountability	76) All staff have been reminded of the importance of completing a Datix. A list of Datix applicable incidents is available across the ED and Assessment Areas. (E20)	Clinical Director/ Senior Nurse/ Directorate Manager	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
SSU, to address any potential conflicts. 49. The Health Board is to inform HIW of the actions it has taken to address the recommendation made in the HIW Review relating to improving patient flow.		77) CEAU remodelling is ongoing to improve patient flow which will reduce current conflict on bed allocation and enable full utilisation of all areas.	Director of Ops	July 2022 **(10)**
		78) The Health Board will provide HIW with an update on flow improvements.		June 2022 **(11)**
The health board must ensure that processes are in place:	7.1 Workforce (Equality)	79) There is “Open Door” approach to meet with the ED Leadership Team.	Service Lead / Clinical Director /	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
50. To allow any member of staff to report any issues of concern internally, as well as to ensure that any concerns raised are appropriately investigated and responded to 51. To ensure that staff are treated fairly and equally and that any instances of discrimination will not be tolerated and appropriate action taken 52. To address the concerns of staff who believe they are not being able to care for patients as they believe they deserve to be treated		80) Staff have been encouraged to raise concerns verbally to a senior member of staff in confidence. (E21)	Senior Nurse / Divisional Nurse	Completed
		81) All concerns and actions will be discussed with staff members and timely feedback provided of actions taken to address issues raised.		Completed
		82) Senior Leadership Team are visible enabling staff the opportunity to raise concerns.		Completed
		83) Wellbeing services are available to all staff within the ED with regular bespoke sessions also provided. (E22)		Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
53. To address potential issues with the wellbeing of staff.		84) There are 2 wellbeing consultants and x2 Band 7 nurses who focus on wellbeing and equality.		Completed
The Health Board must ensure that: 54. The levels of mandatory training are increased to ensure all staff have the necessary training to do their job properly 55. All staff working in the paediatric area, whether paediatric nurses, or adult nurses supporting the area must be in date with level two	7.1 Workforce (Training)	85) Two Band 7 and four Band 6 Practice Educators are now in place within ED to support training and ensure increased compliance to mandatory & statutory training.	Service Lead / Clinical Director / Senior Nurse / Nurse in Charge	Completed
		86) A review of staff compliance re: safeguarding will be undertaken. Dedicated time will be provided to improve current compliance. (E24)	Leadership Team	September 2022 **(12)**

Improvement needed	Standard	Service action	Responsible officer	Timescale
safeguarding. The safeguarding lead must be level three in safeguarding. 56. Processes are put in place to ensure that appraisals are completed annually 57. The appraisals are completed in full, including identifying training, learning and development 58. Clinical supervision is completed annually 59. Full training is given to all staff as necessary for each area in which they work.		87) An improvement trajectory has been introduced to improve compliance with PADRs. (E25)		Completed
		88) The Health Board is currently reviewing a new model for Clinical Supervision.	ED/Surgical Leadership Team	October 2022 **(13)**
		89) Ongoing training programme in place for ED staff, enhanced by the appointment of Practice Educators.		Completed

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Penny Gordon**

Job role: **Head of Nursing, Urgent Care**

Date: **18 May 2022**

Hospital Inspection (Unannounced)

The Grange Hospital, Aneurin Bevan University Health Board, Emergency Department and Surgical Assessment Unit

Inspection date: 1-3 November 2021

Publication date: 29 March 2022

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Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care
Promote improvement:	Encourage improvement through reporting and sharing of good practice
Influence policy and standards:	Use what we find to influence policy, standards and practice

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the Emergency Department (ED) and Surgical Assessment Unit at The Grange University Hospital (the hospital) within Aneurin Bevan University Health Board on the 1 – 3 November 2021. The following areas were visited during this inspection:

- Outside the Emergency Department including the Ambulance Bay
- Waiting Room
- Triage
- Majors
- Resuscitation (Resus)
- Rapid Assessment Unit (RAU)
- Children's Emergency Assessment Unit (CEAU) and Short Stay Unit (SSU)
- Paediatrics Emergency
- Covid Corridor
- Surgical Assessment Unit (SAU).

We did not inspect the areas known as the:

- Medical Assessment Unit (MAU)
- Covid Ward A1.

Our team, for the inspection comprised of two HIW Inspectors, three clinical peer reviewers and one patient experience reviewer. The inspection was led by a HIW inspection manager.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we were not assured that all the processes and systems in place were sufficient to ensure that patients consistently received an acceptable standard of safe and effective care. This was despite all the efforts of staff who were working hard under pressure from the number of patients presenting at the ED.

There were a number of issues identified where the health board needs to address issues to improve patient experience and to ensure dignified and timely care. This includes work required to the physical environment of the waiting room to ensure that it is fit for purpose.

Until the flow of patients into and through the ED can be improved, the health board may find it difficult to address a number of our concerns.

We observed all staff striving to deliver good quality, safe and effective care to patients, within very busy units. However, the comments of staff in the staff survey show that they could not always deliver the care they wanted to.

This is what we found the service did well:

- Patients, including those on ambulances were provided with food and drinks during their time at the unit
- The permanent internal bilingual signage that showed where the patient was on their journey through the unit was very good
- Paediatric patients were seen in a timely manner
- There were aspects of medicines management which were noted as positive
- There were designated specialist treatment rooms
- Patients thought the ED was clean and COVID-19 compliant
- Patients were triaged for COVID-19 outside the ED

- The controlled drugs register checks were completed in full
- We found evidence of good teamwork and support amongst nursing and medical teams within all units
- We found that management and leadership was focused and robust
- Practice educators were in place and more were being recruited
- The preceptorship and mentoring programme in the SAU
- Patients were generally complimentary about their time in the ED and SAU.

This is what we recommend the service could improve:

- The waiting area was a major cause of anxiety for patients, with little privacy, and for staff due to the inability to triage and medically manage patients in a timely manner
- Reducing the delay in being able to find patients a space in the ED, will result in less time being spent by patients in chairs
- Complete all areas of the patient records as required, to ensure there is a full record of treatment, observations and medication
- Ensuring patients are offered hand wipes or the ability to wash their hands before and after meals
- Reducing the over reliance on agency and bank staff
- The flow of patients from the ambulance bay through the ED and out into the other wards or discharge
- Increasing the mandatory training compliance so that all staff complete the training on a regular basis
- Appraisals process, including ensuring all staff receive an annual appraisal.

We had some immediate concerns about patient safety which were dealt with under our immediate assurance process. This meant that we wrote to the service immediately after the inspection, outlining that urgent remedial actions were required. These were in relation to the delivery of safe and effective patient care. Details of the immediate improvements required are provided in Appendix B, which includes the following:

- Patients in the waiting areas were not overseen by staff at all times and could deteriorate without being seen by staff
- Infection control issues surrounding the COVID corridor, including issues of potential cross contamination and staffing
- Poor staff survey results where staff believed they could not always deliver the care they wanted to, due to a number of issues
- Resuscitation trolley checks were not signed as completed.

3. What we found

Background of the service

Aneurin Bevan University Health Board (ABUHB) covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys. The health board employs over 14,000 staff, two thirds of whom are involved in direct patient care. ABUHB is responsible for promoting wellness, preventing disease and injury, and providing healthcare to a population of approximately 594,164 people[1].

The Grange University Hospital was opened in November 2020, ahead of schedule, to help the health board respond to winter season pressures and the second wave of COVID-19. The hospital has 560 beds (including trollies and cots) and features a 24-hour acute assessment unit, emergency department (ED) and helicopter pad. It provides a 24/7 emergency service for patients that need specialist and critical care.

The hospital provides care for people who are seriously ill or have complex problems or conditions that cannot be safely managed at one of the enhanced Local General Hospitals (eLGH). The following services are available at the hospital:

- Emergency admissions for major illnesses and injuries and those in need of resuscitation
- Emergency Surgery and Trauma care
- Major and Co-morbidity (more than one serious condition) Surgery
- Emergency Assessment Unit
- Children's Assessment Unit.

The ABUHB Flow Centre is a new service based at Vantage Point House, Cwmbran, set up to provide pre-hospital streaming and transport co-ordination

[1] Stats Wales

across the hospital sites. The service is run by a multi-disciplinary team consisting of call navigators, triage/transport nurses and medical consultants.

The areas covered by the inspection and numbers of beds were:

Triage – A team of nurses with triage skills will rapidly assess all the patients who book into the ED. Each patient will be categorised in order of urgency to be seen by the doctor. The triage nurse will then allocate these patients to an area to be nursed/seen by the doctor. The triage nurse can redirect patients to other hospitals/GPs if appropriate.

Majors – An area containing 27 spaces for patients. One is used for electrocardiograms (ECGs)[2], four for assessment, one for ear nose and throat (ENT) patients and two trolleys removed to change to a six chair area. There is also an immediate release area and a mental health assessment areas. Majors is an area where patients have their assessments, care and treatments. The type of patients who will present to majors are stable chest pains, shortness of breath, history of seizures, collapses and abdominal pains. Patients are often referred to a speciality from majors, for example the medical, surgical or orthopaedic team. There will be one nurse to four patients in Majors.

Resuscitation (Resus) – The department has eight resus bays for those patients who are critically ill. One bay in Resus is for a child who needs resuscitation. The nurses working in this area will have their immediate life support qualification and care for the sickest patients in the department. The type of presentations in resus would be a segment elevation myocardial infarction (STEMI)[3], major trauma, cerebrovascular accident (CVA)[4], cardiac/respiratory arrest and patients with a significant altered conscious level. There will be one nurse to two patients in Resus and a Resus lead.

[2] An ECG is a simple and useful test which records the rhythm, rate and electrical activity of your heart.

[3] https://www.wales.nhs.uk/ourservices/unscheduledcareconditions/acutemyocardialinfarction

[4] A cerebrovascular accident is also called a CVA, brain attack, or stroke. It occurs when blood flow to a part of the brain is suddenly stopped and oxygen cannot get to that part. This lack of oxygen may damage or kill the brain cells. Death of a part of the brain may lead to loss of certain body functions controlled by that affected part.

Rapid Assessment Unit (RAU) – This area has a dedicated ECG room and four cubicles to assist with assessments and care of the patients in the waiting room. Two qualified nurses and a healthcare support worker (HCSW) would usually be allocated to work in assessment. The RAU also includes an area outside the majors office where patients need to be monitored and they sit on chairs, to await a bed space or discharge.

Children's Emergency Assessment Unit (CEAU) – This is staffed by ED and paediatric nurses. The unit has two separate waiting areas, one for COVID positive patients and one for COVID negative patients. There is a cubicle in adult resus that is dedicated for children and a high care room in CEAU. ED paediatric nurses will be based in CEAU. However, cover from adult nurses was sometimes required. The clinical area in CEAU includes a triage room, 10 designated assessment spaces (six cubicles and four curtained bays), a nurse assessment room, plaster room, two treatment rooms, consultation room and a child protection suite. The SSU comprises six inpatient single occupancy cubicles, with en-suite facilities, in the area adjacent to CEAU.

Covid Assessment Zone – Patients will be streamed to the appropriate triage area from outside the department depending on their answer to set COVID-19 related questions. The patients who enter via the COVID entrance will be triaged in the A1 corridor outside CEAU. The patient will then be transferred to the assessment zone which is currently on ward A1 to be nursed/assessed. A1 has eight resus cubicles, eight majors' cubicles and an ambulatory area. Ward A1 was not the subject of this inspection.

Surgical Assessment Unit (SAU) – The SAU is where patients are referred to a surgical on-call team for a full assessment via the general practitioner (GP), out-patient clinics and ED. On arrival at the SAU patients remain nil by mouth until they have a senior surgical review and depending on the surgical plan this may continue.

The term emergency department (ED) is used in this report to refer to all areas described above except for the SAU and ward A1. The total number of patients in the ED, including the waiting room, at the start of the inspection was approximately 156 patients.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Most patients rated the quality of the patient experience provided during their stay in hospital as very good and were complimentary about the staff in the patient survey completed.

Patients, including those on ambulances, were provided with food and drinks during their time at the unit.

The internal permanent bilingual signage that showed where the patient was on their journey through the unit was very good.

There were a number of issues identified where the health board needs to address issues to improve patient experience and to ensure dignified and timely care.

Until the flow of patients into and through the ED can be improved, the health board may find it difficult to address a number of our concerns.

The majority of staff, who told us they were not based in the ED, stated that they did not feel that the ED and the service they provided worked together to provide seamless patient treatment or care.

During the inspection HIW issued both online and paper questionnaires to patients and carers to obtain their views on the services provided. A total of 38 responses were completed. We also spoke to eight patients during the inspection. Patients were asked in the questionnaire to rate their overall experience of the service, and 84 percent of patients rated the service as 'very good' or 'good'. However, 16 percent described it as 'poor' or 'very poor'. Patients were asked how the service could be improved, their comments included:

> *"Waiting times and conditions are appalling. I've had to wait for 9hrs so far just sat in an uncomfortable chair with no options for good sleep. I felt ignored by staff until i spoke out and asked for food / drink / help"*

"No beds / trolleys, just chairs"

"The night shift seems understaffed v days especially with doctors. There is not enough space (beds) for patients to wait comfortably. Seems like only patients over the age of 65 get a bed and regular treatment"

"Very slow at every stage. Too many patients. Staff very busy."

"Staff were very lovely and respectful despite the amount of patients they had"

"The staff were very busy but amazing, friendly, helpful and knowledgeable"

"The nursing staff are amazing however definitely overworked, they run around all night."

Patients were asked in the questionnaires how the setting could improve the service it provided. Some comments received are shown below:

"I was sat on a chair in a corridor for 17 hours with no food or drink. This needs to be addressed"

"Less time waiting in ambulance before admission"

"Decrease waiting times"

"Triage room was very overcrowded. Better explanation on what was happening next"

"More staff to improve wait times."

HIW issued an online survey to obtain staff views on the ED and SAU at the hospital. In total, we received 136 responses from staff at the hospital.

Staying healthy

There was information displayed about how patients could help their health and wellbeing. We saw posters displayed on weight management, healthy eating, stopping smoking and active lifestyles on posters throughout the ED. Additionally, there were posters reminding patients to wear a face mask correctly. However, there was no information regarding support groups on display other than Wales Wellbeing.

There was also information displayed highlighting the appropriate use of the ED and signposting to other services. These were seen on the COVID-19 testing

porta cabins and in several areas throughout the ED. The poster was called The Right Place. However, this advice was probably too late to allow the public to make an informed decision about which hospital / minor injury unit is appropriate for their health concern as patients had already arrived at the hospital. The health board were embarking on a series of 'Work with Us' roadshows. This is a tour around the health board area to recruit new members of staff and to ensure local residents know where they should go when they need healthcare.

There were also posters explaining that the hospital was a smoke-free environment. This also extended to the use of vapour or e-cigarettes. These arrangements complied with Smoke-free Premises Legislation (Wales) 2007. We did not see any patients smoking during our visit outside the ED. The security staff we spoke with said that they would normally ask anyone attempting to smoke to move outside the hospital grounds.

All patients we spoke with said they were not asked directly about looking after their own health.

Improvement needed

The health board must ensure that

- More leaflets or posters are available in all areas of the ED relating to support groups
- Where applicable patients should be questioned about how they are looking after their health and this should be documented on patient notes
- The Right Place message is advertised further throughout the health board area, including in health centres, clinics and GP practices.

Dignified care

We noticed that patients were moved to private rooms in the RAU for examination and assessment by medical staff. However, when the ED was under pressure, medical staff reported difficulties in accessing rooms to carry out confidential examination and history taking. The lack of appropriate private rooms available resulted in a delay in taking medical assessments. The staff also reported that intra-venous (IV) infusions and blood taking did take place in the corridors when there was no available clinical space. All staff demonstrated sensitivity in maintaining patient confidentiality at all times. However, whilst there were curtains to the ambulance triage cubicle as these were not soundproofed, the discussions could be heard outside the cubicle.

We were told that the waiting area was a major stress for patients, with little privacy and no accompanying visitors allowed, except for children's parents and carers. The hospital did not allow relatives or carers to accompany patients due to COVID-19 restrictions. This could impact on the anxiety of unaccompanied vulnerable patients or patients who were unable to express themselves adequately or retain information given to them about their treatments by health professionals. Patients we spoke with in the waiting room expressed concern that they were alone and concerned for relatives waiting for them in the car park for extended periods. This was partly mitigated with ED staff conveying information to relatives via the telephone. We noted a number of signs throughout the unit reminding staff to contact and update relatives on the patients' condition. All patients, bar one, who expressed an opinion said they had been treated with dignity and respect by the staff at the hospital. The majority of patients who expressed an opinion said they were able to maintain their privacy and dignity during their time at the ED. Almost all staff said patients' privacy and dignity was at least sometimes maintained. One patient commented that:

> *"It feels like because i am young i am not taken seriously and neither is my condition. There is no urgency at all."*

We spoke with eight patients about how they were treated and whether staff were kind and treat them with dignity and respect. They all responded positively and said that they were treated with respect and were positive about their treatment in the ED.

We were told that if the waiting room was full, efforts would be made to find additional chairs, for those waiting, to sit on. There were multiple instances observed of staff apologising to patients for the long waiting times. Staff felt frustrated that patients were being nursed in an inappropriate area and that their personal care standards were being compromised. Staff we spoke with said that this level of care was affecting staff and potentially leading to a state of physical and emotional exhaustion.

We saw staff speaking to patients with respect, courtesy and introduced themselves on initial contact. Patients we spoke with said that the majority of staff asked them how they would like to be addressed. However, we noted one member of staff going through the motions of explaining the reasons for a test. The patient had hearing issues and evidently did not understand what was happening. We confirmed with the patient that they did not hear staff properly to understand the need for the test but they allowed it anyway. The staff possibly did not know that the patient had problems with their hearing.

We observed staff trying to be discreet when speaking to patients, despite the issues of privacy as many patients were hard of hearing. All personal care was completed with the curtains drawn.

We also noted that the microphones on the reception desk were not working properly. They were at waist level on the counter and patients had to shout with their personal details to the receptionists. This created issues with privacy and dignity for the patients. There was a portable hearing loop in reception that we were told was not working correctly when tested recently. There was access to language line for translation if required.

There were no trolleys for patients in the corridors and patients would sit on chairs. The chairs were separated by Perspex screens to try to mitigate the lack of social distancing for these patients, both in majors and the RAU.

Patients appeared well cared for and appeared to be comfortable in their beds, which were set at different angles for their comfort. Staff were seen nearby and attentive to patient needs. Patients appeared to be clean and presentable with clean bedding. Staff we spoke with said that maintaining the patients dignity was challenging on the corridors where other patients could see them. One nurse reported that cancer patients accessing the 111[5] advice were directed to the ED with suspected neutropenic sepsis[6]. Waiting in a crowded waiting room prior to triage added to the risk of infection in immune vulnerable patients. An alternative pathway for cancer palliative patients' needed to be put in place to avoid attending the ED.

There were no issues with the environment of the majors area that would affect patient dignity. The toilets were clean and all the locks were working properly. However, ambulatory patients had to walk the length of majors, about 30 to 40 metres to the examination rooms at the other end of the ward. Two trolley areas in the majors area had been removed to enable the area to be used to accommodate six patients in chairs. Not all the chairs were reclining chairs so there were issues here with comfort, privacy and dignity.

Efforts were made by staff to maintain the privacy and dignity of patients in the chairs, in the corridors of the SAU. Staff were seen helping patients to go to a

[5] 111 is a free-to-call single non-emergency number medical helpline operating in parts of Wales. The 111 phone service is part of the National Health Service: in Wales the service is known as either NHS Direct Wales or 111 depending on area.

[6] Neutropenic sepsis is a life threatening complication of anticancer treatment, the term is used to describe a significant inflammatory response to a presumed bacterial infection in a person with or without fever.

suitable area to ensure they could maintain their personal care in the SAU. However, there was one elderly patient on the SAU that said they had not had the opportunity to wash and clean their teeth since leaving home, 18 hours previously. Not all patients in the corridor were on reclining chairs, which made it difficult to ensure their comfort. We were told that patients in the corridor were allocated a qualified member of staff who carried out all their nursing duties and reviewed their care regularly as they did not have a call bell.

Staff acknowledged that it was not acceptable to have patients in the corridor. However, they said that all patients were well cared for, effectively communicated with and all attempts were made to make the patients as comfortable as possible. The patients spoken with were complimentary of the staff and understood the service was under pressure. Staff risk assessed the patients in the corridor to assess if sitting in a chair in a corridor was detrimental to their care.

We were told that paediatric patients in the waiting area were informally risk assessed to ensure it was appropriate for them to wait there. There was a feeding room in the paediatric area as well as a changing area. Once in the main paediatric area, all patients were nursed in a cubicle or in a curtained pod and all staff appeared organised with noise kept to a minimum.

The ambulance triage area only had a curtain to separate this area from the ambulance corridor. Other patients and ambulance staff could therefore overhear some clinical questions and history taking. However, all staff observed were carrying out personal care discreetly and maintained patient privacy and dignity at all times before they were admitted to the majors area. Patients were brought in regularly for toileting purposes from the ambulances. Urine bottles were provided for male patients on the ambulances with the doors closed. We were told that there would be a difficulty turning patients onto bed pans on ambulance trolleys. Patients were observed on ambulances being assessed for pain by the Welsh Ambulance Service NHS Trust (WAST) staff.

We were told that there was regular liaison between ambulance and hospital staff. The duty operational manager (DOM)[7] liaised regularly with the crews, triage nurse and nurse in charge. The Hospital Ambulance Liaison Officers

[7] The DOM is responsible for the operational leadership and supervision of a defined group of Paramedics, Emergency Medical Technicians and Urgent Care Assistants.

(HALO)[8] was present between 10:00 and 20:00 hours. There was not a formal liaison arrangement in place overnight unless WAST deployed a DOM at times of high demand. We observed one crew express concern about a deteriorating patient to the DOM, who liaised with the triage nurse to arrange a move into resus. We believe that the input of the WAST representative at these meetings was useful, where they could report any concerns about individual patients waiting outside to facilitate quicker offloads. WAST staff also commented that communication as a whole was excellent, especially during the day when HALOs were present. Crews reported that communication overnight was not always as effective.

We were told that there were three daily site patient flow meetings between WAST staff, the HALO and senior nurses and change nurses within the ED.

We asked a series of questions about the ED environment of staff who stated they were not based in the ED. The replies were as follows

- 68 percent who answered the question said facilities within the ED were not appropriate for them to carry out their specific tasks
- 72 percent said they felt the working environment within the ED was not appropriate in ensuring their patients received the care they require at their 'point of attendance'
- 80 percent said that patients were not able to access their service from the ED in a timely way
- 54 percent said they did not feel that the ED and the service they provided worked together to provide seamless patient treatment or care
- 84 percent said that from their time spent within the ED, they did not feel that ED staff were able to perform their duties in line with patient needs

[8] Hospital Ambulance Liaison Officer are responsible for managing the ambulances that arrive at the hospital, liaising between the ambulance service and the hospital

- 48 percent said that they felt that issues raised with ED senior management team were not dealt with in line with health board process and procedures.

There was a section on the patients' notes in relation to capacity, comfort and dignity. However, these were incomplete on all notes seen.

Improvement needed

The health board must ensure that:

- Staff are reminded of the need to consider any communication issues with patients when speaking with patients
- Staff are remind about the need to ensure privacy and dignity and confidentiality when speaking to patients in areas where they can be overheard
- The communications with patients in the waiting room are improved to ensure confidentiality, including the hearing loop
- More room is made available in the main reception area and for the triage area for patients
- They consider the comments raised by staff we do not work in the ED and provide HIW with the work they are carrying out to address these issues
- The section on the patients' notes in relation to capacity, comfort and dignity is completed in full
- That patients are not required to wait on chairs overnight
- The chairs used in the corridors are changed to reclining chairs to ensure patients can wait comfortably for their treatment, especially when having to wait long periods
- The use of alternative pathways for cancer palliative patients to avoid attending the ED
- A secure soundproof confidential area be provided where ambulance staff can exchange information and handover patients away from a public corridor.

Patient information

There were permanent large bilingual signs describing the patients' journey through the various departments. There were also permanent smaller bilingual signs describing where the patient was in the ED and SAU and explaining what the area was, for example explaining the triage process in simple terms for patients along with identifying clinical need. Additionally, in the SAU there were leaflets, in addition to the permanent signage, explaining more about the SAU, triage and aims of the triage, and what happens on admittance.

Directions to the ED were clearly displayed outside the hospital. Once inside each unit, there were signs directing patients to the toilets and exits and also the emergency exits. However, the signs were small and difficult to identify from a distance. As described above there was information displayed about how patients could help their health and wellbeing.

Improvement needed

The health board must ensure that all signage is in an area that can be seen and that patients, including those with sight difficulties, can see the signs.

Communicating effectively

We noted that staff were discrete in communicating personal information with patients. Whilst all staff seen demonstrated sensitivity in maintaining patient confidentiality, the ambulance triage cubicle had curtains, which were not soundproof.

There were patient safety at a glance (PSAG)[9] board containing identifiable information in discrete places in the ED and SAU. The details on the board included when observations were next due, bloods, ECG, X-ray and treatments given or next due.

We observed most staff speaking with patients about their care and treatment in a way that they understood. One of the conversation we heard involved a nurse on triage explaining the waiting time and arranging an appointment with urgent

[9] The Patient Status at a Glance Board (PSAG) is used in hospital wards for displaying important patient information such as; the infection risk levels, mobility, admission and discharge flow, occupied number of beds, nursing and medical teams, amongst others.

care and primary care as an alternative treatment plan. Patients were moved to private rooms for their examination and assessment by medical staff.

We asked patients a series of questions about their experiences relating to their healthcare. 97 percent of patients said that they felt listened to by staff and 73 percent said they were able to speak to staff about their health without being overheard by other people. 90 percent of patients said that they were involved as much as they wanted to be in decisions about their health care and that they were given enough information to help them understand their health care.

We also noted staff wearing a Welsh speaking logo, to make patients aware that they could speak to them in Welsh. We were told that the Welsh speakers were able to offer consultations or part consultations in Welsh. Staff in paediatrics also spoke in age appropriate terms, involving the children or young person in care decisions as appropriate.

Bilingual posters were seen that had been printed from the health board website. Senior staff we spoke with said that part of the performance appraisal included enquiring about whether staff were interested in taking part in the Welsh language online training.

Patients we spoke with had mixed comments about how staff communicated with them. Five patients were positive or did not have issues. One had poor eyesight and staff were aware they needed to keep their drink topped up frequently. They said that staff were less efficient at filling the glass at night. One wasn't asked about how they'd like to be addressed. One said that they were not able to speak to staff without being overheard.

We also saw information displayed on staff working in the ED (a who's who board). Staff stated that information was not available for patients and carers to help them understand their care and journey throughout the ED. However, they stated that patients received a verbal report on the next stage of the care. There were also large boards to describe their journey through the various areas, as described previously.

We were told that telephone calls for patients were taken by a member of staff referred to as a patient liaison who would hand the message to a nurse if a relative needed to contact the patient.

Staff considered that they needed a tannoy or similar, as patients could not always hear their name when it was called, particularly when outside the waiting room. There were occasions when receptionists had to shout patient's names outside the waiting area. We were told that during one day of the inspection, one patient was in the waiting area for 13 hours as they missed their name being called and they also missed the coffee trolley.

There was a voice activated communication system used within the hospital that staff were able to wear on a lanyard.

Improvement needed

The health board must consider ways of ensuring that communication with patients waiting for care or triage is effective, on the initial call to avoid delays in treatment.

Timely care

Patients we spoke with told us about the wait they had before being admitted into the ED from the ambulance or waiting room. This varied from being seen immediately in the ED to 15 hours in total in an ambulance and a waiting area.

We checked a sample of patient records and noted that five of the ten records checked had not been triaged within 15 minutes of arrival at the ED. However, there was one instance of a wait of 165 minutes on an ambulance before being triaged.

We explored how WAST and the ED ensured that patient handover times were appropriate and took place within agreed national timescales. On the day of our arrival at the ED, mid-afternoon, there were approximately 20 ambulances waiting to move patients (offload) from the ambulances. Paramedics we spoke with reported one instance of a significant offload wait time for a patient with a fractured neck of femur overnight. We were told that there was an issue with the flow of patients within and out with the hospital. There had been insufficient discharges from the wards at the hospital and other settings to match the admissions into the ED, only two patients had been discharged that morning from the entire hospital. The volume of self-presenting patients that required admission into a speciality bed in the ED was another cause of the delays for offloading patients.

Overnight during the inspection we noted that there had been two patients waiting for 10 hours in an ambulance without a medical assessment. Both patients were clinically stable, they had been triaged and had received analgesia. We were told

that urgent calls from WAST required age, sex, history, injuries/illness, condition, estimated time of arrival (ASHICE)[10] were taken directly to resus.

The average triage time on the day of our visit was approximately 45 minutes due to additional pressure on the triage team to triage self-presenting waiting room patients. There was a target to complete the triage within 15 minutes and compliance was monitored. Both the triage nurse and nurse in charge (NIC) reported that the greatest clinical risk within the ED were the patients in the waiting room who had not been triaged. Ambulance patients had clinical supervision of trained paramedics and vital signs monitoring. There was a difference of opinion on who was ultimately responsible for the patient. WAST staff stated that hospital staff were ultimately responsible for the patient once they were booked in and reported to triage nurse on arrival. ED staff believed responsibility should be joint care as there are two health professionals looking after one patient in the ambulance. The health board stated that there was joint care responsibility.

A health board self-assessment completed as part of a HIW local review of WAST handovers stated that the ongoing monitoring and escalation of patients was the responsibility of the WAST team prior to handover. The provision of the fundamentals of care and ongoing treatment prior to handover was jointly managed by WAST and ED staff.

WAST staff we spoke with were not aware of any policy in place to divert patients to other hospitals, other than if a major incident had been instigated. All movement of patients within the health board is controlled by the health board managed patient flow centre. Additionally, there may not an alternative appropriate hospital within the health board area to divert a patient too. We also saw a pilot taking place with an operator using a clinical patient management software to redirect any suitable patients, when they were being triaged.

There had been occasions, we were told, when the delay in offloading patients from ambulances had resulted in an inability to respond to other urgent calls. We

[10] ASHICE is mnemonic acronym used by emergency medical services to pass the important details of a patient over to a receiving hospital, or other definitive care provider. An ASHICE message is generally undertaken in order to pre-alert a receiving emergency department that a critically ill patient is being brought in

were told that if an urgent release was needed, it took time to offload the existing patient before they could leave for the red call. This would usually result in the failure to attend the call in the eight minute response time. Again this was anecdotal.

We spoke with WAST staff about any occasions when delays in offloading had resulted in an inability to respond to other urgent calls. Also, whether these incidents resulted in patient harm. All WAST staff questioned reported many incidences of patients being on the floor at home for several hours after falling, waiting for the arrival of the ambulance. These long lay incidences resulted in pressure area breakdown[11], aspiration pneumonias[12], dehydration[13] and acute kidney injury (AKI)[14]. All WAST staff had examples of ambulance delays in the community leading to delayed treatment and patient harm. The Royal College of Emergency Medicine report called 'Crowding and its Consequences[15]' (November 2021) referred to recent evidence that poor flow contributed to patient harm.

We noted that patients were not being received into the ED from ambulances in a timely and effective way. In majors, there were delays in offloading and the handover of patients within 15 minutes of arrival as required by national guidelines. We were told that there had been multiple breaches of handover timelines. There were delays in triaging patients on the back of ambulances

[11] Pressure sores are wounds that develop when constant pressure or friction on one area of the body damages the skin. Constant pressure on an area of skin stops blood flowing normally, so the cells die and the skin breaks down. Other names for pressure sores are bedsores, pressure ulcers and decubitus ulcers.

[12] Aspiration pneumonia is a type of lung infection that is due to a relatively large amount of material from the stomach or mouth entering the lungs. Signs and symptoms often include fever and cough of relatively rapid onset.

[13] Also known as: water loss, fluid loss.

[14] Also known as: acute renal failure, acute kidney failure.

[15] https://rcem.ac.uk/wp-content/uploads/2021/11/RCEM_Why_Emergency_Department_Crowding_Matters.pdf#:~:text=Crowding%20is%20associated%20with%20increased%20mortality%20and%20increased,Against%20the%20backdrop%20of%20long%20ambulance%20delays%202.

within 15 minutes of arrival, due to triage nurses having to triage waiting room patients.

The hospital was at full capacity, on the day of our arrival for the inspection. There were no empty beds in the ED or in the hospital. The hospital was at escalation level four, red[16]. Staff spoke to us about the previous nights' arrangements for patient flow. Patients had been boarded overnight with each ward requested to take extra patients. Medical staff were requested to review all patients fit for discharge or for step down to other hospitals, to expedite more discharges to create capacity.

There were processes in place to admit directly to the wards within the hospital, if safe to do so, and also direct admission to the Acute Medical Assessment Unit (AMAU)[17], SAU, ENT and other areas. However, whilst patients could be referred directly to specialities, during the inspection there was not the capacity in the other areas, therefore some patients' were waiting inside the waiting room to be seen.

We asked patients a series of questions about their arrival by ambulance. Of the four who arrived by ambulance, one waited in the ambulance before admission to the ED for 15 minutes, and three waited for over two hours. All four stated they received sufficient food and drink while waiting and that they were given access to a toilet during the wait. Furthermore they said that they were treated with dignity and respect by the ambulance staff and they felt safe and cared for by the ambulance staff. They all stated that the ambulance staff were knowledgeable and that they treated their condition effectively. Three of the four said they were regularly checked by hospital staff, and one answered 'not applicable'.

We also asked all patients about their experience when they arrived at the ED, they stated that assessment times varied between immediately and more than

[16] Level Four (extreme pressure) emergency admissions significantly exceeding predicted levels and available capacity, some patients are spending longer than 12 hours in A&E, A&E capacity unable to meet further demand, ambulances are spending an hour or longer transferring patients into hospital, no transfers or discharges of patients taking place and all planned admissions have been cancelled.

[17] A dedicated facility within a hospital that acts as the focus for acute medical care for patients that have presented as medical emergencies to hospitals or who have developed an acute medical illness while in hospital.

30 minutes, although one of the 37 said they were not assessed or triaged. The treatment or referral times also varied between under two hours and a wait of more than 12 hours.

ED staff suggested a dedicated ambulance triage team would facilitate early triage and carry out blood tests and ECGs in back of ambulance in a timely way.

We did not ask a question about patient flow and overcrowding, but many staff comments mentioned this specifically. A selection of relevant comments is included below:

> *"Long ambulance delays where patients are kept outside on ambulances for many hours due to lack of space within the department."*
>
> *"Patients are deteriorating and spending days in chairs with complaints that are inappropriate to sit out with."*
>
> *"They know it's overcrowded and under staffed …It's too much soul destroying working there…Staff are just leaving all the time"*
>
> *"The shortage of staff is currently a concern, in addition to the daily high attendance of patients, long ambulance waits due to overcapacity issues. This affects overall patient experience and treatment"*
>
> *"GUH does not have capacity to manage the number of admissions. Patients that are acutely unwell are managed on chairs, sometimes for days at a time. Assessment areas in the surgical admissions unit are constantly breached. Patients deemed fit enough for step down to RGH wait for days before transfer, therefore blocking acute beds. Nursing staff are rushed off their feet"*
>
> *"The department is so busy is affects all areas of care. Having worked in the NHS for [decades] I never thought I would care for children sleeping in corridors and overcrowded waiting rooms. It is not dignified or safe."*
>
> *"The physical footprint of the building is inadequate for a new 'super-hospital' - not enough space and not enough flow as well as not enough provisions for staff. Patients are constantly let down and put at risk by long waiting times, numerous transfers (especially the frail and elderly)."*
>
> *"It's embarrassing when u have to apologise for the waits when people have to que outside with their children to book in or sat on*

floors because there is no rooms to put them anywhere. Or waiting 8 + hours to see a Dr"

"The high demand of patients, staff shortages and no space to see children is having a massive impact on the care we are providing to the children. Shift after shift we are abused by parents and made to feel like we aren't doing enough when we are working the best we can with the space that we have. All the team has worked so hard to safeguard protect and care for children from the opening of the department and nothing is appreciated. I know that myself and other members of my team are really struggling. We aim to provide the best care possible and it has been quiet challenging due to the lack of space and health professionals to care for these children. Every day is a constant worry about how many children will attend the department and require emergency care and the lack of space is causing serious issues. When three or four poorly children come in at once requiring immediate treatment sometimes there is no space for these children which is very worrying for staff. It's affecting everyone mental health massively as staff don't want to come in to be abused by parents for the lack of space and the length of stay in the department. And god forbid if something was to happen the blame would be on the nurses and we would lose our pins"

"The people I work with give the most amount of care they can to patients but there is not enough space or staff to give the right care. We are firefighting every single shift and just hoping nothing seriously bad happen. Rapid assessment is the biggest risk. Normally has 2 qualified and a HCSW for up to 60 patients. How can they be expected to care for that many?"

"The ED is so thinly stretched, lack of capacity and lack of skilled staff, the standards of care is compromised."

"The newly introduced one staff nurse to five patients in green majors is not safe and bad"

"Lots of good practice overshadowed by lack of patient flow, long waits & overcrowding"

"I have never seen a busier place in the UK! It is unsafe sometimes. Priority seems to be "patient flow" rather than patient care, in many instances"

"We always want to deliver excellent care but sometimes are prevented doing so by sheer volume of patients and lack of space"

“The front door is overwhelmed and there aren’t enough adult beds in the system. There needs to be a discrete PEM service of senior opinion at least until midnight as children are being denied this at present”

“The ambulance service attempts to meet the needs of patients however it is limited in this ability. Long handover delays make patient wellbeing often impossible to maintain. Imagine keeping an elderly patient with dementia who is confused and wants to be home on an ambulance for 8 hours, reassuring and attempting to maintain their safety while preventing them from being gassed by exhaust fumes. An impossible task”

“Full capacity and high escalation causes reduced standards of care, especially for patients who are not in the correct areas.”

“Unfortunately the dangerous levels of short staffing both doctors and nursing wise and the high volume of patients pressures staff are dealing with”

“It’s dangerously under staffed, too small for the capacity and I fear nursing staff are going to have a serious incident on their hands the further in to the winter we go! Staff are off sick, including myself I, I had two months off with work related stress as a senior member of the team I felt useless in trying to escalate staff concerns and the safety of our patients. There are many times I fear a mum arriving with a baby not breathing and I don’t have the space nor staff to put them or that a child deteriorates without us noted due to having so many other patients, you just can’t physically get around every patient. Observations are missed, medications are missed.”

“As per my previous comments, patients stuck in waiting rooms for 12+ hours, some only being given a chair for 36 hours in sub-wait or in ambulatory in a1. Not appropriate!”

“The department regularly has very high numbers of patients and ambulance waiting outside which is incredibly unsafe. There is no patient flow, no space to see patients. Any escalation plans seem to be ineffective and futile for that matter as every day is essentially a 'critical incident' or a near one. Not once have ambulances been put on divert and the department 'closed' when this appears to actually be the safest option”

“The department is almost always at full capacity and consistently escalated. Senior nurses work hard to make room for patients but it

is simply impossible with the number of patients in the department and hospital. Sometimes moves are barely made to gain a resus or red release space due to no beds available in the hospital which is unsafe"

"The department is always at capacity. This has become the "norm""

"It is all well and good escalating but there is no way of dealing with the number of patients when we can't get people through the system. If the department didn't constantly have 30+ patients waiting to go towards/ step down then we might be able to see patients in an appropriate space, not chairs, in offices, back of ambulances etc"

"The department is always over capacity. Bed managers never do anything when we escalate and just think it's acceptable to keep patient on ambulances and in the waiting room for 12 hours. There is no flow through the department. How are we meant to do our job when there is no room!"

"We are full most of the time. Too many sick patients end up stuck in the waiting room because there is no flow and nowhere in ED to put them"

The main theme for patients we spoke with were the waiting times, from the waiting times for ambulances at home, the time spent in the ambulances on arrival at the ED and the time spent waiting in the waiting room. However, patients said that ambulance staff were 'brilliant'. Additionally, patients described staff as brilliant in very difficult circumstances.

We were supplied with a number of charts and statistics, after the inspection that showed the following numbers, for the period 1 April 2021 to 1 November 2021:

- Median[18] total time in ED – 6 hours 7 minutes
- Four Hour Compliance in ED – 44 percent

[18] In statistics and probability theory, the median is the value separating the higher half from the lower half of a data sample, a population, or a probability distribution. For a data set, it may be thought of as "the middle" value.

- 12 hours compliance in ED – 78 percent
- Number of over 4 hour breaches – 104
- Number of over 12 hour breaches – 41
- Triage median wait – 31 minutes
- Clinician median wait – 2 hours 02 minutes
- Referral to speciality median wait – 2 hours 30 minutes
- Bed allocation median wait – 7 hours 43 minutes.

These times varied from a low of 3 hours 31 minutes median daily time in ED to a maximum of 9 hours 31 minutes. There was also a low of 12 minutes to a high of 1 hour 15 minutes median daily triage wait. Senior staff also wanted to point out that whilst these times were not acceptable for the patients, overall in the health board, the averages were lower. This was because they also had to manage three other minor injury units in their eLGHs at Nevill Hall Hospital, the Royal Gwent Hospital and Ysbyty Ystrad Fawr.

The inspection team were also aware of the current pressures being felt in this hospital as with other hospitals in Wales and on WAST in general. In addition, the team understood that until the patient flow could be improved, starting with the ability for patients to be managed in the community and then flowing back into the ED, it was difficult to improve on these figures. This flow included being able to discharge patients into care homes, from and to community hospitals and from and to wards in the hospital and other eLGHs.

There was not a system in place to inform patients of the average waiting time for patients at the ED. The health board stated that the Royal College of Emergency Medicine did not support systems to display waiting times and that the health board supported this.

Doctors we spoke to were also frustrated with the amount of time that patients spent in beds in majors before being moved on to another area and in not being able to find appropriate rooms to assess patients. They also said that the care they provided once they saw patients was good, the problem was being able to see those patients.

Access to the paediatric area was considered to be good, with children being seen quickly. The unit was colourful, light, bright and airy and attention had been paid to the detail to make the area less intimidating for children.

A recent Community Health Council[19] Engagement Report called "7 days in the ED at the Grange University Hospital" dated September 2021, recommended that '…. Information about waiting times and waits for treatment would be helpful. The health board reply stated that work had already been triggered to introduce an electronic waiting time 'board' within the ED Waiting Area. Additionally an update on progress would be provided to the CHC.'

Improvement needed

The health board is to provide HIW with the update on the actions taken to:

- Introduce an electronic waiting time board
- Reduce the waiting times for patients
- Ensure a system wide solution to poor flow and overcrowding at the ED waiting rooms.

The health board must ensure that staff in the ED and WAST staff are all aware of their responsibilities for the patients when in the ambulance until they have been offloaded into the ED, including for pressure relief.

Individual care

Planning care to promote independence

The doors on the corridors were all the same colour and did not help to assist patients with sensory problems or cognitive difficulties. Nursing staff, including HCSWs, that we spoke with said that staffing levels at times meant there were not sufficient staff to encourage patients to move. There were physiotherapist and occupational therapists available during the day. We were told that maintaining the patients' own independence was encouraged in the SAU.

The patients in the CEAU did not require assistance in being active. However, the nursing assessment included sensory and mobility documentation.

[19] Community Health Councils (CHCs) are the independent watch-dog of NHS services within Wales and we seek to encourage and enable members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for their families and local communities.

We were told that when the ED was ‘gridlocked’ staff were unable to promote independence as staff time was limited and they were unable to always devote time to individual patient requirements. However, we did note several HCSWs assisting patients to walk down the corridor and to assist in repositioning patients after long waits in the various chairs.

In the sample of patient records that we checked we noted that care and treatment given was documented on the patient care records, with care planned in a way that promoted independence. The assessment or treatment plans seen were based on an individualised patient need. There was only clear evidence on transfer of care or discharge planning on one of the three records checked in SAU. For one patient waiting in the RAU who was considered to be fit for discharge by a medical consultant, there was no documented evidence that plans for discharge home had been planned. Additionally, no transport had been ordered, neither had community support been requested. There was also no evidence of appropriate support in place for both patients about to be discharged from the SAU. It was also not recorded when the patient was medically fit to be discharged from the SAU.

In resus and majors, the patient notes showed that there was clear evidence of transfer of care or discharge planning. It was also recorded when the patient was medically fit to be discharged. In two out of five cases, there was no evidence of appropriate support in place for the patients about to be discharged in assessment or treatment plans or records. However, important decisions such as Do Not Attempt to Resuscitate (DNACPR)[20] had been documented where appropriate.

We asked staff a series of questions in this area, their percentage (%) replies are given below:

[20] A DNACPR decision is a written instruction that tells medical staff not to attempt to bring a person back to life if their heart stops beating or the person stops breathing.

Questions / Answer Choices	Always or usually	Some-times	Never	Not applicable
I am satisfied with the quality of care I give to patients	43%	50%	7%	0%
Patients and/or their relatives are involved in decisions about their care	74%	22%	2%	2%
Patient independence is promoted	78%	17%	1%	4%
The organisation has the right information to monitor the quality of care across all clinical interventions and takes swift action when there are shortcomings.	42%	47%	11%	0%
Overall I am content with the efforts of my organisation to keep me/ patients safe	30%	51%	19%	0%

Comments from staff included:

> *"Staff shortages are impacting the standard of care I am able to provide to my patients"*
>
> *"The people I work with give the most amount of care they can to patients but there is not enough space or staff to give the right care."*
> *"We are firefighting every single shift and just hoping nothing seriously bad happen."*

Improvement needed

The health board must ensure that:

- Patient records are completed in full including clear evidence of a transfer of care and discharge planning
- The necessary arrangements are in place to ensure that transport had been ordered and community support had been requested.

People's rights

We noted there were specific and suitable places for patients to meet with family and friends in private. However, there were not any tea or coffee making facilities in the room. Whilst the room was plain, the seating was adequate and well placed. There was also a dedicated viewing room for bereaved relatives. There was a multi faith room that was situated on a different level to the ED.

Due to COVID-19 restrictions, patients' family and carers were discouraged (apart from in the children's assessment unit) from providing assistance with, and be involved in, the patients care. However, vulnerable patients, such as patients living with dementia and patients with learning difficulties could be accompanied by relatives. Staff believed that the lack of relative support placed additional demands on the nursing staff to provide all care, especially at times of peak demand. Staff also told us that the relatives' rooms in the RAU was usually occupied by patients waiting for beds or used to assess patients by doctors when space was at a premium.

In paediatrics, the equality impact assessments were also carried out and the spiritual, religious or pastoral needs of patients were discussed on admission and plans developed. Where paediatric patients were critically ill, they were allocated a staff member to ensure that the patients and carers were updated and they were offered an area to allow privacy when available. There was good access for wheelchairs in paediatrics.

Whilst we did not observe a specific room for the relatives in resus, the health board stated that there was a relatives' room – this had a sink and cups etc and that tea and coffee would be provided on request. A patient was noted in resus, where a decision was made that there was no further treatment for the patient as they were at end of life, in a normal cubicle. They were subsequently moved to majors where they were allocated a cubicle that could be closed for privacy. Resus is an inappropriate environment for patients at the end of life, as once it has been decided there was no more treatment, the patient should be moved to a more appropriate environment.

Staff we spoke with said, regarding equality and diversity in the organisation, that all patients were treated according to their clinical need. They all said that they were aware of the importance of individual needs and rights. Equality and diversity awareness was part of the mandatory training requirements for staff. Staff were also aware of individual requirements of various religious faiths, including after death.

Senior staff we spoke with said there was level access to the ED, with unisex toilets. There were disabled parking spaces close to the front of the ED. The toilet

in the main waiting room opened inwards, which caused some issues, but the ED were trying to change that.

We noted permanent signs throughout the ED, as mentioned above. These stated that everyone was assessed using the same scale of priority categories and that staff treat the most serious cases first. Including that patients who arrived by ambulance would be assessed in the same way as people who walked in. We asked patients about whether they agreed with the statement that they felt they could access the right healthcare at the right time (regardless, on grounds of the nine protected characteristics[21]). However, six said they could not and six answered 'prefer not to say'. Additionally, two patients answered the question as to whether they had faced discrimination when accessing or using this health service, ticking the 'prefer not to say' box.

Improvement needed

The health board must ensure that:

- The location of the room for patients at end of life should be reconsidered to ensure that the patient and relatives are able to spend their remaining time together at peace in a secluded or quiet area
- Further arrangements are put in place to ensure that all patients are made to feel that they can access the right healthcare at the right time.

Listening and learning from feedback

There was information displayed in the ED about how patients and families were able to supply feedback about their care, although the writing was small. CHC posters were also seen with details of assistance available to raise concerns as required. Information was also displayed on 'Putting Things Right'[22].

[21] Age, Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion or belief, Sex and Sexual orientation.

[22] Putting Things Right relates to the integrated processes for the raising, investigation of and learning from concerns within the NHS across Wales.

Senior staff we spoke with said that patient compliments were all shared with staff and if a specific member of staff was made they were also told of this. Any patient feedback was also shared with staff. They stated that patient satisfaction survey results were uploaded onto the health board dashboard. Some complaints had been received relating to the waiting area. They told us how complaints were dealt with. The main complaints related to the waiting area. We were told that the ED were working on communicating with patients through a video loop to be installed in the waiting area, relating to 'Choose Well[23]' and violence and aggression. In addition, there have been engagement events with staff to give them and higher management the opportunity to meet, be open about their experience and to discuss and share. They also referred to Schwartz Rounds, which were group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare. The Director of Planning told us of the plans to build an extended waiting room, which should be in place by January 2022. However, there was not a facility in place to inform the patients of the results of the feedback.

We asked staff to answer a series of questions relating to feedback from patients or service users within their directorate or department. The percentage (%) replies are given below:

Question / Answer Choices	Agreed	Disagreed	Don't know
Patient or service user experience feedback was collected.	60%	12%	28%
They receive regular updates on patient / service user experience feedback.	36%	46%	18%
Feedback from patients / service users is used to make informed decisions.	27%	19%	54%

Improvement needed

The health board must ensure that:

[23] 'Choose Well' in order to encourage the public to think about and make informed decisions on which health care service is appropriate for different illnesses and injuries.

- A system is put in place to ensure that patients are made aware of the actions being taken as a result of their feedback
- They address the staff perception that no action is taken on patient feedback
- Staff are all made aware of the results of the feedback and of the actions they are taking to address the comments made.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Overall, we were not assured that all the processes and systems in place were sufficient to ensure that patients consistently received an acceptable standard of safe and effective care. This was despite all the efforts of staff who were working hard, under pressure from the number of patients presenting at the ED.

We had a number of immediate concerns relating to the safe care of patients, and these were dealt with under our immediate assurance process.

Patient notes we checked were clear and easy to navigate, with a structured rapid assessment pathway. There were aspects of medicines management which were noted as positive.

Safe care

Managing risk and promoting health and safety

The main waiting room in the ED had treatment rooms to one side where staff would triage patients from the waiting room. There was limited visibility of the waiting room from the reception area, and the staff who sat in this area also had limited knowledge of first aid. There was CCTV in the waiting room, this was monitored on an ad hoc basis from a monitor in an area known as the RAU.

If the condition of a patient deteriorated, the unit were reliant on:

- Reception staff informing staff in the RAU if they saw anything relating to a patients' condition
- Patients informing reception staff
- Triage staff noticing anything when they went into reception to call out the names of the next patient
- A staff member seeing an incident on the CCTV monitor.

The Director of Planning told us that there were both short terms plans (by January 2022) and longer term plans (by mid-year 2022) to move the waiting area, to ensure better patient visibility.

Children's Assessment Unit - The waiting area is closed off from the ward and requires a swipe card to access. We were told that there was a receptionist there most of the time, but not all the time. As child health can be unpredictable and deteriorate quickly, relying on parents is not acceptable. Whilst staff observe the children often, if the ward is busy it may not be as regular as required. Staff should be able to observe all the children in the department.

The Director of Planning also told us that plans were in place to extend this assessment unit, but this is unlikely to be completed before August 2022.

SAU – We were told that patients sitting in the chairs along the corridor wall were allocated a qualified member of staff who undertook all their nursing duties, reviewing their care regularly. However, the unit were aware that the patients did not have a call bell. Staff sitting in the reception area had limited visibility of the majority of the patients sitting in the chairs and staff were not present in this area at all times. During the visit, one HIW Inspector noticed a patient in some distress who said they were having a panic attack. There were no nursing staff visible in the area at that time. The Inspector asked a healthcare support worker (HCSW) in a nearby room to assist the patient.

If the condition of a patient deteriorated, the unit were reliant on:

- Reception staff informing staff in the SAU if they saw anything relating to a patients' condition
- Patients informing reception staff
- Staff noticing anything when they attended to another patient.

HIW was not fully assured that the unwell patients, in the various waiting areas, were being sufficiently monitored at all times.

The above issues were discussed with managers from the health board during our inspection feedback meeting, which was held immediately following the inspection, and were subsequently dealt with under HIW's immediate assurance process. This involved us writing to the health board, within two days of completion of the inspection, outlining the issues and requiring a written response within seven days. The immediate assurance issues, and the health board's response, are referred to in detail within Appendix B of this report.

We noted in majors and resus that patient risk assessments were completed, dependant on individual assessments. The environment was spacious with room

for patients to move around. The layout was designed for ambulance only access. We observed emergencies being escalated rapidly between majors, resus, medics and cardiology. We were also told that there was a cardiac arrest team and stroke team on call 24 hours a day.

Escalation of the unit was managed through regular huddles and site meetings. Staff were clear about what they had to do when the ED was at, or close to capacity and they stated that the ED had been 'severely compromised' for the past four days. In general there was a robust escalation policy in place to escalate the issue up the chain of command. We were told of teleconferences between WAST and senior health board, bronze, silver and gold commands[24]. The nurse in charge could reallocate staff to areas of high acuity from less busy areas when staffing levels allowed. We were told that the number of triage nurses could be increased from two to three during peak demand. The WAST HALO regularly communicated and updated triage nurses and the nurse in charge of the clinical condition of patients in ambulances.

We noted on the outside of the ED and into the RAU that the area was generally clutter free, well lit and clean, with a well maintained infrastructure. The majors ward areas and surfaces were mainly clear except for any work in progress. The corridors were generally clear of any obstructions. There was tape on alternate chairs in SAU to encourage social distancing, but the chairs were facing the opposite direction to the television.

Security was very visible, to give assurance against violence and aggression. Security staff on site had body cameras that could be activated where necessary. ED staff reported that intoxicated patients or those presenting with mental health problems could pose a patient management problem if they were verbally or physically aggressive. However, there was training for de-escalation techniques (although not all staff had completed this training in the last two years) and there was CCTV available throughout.

The mental health assessment room had ligature free door handles and was risk assessed. The furniture in the room was also designed to avoid harm to patients and staff. We were told that the room was often occupied and other high risk patients would be nursed on the chairs in the RAU, that were generally visible to staff.

[24] Gold (strategic), Silver (tactical), Bronze (operational) command structure.

On the first day of the inspection the waiting room was overcrowded and patients in wheelchairs were observed to have difficulty in manoeuvring between patients. The triage and assessment room doors were narrow and the RAU was small and cramped. There was not adequate physical space in the waiting room for the volume of patients self-presenting. We observed the potential for overcrowding leading to breaches in social distancing. The environment was also uncomfortable to wait in for extended periods. There appeared to have been an underestimation of the anticipated demand and types of patients that would present to the service at the planning stage of the health board's new care model. These included patients not attending the appropriate service and self-presentations. The model was not designed for these patients and we were told there had been a conscious decision made not to have a minor injury unit[25] at the hospital. There were three minor injury units in the health board area as described above. The ED was designed as a major trauma centre to treat major emergencies and resuscitation, which could require onward intensive care.

Those patients who were in custody, would be recognised on the system with blue dots and the psychiatric room would be used on occasions to ensure patient dignity. We were also told that when the ED was full, patients in custody would be sent to the police van to wait. However, staff had concerns when sending patients back to wait in police cars or vans as police officers were not medically trained. They may not be able to identify deteriorating patients and may be unsure how to escalate the issue. We were also told there was a policy for managing high risk prisoners.

A member of staff we spoke with were not aware of any specific policy or standard operating procedure (SOP) for children on ambulances, However, we were told that the majority of paediatric patients were offloaded into the children's assessment unit immediately as capacity and flow was generally better there than in the main ED.

In the paediatric area we were told that there were regular health and safety risk assessments. There was a mental health consulting room in paediatrics that would be used for children and adults in crisis as described above. Patients would be managed in this room by staff from the appropriate areas. The area was co-located within easy reach of the main ED. During the early hours of the day, before 09:00 hours there was only one registrar to cover all of paediatrics. Due

[25] https://111.wales.nhs.uk/localservices/minorinjuryunit/

to COVID-19 the majority of toys and aids to keep paediatric patients interested, had to be removed, for infection control reasons. Parents and carers were advised to bring small toys to distract the patients. The children's ED and CEAU were co-located, but staff reported to two different directorates. There were clear lines of escalation in both areas and there was collaborative working, between both areas.

The SAU had up to date health and safety risk assessments. The SAU was in close proximity to all diagnostic areas. Patients in custody were regularly admitted to the SAU and there was an established process followed, although we did not see any written procedure. There was a resus team available 24 hours a day and an outreach team available between 7:00 hours and 19:00 hours linked to the intensive therapy unit. Whilst the SAU sits within the ED footprint, it is managed by surgical services that could also cause some conflict. Both paediatrics and SAU were aware of the escalation process.

We were told that whilst the environment and equipment was all new and in a good state of repair we were told that there had been ongoing issues with the folding chairs. The hinges kept breaking and needed repair. However, maintenance were aware of the issues. The waiting area was too small for the current numbers of patients that were presenting to the ED. Some patients said they would wait outside of the waiting room on occasion, by choice due to COVID-19. They could then miss their name being called out by triage staff or could miss the drinks trolley.

As previously mentioned there was large signage in various areas of the ED and SAU that would show where they were on the patient journey and would they could expect next on the journey in the SAU, paediatrics and the ED. This signage was bilingual and provided useful information to the patients to better understand why they were in that location.

Improvement needed

The health board must ensure that a procedure is put in place for the management of patients in custody that ensure that their dignity and safety is maintained, should their condition be liable to deteriorate. This procedure should be agreed with the local constabulary to ensure they are aware of the procedure.

The health board must inform patients of the current plans in place to change the design of the ED, including the changes to the waiting rooms and any plans for an additional minor injuries area.

Preventing pressure and tissue damage

Pressure risk assessments were completed in majors, resus, paediatrics and the SAU as required. There was a system of intentional rounding[26] in place depending on the patient risk and there were also beds with pressure relieving mattress available in these areas. However, there was no evidence of pressure risk assessment seen in the RAU, despite there being elderly and frail patients sitting on chairs waiting for a space in majors. We were also told that there had been several occasions where there were insufficient pressure relieving mattresses available for patients at risk.

The paramedics we spoke with stated that tissue viability was not part of their training and day to day practice and they would be unable to classify different grades of pressure damage. We were told that the risks were recognised by ED staff and some mitigation was in place, with some patients being put on a repose mattress[27] on the ambulance. The repositioning of patients and skin inspection is difficult in a confined space on a narrow trolley. Only nurses were trained on the Waterlow[28] scoring, pressure relief techniques and the classification of pressure damage. This is not included in paramedic curriculum. The joint care document helps to facilitate shared care and sharing information between hospital staff and WAST staff. The lack of clarity between ED and WAST staff over who was responsible for patients waiting to offload was still in evidence at the hospital. This was also evidenced as part of the HIW 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover'[29].

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[26] Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs.

[27] The Repose Mattress Overlay has been designed for use on a standard single bed where it has proven to provide effective pressure redistribution for patients at very high risk. Repose Mattress is an inflatable pressure relieving device and is designed for temporary mitigation of potential pressure damage. It is the only equipment available that is portable enough to be used on an ambulance trolley.

[28] Waterlow score is the score that is used to assess the risk of Pressure ulcer that occurs in the pressure points of the human body due to the pressure or combination of shear and pressure.

[29] https://hiw.org.uk/sites/default/files/2021-10/20211007WASTReviewHandoverDelay-EN.pdf

We were told of the practical difficulty in repositioning patients on ambulance trolleys, which were not designed for pressure relief, to relieve pressure points. Many patients may already have pressure damage before ambulance arrival, for example from sleeping in chairs at home or being on the floor for a period of time after falls. Additionally, for some patients there would be a general deterioration in health, nutrition and mobility in the weeks or days prior to admission. When patients were moved from an ambulance into the majors' clinical area, pressure relieving mitigation was available on a pressure mattress.

Patients with pressure issues should be managed in the ED not in the back of an ambulance. This also pushed the problem out of the hospitals sight, could be a safeguarding issue and also affected the response times for vehicles to attend other calls. The ambulance was tied up and this depleted the availability to respond to 999 calls in the community and there is then the potential for missing red calls with subsequent implications for the patients and families. Extended pre-hospital ambulance waiting was a contributor to harm regarding pressure area breakdown[30]. The majority of patients waiting in ambulances were also elderly, with pre-existing morbidities.

We checked a sample of patient records and noted that two of the patients had been on the floor for an extended period of time prior to the ambulance arrival due to the delayed response time. As described above, the inspection of skin on an ambulance was difficult and not always practical. We also noted that there was no evidence of repositioning in the RAU, although patients were fit to sit and could move around if needed. One patient record we checked, had been on a chair for seven hours and staff were observed moving the patient and help them stand up and walk to the toilet. However, this was not formally documented.

For patient records we checked in majors and the SAU we noted that pressure ulcer risks were assessed and that patient's skin was assessed on a regular basis, depending on the patient requirements. An appropriate care plan was developed and documentation indicated repositioning, where needed. There was also evidence of pressure relieving aids on the beds of these patients. Where required, patients with high Waterlow scores were also assessed.

[30] All Health Acquired Pressure Ulcers (HAPU) are reportable to the Welsh Government reportable and must be entered on datix and investigated using the All Wales Pressure Ulcer Investigating tool.

Improvement needed

The health board needs to ensure that:

- Pressure risk assessments are completed in full for all patients
- Sufficient pressure relieving mattress are available for patients at risk.

Falls prevention

Falls risk assessments were observed as being completed as appropriate and that patients were encouraged to wear shoes or slippers when walking around the ED. Patients waiting on ambulances would be observed by at least one WAST staff member at all times.

We were told that all falls were recorded on Datix, the incident management system used in the NHS in Wales. However, staff we spoke with, including agency staff, said that they did not always receive feedback on the Datix they submit, in majors. That being said, most staff were able to describe examples of lessons learned that had been shared. We were told by one member of staff that there would be insufficient staff to enable patients who required support to walk within the ED to safely use the toilets and other methods would be used. We did note that the ED was under considerable pressure due to the volume of patients presenting at reception.

Call bells were available for patients in majors, but not all patients had easy access to them. We observed one patient asking for help verbally because of this. There were also call bells for the patients on beds in the SAU, patients in the SAU chairs area, we were told, would be observed at times. Patients in the fit to sit chairs or corridor area were asked to call for help from passing staff. The issue of patients being observed at all times is covered in the immediate assurance above.

Multidisciplinary teams (MDT), including physiotherapists and occupational therapists (OT) were observed in the ED on several occassions. Additionally, we saw that physiotherapist and OTs carried out the relevant assessments prior to patients being deemed safe for discharge.

We checked a sample of patient records and for those admitted following a fall there was an assessment and physiotherapist input prior to discharge. The physiotherapy assessment of care was planned around individual needs. There was a referral service to the physiotherapist, which was effective in meeting the patient needs. We also noted that patients were not left with trolley sides down, unless there was a bedside table holding food or drinks in place.

Improvement needed

The health board must ensure that patients in beds have easy access to the call bells.

Infection prevention and control (IPC)

There were two small porta cabins outside the ED to screen patients for COVID-19, one for use by adults and one for children and their parents or carers. A HCSW manned these porta cabins and they asked a series of triage screening questions and they also took the temperature of the patient or carer. Those patients with suspected COVID-19 based on the initial screening were then directed into a corridor of the ED, known as the 'COVID corridor'. The remainder were directed into either the main ED or the paediatric ED. There were a number of security staff in this area to ensure the patients or carers took the correct route and did not try to enter the ED without first being screened.

Approximately 15 metres down the 'COVID corridor' there was an area with equipment for a patient to be briefly triaged and tested for COVID-19, using a point of care test kit. The patients would then sit in soft chairs, with screens between each patient, along this corridor. Positive patients would then go into a COVID-19 assessment area. Negative patients would go into the waiting room unless a cubicle was available. At the end of the corridor, approximately 80 metres long, was the COVID-19 ward known as A1. The area was not a public thoroughfare, other than the other patients in the corridor passing each other. There would normally be two members of staff on duty, one qualified nurse and one HCSW. Staff would wear the appropriate PPE with patients (apron, mask and gloves).

We noted the following points:

- There were no wash hand basins for patients or staff in this area, although there was sanitising gel available
- The staff manning this station would have to go into the non-COVID paediatric area to print off the 'casualty cards' for each patient and then return to the COVID-19 corridor
- Staff from other areas, such as resuscitation, the main ED or the paediatric area could and did pass this area from time to time if they needed to walk between these areas creating additional footfall and risk of cross infection
- The staff on duty in addition to testing the patients, would also have to monitor the patients in case their condition deteriorated, view patients

in an ambulance with suspected COVID-19, from time to time, as well as the testing in the corridor. If the staff in this area needed additional support because of the number of patients, they would escalate to the nurse in charge of ED. We were told this would then be risk assessed to see whether another member of staff should be sent to assist this area, but there was not always someone available.

HIW consider that this provided a risk of cross contamination, a failure in infection prevention and control and of being unable to appropriately manage the patients in this area. We were told by the director of nursing that as a result of our observations, there will be a rapid installation of a sink, but that infection control considered that the wearing of PPE provided sufficient mitigation.

The above issues were discussed with managers from the health board during our inspection feedback meeting, which was held immediately following the inspection, and were subsequently dealt with under HIW's immediate assurance process. This involved us writing to the health board, within two days of completion of the inspection, outlining the issues and requiring a written response within seven days. The immediate assurance issues, and the health board's response, are referred to in detail within Appendix B of this report.

We spoke with the IPC head of service who told us that the IPC team provide a seven day a week service. Audits were completed regularly with almost three whole time equivalent safety advisors to support the wards to complete these audits. However, we did not see IPC results displayed in any area of the ED. We observed social distancing in all communal areas and all staff wore a minimum of a face mask at all times.

In the paediatric area there was a clearly identified one way system around the ward with a clear pathway for COVID-19 suspected or confirmed (red) or other (amber) patients. Staff were encouraged to challenge non-compliance with social distancing, bare below the elbow and hand washing. The waiting area was separated into individual pods to reduce cross infection.

In the SAU we also saw socially distanced pods, separated by Perspex screens in the corridors and triage areas to provide social distancing. Patients that were sent to the unit by GP referral, would go into SAU through the main hospital and a swab team tested all admissions.

In the remainder of the ED (except the COVID corridor) we also noticed staff were bare below the elbow, washed their hands regularly and maintained social distancing where possible. Although because of the nature of the work and some of the areas, such as the RAU, the cramped areas did not always allow for social distancing. Staff would all wear face masks.

All staff we spoke with were aware of the standards they should follow on IPC. There had not been any issues in the supply of PPE. There were sinks available in the majority of the ED for staff to wash their hands and there were sanitising gels available throughout.

During the inspection we saw domestic staff regularly clean the areas. In the main ED there was a cleaning environment team that undertook an enhanced level of cleaning, using a chlorine disinfectant with access to hydrogen peroxide and ultraviolet light for enhanced and deep cleaning. There were also twice weekly meetings to discuss any issues. All furnishings appeared to be in a good state of repair and were all wipe clean.

Ambulance staff we spoke with said that they followed the decontamination process when they transferred potentially infectious cases from the ambulance into the ED. We were also told that the ED would be alerted if any chemical contaminated patients were being moved into the hospital to ensure a decontamination room was available. There was direct access to the decontamination room from the ambulance bay via swipe access doors. Any contagious patients would be transferred to a negative pressure isolation suite in the ED.

The majority of patients we spoke with said that the area was clean, tidy and all surfaces were cleaned. Additionally, they said that all staff washed their hands at every visit. We asked patients a question about the cleanliness of the area, 95 percent of patients said that the setting was ‘very clean’ or ‘fairly clean’, the remainder said it was not. We also asked patients a question about COVID-19 compliant procedures being evident during patient visits. 89 percent said procedures were followed where appropriate, eight percent said they were not and remainder answered that they did not know.

Senior staff we spoke with said that infection rates were low in the ED. If any issues were identified they would be investigated using root cause analysis with a team of doctors and infection control nurses as necessary. Any lessons learned would be cascaded to staff. Any healthcare aquired infections would also be investigated in the same way. We were also told that the ED were looking at changing the way of swabbing patients with suspected COVID-19, using a

temporary structure in an external space and also completing the Manchester[31] triage for those patients in this area.

We asked a series of questions of staff regarding to what extent the statements reflected their view on how much your organisation had adapted to becoming COVID-19 compliant.

Question / Answer Choices	Strongly agree or agree	Disagree or strongly disagree
My organisation has implemented the necessary environmental changes	69%	31%
My organisation has implemented the necessary practice changes	75%	23%
There has been a sufficient supply of PPE	85%	15%
There are decontamination arrangements for equipment and relevant areas	82%	18%

Comments were received in relation to COVID arrangements, shown below:

> *"Having worked previously in pandemic for another large UHB, in comparison my organisation is excellent, and really puts the safety and protection of staff and patients priority with COVID"*
>
> *"I'm not aware of decontamination units"*
>
> *"However the department was not built to have a covid area and running 2 EDs is difficult."*
>
> *"We need more UV machines to help decontaminate the Red areas"*
>
> *"Although I agree that there are changes made for covid, there is inadequate space in the covid (red) area of ED which on most shifts results in patients (sometimes more than 10 on particularly bad*

[31] The Manchester Triage System is one of the most commonly used triage systems in Europe. It enables nurses to assign a clinical priority to patients, based on presenting signs and symptoms, without making any assumption about the underlying diagnosis.

days) sat lined up the corridor. The corridor has no toilet and no hand washing facilities. It also is next to the paediatric Emergency assessment unit and red triage staff have to walk in to CEAU to book in ?covid patients and also to wash hands. The corridor is almost the full length of the hospital which leads to the red area and if patients need to use the toilet or any emergencies then have to be taken up the full length of the corridor."

"The issue is staff jumping between A1 COVID ward and Green ED every day. A1 should be staffed separate from Green ED. Have their own COVID staff"

"The whole covid system here is awful. A1 ward is so far away from A&E. A1 should be MAU as a whole, MAU become SAU or our Covid place. The covid corridor is dangerous in every aspect, people are spread along the corridor, there are no emergency bells/dignified areas, no toilets whatsoever. It's disgraceful and undignified and I do not feel confident working in such an area. Especially when before I've had extremely poorly patients given to me in there with no access to proper oxygen tanks, buzzers, toilets, sluice access etc."

Additionally, 72 percent who expressed an opinion said infection prevention and control procedures were 'always' or 'usually' followed with 26 percent saying they 'sometimes' were.

Nutrition and hydration

We noted that patients were not assessed to establish their ability to eat and drink and then given support. Generally, if staff noticed that a patient was not eating in majors then assistance was given. There was a system in place to provide food for patients through a meal trolley and regular drinks. We also noticed British Red Cross staff assisting in delivering sandwiches to patients and in providing hot drinks to patients. However, some patients struggled to eat in the beds, when they were not repositioned. We also did not observe patients being offered hand washing or hand wipes prior to or after eating. We also noted food and drinks being taken to patients in ambulances, this would normally be cold food such as sandwiches and mainly during the day. This is due to the policy of not supplying hot food to patients in an ambulance.

We noted that fluids and food was recorded for some patients, but fluid output was not generally recorded on the All Wales Fluid Balance charts. We also noted that the All Wales Nutrition Pathway was not widely used in most areas of the emergency pathway, although there was some evidence of use in majors. Nursing staff we spoke with commented that nutrition assessment was not

suitable for emergency pathway care as it was designed for ongoing care and patients should be moved out of the ED within four hours. The poor flow contributed to patients having to be fed in the ED. If patients were in the ED for extended periods, practice changes would be required to train ED staff in the use of the nutrition score and pathway. The poor compliance with filling in the nutrition scores potentially reflected this lack of training.

Fluids including intra venous (IV) fluids were noted as being monitored on majors on the All Wales Nutrition charts. However, patients receiving IV fluids on ambulances and the the corridors were not recorded on the All Wales Fluid Balance chart. Staff on the RAU reported that nutrition charts were not routinely completed due to the anticipated short stay of patients.

In the paediatric area staff worked collaboratively with patients and carers to ensure adequate fluids and nutrition was taken. Additionally, food outside of meal times was available such as fruit and yoghurts. Staff had requested a larger fridge, as the current fridge was too small to keep these sandwiches and healthy snacks. Nutrition charts were noted as being completed for all fluid and food consumed.

There were regular reviews in the SAU of patients nutrition and good documentation was observed. Fluids, including IV fluids, were recorded on the All Wales Fluid Balance charts and nutrition charts were also completed for all fluid and food consumed.

Staff we spoke with said that patients had access to a choice of what to eat and drink if they had been in the ED for a long period of time. There were three scheduled meals per day, with drinks of tea and coffee available five times a day. All patients had access to water and squash if required. The water jugs seen were mainly in easy reach of patients depending on mobility. All hot meals served were temperature checked before serving. The food looked appetising with good sized portions. Patients we spoke with said that there was a good choice of food that was tasty and hot. Help was given to cut up some foods for one patient with poor eyesight. Another patient said they had help with eating toast when asked. Generally patients we spoke with were complimentary about the access to food and drink.

We checked a sample of patient records and noted that a joint care form was completed for patients on the ambulance to record hydration, nutrition, toileting, analgesia and presure area care on an ambulance. It was noted that WAST and ED staff liaised closely to see if patients waiting on an ambulance were able to eat and drink according to their clinical condition. The British Red Cross staff were available to cater for patients on ambulances during office hours. At other times, WAST staff were responsible for feeding patients.

We saw that nutritional risk assessments had been completed for patients on the basis of triage and frailty need, once patients had been admitted into the ED. In one of the six relevant patient records we noted that the fluid chart was incomplete with regard to fluid output. However, overall the nutritional and hydration needs had been addressed to a reasonable standard. There was only one patient record checked who was nil by mouth. An assessment had been made in relation to the duration of this and there were plans in place to maintain nutrition and hydration.

Improvement needed

The health board must ensure that:

- Assessments are carried out on patients about their ability to eat and drink
- That appropriate support is given to those patients who needed support
- Patients are repositioned prior to eating, to ensure that they are able to eat and drink the food
- Patients are offered hand washing or hand wipes prior to or after eating and that they are encourage to use these facilities before and after meals
- Nutrition and fluids are recorded appropriately on the relevant documentation
- All staff are trained on the use of the All Wales Nutrition charts.

Medicines management

We considered the arrangements for the checking of the contents of resuscitation trollies in the various areas of the ED. The records in the resus and majors areas showed there were a number of gaps in the record of checks completed in October 2021 on both units. This demonstrated that the resuscitation equipment had not always been checked daily. We reviewed the contents and we found the items to be in date and serviceable.

HIW consider that the lack of regular checks meant that there was a risk to patient safety, as the resuscitation trollies in both units may not be sufficiently stocked, or equipment / medication may not be in-date and ready for use, in the event of a patient emergency. We were told by the director of nursing that as a result of this and a previous failing in another inspection, the health board have now

issued an organisational-wide alert. This is to ensure that these checks were carried out daily and evidenced. The health board will be carrying out a health board wide audit to ensure compliance with these checks.

The above issues were discussed with managers from the health board during our inspection feedback meeting, which was held immediately following the inspection, and were subsequently dealt with under HIW's immediate assurance process. This involved us writing to the health board, within two days of completion of the inspection, outlining the issues and requiring a written response within seven days. The immediate assurance issues, and the health board's response, are referred to in detail within Appendix B of this report.

The ED used an automated medication dispensing systems that could only be accessed by authorised staff. This system gave an electronic record of medication removed and by whom, all access attempts were electronically recorded. Medications were then re-ordered automatically by the system.

We observed drug administration in majors and resus and noted that it was calm and safe. All patients in the ED were observed with identification bands. However, we did note an instance where a staff member was called away from the drugs round to help a patient that was wandering and the medication for the patient was left by the side of the table. The member of staff returned ten minutes later to ensure that the medication was then administered correctly. Additionally, there were difficulties in maintaining patient confidentiality when administering medication to patients waiting on corridors. This was because patients would be asked their name and date of birth in an area where other patients could hear the reply.

The daily controlled drugs (CDs) check was carried out by two registered nurses, using the automated medication system inventory adjustment and this was cross checked to the CD register. We noted that there were no omissions in the daily check in the CD register.

Fridge temperatures were recorded daily and any out of range temperatures would be reported to the nurse in charge of the area for their further action. We were told that the nurse in charge would then inform pharmacy staff of the potential effect on the medication stored. The ED had a dedicated pharmacist during the day. Staff reported difficulties in obtaining certain medication during out of hour's periods. There was an on call pharmacist or site manager available to access medicines out of hours.

Sharps boxes, to dispose of medical supplies such as needles or similar medical supplies were stored in a disposal area off the main corridor. All boxes were observed to be locked, signed and dated.

To take out (TTOs)[32] documentation was completed for patients being discharged, including the over labelled medication from the pharmacy.

Improvement needed

The health board must ensure that:

- Staff on a medication round, wear the appropriate tabard and are not disturbed when dispensing medication
- Further attempts are made to maintain patient privacy when asking patients to confirm their information during the dispensing of medication.

Safeguarding children and adults at risk

Staff we spoke with were all aware of the escalation processes for safeguarding in addition to being aware of the All Wales guidance. We were told of a safeguarding checklist and that all suspected non-accidental injuries were reported. Staff were also able to describe the social service referral process and the out of hours contacts. The paediatric staff we spoke with said that all paediatric staff were trained up to level two child protection and had a good understanding of safeguarding issues, including escalation. They also told us of team days incorporating guest speakers on safeguarding. The NIC said that staff appeared clear about raising safeguarding concerns. Triage staff appeared to be very vigilant to safeguarding concerns and knew the protocols for escalating these concerns.

Patients at risk of abuse including domestic violence were identified using a hurt, insult, threaten, scream (HITS)[33] tool and there would be a subsequent multi-

[32] The TTO (to take out), is a form that should be completed for all patients being discharged from hospital. It both summarises the patient's hospital stay for their general practitioner and acts as a prescription to order the drugs they need to take home with them.

[33] HITS is an easy to use screening tool and scale that stands for Hurt, Insult, Threaten and Scream. The tool includes four questions that physicians can provide to patients via a questionnaire to assess risk for Intimate Partner Violence (IPV). The questions can also be asked verbally.

agency risk assessment conference (MARAC)[34] referral. Adults at risk of harm who were unable to protect themselves from that harm were also referred. We were told that patients with a high risk of self-harm behaviour would be observed in an area within the RAU, outside the majors office. At the triage stage, staff also told us that documentation was completed on patients with a risk of absconding, including a physical description of the patient.

There appeared to be limited understanding of Deprivation of Liberty Safeguards (DoLS)[35], in the main ED. However, we were told that the forget me not flower symbol was used for patients living with dementia on the emergency care system. Additionally, in majors and resus, staff were aware of DoLS but there was little evidence of documentation of patients mental capacity in the notes seen.

We were told that there was a designated area, with an absence of ligature points, within the main ED suitable for those in mental health crisis. There was also a cubicle in the paediatric area that had been risk assessesed as appropriate for a patient assessed as at risk of self-harm and suicide. Staff stated that they had access to training regarding female genital mutilation, although they believed this was not a common occurrence locally.

During our inspection there were no patients under constant observation, due to safeguarding concerns. All patients we spoke with said they felt safe in the ED and were willing to speak up if required.

[34] A multi-agency risk assessment conference (MARAC), is a meeting where information is shared and a co-ordinated action plan developed in high-risk domestic violence situations. The primary aim is to safeguard those experiencing domestic violence. MARACs are attended by representatives of relevant agencies such as local police, probation, health, child protection, housing practitioners, domestic violence advisors and other specialists from the statutory and voluntary sectors.

[35] DoLS - The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect vulnerable adults, who may become, or are being deprived of their liberty in a care home or hospital setting. These safeguards are for people who lack capacity to decide where they need to reside to receive treatment and/or care and need to be deprived of their liberty, in their best interests, otherwise than under the Mental Health Act 1983 (MCA Code of Practice). The safeguards came into force in Wales and England on the 1st April 2009.

Improvement needed

The health board must ensure that:

- Additional training is given to staff to raise their awareness and knowledge of staff on DoLS
- Documentation is completed in full on the capacity of patients in their notes.

Blood management

Staff we spoke with said they used the All Wales Transfusion[36] documentation to ensure that a safe system for blood transfusion was in place. Blood products were not stored in the ED but were transferred from the hospital blood bank when required. We were told that agency staff do not take part in pre-blood transfusion checks. All trained staff we spoke with were aware of the post transfusion reactions and the requirements for patients to be monitored. Pathology and laboratory staff were responsible for maintaining adequate supplies of blood products.

Staff in resus referred to the massive transfusion protocol that would be instigated when patients arrived requiring large volume of blood products. Those members of staff we spoke with were aware of the expiry time of blood products when issued from the blood fridge. We were told that cool boxes were used to store multiple blood units for trauma. Again, staff we spoke with were able to describe the safe and appropriate use of blood components and products. This involved double identity checks by two qualified and trained nurses, prior to the administration of the blood transfusion and the use of the All Wales Transfusion documentation.

[36] Includes a pre administration checklist, prescription section and observation chart. Any special transfusion requirements (e.g. irradiation of blood/component or cytomegalovirus (CMV) negative or must be indicated on the prescription section of the record and special requirements are discussed in appendix. Any transfusion-related drugs must be prescribed on the All Wales in-patient medication chart. Blood components can only be prescribed/authorised on The All Wales Transfusion Record by Doctors and staff who have successfully undertaken the non-medical authorisation of blood component course.

Datix would be used to report any adverse reaction with blood management and transfusion. However, staff we spoke with, were not aware of reporting via the Serious Hazards of Transfusion[37] (SHOT).

Improvement needed

The health board must ensure that all staff are made aware of SHOT and the importance of reporting any instances.

Medical devices, equipment and diagnostic systems

The equipment at the ED appeared to be new and in a good state of repair and recently installed. The areas had all the equipment needed to meet the needs of the patients. Faults were reported and equipment that was taken out of circulation was removed from the patient facing areas to await removal to electrical and biomedical engineering (EBME).

All commodes seen had been decontaminated and cleaned and were labelled after use.

Effective care

Safe and clinically effective care

Patients and carers that we spoke with were all complimentary of the care overall, with overwhelmingly positive comments on staff from all disciplines. We also spoke to a number of staff in the various areas of the EDs. In majors, staff were aware of the clinical pathways in place and were aware of how to access the relevant clinical policies and procedures in place via the health board intranet. Staff were also made aware of patient safety notices.

In the RAU and triage there were also stroke[38] and STEMI protocols for patient pathways, that were audited by the medical team. Staff said that they knew how

[37] SHOT is the United Kingdom's haemovigilance scheme. It collects and analyses anonymized information on adverse events and blood transfusion reactions. When SHOT has identified risks related to transfusion, it produces recommendations within its annual reports to improve patient safety.

[38] https://www.wales.nhs.uk/document/180006

to access the relevant clinical policies and procedures but would not have time to access these during most shifts. Staff said that there had been an increasing use of bank and agency nurses who were not familiar with all health board protocols and procedures. Staff in the RAU said that best practice guidelines and care was delivered at the minimum level and believed that staffing and acuity prevented them from delivering the best possible care.

Staff felt that their personal standards of care were comprimised due to the sheer volume of patients and that patients were nursed in inappropriate areas. Staff described their frustrations in not being able to deliver care and treatments in a timely manner due to acuity. They felt they were able to deliver the minimum standards in order to deliver safe care for all patients but not their best care. All patients asked felt they were looked after and appreciated the staff were 'run ragged'.

In paediatrics and SAU the audits included health and safety and quality assurance. Staff in SAU said that best practice was facilitated for newly qualified staff by the Journey of Excellence (JOE) preceptorship[39] scheme. The journey of excellence competency based support programme, incorporated opportunities for rotation within and between divisional specialist areas. During this period staff would initially be of supernumerary status, then a novice period and finally a competent practitioner. Each stage would be supported by appropriate training days and objective setting.

Both paediatrics and SAU had an establishment that was currently fit for purpose. However, sickness and maternity leave would leave gaps in the rota that would be filled by bank or agency staff.

We saw evidence of regular audit activity, but the results of these audits were not displayed, in the main ED and SAU areas. These included dignity and essential care investigations, where the recommendations were shared with the staff in the relevant area. Additionally, there were one patient, one day audits that related to the care given to the patients, the records of the care and the environment around the patient. There was also a triage working group that met on a weekly basis to discuss triage audit results. We were told that triage nurses had ten sets of assessments audited before they were deemed competent.

[39] Preceptorship is a period to guide and support all newly qualified practitioners in the transition from student to autonomous practitioner.

Senior staff we spoke with said that they completed a number of audits, and the results were laminated to display to staff in the office. They said that risks were monitored throughout the day at the three daily safety huddles. They go through the safety in the ED and also look at ambulance issues, as well as the various areas in the EDs. We were also told there was a live risk register on Datix as well as three monthly meetings to discuss the risk register. One of the current risks relates to exhaust fumes from the ambulances outside the ED.

In the survey we asked staff whether senior managers were committed to patient care, 56 percent who expressed an opinion said senior managers were, 32 percent said they sometimes were, but 12 percent said they never were.

Sepsis

Staff were aware of the sepsis six[40] screening tool and identified cases as soon as they were able to. The national early warning score (NEWS)[41] and sepsis six screening tool were seen as being followed in practice, in majors and resus. When identified, patients were isolated where possible and treated along national guidelines. Nursing staff in the RAU reported that all doctors were receptive and approachable to concerns regarding the deterioration of patients and acted rapidly to instigate a sepsis six bundle. However, WAST staff reported delays in communication relating to antibiotics within the timeline, on some occasions, over the past few weeks for delayed ambulance patients. Again these were anecdotal comments and not witnessed during the inspection.

We were told by the practice educators that sepsis training was available for staff, this started at induction and the educators delivered the training, about how to recognise sepsis, what to do and how to complete a bundle.

From the sample of patient records checked we saw evidence that pain was being measured, actioned and evaluated in majors and the SAU. This was documented on the NEWS chart. Generally patients did not complain of pain, although one patient indicated that although they had paid relief, it was

[40] The Sepsis Six is the name given to a bundle of medical therapies designed to reduce mortality in patients with sepsis.

[41] NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

insufficient and they wanted to find out what was the cause. In majors and resus, sepsis was recognised and managed in a timely manner.

In the RAU and triage, staff were aware of flagging sepsis patients on questioning. The NEWS score was regularly calculated to ensure that sepsis risks and deterioration was captured early. We were told and saw evidence of the use of pain scores on triage as well as the use of Paediatric Glasgow Coma Scale (PGCS)[42] by triage nurses.

50 percent of patients agreed that care of patients / service users was the organisation's top priority, but 25 percent disagreed.

> *"As per my previous comments, patients stuck in waiting rooms for 12+ hours, some only being given a chair for 36 hours in sub wait or in ambulatory in a1. Not appropriate"*
>
> *"Standard of care cannot be seen as being toileted, fed sandwiches, developing pressure sores and further breakdown of skin caused by urine, and overall lengthily delays outside of A&e. History shows the lack of care provided by the Health Board by patients dying outside of A&e in ambulances. Members of the public arriving via own transport outside of A&e with family members in cardiac arrest due to no available ambulances"*
>
> *"Too dangerous to be a patient here accident waiting to happen"*
>
> *"I think money is the organisations top priority. Staff are the organisations lowest priority. Patients sit somewhere in the middle"*
>
> *"I feel we can never give the care that the patients need because we are always short staffed."*

51 percent agreed that the organisation acts on concerns raised by patients / service users and 23 percent disagreed.

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[42] The Paediatric Glasgow Coma Scale (British English) or simply PGCS is the equivalent of the Glasgow Coma Scale (GCS) used to assess the level of consciousness of child patients. The PGCS comprises three tests: eye, verbal and motor responses.

Only 31 percent of staff agreed they would recommend their organisation as a place to work and 36 percent disagreed. The remaining 33 percent neither agreed nor disagreed.

> *"I would strongly recommend that no-one should work in ABUHB and especially GUH. I would certainly not recommend it patients and would feel afraid if my family needed to attend."*

> *"Since the move to the Grange I no longer feel pride and a sense of achievement in my work. Work pressures and lack of staff mean I dread going in to work and don't feel I give a good standard of care. There are too many patients most shifts with unsafe levels of appropriately trained staff to care for them and I fear that serious incidents will occur because of this"*

Again, only 20 percent of staff agreed they would be happy with the standard of care provided by their organisation for themselves or for friends or family, 53 percent disagreed and the remaining 27 percent neither agreed nor disagreed.

> *"I fear the day I have to bring my own children to this department. It's dangerously under staffed, too small for the capacity and I fear nursing staff are going to have a serious incident on their hands the further in to the winter we go"*

> *"I would be nervous for a family member to be admitted to hospital at the moment as it is not physically possible to provide the best level of care to all patients as we just do not have the resources"*

> *"I would be mortified to bring my own children to the department. Although the nurses and doctors are wonderful and do their best the wait times are horrific and frustrating. There are not enough staff, waiting areas (nursing in corridors) beds, bathrooms, A&E just is not big enough for the volume of patients and nowhere near staffed well enough"*

> *"Personally for myself, if any of my family members or friends needed urgent medical care I would take them to a different hospital out of the AB Health Board/Welsh Hospitals"*

Quality improvement, research and innovation

Senior staff we spoke with described the quality improvement activities that had taken place. These mainly involved working on triage times, including redirection of patients, and the instigation of the RAU to improve the patient waiting times.

Additional Manchester triage training, led by the Nurse Consultant[43], was considered as excellent and had been effective in assuring safe and effective assessment at the 'front door'.

The ED had also welcomed the work of St Johns Ambulances, to support WAST colleagues and the British Red Cross in delivering patient care and comforts. These were widely appreciated by staff, patients and their relatives.

Record keeping

We viewed a total of 13 patient records in the various areas throughout the ED and the SAU. Notes we checked were clear and easy to navigate, with a structured rapid assessment pathway. Paper notes were folded and put into numbered metal racks in the RAU, which were situated away from members of the public or other patients. Medical staff document their notes on the digital system, when they saw patients.

Overall, we noted that the assessment of mental capacity was not documented in all patients as there was a presumption of mental capacity that negated the need for the assessment.

The records showed that the effectivenes of the care and treatment was evaluated regularly and that they were up to date and completed after care and treatment. In the main, documentation was legible and of a reasonable standard. Entries were signed, dated and timed in 10 of the 13 records checked. Nursing staff caring for a patient on a shift would sign the information form to demonstrate who was caring for the patient. Patient information was available at handover in majors and resus but was not seen in the SAU and in RAU. As described above there was evidence that other members of the MDT contributed to the patient's treatment plan, where a medical assessment and examination had been completed. Casualty assessment documents were not always completed fully.

Overall we considered that the quality of records was of a reasonable standard indicating the plan of care and management of patients whilst in the ED. The records were up to date and contemporaneous and were kept in an area that was

[43] The role of nurse consultant was introduced in the late 1990s to strengthen leadership in nursing, improve patient outcomes and enhance the quality of healthcare services. Nurse consultants have a wide-ranging remit that includes expert practice, professional leadership and consultancy, education, and service development.

not accessible to the patient and out of view of other patients. Triage records were concise and gave a good history of the patients complaint to staff. However, we noted that for three patients there was not evidence that oxygen had been prescribed, although the patient was using oxygen. Also as described above there were instances where fluid charts, sepsis pathway notes and capacity assessment were incomplete.

However, we did note that there were boxes of paper records awaiting scanning at the back of the reception desk. Some papers were considered to be on the verge of falling out of the boxes and could result in some notes being mis-placed or mis-filed. Whilst the contents of the notes could not be seen by patients in the reception area, we considered it did not give assurance to the public that records were stored securely.

Improvement needed

The health board must ensure that:

- All entries in patients records are completed in full, signed, dated and timed
- Paper records are appropriately stored away from patient view
- All medication is appropriately prescribed and signed
- Patient information is made available on handover and takeover.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

We observed all staff striving to deliver good quality, safe and effective care to patients, within very busy units. However, the comments of staff in the staff survey show that they could not always deliver the care they wanted to, due to a number of issues.

We found evidence of good teamwork and support amongst nursing and medical teams within all units.

We found that management and leadership was focused and robust, however, there was a reliance on temporary staff (bank and agency).

Governance, leadership and accountability

During our inspection, we invited staff working on the units to provide their comments on topics related to their work. As referred to above, HIW issued an online survey to obtain staff views on the ED and SAU at the hospital. In total, we received 136 responses from staff at the hospital. Not all respondents answered all the questions. The staff grades included care assistants, consultants including consultant paediatricians, doctors, emergency medical technicians and paramedics, HCSW, nurses and other roles. The staff stated that they had been in their current role from under six months to over 10 years. The majority of staff (111) said the ED was their base, and 25 said they regularly visited the ED to work, but it was not their base. We also spoke to a number of members of staff and senior staff during the inspection, both while we were inspecting the various areas and as formal interviews.

The HIW online survey indicated that staff were feeling overworked, due to understaffing, the volume of patients, and a shortage of ED experience. In addition, the survey indicated that staff believed there was insufficient space in the ED, hospital and the community to cope with the patient numbers.

We made arrangements for staff to be able to complete an online survey relating to their experience at the various areas within the ED and the SAU at the hospital. The survey was open between the 1st and 5th of November 2021.

Based on the responses received there were a number of tick replies to various statements. Whilst the majority of these were not negative, the number of 'sometimes' and 'never' or similar less positive replies, were considerably worse than has been previously noted on inspections. There were also a number of negative and strong comments made by staff.

From what we saw during the inspection, and the comments made to HIW inspectors, the management and leadership was good. We also noted the environment was quiet and calm, with staff going about their work efficiently, treating patients with respect. However, based on the survey comments, staff clearly feel that:

- There were insufficient staff to deal with the number of patients presenting, in a timely manner
- There is insufficient space to treat patients in a timely manner
- Some staff may not have sufficient experience in the ED
- General frustrations with patient flow as a whole
- Not being able to provide the level of care that patients deserve based on the above.

We also spoke to medical staff who had similar concerns regarding the availability of beds to move patients into, outside of the ED and being unable to treat patients because there were no treatment rooms available.

The percentages of the various replies and the staff comments are described elsewhere in this report. We were also told of a number of initiatives within the areas covered that have been introduced including the weekly nursing news and that 19.44 whole time equivalent staff were being recruited.

The above issues were discussed with managers from the health board during our inspection feedback meeting, which was held immediately following the inspection, and were subsequently dealt with under HIW's immediate assurance process. This involved us writing to the health board, within two days of completion of the inspection, outlining the issues and requiring a written response within seven days. The immediate assurance issues, and the health board's response, are referred to in detail within Appendix B of this report.

We were provided with the daily situation reports during the inspection, which showed the numbers of patients in the various areas of the hospital, including the ED as well as the other minor injury units in the health board. This showed that there were more patients in the ED, than there were beds for them in the hospital and other eLGHs within the health board. The risks and issues related to the demand in the hospital and the (eLGHs) front doors remained higher than predicted, as well as staffing issues and COVID-19 presentations.

We were provided with the majority of the information we requested as part of this inspection after the feedback session. The health board dashboard of the health care standards showed that all the scores were good apart from communications which was recorded as 67 percent. Additionally we were sent training compliance percentages for each of the areas within the ED.

The CEAU SOP supplied, had the purpose of providing an overview of how the (CEAU) and Paediatric Short Stay Unit (SSU) would function. The SOP aimed to provide assurance that the CEAU and SSU provided safe and effective care to children in CEAU or by redirecting to alternative care providers and setting. The SOP ensured that the environmental processes and procedures were adhered to when emergency and GP patients attended the CEAU. Also, to ensure they were triaged, assessed and treated in a timely manner, promoting safety and effective quality care.

We asked a series of questions of staff about what happens when incidents and errors occur:

Question / Answer Choices	Agreed	Dis-agreed	Comment
Have you seen errors, near misses or incidents affecting staff in the last month.	63%	37%	
Had seen errors, near misses or incidents affecting patients in the last month.	70 %	30%	
The last time they saw an error, near miss or incident they reported it.	79%	6%	15% not applicable
Their organisation treats staff who are involved in an error, near miss or incident fairly.	49%	11%	40% neither agreed or disagreed
Their organisation encourages them to report errors, near misses or incidents.	83%	4%	13% neither
Their organisation treats reports of errors, near misses or incidents confidentially.	54%	8%	38% neither agreed or di
When errors, near misses or incidents are reported, their organisation takes action to ensure that they do not happen again.	52%	13%	35% neither

They were informed about errors, near misses and incidents that happen in the organisation.	42%	21	37% neither
They were given feedback about changes made in response to reported errors, near misses and incidents.	37%	22%	41% neither
If they were concerned about unsafe clinical practice, they would know how to report it.	95%	5%	
They would feel secure raising concerns about unsafe clinical practice.	70%	19%	11% did not know
They were confident that their organisation would address their concerns.	40%	29%	31% did not know

Staff reported, as above, that they did not always receive regular feedback on the Datix they completed with regard to poor flow and overcrowding. They stated that this made them less inclined to report in the future. One questioned what the point was and that they did not have time to Datix anyway. Staff comments on these areas in the survey included:

> *"Today I reported a patient that was admitted two days ago with acute pancreatitis and had been managed in a chair since admission"*
>
> *"We datix daily on near miss"*
>
> *"We datix everything! Majority of the time it is the only way we can cover our backs! When you have over 40-60 patients in the department and your short staffed medication is going to run late, checking and observing patients is delayed, staff don't get breaks, parents are constantly abusive"*
>
> *"We try to always report errors, near misses and incidents"*
>
> *"Concerns raised to hospital staff regarding patient with a suspected neck of femur. Unable to toilet patient and provide further pain relief. Datix completed regarding hospital delays outside A&E, quality of care provided, and harm caused. No initial actions taken by hospital staff. Response via health board due to datix raised. "*
>
> *"Raised numerous datix s about long patient waits, ASHICEs not being admitted on time etc. This practice has been getting worse not better."*
>
> *"Trauma calls were not put out for patients who met the Major trauma network escalation criteria, this lead to delay in CT trauma*

series and diagnosis. Some diagnosis were severe injuries, there were delayed diagnosis and treatment duration of several hours in some cases. Most of these cases were silver trauma. This was dealt with through discussion and evaluation at Governance meetings, and changes initiated. This is undergoing audit"

"Yes to my clinical lead. No to incident reporting. If I did, then I would not have enough time to see patients or would constantly be leaving work late. These events occur every shift. The consultants are aware of the issues but they themselves feel powerless to implement change due to the impositions placed on them by the health board. Fundamentally the place is unsafe"

"I do feel there could be more cross divisional shared learning. Some of what is needed with learning from incidents is more resource which is not always available due to lack of staff out there and lack of resource to the NHS"

"…We datix every shift and I've emailed right up to director of paediatrics and whilst they listen the department is still the same"

"Consultants are informed but juniors often aren't informed of these near misses"

"I am not too sure about feedback, as we all work too different and might not have a chance in time for feedback"

"Reported error …still not received an update"

Senior management we spoke with said that all incidents were reported on Datix and would be reviewed by the nurse in charge and then reviewed by the serious incident team. Depending on the severity of the incident the review could be carried out at corporate or directorate level. A senior clinician from ED would attend the serious incident meetings. Any actions plans would be fed-back to staff, through various methods including the nursing newsletter, email, and the online messaging application or to individual staff. We were told that staff would report incidents and that staff were aware of the list of incidents that should be reported. These included falls, pressure damage, medication errors, shortage of staff and patients held on ambulances, this would be done each shift. However, staff we spoke with said they felt they did not have sufficient time on the shift to complete Datix. Any concerns would be initially managed locally, and signed off at a directorate level. The concerns would be entered onto Datix.

We asked staff a series of quesions in the survey about the organisation they worked for, they replies are as follows:

Question / Answer Choice	Always or usually	Some-times	Never
My organisation encourages teamwork	80%	17%	3%
My organisation is supportive	59%	35%	6%
Front-line professionals who deal directly with patients, are sufficiently empowered to speak up and take action if they identify issues in line with the requirements of their own professional conduct and competence	62%	35%	3%
There is a culture of openness and learning within the organisation that supports staff to identify and solve problems	57%	33%	10%
The organisation has the right information to monitor the quality of care across all clinical interventions and take swift action when there are shortcomings.	42%	47%	11%
Overall I am content with the efforts of my organisation to keep me/ patients safe	30%	51%	19%

A management structure was in place and senior staff described clear lines of reporting to the wider health board management team. Roles, responsibilities and lines of accountability were also described. However, we noted that in paediatrics the non-clinical operational responsibility was held jointly between ED management and the family and therapies management. We were told that this may cause an element of tension in the area.

Senior staff we spoke with described the on-call system, with a senior nurse at work throughout the week with onsite cover. There was an on call consultant during the silent hours. Additionally, senior staff were able to describe the gold, silver and bronze on call out of hours arrangements, with managers available during the core hours.

Senior managers we spoke with told us that whilst the four hour response time compliance at the ED were under 50 percent, the other minor injury units in the health board area had four hour response times over 90 percent. This meant that overall, the health board were just below the Welsh average for response times. The hospital was designed to accept ambulance only admissions, from patients with the most acute injuries or illness. However, the unprecendented demand, together with the pressures of COVID-19 had resulted in the issues described above in the staff comments. These included very long waiting times on

ambulances and in the waiting room. In addition, the inability to discharge patients out of the ED into wards in the hospital and in the community, as those hospitals were also full had added to the issues.

There were plans in place to build temporary and permanent additional waiting room space outside and adjoining both the main and paediatric EDs. Whilst these plans were in place, they will not be operational until 2022.

The inspection team saw evidence of good management throughout the areas inspected. This included ward managers ensuring they came in early to see the night staff in the SAU, a positive rappour between the senior nurse and staff in resus and majors and doctors and nurses working well in the paediatric area. We also saw strong leadship in paediatrics between flow co-ordinators, senior nurses and service managers, with the issues of the child at the centre.

We noted that triage staff were resilient and worked hard in a difficult working environment and that they balanced the risk to patients in the waiting room and the risk in the ambulance well.

We also visited the health board patient flow centre that is adjacent to the WAST headquarters near to the hospital in Cwmbran. The purpose of the flow centre is to aid the flow and direct patients to the correct places within ABUHB. It also assists with the step up and step down system. We were told that the majority of calls were from GP and healthcare professionals. The flow centre was operational 24 hours a day.

We were told staffing at the flow centre had not been a problem and they had recently recruited more non-clinical staff members, using bank staff when necessary. There were four non-clinical staff and four clinical staff on duty and there is also a consultant available on most days. Non-clinical staff go through specific training on using the pathways for each health condition such as falls, chest pain, stroke etc. They were supported by the clinical team who oversee decision making. The ability for the flow centre to facilitate the step up step down of patients depends on patients being identified early for discharge.

HIW published a Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover, as described above. The review recommended that health boards, and Welsh Government should consider what further actions were required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach was required by WAST, health boards, and social care services within Wales, to that taken to date in tackling this system-wide problem.

Improvement needed

The health board must ensure that staff are reminded of the need to complete a Datix report in every instance that met the relevant criteria.

The health board should consider the separate reporting arrangements in the CEAU and SSU, to address any potential conflicts.

The health board is to inform HIW of the actions it has taken to address the recommendation made in the HIW Review relating to improving patient flow.

Staff and resources

Workforce

Staffing

We noted that the paediatric area was well staffed during the inspection and able to provide all care requirement. Staff we spoke with also felt that there were sufficient staff numbers to meet clinical demand. We were told the senior and lead nurses review the acuity and use their professional judgement to staff the area accordingly. Staff understood their responsibilities when escalation was necessary for staffing reasons. There was also evidence seen during the inspection that the MDT worked well together. There was a paediatric emergency medicine consultant with dedicated session time allocated to paediatrics. Additionally, there were at least two registered children's nurses on duty.

Whilst the Nurse Staffing Levels (Wales) Act (2016) do not apply to the ED, there is a ratio and skill mix required within the ED establishment. We noted that staffing levels in majors throughout the inspection showed a deficit of a safe level of permanent staffing, in majors, during the inspection. There were shortages on all shifts and a high use of agency staff. Staff we spoke with indicated that they struggled on occasions in the ED. Senior staff were aware of their responsibilities when escalation was necessary for staffing reasons. However, the health and

care standards[44] dashboard for Standard 7.1 Workforce[45] (Health services should ensure there were enough staff with the right knowledge and skills available at the right time to meet need) – showed 100 percent compliance for the hospital since April 2021. We saw evidence of physiotherapists and OTs on the ward.

With regard to the reception, triage and RAU, staffing was within the agreed template during the inspection, but staff stated that acuity was stretching staff in all areas. Additionally, last minutes sickness or unplanned absences affect the staffing levels. We were told that acuity at the front door had been overwhelming in the past few days. Additionally, one member of staff said that the previous day had been the busiest shift of their career. Staff on triage and the RAU felt particularly stretched as demand was outstripping resources and triage times were not within the Manchester triage guidelines. At times of high demand, staff would recommend an extra nurse to carry out treatment for patients waiting in ambulances. When the area is overstretched, triage nurses were pulled to triage waiting room patients. The triage training group had regular meetings and staff had mentored sessions and training sign off. This promoted a safe and an evidence-based triage process. Safe and effective triage decisions have a fundamental impact on patient safety and outcomes in the ED.

HCSWs reported that the number of frail elderly patients requiring additional support and care had increased. We saw excellent co-operative working in the RAU between ECG technicians, triage nurses and receptionists. The work of the British Red Cross volunteers was appreciated by triage nurses and WAST staff. Also, we saw good collaborative working observed between porters and radiology staff.

In the SAU we also observed the MDT working well together, there were also rotational opportunities available for staff to the inpatients wards in the hospital and to wards on the Royal Gwent.

We were told by senior staff that an additional 19.44 whole time equivalent staff were being recruited, including two practice educators, to address the staffing issues described. Senior staff said that they follow RCEM guidelines when

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[44] https://gov.wales/sites/default/files/publications/2019-05/health-and-care-standards-april-2015.pdf

[45] Health services should ensure there are enough staff with the right knowledge and skills.

staffing the ED and that additional staff were requested following papers sent through the management structure. They said that the staff roster was reviewed daily to ensure there were the relevant and qualified skill mix on the ward. We were also told of the roster creators who send out the requests to the hospital bank and agencies to cover the shortfalls.

Sickness in the ED was described as high at 10 percent, whereas staff turnover was low at four percent. However, agency staff usage could be as high as 40 percent. The ED attempted to block book agency staff that were known to have the necessary induction and training, in addition to being able to access the hospital management system.

The Nurse Consultant we spoke with said they received incredible support from senior managers and from consultants and doctors. The deputy head of nursing for the health board told us that there was a close team in the ED, due to the work of the two nurses in charge. Additionally, one of ED sisters described the senior management support as ‘fabulous and faultless’.

The Nurse Consultant described the culture in the ED as very supportive, with a team approach. This was especially good considering the challenges that had been with the reconfiguration when the hospital opened, COVID-19 and the demand on the ED. The deputy head of nursing said that the culture was challenging at the moment, and that some staff only know working in this hospital. There may have been challenges with combining the different cultures in the Royal Gwent and Nevill Hall hospitals and there was still work to do, but all the changes were made with the patient at the heart of the work.

We checked the staffing rotas for the three months August to October 2021, the rotas covered all areas of the ED and a range of staff bands and skills mix. The areas were at the levels to ensure safe staffing, there were a substantial number of agency staff employed.

We were provided with the staff induction programme and the relevant organisational management structure for the urgent care division. We also saw the minutes of various meetings including a Patient Safety Forum, which showed the areas that were looked at such as audits, Datix and staffing. In addition, there were actions following the discussion including lessons learned for the staff.

The latest minutes of the band five nurses meeting covered topics including staffing and red resus, Datix, training and induction, and wellbeing and team building. The minutes included reference to discussions on staffing and skill mix, number of patients, wellbeing and the care that the nurses can provide in light of numbers of patients presenting to the ED. One nurse said they feared for their registration, resulting in the concerns being taken home by staff. We were also

supplied with copies of a document called the nursing news. This is a weekly update of any changes in the ED sent by the NIC.

In reply to the request for information relating to the hospital or health board policy relating to dealing with patients on ambulances in ED, we were provided with the self-assessment provided for a previous HIW WAST review and supporting documents.

Equality

We asked whether staff had faced discrimination at work within the last 12 months. 23 percent said they had (25 out of 111 staff), this included eight percent (9 out of 111 responses) who answered 'prefer not to say'. 85 percent of staff agreed that they had fair and equal access to workplace opportunities (regardless of the nine protected characteristics), five percent disagreed and the remainder preferred not to say. Additionally, 87 percent of staff who expressed an opinion agreed their workplace was supportive of equality and diversity, six percent said it was not and the remainder preferred not to say.

> *"I …have frequently heard discussions (in non-clinical areas) between staff that has been derogatory towards Transgender people (not patients - people in general). I have challenged these people when I have heard this but don't feel my concerns have been taken on board. I feel this could be detrimental to any transgender people who attend as patients as they have a fixed view on what the staff perceive as a life style. I've also heard derogatory comments between staff about attendances of people who have attempted suicide. As someone who has had MH concerns previously I find this very concerning and I find their behaviour discriminatory."*

All but one of the staff who expressed an opinion said English was their preferred language. However, only 44 percent of staff said patients were asked to state their preferred language and only half said that arrangements were in place to meet the needs of patients who had stated their preferred language is Welsh.

Senior staff we spoke with described how equality and diversity was promoted in the organisation. This included training days organised by workforce and organisation and development, where talks have been made. They said that the surrounding area had a diverse population as did the workforce. Attempts have been made to ensure the necessary equipment is accessible and considerate of people's needs.

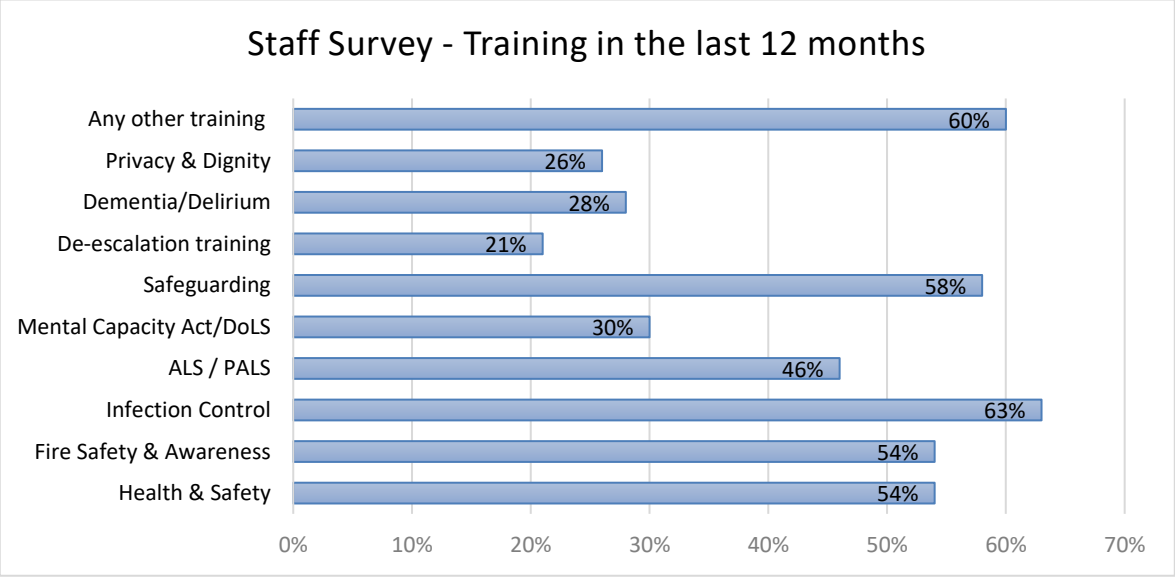
Improvement needed

The health board must ensure that processes are in place:

- To allow any member of staff to report any issues of concern internally, as well as to ensure that any concerns raised are appropriately investigated and responded to
- To ensure that staff are treated fairly and equally and that any instances of discrimination will not be tolerated and appropriate action taken
- To address the concerns of staff who believe they are not being able to care for patients as they believe they deserve to be treated
- To address potential issues with the wellbeing of staff.

Training

Staff who completed the questionnaire answered the question, yes in the last months to the question, have you had any training, learning or development (paid for or provided by your organisation) in the following areas as given in the graph below. It should be noted that some training does not have to be completed annually:



We received several comments on training, that staff would find useful, some of which are shown below:

> *"Preventing pressure sores/areas. Managing patients with cognitive issues such as dementia"*

"Training in long term care of patients on the back of ambulances, pressure sore prevention, toileting and changing patients who have been on an ambulance for a long time"

"Bloods and Cannulation"

"Mental health, we see so much mental health problems in the department but never have any training on how to best look after them"

"Trained to use all equipment that my band is allowed to such as blood gas and blood sugars. I feel this should have been done before I started as it impacts on my ability to help in emergency situations"

"Any training would be useful! Especially as we're expected to work in area's such as resus, paeds, covid. This is the most unorganised trust I've ever worked for, and everyone around me is saying the same"

"Injury training/plaster care/minor injuries as haven't received any since working at GUH and combined teams but expected to look after them and triage appropriately"

We also received general comments on training, some of which are shown below:

"I do a lot of training in my own time as the department is unable to release all the time I need to stay up to date with the skills I use daily. I am supported as much as the department can allow but it has been so busy and staff shortages are a constant battle."

"I joined the trust recently, I had no uniform on the day I joined, I had no pre inductions/ training. I was put with a mentor … for 1 week/3 shifts when I was told it was going to be for 2 weeks/6 shifts."

"We have been made to work in a very busy emergency department with little Emergency nursing skills. Especially hard when ED cannot staff the dept and it's left to Paediatrics to run the flow of the department with no skills in certain areas like plastering and dressings etc"

"I am now asked to help deliver training for level 1 major trauma competencies. I still have to complete these competencies myself, this is going to be completed with senior medical staff prior to teaching sessions to train staff"

The nurse in charge described the level of mandatory training as below what would have been expected. Management have been unable to give staff study leave because of the demand and staff self-isolating. As the ED was also an area that attracted newly qualified nurses, there had been a need to do other training to make sure that staff were fully competent within the area. New staff were given more time as part of the induction to ensure they met the competencies and they now had access to the systems at home. We were also told that appraisals had increased from 27 percent to 55 percent recently. All band sevens were emailed with compliance and who was overdue or about to require an appraisal to enable them to identify the appraisals due at an early stage.

We were pleased to note that there were two practice educators, at band seven, who also spend some time working as a sister in the ED. As described above the ED were about to recruit two band six practice educators. We were told that the two practice educators delivered a comprehensive training package, with new staff needing a wide depth and breadth of training. They provided triage training and also training on the requirements of being a non-medical referrer when requesting X-rays. In addition to providing induction training they also facilitated separate medication, safeguarding, violence and aggression, bereavement and other mandatory training. We were also told there was a plan to update every HCSW to update their basic life support (BLS) and to provide intermediate life support (ILS) and paediatric intermediate life support (PILS) for qualified staff, delivered by the resus team.

As described elsewhere, there were preceptorship and mentoring programmes in place for new members of staff to the ED. The educators also facilitated the learning audit with the local University. The educators aimed to have all trained staff up to the level of advanced life support (ALS) and paediatric advanced life support (PALS). However, places were limited.

The overall mandatory training percentages supplied ranged from 46 percent for Aseptic Non Touch Technique (ANTT)[46] Assessment to 91 percent for personal safety modules one and two. The mandatory training for staff working in the paediatric areas showed compliance for safeguarding level one and two to be 97

[46] This is a method of working where the practitioner follows the principles of asepsis to ensure that the sterile component (key part), for example, a needle, does not come into contact with non-sterile surface. Sterile gloves are not always required to undertake ANTT as long as the key parts are not touched by anything that is not sterile.

percent. However, this was not broken down as percent completed for each level. Additionally, the records provided did not show compliance for other non-paediatric staff who were required to support the paediatric area.

83 percent said training always or usually helped them do their job more effectively and 84 percent said training always or usually helped them stay up-to-date with professional requirements. 79 percent said training always or usually helped them deliver a better patient experience.

Regarding staff appraisals and clinical supervision, we asked a series of questions with the replies as follows:

- 75 percent said they had an annual review or appraisal within the last 12 months
- Only 28 percent said they have had clinical supervision[47] in the last 12 months, 63 percent said they have not
- 43 percent said their learning or development needs were identified and 57 percent said they were not
- 66 percent who answered the question, said their manager supported them to receive training or development, and 34 percent said they did not
- 52 percent who expressed an opinion said they had received full training on all areas within the ED.

We received comments from staff setting out where they had not received full training, some are shown below:

"Grange opened without cau staff having any a&e training"

"I'm a paediatric nurse, majority of the time department is so overwhelmed with A&E patients CAU patients are neglected, I'm

[47] The Royal College of Nursing states "[Clinical supervision is] the term used to describe a formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety of care in complex clinical situations.

required to do minor injury and A&E care without any training! I'd rather be providing proper care to my sick CAU patients"

"Minors - not applicable in GUH at present, Resus - no training dates available, Majors - no training dates available, Paeds - not seen as a priority"

"Paediatric Life Support (limited availability of training dates)"

"Not had injury training since teams joined together within paediatrics"

"SAU have a triage area i have not been specifically trained for"

69 percent who expressed an opinion said their competency based learning objectives were signed off before they started practicing in all treatment.

Improvement needed

The health board must ensure that:

- The levels of mandatory training are increased to ensure all staff have the necessary training to do their job properly
- All staff working in the paediatric area, whether paediatric nurses, or adult nurses supporting the area must be in date with level two safeguarding. The safeguarding lead must be level three in safeguarding
- Processes are put in place to ensure that appraisals are completed annually
- The appraisals are completed in full, including identifying training, learning and development
- Clinical supervision is completed annually
- Full training is given to all staff as necessary for each area in which they work.

Wellbeing

We asked staff in the survey whether their job was not detrimental to their health, and 65 percent of staff who expressed an opinion disagreed with this statement. Staff comments included:

"Work is no longer enjoyable and a pleasant place to be. The work load has increased massively which is what we expected but GP's are not seeing the simple things or refusing to even have a telephone call with the parents and directing children to ED which then creates a massive back log for the department and a significant number of children who do not to be seen in the ED department. They are then waiting for long periods and becoming aggressive towards staff which again makes the work place a horrible environment to be in"

"I'm exhausted on my days off. I often can't sleep when I get from home because of the stress"

"Don't feel enough break is given in between nights and day shifts. Too tired to do anything on my days off"

"The job in general is now detrimental to my health since moving to GUH and with the lack of space in the department, space in the hospital as a whole and the lack of staff. Some agency staff have commented that they would not come back to the department due to the above reasons. Stress levels are at an all-time high, anxiety levels are constantly raised both in and out of shift due to the worry of being unable to complete my work to my high standards with the situation of the department and worrying about what I have missed or the pressures on other staff members"

"My mental health suffers from working here, myself and I know many colleagues cry before and after shifts"

71 percent who expressed an opinion agreed their immediate manager takes a positive interest in their health and well-being and 55 percent who expressed an opinion respondents said their organisation takes positive action on health and well-being. The staff comments included:

"GUH lacks any facility for staff rest/relaxation. Staff welfare was not taken into account when building the hospital"

"I was assaulted in work and it was reported but I have not received any support, help or even been asked how I was. This occurred …months ago"

From the staff who expressed an opinion relating to further questions about their wellbeing and support:

- 64 percent said they are offered full support when dealing with challenging situations

- 90 percent agreed they were aware of the Occupational Health support available
- 55 percent agreed their current working pattern/off duty allows for a good work life balance.

Staff comments included:

"My work/home balance has been accommodated well"

"We get our shifts so last minute. We currently don't know what's we're working in 2 weeks. How are you meant to have a work life balance when you can't make plans?"

"Breaks are often missed due to demands within the department. Lack of staff and the acuity of patients mean that things cannot wait and staff regularly end up going late for breaks sometimes going up to 6/ 7 hours without a break or even a drink. Senior nurses try their best to support breaks and move staff to help but unable to do so resulting in long waits when short staffed"

"I frequently do not leave the clinical area to go home until 1-2 hours after my contracted finish time. This is due to staff shortage"

Senior managers we spoke with said that they were open to any feedback from staff, including through an online messaging group, an open door policy and staff were encouraged to email or speak to the nurse in charge.

Senior staff also stated that sickness was about supporting staff and identifying any issues. They regularly made referrals to occupational health, normally within three weeks. There were telephone consultations and advice given over the phone as well as face to face. Referrals to the wellbeing service is by self-referral. During the height of the pandemic there was a clinical psychologist available in the ED and people were aware of the services available. There were wellbeing leads in the ED with responsibility for various areas.

We asked staff a series of questions about their immediate manager. From those who expressed an opinion their replies are below:

- 74 percent said their immediate manager encouraged those who work for them to work as a team
- 68 percent said their immediate manager can be counted on to help with a difficult task at work
- 58 percent said their immediate manager gives clear feedback on their work

- 49 percent said their immediate manager asked for their opinion before making decisions that affect work
- 75 percent said their immediate manager was supportive in a personal crisis.

We received comments on ‘my immediate manager’, some of which are shown below:

“My manager [NAME] has been so supportive, she really is trying hard, she’s constantly fighting for us and advocates for our department. Whereas the [OTHER MANAGER NAME] does NOT work with her or support a united front.”

“Extremely supportive and empathic manager who wants what is best for staff and patients”

“I have recently been bereaved and have had amazing support from all my managers”

“I feel fully supported by our senior nurses, they are incredibly hard working and I always feel positive working with them. They encourage the best standards of care and act on problems immediately. True role models.”

“I don't feel supported at all (in) my work place, especially as an NQN”

“I have not frequently needed support for personal crisis but have found support is poor for both professional and personal matters”

“All of the senior nurses try to help staff as much as they can but are stretched due to the amount of staff in the department and the workload that things can get missed. They always aim to be approachable and helpful when required. Teamwork is always promoted and encouraged and serious issues are never ignored.”

“My line managers in the last 12 months have been very supportive and understanding, looking after me. Truly hard working, trying to keep patients and staff together. Working out different ways to keep patients and staff safe and happy, so important”

“Many colleagues have not been supported through work & personal crisis and feel left to deal with this alone or come to work when they shouldn't”

We also asked a series of questions about the senior managers, the replies, where staff expressed an opinion and staff comments are below:

- 84 percent said they knew who senior managers were

"[NAME] is always visible, always emails and shows her presence. Always listens if staff have something to say and is constantly trying to help…She takes our feedback and tries to work with the senior nurse for A&E."

"Never see our senior managers. We go to our band 6s or 7s with our problems"

- 49 percent communication between senior management and staff is usually effective

"Our senior managers are constantly within the department and looking for ways in which to improve the area taking on board staff feedback. They are always very approachable and friendly and will listen to concerns…"

"Never met or been introduced to our senior nurse. Feedback was asked for off staff only after 7 (maybe more) qualifieds left for a new job due to stress. Never had any outcome or response from feedback following its collection…Our senior nurse has never attended or called a staff meeting despite multiple issues being raised. Constant criticism of staff and ward level managers despite rarely coming to the unit"

- 38 percent said senior managers try to involve staff in important decisions

"Dr [NAME] comes in every Wednesday, on top of her ward weeks, on calls, night and day cover, to explore improvement and changes, which are helping"

- 38 of the 105 who expressed an opinion said senior managers acted on staff feedback.

We asked staff a series of questions about their work environment, the replies of those who expressed an opinion and their comments are given below:

- 26 percent said they were 'always' or 'usually' able to meet all the conflicting demands on their time at work, 10 percent said they were never able to

- 45 percent said they ‘always’ or ‘usually’ had adequate materials, supplies and equipment to do their work, eight percent said they never do

- Nine percent (11 of the 127 who expressed an opinion) said there were always or usually enough staff working in the department to do their job properly, 42 percent said there were never enough

“The newly introduced one staff nurse to five patients in green majors is not safe and bad”

“… very often there are too many patients and not enough staff to provide the standard of care that everyone deserves”

“I have never seen a busier place in the UK! It is unsafe sometimes”

“The ED is so thinly stretched, lack of capacity and lack of skilled staff, the standards of care is compromised.”

“The frontline staff try so hard to provide care of a high standard and to the best of their ability but staffing is so poor and support from managers (&higher) is so lacking it is difficult for them to safely meet the demands of the service and ensure care is of an adequate standard. Observation/assessment/treatments can be delayed, nutrition and hydration needs can be unmet and there can be lengthy waits in the department due to the pressures of poor staffing, high patient volumes and lack of space”

“Rapid assessment is the biggest risk. Normally has 2 qualified and a HCSW for up to 60 patients. How can they be expected to care for that many?”

“Staff are overworked as there are up to 10 nurses short and more HCSW each shift. This then escalates to training days being cancelled due to the department being unsafe which has a lasting effect on care, safety and staff education/ well-being”

- 56 percent said they were ‘always’ or ‘usually’ able to make suggestions to improve the work of their team / department and 13 percent said they never could

- 39 percent said they were always or usually involved in deciding on changes introduced that affect their work area / team / department, but 35 percent said they never were

- 88 percent said they knew how to escalate concerns when the department was close to capacity

"We can escalate, but nothing happens, as there is no flow/space/staff to change what is happening in the department"

"No matter how high we escalate our concerns over high acuity and no capacity we are always told to do the best we can at the time and that adults are 10 times worse than us! I feel as a management team within CEAU we cannot escalate any further than we already have! The department is at its all-time lowest and although changes are being made to help the flow in the day time, nights are worst and I fear the further in to the winter we go the more staff are going to be worried"

"Escalation to ED nurse in charge and EPIC - rarely with any help or benefit! Then to Paeds consultant and coord who usually try and help if their able to"

"Often concerns of escalation are ignored, or answered with " well there's no space" or " nothing I can do about it""

"Quite often even when concerns are escalated there is simply not the capacity to do anything about it"

"The department is always over capacity. Bed managers never do anything when we escalate and just think it's acceptable to keep patient on ambulances and in the waiting room for 12 hours. There is no flow through the department. How are we meant to do our job when there is no room?"

"It is all well and good escalating but there is no way of dealing with the number of patients when we can't get people through the system"

"Yes but no time to Datix and I have been reprimanded for datixing in the past"

"I often feel very unsupported from senior staff even when I've escalated concerns"

- 79 percent said their organisation encouraged teamwork
- 59 percent said the organisation is 'always' or 'usually' supportive
- 66 percent said front-line professionals who deal directly with patients, are 'always' or 'usually' sufficiently empowered to speak up and take

action if they identify issues in line with the requirements of their own professional conduct and competence

- 57 percent said there is always or usually a culture of openness and learning within the organisation that supports staff to identify and solve problems and 10 percent said there is not.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified.			

Appendix B – Immediate improvement plan

Hospital: The Grange University Hospital

Ward/department: Emergency Department, including Paediatrics, Majors and Resuscitation, and the Surgical Assessment Unit

Date of inspection: 1 – 3 November 2021

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
HIW requires details of how the health board will ensure that there are measures in place to ensure that:				
All patients accommodated in the waiting room are observed and monitored to ensure their safety, at all times.	Standard 2.1 Managing Risk and Promoting Health and Safety	Additional cameras to be installed into main wait to observe all areas and ensure no blind spots. Triage TV already installed, a further TV to be installed into reception and majors office, this will ensure waiting area can be observed at all times.	Director of Operations Service Lead / Clinical Director / Divisional Nurse	November 2021
All patients accommodated in the children's assessment unit waiting room are observed	Standard 2.1 Managing Risk and Promoting	A call bell and additional cameras will be installed in the CEAU environment, the latter to ensure	Service Lead	December 2021

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
and monitored to ensure their safety, at all times.	Health and Safety	view of the blind spots within the area.		
		Additional Health Care Support Workers (HCSW's) currently being recruited to improve visibility into the waiting room and to support the 'rounding' / assistance to families and children in the area. Temporary staffing will be utilised in the interim.	Senior Nurse	January 2022
All patients accommodated in the surgical assessment unit chairs are observed and monitored to ensure their safety, at all times.	Standard 2.1 Managing Risk and Promoting Health and Safety	Corridor care moved into main wait area by converting a large cubicle space to ensure patients are observed at all times.	Divisional Nurse/Senior Nurse	Completed
The health board is required to provide HIW with details of the action it will take to ensure that:				
The risk of cross contamination is reduced in the area known as the COVID corridor.	Standard 2.4 Infection prevention and Control (IPC)	Ensure robust IPC precautions and pathways are adhered to as directed by Infection Prevention and Control Team this will be monitored and audited.	Assistant Divisional Nurse/ Head of IP&C	December 2021

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
Suitable hand washing facilities are provided.	and De-contamination	Hand wash basin was installed on 5th November 2021.	Service Lead/ Clinical Director/ Senior Nurse/ Divisional Nurse	Completed
Printing facilities are available within the corridor.		Photocopier installed.	Director of Operations/ Operational Service Manager	Completed
Risks are mitigated in the corridor care when the number of patients is greater than can be managed by the normal staffing level.	Standard 2.1 Managing Risk and Promoting Health and Safety.	Staffing is risk assessed across the department, hospital and HB wide. Staff deployed as clinically appropriate. Additional substantive ED nurses currently being secured following agreement from Executive Team to increase ED Nursing establishment by 19.44WTE.	Service Lead/ Clinical Director/ Senior Nurse/ Divisional Nurse	Completed January 2022
Resuscitation equipment and medication is always available and safe to use in the event	Standard 2.6 Medicines	Safety ALERT distributed across the Health Board.	Senior Nurse / Divisional Nurse	Completed

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
of a patient emergency within the emergency department and within all other wards and departments across the health board.	Management and Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	IA-2001-18 resuscitation trolley A new sealed system is currently being implemented across the Health Board for emergency trollies. As a priority this has now been implemented in ED**.**	Resuscitation service Senior Nurse/Divisional Nurse	Completed Completed
The health board is required to provide HIW with details of the action it will take to ensure that:				
The areas of dissatisfaction shown by staff are addressed.	**Standard 7.1** Workforce	Executive Team are leading a "People First Staff Engagement" programme to concerns highlighted through a series of internal and all Wales staff surveys. To commence w/c 15th November 2021.	Executive Director for workforce and Organisational Development	Commence November 2021

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		ABUHB Staff Survey to commence 22nd November 2021. The on-going support being provided will identify and support the concerns raised.		
Staff are updated regularly on the action taken to address the issues raised.		Nursing News sent every Friday which contains relevant departmental information and any new developments. 'You said, we did' board to be implemented.	Senior Nurse / Divisional Nurse	Completed
		Quarterly staff meetings to be arranged.		January 2022
A similar exercise is carried out to establish the improvements in the actions taken by the health board.		Regular Health Board Wellbeing Surveys are already in place and have been used to inform our wellbeing offer across the Health Board.	Executive Director for workforce & Organisational Development	November 2021

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		ABUHB Staff Survey to commence 22nd November 2021.		
On-going support is provided to staff, to promote and maintain staff well-being.		Fully trained and supervised peer support network to be set up from 30th November 2021, including input from Prof Richard Williams – specific to ED Access and training provided for psychological debriefing encompassing the 'critical incidence stress management' process. Access to the ABUHB staff wellbeing service. OD support provided for staff including management drop in sessions. 2 Wellbeing Consultants and 2 Band 7 Nurses – facilitating well-being sessions.	Executive Director for workforce and Organisational Development	Immediately / Ongoing

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Open door availability to meet with Senior Nurse.	Senior Nurse	Immediately / Ongoing

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C – Improvement plan

Hospital: The Grange Hospital

Ward/department: Emergency Department and Surgical Assessment Unit

Date of inspection: 1 – 3 November 2022

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that: • More leaflets or posters are available in all areas of the Emergency Department (ED) relating to support groups • Where applicable patients should be questioned about how they are looking after their health and this should be documented on patient notes • The Right Place message is advertised further throughout the health board area, including in health centres, clinics and GP practices.	1.1 Health promotion, protection and improvement	A selection of Health promotion and awareness/support posters are now in place. Within the medical clerking proforma the assessing clinician will ascertain a number of social, health and wellbeing information including home circumstances, weight, BP, smoking, drugs and alcohol. Where necessary appropriate referrals will take place When patients are admitted to a ward the Patient Care Record is completed and Health Promotion is discussed Choose Well has been reinforced to service users and Health Care Professionals via the Health Board's website and social media platforms.	Service Lead / Clinical Director / Senior Nurse / Communications Team	Completed
Health board must ensure that: • Staff are reminded of the need to consider any communication	4.1 Dignified Care	The intercom/hearing loop on the main reception has now been moved which has improved communication /confidentiality during the booking in process.	Service Lead / Clinical Director / Senior Nurse / Nurse in Charge	Completed & Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
issues with patients when speaking with patients • Staff are reminded about the need to ensure privacy and dignity and confidentiality when speaking to patients in areas where they can be overheard • The communications with patients in the waiting room are improved to ensure confidentiality, including the hearing loop • More room is made available in the main reception area and for the triage area for patients • They consider the comments raised by staff who do not work in the ED and provide HIW with the work they are carrying out to address these issues		Staff have been reminded of the importance of maintaining patient privacy throughout the department. Private rooms are available if required. There is ongoing work to improve the space within the waiting room and majors area of the ED. In May 2022 a temporary structure is planned to be installed which will house a larger waiting area, triage area and assessment rooms whilst a permanent solution is developed to improve the current waiting area. When this opens the current waiting area will be redesigned to accommodate an improved rapid assessment area where the nursing staff can visualise the patients safely and patients receive timely treatment and care in an appropriate environment. Weekly meetings with WAST colleagues continue with a focus on QPS. There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas.		May 2022 / Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
• The section on the patients' notes in relation to capacity, comfort and dignity is completed in full • That patients are not required to wait on chairs overnight • The chairs used in the corridors are changed to reclining chairs to ensure patients can wait comfortably for their treatment, especially when having to wait long periods • The use of alternative pathways for cancer palliative patients to avoid attending the ED • A secure soundproof confidential area be provided where ambulance staff can exchange information and handover patients away from a public corridor.		Comfortable chairs have been purchased and delivered to improve patients comfort within sub wait, Red corridor and A1. Fit to sit criteria in place and all patients in chairs are assessed with appropriate escalation to the site ops team in the event of concerns. ED escalation process is in place. All staff have been reminded of the importance of completing documentation fully. Daily one patient one day audits to continue to monitor completion of documentation. Monthly Dignity & Essential Care Inspections undertaken by Senior Nurse and Deputy Head of Nursing. Cancer pathways are in place but will depend on the patient's presentation in terms of where they need to attend. There is a dedicated ambulance triage area. A private room is available if required.		

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Where crews are held the ambulance triage nurse will go to each ambulance to undertake timely triage. Crews' handover at the patient's bedside to maintain confidentiality.		
The health board must ensure that all signage is in an area that can be seen and that patients, including those with sight difficulties, can see the signs.	4.2 Patient Information	All signage on the first floor has been reviewed. Plan in place to remove and install new signage where the font was assessed as being too small.	Estates Manager	May 2022
The health board must consider ways of ensuring that communication with patients waiting for care or triage is effective, on the initial call to avoid delays in treatment.	3.2 Communicating effectively	Patient information screens have been installed in the ED waiting area and the content for the screens including Choosing Well, Health promotion, support groups is being finalised Reception staff will inform patients when booking in of the approximate waiting times.	Service Lead / Clinical Director / Senior Nurse	May 2022
The health board is to provide HIW with the update on the actions taken to:	5.1 Timely access	The ED is working towards an automated display of live waiting times for triage and wait to be seen by a clinician in keeping with accepted good	Service Lead / Clinical Director / Senior Nurse	Completed / Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Introduce an electronic waiting time board • Reduce the waiting times for patients • Ensure a system wide solution to poor flow and overcrowding at the ED waiting rooms. The health board must ensure that staff in the ED and WAST staff are all aware of their responsibilities for the patients when in the ambulance until they have been offloaded into the ED, including for pressure relief.		practice as recommended by the Royal College of Emergency Medicine. The ED medical staff rotas are matched to attendances to ensure the staffing is maximised at the busier times of the day to improve wait times. The ED and assessment units have invested in alternative roles to support medical staff and reduce the wait to be seen time (Nurse Practitioner's / Physician Assistants / Acute Care Practitioners). There is continued work across the Health Board to improve the flow of patients through the ED and assessment units. There are agreed policies with the ED and WAST in place, with roles and responsibilities outlined.		

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that: • Patient records are completed in full including clear evidence of a transfer of care and discharge planning. • The necessary arrangements are in place to ensure that transport had been ordered and community support had been requested.	6.1 Planning Care to promote independence	The HIW report has been shared widely across the teams working in ED / CEAU and SAU to share learning. Daily one patient one day audits to continue to monitor completion of documentation. Monthly Dignity & Essential Care Inspections undertaken by Senior Nurse and Deputy Head of Nursing. Nursing staff will ensure appropriate discharge arrangements and transport is in place to ensure a safe, effective and timely discharge. A discharge checklist is available within the nursing documentation. Staff have been reminded about the importance of completing a timely and safe discharge.	Band 7's / Senior Nurse / Nurse in Charge	Completed / Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that: • The location of the room for patients at end of life should be reconsidered to ensure that the patient and relatives are able to spend their remaining time together at peace in a secluded or quiet area • Further arrangements are put in place to ensure that all patients are made to feel that they can access the right healthcare at the right time.	6.2 Peoples rights	Where possible all patients who are End of Life will be transferred to a ward cubicle. If this is not possible patients will be cared for within a cubicle in the ED or assessment units. A new End of Life ED nursing document is being implemented to improve the management of End of Life patients. Choose Well has been reinforced to service users and Health Care Professionals via the Health Board's website and social media platforms. A redirection policy in place within GUH and is constantly being re-enforced.	Service Lead / Clinical Director / Senior Nurse	Completed / Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that: • A system is put in place to ensure that patients are made aware of the actions being taken as a result of their feedback • They address the staff perception that no action is taken on patient feedback • Staff are all made aware of the results of the feedback and of the actions they are taking to address the comments made.	6.3 Listening and Learning from feedback	All informal concerns raised are addressed contemporaneously. In line with PTR guidance, all complaints / concerns are followed up with a telephone call from a senior member of the relevant department. If unable to resolve the concerns verbally a formal response will be provided from the Chief Executive. Staff encouraged to raise concerns verbally and/or via Datix. Senior management team visible daily giving staff the opportunity to raise concerns and escalate issues. Concerns and actions will be discussed with staff members and feedback provided of actions taken.	Service Lead / Clinical Director / Senior Nurse / Nurse in Charge	Completed
Delivery of safe and effective care				
The Health Board must ensure that a procedure is put in place for the management of patients in custody	2.1 Managing risk and promoting	Patients in custody will be cared for in a private, discreet area.	Service Lead for Surgical Assessment Unit	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
that ensure that their dignity and safety is maintained, should their condition be liable to deteriorate. This procedure should be agreed with the local constabulary to ensure they are aware of the procedure. The Health Board must inform patients of the current plans in place to change the design of the ED, including the changes to the waiting rooms and any plans for an additional minor injuries area.	health and safety	ED have an agreed process in place to manage patients in custody. Communications team have informed the public of planned developments via social media.	/ Clinical Director for Surgical Assessment Unit / Senior Nurse for Surgical Assessment Unit / Communications team	
The Health Board needs to ensure that: • Pressure risk assessments are completed in full for all patients • Sufficient pressure relieving mattress are available for patients at risk.	2.2 Preventing pressure and tissue damage	Patients identified at risk will receive the appropriate pressure relieving devices. The importance of pressure area care has been shared via the nursing news in ED. All pressure ulcer Datix are reviewed by the Band 7's and appropriate actions implemented. Equipment is available for use based on patient risk assessment.	Service Lead / Clinical Director / Senior Nurse / Nurse in Charge	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The Health Board must ensure that patients in beds have easy access to the call bells.	2.3 Falls Prevention	The importance of call bells within reach has been reinforced through ED Nursing News. Daily one patient one day audits continue, which includes checking call bells are within reach. Monthly Dignity & Essential Care Inspections are undertaken by the Senior Nurse and Deputy Head of Nursing.	Senior Nurse/ Nurse in Charge	Completed
The Health Board must ensure that: • Assessments are carried out on patients about their ability to eat and drink • That appropriate support is given to those patients who needed support • Patients are repositioned prior to eating, to ensure that they are able to eat and drink the food	2.5 Nutrition and Hydration	Patients are assessed on their clinical presentation which includes eating and drinking. Patients will be repositioned to ensure they are in a safe position for feeding. Patients will be offered hand wipes prior to mealtime. This will be supported by all staff, including Red Cross and the ward assistants. The ED will ensure intravenous fluids are recorded on the All Wales medication charts.	Senior Nurse/ Clinical Director	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Patients are offered hand washing or hand wipes prior to or after eating and that they are encourage to use these facilities before and after meals • Nutrition and fluids are recorded appropriately on the relevant documentation • All staff are trained on the use of the All Wales Nutrition charts.		Fluid balance is recorded within the ED Patient Care Record which is a mirror image of the All Wales Fluid Balance Chart. The All Wales Nutrition chart is being introduced into ED. Training is included within induction for new staff.		
The Health Board must ensure that: • Staff on a medication round, wear the appropriate tabard and are not disturbed when dispensing medication • Further attempts are made to maintain patient privacy when asking patients to confirm their information during the dispensing of medication.	2.6 Medicines Management	Tabards are not used within the ED and assessment units due to the variability of timing of admissions and need for medication The correct medication administration process has been reinforced to all nursing staff. Staff have been reminded of the importance of confidentiality when checking patient's demographics prior to administering medication.	Senior Nurse	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The Health Board must ensure that: • Additional training is given to staff to raise their awareness and knowledge of DoLS • Documentation is completed in full on the capacity of patients in their notes.	2.7 Safeguarding children and adults at risk	Additional safeguarding and DoLS training will be undertaken and cascaded through the department. All staff to be reminded of the importance of completing documentation in full. Daily one patient one day audits to continue to assess compliance. Monthly Dignity & Essential Care Inspections are undertaken by Senior Nurse and Deputy Head of Nursing to monitor documentation. Medical notes will include a full overview of a patient's cognition and plan of care.	Clinical Director/Senior Nurse	May 2022
The Health Board must ensure that all staff are made aware of Serious Hazards of Transfusion (SHOT) and the importance of reporting any instances.	2.8 Blood management	SHOT awareness forms part of the IV training package. SHOT awareness re-enforced via Nursing News. Any infusion incidents are reported on Datix. The blood transfusion service then report these incidents to SHOT.	Clinical Director / Senior Nurse	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
The Health Board must ensure that: • All entries in patient's records are completed in full, signed, dated and timed • Paper records are appropriately stored away from patient view • All medication is appropriately prescribed and signed • Patient information is made available on handover and takeover.	3.5 Record keeping	The ED will ensure patients records are completed fully and all medication signed for correctly, with assessment. Via daily one patient day audits. Monthly Dignity & Essential Care Inspections are undertaken by Senior Nurse and Deputy Head of Nursing. The ED will ensure all medication is prescribed correctly, assessed through auditing. Pharmacy will undertake medicines reconciliation. Scanned notes currently stored securely within appropriate boxes in the reception area to be removed from reception in a timely manner. Nursing staff have been reminded of the importance of a thorough and comprehensive handover of patients.	Senior Nurse Clinical Director	Completed
Quality of management and leadership				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The Health Board must ensure that staff are reminded of the need to complete a Datix report in every instance that met the relevant criteria. The Health Board should consider the separate reporting arrangements in the CEAU and SSU, to address any potential conflicts. The Health Board is to inform HIW of the actions it has taken to address the recommendation made in the HIW Review relating to improving patient flow.	Governance, Leadership and Accountability	All staff have been reminded of the importance of completing a Datix. A list of Datix applicable incidents is available across the ED and Assessment Areas. CEAU remodelling is ongoing to improve patient flow which will reduce current conflict on bed allocation and enable full utilisation of all areas. There is continued work across the Health Board to improve the flow of patients through the ED and assessment units. The Health Board will provide HIW with an update on flow improvements.	Clinical Director/ Senior Nurse/ Directorate Manager Director of Ops	Completed May 2022 April 22
The health board must ensure that processes are in place: • To allow any member of staff to report any issues of concern internally, as well as to ensure that any concerns raised are	7.1 Workforce (Equality)	There is Open Door availability to meet with the Senior Nurse, reinforced through nursing news. Staff have been encouraged to raise concerns verbally to a senior member of staff with confidence.	Service Lead / Clinical Director / Senior Nurse / Divisional Nurse	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
appropriately investigated and responded to • To ensure that staff are treated fairly and equally and that any instances of discrimination will not be tolerated and appropriate action taken • To address the concerns of staff who believe they are not being able to care for patients as they believe they deserve to be treated • To address potential issues with the wellbeing of staff.		All concerns and actions will be discussed with staff members and timely feedback provided of actions taken. Senior management team visible daily to allow staff the opportunity to raise concerns. Wellbeing services are available to all staff within the ED, with regular sessions. There are 2 wellbeing consultants and a Band 7 Lead Nurse in place.		
The Health Board must ensure that: • The levels of mandatory training are increased to ensure all staff have the necessary training to do their job properly • All staff working in the paediatric area, whether paediatric nurses, or	7.1 Workforce (Training)	Two Band 7 and four Band 6 Practice Educators are now in place within ED. Ongoing training programme in place for ED staff. Journey of Excellence (JoE) programme available to all new nurse starters to the Health Board.	Service Lead / Clinical Director / Senior Nurse / Nurse in Charge	Completed / May 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
adult nurses supporting the area must be in date with level two safeguarding. The safeguarding lead must be level three in safeguarding. • Processes are put in place to ensure that appraisals are completed annually • The appraisals are completed in full, including identifying training, learning and development • Clinical supervision is completed annually • Full training is given to all staff as necessary for each area in which they work.		Improvement plan in place for annual appraisals. Statutory and mandatory training. A review of staff compliance re: safeguarding will be undertaken. Dedicated time will be provided to improve current compliance. An improvement trajectory will be introduced to review compliance monthly. Staff support and achievement of PDP's will be reviewed through the PADR process.	Directorate Manager ED/Surgical Leadership Team	April 2022 May 2022

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print):	**Amanda Hale**
Job role:	**Head of Nursing, Grange University Hospital**
Date:	**16 March 2022**

Committee:	Patient Quality, Safety & Outcomes Committee
Date: **7th June 2022**	
Agenda Item:	**2.6**
Document Title:	A summary of the independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust (the final report produced by Donna Ockenden, March 2022)

Aneurin Bevan University Health Board

Patient Quality, Safety and Outcomes Committee

The Independent Review of Maternity Services at SaTH (The Ockendon Review): a Summary

Summary

On 30 March 2022, the final report from the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust (SaTH) was published. This follows the first report from the inquiry, published in December 2020 which set out local actions for learning as well as immediate and essential actions to improve quality, safety and service user experience. The second, and final report, identifies several new themes intended for wider sharing across NHS England.

The report is substantial, covering a period from 2000–2019, over 5 years, exploring 1592 clinical incidents involving mothers and babies. The review found "significant or major concerns" around the maternity care provided by the Trust in 201 deaths (maternal and baby), 131 stillbirths and 70 deaths during the neonatal period. Together with nearly 100 children experiencing permanent, life-impacting damage/injuries.

This paper summarises the key points from the report and identifies actions being taken in Wales to review the report and extract learning. The report is for noting at this stage.

Purpose: **Patient Quality, Safety and Outcomes Committee is asked to:**	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	X
Author: Rhiannon Jones – Executive Director of Nursing	
Report Received consideration and supported by:	

Executive Team	TBA	**Sub-Committee**	

Date of the Report: 23 May 2022

Supplementary Papers Attached:

- 7 Point Briefing - Independent Review of SaTH Maternity Services
- Ockenden Report – National Recommendations

Background

This is the largest clinical review of a single service in the history of the NHS. The inquiry was initially commissioned by Jeremy Hunt (MP) Secretary of State (England) in 2016. It was triggered by stories of 23 families but extended further and has culminated into a 5 year review of maternity services, involving harrowing first-hand accounts from mothers and families of their experiences of care and impact of failings. The report also covers opinions from past and present staff at the Trust.

An interim report was published in December 2020 encompassing 250 family cases and outlined 7 immediate and essential actions for maternity services in England and 27 local actions for learning for SaTH. This triggered a revised quality assurance process for maternity services across NHS England, together with investment £95.6 million. A further £127 million has been allocated to increase and maintain staffing, enhance neonatal bed provision and improve culture. Oversight is through the Maternity Services Transformation Programme, as a direct result of the publication of the final report.

Assessment

Donna Ockenden, and a review team of 90 Doctors and Midwives found failings across governance and the quality of care, influenced by workforce gaps, lack of training, safety concerns not voiced, inadequate review of incidents/concerns and sub-standard organisational culture and leadership.

The Maternity Service at SaTH is based on a hub and spoke model, with a centralised consultant-led maternity unit surrounded by a number of midwifery-led units across Shropshire – a geographically rural area. The review also considered deprivation rates, maternal age distribution together with ethnicity and concluded there was not a disproportionate effect on morbidity and mortality when compared to national figures.

The review covered clinical governance, clinical leadership and scrutiny.

In terms of:

- **Clinical Governance** – the review team found the quality of incident investigation poor and did not translate into learning. The handling of complaints lacked oversight and transparency. In addition, there were failings identified with statutory supervision of midwifery investigations and concerns regarding the review and use of clinical guidelines and audit.

- **Clinical Leadership** – the review team found the cultivation of an image that the maternity service was safe with a lack of constructive or detailed review of the leadership. The report indicates "fake assurance" was provided, staffing shortages have not been addressed, concerns raised by families were not prioritised and accountability was unclear. Staff identified a fear of speaking up.

- **Scrutiny** – the report provides in-depth and extensive insight into the failings in care at SaTH, identifying where and when harm occurred through antenatal care, intrapartum care and postnatally to include maternal deaths, obstetric anaesthesia, and neonatal care.

The final report identifies immediate and essential actions for maternity services across England and greater than 60 local actions for learning for SaTH.

The National picture and 15 immediate/essential actions include:

- A funded maternity service, to include adequate budget for training.
- Safe staffing and robust escalation processes.
- Guidelines for when a Consultant Obstetrician should attend.
- Board oversight of maternity services.
- Incident investigations should be meaningful for families and ensure lessons are learned in a timely manner.
- Maternal post mortem examinations must be conducted by an expert in maternal physiology, with MDT learning.
- MDT learning and training, with emergency skills and CTG.
- National guidance to be followed for complex antenatal care with access to pre-conception care.
- Systems to manage woman at high risk of very pre-term birth with full engagement of woman and families re: risk of disability and neonatal survival.
- Advice for woman who chose to birth outside of hospital and a requirement for centralised CTG monitoring.
- Robust follow-up of woman postnatally, with post anaesthesia, strengthened with clear pathways, together with improved records and record keeping.
- Timely Consultant review for all women readmitted to a postnatal ward.

- Appropriate bereavement care for woman and families who suffer pregnancy loss (7 days a week). This includes staff training for post-mortem consent.
- Clear pathways for neonatal care and reporting of deviance from the pathway.
- Care and consideration of the mental health and well-being of mothers, their partners and family as a whole, must be integral to maternity services.

As well as the 15 national actions, there are 9 actions specific to SaTH (with some 60 recommendations) covering:

- Management of patient safety
- Involvement of patients and families in investigation processes
- Management of complaints
- Care of high risk and vulnerable women
- Care of diabetes
- Multidisciplinary working
- Births at home and at midwifery led units
- Staffing, particularly anaesthetics
- Communication with GP's

The Ockenden reports provides an extensive but clear and structured plan to improve the quality of care and patient safety across maternity services in England, addressing workforce gaps, Board governance, oversight of maternity services, improving training for team working, learning from safety incidents and the promotion of a culture based on learning and continuous improvement.

Conclusion

The Ockenden Report outlines wide-ranging failings in care at SaTH and indicates improvements required across maternity services in England. Whilst there has been significant strides in improving maternity outcomes over the last decade there remains much work to do. It is important to flag over 600,000 babies are born (and delivered) by the NHS each year and an overwhelming majority are delivered safely. Maternity care can be high risk but stillbirth rates are reducing (25% decrease) and baby mortality has reduced by 36%. Despite this maternity care at SATH was sub-standard resulting in mother and baby deaths.

In terms of actions for Wales, the Chief Nursing Officer has written to each Chief Executive requesting an assessment of maternity services to include relevant elements of the Ockenden Report, the previous HIW review of maternity services and compliance to recommendations and actions from the CTMUHB maternity review. The self-assessment is to be RAG-rated with evidence for any areas rated red or amber.

The response is required by the 28th May 2022, with all results being reviewed by the newly formed national Maternity and Neonatal Improvement Board.

Recommendations:

The Patient Quality, Safety and Outcomes Committee is asked to:

- **NOTE** the final report of the independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust;
- **NOTE** the requirement for a formal self-assessment, as requested by Welsh Government by the Chief Nursing Officer for Wales.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring, recommendations and actions within this report will provide a framework for assurance in Maternity Services.
Financial Assessment, including Value for Money	Direct or indirect impact on finance.
Quality, Safety and Patient Experience Assessment	This report highlights key learning to improve the safety and quality of care provided to women and families.
Equality and Diversity Impact Assessment (including child impact assessment)	Not applicable for the purpose of this summary report
Health and Care Standards	This report provides information around standards 1.1, 2.1, 3.1,3.2, 3.3, 3.5, 4.1, 4.2, 6.1, 6.3 and 7.1
Link to Integrated Medium Term Plan/Corporate Objectives	Aligned to all IMTP Priorities through the life course.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –**Improving the quality and safety of the services will help meet the long term needs of the population and the organisation
	Integration – The quality and patient safety improvements described work across directorates, divisions -maternity/neonates/anaesthetics
	Involvement –Improvement initiatives are developed using feedback from the population using the service.
	Collaboration – The quality and patient safety described work across directorates, and Health Boards nationally.
	Prevention – Improving patient safety will prevent patient harm within our services and improve public confidence.
Glossary of Terms	SaTH – Shrewsbury and Telford Hospital NHS Trust HIW – Health Inspectorate Wales CTMUHB – Cwm Taf Morgannwg University Health Board MDT – Multidisciplinary Team CTG – Cardiotocography: monitoring of fetal heartbeat and uterine contractions

Public Interest	There is considerable public interest in this report.

A summary of the Ockenden Report: 7 point briefing

Independent Review of SaTH Maternity Services (March 2022)

1. What is the final report

The Independent Review of Maternity services at SaTH reported to the Secretary of State for Health and Social Care (England) on 30th March 2022 regarding Maternity services at SaTH which:

- Failed to Investigate
- Failed to Learn
- Failed to Improve.

This review, at commencement involved 23 families but grew to nearly 1500 families between 2000 and 2019 . The inquiry has spanned 5 years.

In the first report (December 2020) there were Local Actions for Learning (LAfL) and Immediate and Essential Actions (IEAs) to be implemented at SaTH and across the wider systems in England.

The final report identifies a number of new themes to be shared as a matter of urgency to bring about positive and essential change for maternity services at SaTH & NHS England

2. What are the findings of the report?

Failure in Governance and Leadership

- Investigatory processes were not followed to an expected standard - often cursory, not multidisciplinary and did not identify underlying systematic failings.
- Significant staffing and training gaps in both midwifery and medical workforce.
- Urgent need for robust and funded maternity wide workforce plan starting right now, without delay and continuing over multiple years.
- Neonatal services operating beyond its designated scope, concerns for capacity which were rejected by the neonatal network.
- Overly confident in ability to manage complex pregnancy.
- Newly qualified midwives should have a robust induction training programme.
- Poor culture and leadership must be addressed.

3. Investigations

Critical need for timely and independent reviews (independent Chair) of serious maternity incidents to ensure lessons are learned and change implemented effectively.

England is creating the “Special Health Authority” to oversee Maternity investigations taking over the work of HSIB.

This will ensure independent, standardised and family focused investigations of maternity cases that provide families with answers.

It is expected that learning and service change from Maternity incidents occur within 6 months.

4. Examples for learning and improvement

Improving midwifery leadership is a key factor in improving safety in maternity services.

Midwifery leaders need the right level of influence and resources.

Midwives responsible for coordinating labour ward attend a recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.

Follow the latest RCOG guidance on managements of locums.

Individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.

5. Hearing the voices of staff

The voices of the staff at SaTH have been important to assist with the understanding of events.

Staff cited suboptimal staffing levels and unsafe inpatient staffing ratios which often led them to be fearful and stressed at work.

Evidence of staff being unsupported and, on occasions, unsafe clinical practice which was not addressed or challenged.

Lack of psychological safety in the workplace which limited the ability of the service to make positive change.
A culture of “them and us” between midwifery and obstetric colleagues which engendered fear amongst midwives to escalate concerns to consultants.

Poor working relationships witnessed by families.

6. Supporting the families

- ✓ The voices of the families are central to the review.
- ✓ Close working with support agencies to ensure listening, counselling, and psychological help has been available for those in need.

The families expressed that they had two key wishes for the review: -

1. They want answers so they can understand what happened during the care they received and why…
2. They want the systems to learn…

The report goes some way to identifying and explaining the factors that contributed to systemic failures which led to the harm the families experienced.

For all the families who contributed to the review, there needs to be visible, measurable and sustainable changes at SaTH and across the wider Maternity systems in England.

7. What next?

- The size and scale of this review is unprecedented in NHS history.
- The Ockenden intention is Maternity Services will be safer, will hear families better and will be more accountable.
- It is the report’s belief that there is a requirement for a “Whole System” approach underpinning maternity systems to commit to the LAfL and IEAs.
- 60 local actions for learning have been identified specifically for SaTH and the review team are encouraged by recent improvements from the December 2020 initial report.
- It is recognised that many of the issues highlighted in the report are not unique to SaTH and have been highlighted in other local and national reports in recent years.
- Only with a well-staffed and trained workforce will we be able to ensure delivery of safe, and compassionate, maternity care locally and across England.
- The pain and suffering of the families had been worsened by having to fight for answers. We owe it to families to work together across NHS bodies and other professional organisations to ensure lessons are learned from these tragic failings.
- Welsh Context HOMAG and the new Maternity and Neonatal Improvement Board will review Ockenden Recommendations and consider in the context of National Review of Maternity by HIW and the CTMUHB Maternity Action Plan to inform a Welsh response and required actions.

Adapted from 7 minute briefing created by Hywel Dda University Health Board and Powys Teaching Health Board

FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS **FROM THE INDEPENDENT REVIEW OF MATERNITY SERVICES** at The Shrewsbury and Telford Hospital NHS Trust

Our Final Report

30 March 2022

Return to an Address of the
Honourable the House of Commons
dated 30 March 2022 for

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HC 1219

Ordered by the House of Commons to be printed on 30 March 2022

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Letter to the Secretary of State for Health and Social Care from Donna Ockenden

30 March 2022

Dear Secretary of State

I publish the final report of the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust, at a time when the NHS continues to face significant challenges arising from the Covid-19 pandemic. In the 2 years of this pandemic since early 2020 the NHS and its staff have had to be ever more innovative in the ways services are delivered to ensure the provision of high quality care to patients.

NHS staff, including maternity teams who have worked throughout this pandemic, are exhausted. We have seen so many frontline NHS staff go above and beyond the call of duty to support and care for their patients in these truly extraordinary times. Our NHS is rightly held in high regard by so many for the lives it saves and the care it provides.

However, this final report of the Independent Maternity Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust is about an NHS maternity service that failed. It failed to investigate, failed to learn and failed to improve and therefore often failed to safeguard mothers and their babies at one of the most important times in their lives.

This review owes its origins to Kate Stanton Davies, and her parents Rhiannon Davies and Richard Stanton; and to Pippa Griffiths, and her parents Kayleigh and Colin Griffiths. Kate's and Pippa's parents have shown an unrelenting commitment to ensuring their daughters' short lives make a difference to the safety of maternity care. It was through their efforts that your predecessor, the former Secretary of State for Health Jeremy Hunt requested this independent review. When it commenced this review was of 23 families' cases, but it grew to include reviews of nearly 1,500 families, whose experiences occurred predominantly between 2000 and 2019.

This final report follows on from our first report which was published in December 2020. In the first report we outlined the Local Actions for Learning, (LAfL) and Immediate and Essential Actions, (IEAs) to be implemented at the Trust and across the wider maternity system in England. This second report builds upon the first report in that all the LAfL and IEAs within that report remain important and must be progressed. For this second report my independent maternity review team have identified a number of new themes which we believe must now be shared across all maternity services in England as a matter of urgency to bring about positive and essential change. Our Local Actions for Learning for the Trust and Immediate and Essential Actions, must be implemented by The Shrewsbury and Telford Hospital NHS Trust with the IEAs considered by all Trusts across England in a timely manner.

Since the publication of our first report, the Government has introduced a range of measures[1] and invested very significantly in supporting maternity services across the country. This focus and funding is a significant stride in the right direction. Much of this funding is for workforce expansion. NHS Providers[2], as cited in the recent Select Committee report[3] has estimated the cost of full expansion of the maternity services workforce to be £200m - £350m. We endorse and support this view.

In the last year since our first report was published we have seen significant pressures in maternity services in the recruitment and retention of midwives and obstetricians. Workforce planning, reducing

1 https://www.gov.uk/government/publications/safety-of-maternity-services-in-england-government-response/the-governments-response-to-the-health-and-social-care-committee-report-safety-of-maternity-services-in-england

2 https://nhsproviders.org/media/690887/2021-02-04-letter-from-nhs-providers-to-hscc.pdf

3 https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm

attrition of maternity staff and providing the required funding for a sustainable and safe maternity workforce is essential. Continuing progress on funding the maternity multi-professional workforce requirements now and into the future will mean that we can continue to ensure the safety of mothers and their babies and meet the Government's key commitment to halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries in babies occurring soon or after birth by 2025[4].

In our first report we wanted to ensure that families' voices were central, as for far too long women and families who accessed maternity care at the Trust were denied the opportunity to voice their concerns about the quality of care they had received. Many hundreds of families who received maternity care at the Trust have told us of experiencing life-changing tragedies which have caused untold pain and distress. In order to ensure families' voices are heard, listened to and acted upon within maternity services the NHS will need to continue progress on the role of the independent senior advocate role within maternity services that was an Immediate and Essential Action in our first report.

Secretary of State, through our work to date we have recognised a critical need for timely and independent reviews of serious maternity incidents to ensure lessons are learned and changes implemented effectively. We note and endorse the creation of a Special Health Authority[5] to oversee maternity investigations, taking over the work of HSIB. We fully support your view that the provision of 'independent, standardised and family focussed investigations of maternity cases that provide families with answers' is essential. We further urge that there must be a timeliness to this work since delay in introducing change and learning leads to the risk of repeated incidents, as we saw at The Shrewsbury and Telford Hospital NHS Trust. We would expect that learning and service change from maternity incidents be introduced into clinical practice within six months of the incident occurring and that all investigations are independently chaired.

Finally and importantly Secretary of State we state that DHSC and NHSE&I must now commission a working group independent of the Maternity Transformation Programme that has joint RCM and RCOG leadership to make plans to guide the Maternity Transformation Programme around implementation of these IEAs and the recommendations of other reports currently being prepared.

Thank you Secretary of State for your ongoing support,

Yours sincerely,

Donna Ockenden

Chair of the Independent Maternity Review

4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

5 https://questions-statements.parliament.uk/written-statements/detail/2022-01-26/hcws560

Acknowledgements

The work contained in this final report and the first report of the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, came about from the exceptional efforts of parents Rhiannon Davies, Richard Stanton, and Kayleigh and Colin Griffiths, who daughters died as a result of the care they received at the Trust.

The deaths of Rhiannon and Richard's daughter Kate in 2009, and Kayleigh and Colin's daughter Pippa in 2016 were both avoidable. Owing to their unshakeable commitment to ensure the precious lives of their babies were not lost in vain, this review has implementation of meaningful change, not only in maternity services at The Shrewsbury and Telford Hospital NHS Trust – but also across England. As we publish this final report, we want to acknowledge and pay tribute to Rhiannon, Richard, Kayleigh and Colin.

Very importantly, and as Chair of this review, I want to extend my heartfelt thanks to all of the families who have come forward to share their experiences. So many families have explained to me that for more than two decades they have tried to raise concerns but were brushed aside, ignored and not listened to. My review team and I have listened to families and heard their concerns and distress. This final report has come about following the careful consideration by my review team of 1,592 clinical incidents involving mothers and babies resulting from the maternity care of 1,486 families. Their contribution to this review and report has, in my view, been central to a review of maternity services which I hope and believe will now save lives and reduce harm in maternity services across England.

Thanks to the bravery and determination of all the families in sharing their experiences we have produced this report, which my review team colleagues and I believe will continue to shape the learning which will profoundly change maternity care now and in the years to come. Never again should families be left to grieve or suffer in isolation, with the additional pain of feeling their legitimate concerns are being ignored. Our intention is that this report will underpin the future journey of maternity services in England, so that maternity services will be safer, will hear families better and will be more accountable.

Why this Report is Important

The impact of death or serious health complications suffered as a result of maternity care cannot be underestimated. The impact on the lives of families and loved ones is profound and permanent.

The families who have bravely contributed to this review know all too well the devastation which follows such events, and have explained to my review team and me that they want this review to answer their questions. Families have also clearly explained that they want what happened to them to matter and to ensure that in future voices, such as their own, are listened to and heard and that meaningful and sustained changes will be made to try to ensure that what happened to them will not happen to others in future.

The accounts of families involved in events at maternity services at The Shrewsbury and Telford Hospital NHS Trust has not only put a spotlight on this service but also on other maternity services across England, as can be seen by recent reports of concerns in a number of other trusts. That is why this report aims to not only address specific concerns about The Shrewsbury and Telford Hospital NHS Trust but to provide Immediate and Essential Actions for all maternity services across England. Sometimes that spotlight can feel harsh to staff on the front line doing their very best in what are often extremely challenging circumstances. As a multi-professional clinical review team, largely made up of midwives and doctors currently working on a daily basis in NHS maternity services across England, we understand that.

Even now, early in 2022 there remains concern that NHS maternity services and their trust boards are still failing to adequately address and learn lessons from serious maternity events occurring now. We recognise that maternity services have very significant workforce challenges and this must change. Clearly, workforce challenges that have existed for more than a decade cannot be put right overnight. However, it is our belief that if the 'whole system' underpinning maternity services commits to implementation of all the Immediate and Essential Actions within this report with the necessary funding provided then this review could be said to have led to far reaching improvements for all families and all NHS staff working within maternity services.

The size and scale of this review is unprecedented in NHS history. After reviewing the experiences of so many families and listening carefully to both those families and to the past and present staff who came forward, we have been given a once in a generation opportunity to improve the safety and quality of maternity service provision for families across England, now and in the future.

Donna Ockenden

Chair

CONTENTS

Section 4: Our call for essential action following completion of this review

Appendices:

Explanation of Terminology

In this report the review team has used words or medical terms which some readers may not be familiar with. While we have tried to keep the use of such words and terminology to a minimum, at times it is unavoidable. This is so we can accurately address specific clinical issues we found within our review as well as make recommendations to improve maternity care now and in the future at the Trust and across the NHS in England.

To try to aid readers' understanding where we think language has become technical, where the terms are used for the first time, we direct readers to a glossary (found at the end of the report) which will give further explanation of their meaning.

Executive summary

This Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust ("the Trust") commenced in the summer of 2017. It was originally requested by the Rt Hon Jeremy Hunt, MP, when he was Secretary of State for Health and Social Care and commissioned by NHS Improvement (NHSI), to examine 23 cases of concern collated by the tireless efforts of the parents of Kate Stanton-Davies and Pippa Griffiths, who both died after birth at the Trust in 2009 and 2016 respectively.

Since the review was commissioned it has grown considerably. Our independent and multi-professional team of midwives and doctors reviewed the maternity care of 1,486 families, the majority of which were patients at the Trust between the years 2000 and 2019. It has previously been reported that this review was considering 1,862 family cases. However after removing duplication of recording, and excluding cases where there were missing hospital records or consent for participation in the review could not be obtained, the final number of families included in this review is 1,486. Some families had multiple clinical incidents therefore a total of 1,592 clinical incidents involving mothers and babies have been reviewed with the earliest case from 1973 and the latest from 2020.

In line with the terms of reference, the review examined the Trust's internal investigations where they occurred. In addition, the review team has considered external reports into the Trust's maternity services over these years (national regulatory reports and locally commissioned reports) and examined local clinical governance processes, policies and procedures, as well as ombudsman and coroner's reports.

Throughout this process our priority has been to ensure that the families impacted by the maternity services at the Trust are heard. They wanted to understand what had happened to them, as well as ensure that finally lessons are learned so that no further families experience the same harm and distress that they did. Families were offered a variety of methods to engage with the review team and share accounts of their care and treatment. Throughout this report we have included vignettes of the care received by families either through our review of their maternity care considering the documentation that was received from the Trust, or by quoting family members directly from their communication with the chair of the review or team members.

As well as listening to families, the review team wanted to ensure that staff had an opportunity to be heard as well. In 2021 the review team interviewed 60 present and former members of staff about their opinions on the maternity services they worked within. We also offered staff the opportunity to complete a questionnaire for the review, which 84 staff did. We have included vignettes of these interviews and questionnaires throughout this report in order to ensure that staff voices are clearly heard. In the final weeks leading up to publication of the report, a number of staff withdrew their cooperation from the report and therefore their content (or "voice") was lost from the report. The main reason for withdrawing from the report as cited by staff was fear of being identified. This was despite our reassurance that staff would only ever be identified as 'a staff member told the review team...'

Within this report we have included a timeline of events which led up to the commissioning of this independent review (see chapter 1). This highlights a number of cases that became known of, many in the public domain between 2001 and 2016, as well as a number of external reviews from the various commissioning and regulatory bodies which took place during the period under review. It would be expected that the number of incidents featured in this timeline would have warranted closer scrutiny of maternity services at an earlier point than we are at now. However, in our opinion due to concerns around other clinical areas within the Trust and also due to the significant turnover at Executive and Board level, issues within maternity services remained largely unseen. This was to the detriment of the families receiving care.

Patterns of repeated poor care

Through the review of 1,486 family cases, the review team has been able to identify thematic patterns in the quality of care and investigation procedures carried out by the Trust, and identify where opportunities for learning and improving quality of care have been missed.

For example, in the nine months preceding the avoidable death of Kate Stanton-Davies in March 2009, the review team has identified two further incidents of baby deaths which occurred under similar circumstances.

In May 2008 Baby Joshua was born in poor condition at Ludlow midwifery-led unit, and was transferred by air ambulance to the Royal Shrewsbury Hospital Neonatal Unit. Joshua's mother was considered to have a low risk pregnancy, and even after she reported episodes of severe uterine tenderness and tightening at 31 weeks this risk profile was not changed. She reported reduced baby movements the day before her labour at 37+5 weeks gestation, but on her admission the baby's heart rate was not monitored appropriately. Joshua was delivered with no signs of life and died at six days old, when care was withdrawn.

In January 2009 Baby Thomas was born following his mother's long, slow labour stretching over more than a day. His mother, who had given birth to a large baby during a previous pregnancy, had been treated as a low risk case throughout this pregnancy, and no check for gestational diabetes was conducted. She had been due to give birth in a midwifery-led unit, but was admitted to the antenatal ward in the consultant-led unit. The review team found that despite abnormal heart rate readings, a high dose of oxytocin infusion was used, and his mother was infrequently monitored. In the hour before birth, examinations showed signs of obstructed labour and uterine rupture, as well as difficulties establishing the baby's heart rate, but despite this a ventouse delivery was attempted before an emergency caesarean was conducted. Thomas briefly had a heartbeat but at 34 minutes of age resuscitation was stopped.

Then on 1 March 2009 Rhiannon Davies gave birth to Kate Stanton-Davies at the Ludlow midwifery-led unit, despite reporting a reduction in her baby's movements in the two weeks before the birth. There was a lack of appropriate heart rate monitoring during labour and missed opportunities to manage Kate's health as she was born severely anaemic. Kate suffered a cardiopulmonary collapse at 90 minutes of life and was transferred by air ambulance to a tertiary neonatal unit, where she died shortly after arrival at six hours of age.

The review team found evidence of poor investigation into all three of these cases which took place within less than a year of each other, as well as a lack of transparency and dialogue with families. This resulted in missed opportunities for learning, and a lost opportunity to prevent further baby deaths from occurring at the Trust.

Unfortunately these three cases were not isolated incidents and throughout this review we have found repeated errors in care, which led to injury to either mothers or their babies. During our work we have considered all aspects of clinical care in maternity services including antenatal, intrapartum, postnatal, obstetric anaesthesia and neonatal care.

In total 12 cases of maternal death were considered by the review team. They concluded that none of the mothers had received care in line with best practice at the time and in three-quarters of cases the care could have been significantly improved. Only one maternal death investigation was conducted by external clinicians, and the internal reviews were rated as poor by our review team. These internal investigations frequently did not, recognise system and service-wide failings to follow appropriate procedures and guidance. As a result significant omissions in care were not identified and in some incidents women themselves were also held responsible for the outcomes.

As part of the review 498 cases of stillbirth were reviewed and graded. One in four cases were found to have significant or major concerns in maternity care which if managed appropriately might, or would have, resulted in a different outcome. Hypoxic ischaemic encephalopathy (HIE) is a newborn brain injury caused by oxygen deprivation to the brain. There were significant and major concerns in the care provided to the mother in two thirds (65.9 per cent) of all HIE cases. After the baby had been born, most of the neonatal care provided was considered appropriate or included minor concerns, however these were unlikely to influence the outcome observed.

Most of the neonatal deaths occurred in the first 7 days of life. Nearly a third of all incidents reviewed (27.9 per cent) were identified to have significant or major concerns in the maternity care provided which might or would have resulted in a different outcome.

The review team found that throughout the review period staff were overly-confident in their ability to manage complex pregnancies and babies diagnosed with fetal abnormalities during pregnancy. There was sometimes a reluctance to refer to a tertiary unit to involve specialists such as paediatric surgeons and geneticists in care. For

example, the neonatal unit at Royal Shrewsbury Hospital continued to work as a neonatal intensive care unit for many years after it had been re-designated as a local neonatal unit. Although the review team noted that care provided by staff in the unit was generally good, it was operating beyond its designated scope. Staff suggested this was due to a lack of capacity within the surrounding services, but this view has been rejected by the neonatal network.

Internally, within maternity services at the Trust women were frequently not referred to or discussed with colleagues from the wider multidisciplinary team. It has been observed that there were repeated failures to escalate concerns in both antenatal and postnatal environments. There are also multiple examples within this report, where there were delays in women being admitted to the labour ward during induction of labour, being assessed for emergency intervention during labour or reviewed by consultants in the postnatal environment. On occasion this resulted in families being discharged from hospital but later readmitted for emergency procedures due to becoming extremely unwell through the lack of earlier appropriate review of care. Other examples of a lack of appropriate escalation are of obstetric anaesthetists involved at the last minute, not enabling them to assess women appropriately for urgent obstetric interventions.

Failure in governance and leadership

Throughout the various stages of care the review team has identified a failing to follow national clinical guidelines whether it be for the monitoring of fetal heart rate, maternal blood pressure, management of gestational diabetes or resuscitation. This, combined with delays in escalation and failure to work collaboratively across disciplines, resulted in the many poor outcomes experienced by mothers or their babies, such as sepsis, hypoxic ischaemic encephalopathy and unfortunately death.

Some of the causes of these delays were due to the culture amongst the Trust's workforce. The review team has seen evidence within the cases reviewed that there was a lack of action from senior clinicians following escalation. The review team has also heard directly from staff that there was a culture of 'them and us' between the midwifery and obstetric staff, which engendered fear amongst midwives to escalate concerns to consultants. This demonstrates a lack of psychological safety in the workplace, and limited the ability of the service to make positive changes.

Unfortunately these poor working relationships were also witnessed by families, and in some cases mothers have described the additional stress these interactions had on them at one of the most vulnerable moments in their lives. In addition, repeatedly throughout this review we have heard from parents about a lack of compassion expressed by staff either while they were still receiving care or in follow-up appointments and during complaints processes. Examples include clinicians being unprepared for follow-up briefings with families, and response letters to complaints including inaccurate information, justifying actions or omissions in care and in some cases even including explanations which laid blame on the family themselves for the particular outcome.

As summarised earlier, there were often delays in escalation of care to appropriate clinicians, in part these delays in care could be attributed to staffing and training gaps at the Trust. The review team found there were significant staffing and training gaps within both the midwifery and medical workforce, which negatively affected the operational running of the service. The review team identified how it was widely accepted that the labour ward coordinator did not have supernumerary status, often having their own clinical caseload, preventing them from being readily accessible to junior staff and the wider midwifery team for clinical advice, care planning and support.

Similarly, the medical staff rotas have been overstretched throughout the time period covered by the review. Inadequate support from consultant obstetric and anaesthetic services caused a consistent lack of clinical expertise to be available. Where locum doctors filled in rota gaps, there is evidence of them being unsupported and on occasions unsafe clinical practice was not addressed or challenged. Staff also cited suboptimal staffing levels and unsafe inpatient to staffing ratios to the review team, and said they often felt fearful and stressed at work due to poor staffing levels.

The review has found the Trust leadership team up to Board level to be in a constant state of churn and change. Therefore it failed to foster a positive environment to support and encourage service improvement at all levels. In addition the Trust Board did not have oversight, or a full understanding of issues and concerns within the maternity

service, resulting in a lack of strategic direction and effective change, nor the development of accountable implementation plans.

Our consideration of clinical governance processes and documents at the Trust has shown that investigatory processes were not followed to a standard that would have been expected for the particular time the incident occurred. The reviews were often cursory, not multidisciplinary and did not identify the underlying systemic failings and some significant cases of concern were not investigated at all. In fact, the maternity governance team inappropriately downgraded serious incidents to a local investigation methodology in order to avoid external scrutiny, so that the true scale of serious incidents at the Trust went unknown until this review was undertaken.

Where investigations took place there was a lack of oversight by the Trust Board, unfortunately the review believes this has persisted in some incident investigations as late as 2018/2019 considered as part of this review.

This meant that consistently throughout the review period lessons were not learned, mistakes in care were repeated and the safety of mothers and babies was unnecessarily compromised as a result.

There were a number of external reviews carried out by external bodies including local Clinical Commissioning Groups and the Care Quality Commission during the last decade. The review team is concerned that some of the findings from these reviews gave false reassurance about maternity services at the Trust, despite repeated concerns being raised by families. It is the review team's view that opportunities were lost to have improved maternity services at the Trust sooner.

Local Actions for Learning and Immediate and Essential Actions

This review has considered all aspects of maternity care at Shrewsbury and Telford Hospital NHS Trust and as a result has made a significant number of recommendations for improvement of care across each of the maternity disciplines.

In total more than 60 Local Actions for Learning have been identified specifically for the Trust in light of the care received by the 1,486 families featured in the review. The review team are encouraged by staff reports that following our first report in December 2020 there does seem to have been a recent improvement in maternity services at the Trust with increased numbers of senior clinicians employed.

It is recognised that many of the issues highlighted in this report are not unique to Shrewsbury and Telford Hospitals NHS Trust and have been highlighted in other local and national reports into maternity services in recent years. This is why the review team has also identified 15 areas as Immediate and Essential Actions which should be considered by all trusts in England providing maternity services. Some of these include: the need for significant investment in the maternity workforce and multi-professional training; suspension of the Midwifery Continuity of Carer model until, and unless, safe staffing is shown to be present; strengthened accountability for improvements in care amongst senior maternity staff, with timely implementation of changes in practice and improved investigations involving families.

It is absolutely clear that there is an urgent need for a robust and funded maternity-wide workforce plan, starting right now, without delay and continuing over multiple years. This has already been highlighted on a number of occasions but is essential to address the present and future requirements for midwives, obstetricians, anaesthetists, neonatal teams and associated staff working in and around maternity services. Without this maternity services cannot provide safe and effective care for women and babies. In addition, this workforce plan must also focus on significantly reducing the attrition of midwives and doctors since increases in workforce numbers are of limited use if those already within the maternity workforce continue to leave. Only with a robustly funded, well-staffed and trained workforce will we be able to ensure delivery of safe, and compassionate, maternity care locally and across England.

Section 1

History, methodology and families

Introduction

Our first report, *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust*, was published in December 2020[1]. The report, which was outside the terms of reference for this review, was prepared at the request of the then Minister of State for Patient Safety, Suicide Prevention and Mental Health Nadine Dorries MP. It observed important emerging themes which required urgent action following review of the maternity care experienced by 250 families. The aim was to focus on immediate improvements for the Trust through **Local Actions for Learning** (LAfL) and the wider maternity system across England with **Immediate and Essential Actions** (IEAs).

This second publication reports on the care of all families included in this review of maternity services at Shrewsbury and Telford Hospital NHS Trust. It explores internal and external factors that may have contributed to the failings in care we have found. Of importance, and in accordance with the Terms of Reference, this report is particularly focussed on the Trust's failings in governance processes which directly led to the harm that families experienced.

From its start, in the summer of 2017, we have seen the number of families included in this Secretary of State Independent Maternity Review increase substantially from the original 23 families. It is now recognised that this review is likely to include the largest ever number of clinical reviews conducted as part of an inquiry relating to a single service in the history of the NHS.

We reported in July 2020 that 1,862 individual families were included in this review. After further analysis and validation of data with the Trust, the total number of families included in this review is now established to be 1,486 resulting in 1,592 clinical reviews of care. The majority of cases are from the years 2000 to 2019. However, a number of families came forward in the early period of the review whose care preceded these years and it was agreed by NHS England that, where possible, their care would also be reviewed.

All care and treatment provided to families, the quality of any Trust-led incident investigations, Trust-led reviews, external reviews and the resultant recommendations, actions and learning have been considered with reference to the relevant guidance and standards of the day, by clinicians who were in clinical practice at the time.

Every clinical review undertaken has been led by expert clinicians and each case has been carefully considered using a consistent standardised methodology. The multidisciplinary review team has been expanded during the process to reflect the growing number of families. The majority of reviewers currently work in clinical posts at trusts across England, with the number of team members who have been a part of the review since its start exceeding 90.

Over the course of the review, the team has faced many challenges and these are explained in more detail within the report. These have been mainly related to systems and processes required in order to undertake a review of this size, as it became evident that the required protocols, procedures and structures were not immediately available to support it. The COVID-19 pandemic at times impeded progress as our clinicians quite rightly prioritised their NHS commitments.

We have always emphasised that the voices of the families are central to this review. Throughout, we have ensured that families have been updated on the review's progress and we have worked closely with support agencies to ensure that listening, counselling and psychological help is and has been available for those in need.

The voices of staff at the Trust have also been important to assist with our understanding of events. We launched our Staff Voices engagement strategy to reach out to both former and current staff at the Trust. They were offered the opportunity to engage with us through an initial questionnaire survey and further conversations to share their experiences of working at the Trust. Despite reaching out through social media and the local press including radio, TV and a local newspaper and joint messaging with the Trust, fewer staff and ex-staff contacted us than we had anticipated or hoped for.

1 Ockenden, D. Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (2020) https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

At the time of publication only just over 100 current and former staff had contributed to the review with a further number of staff withdrawing from the review in the weeks before publication. This led to a number of last minute changes to the report as we were unable to use staff contributions without their consent. Those staff withdrawing were apologetic but most were concerned about being identified in the report. Despite our assurances, they maintained that they did not want to be quoted in the final report and we respected their decision.

Since our first report, we are encouraged to hear of progress at the Trust through its improvement programme in response to both our **Local Actions for Learning and Immediate and Essential Actions**. Indeed, we heard through staff of the willingness of their colleagues and themselves to learn from the review, in order to continue to improve and work towards building and maintaining a safer local maternity service.

The review team was particularly encouraged by the overwhelming positive response to our first report from maternity colleagues across England and the wider NHS. We were equally encouraged to see that our call for action to ensure investigations, reviews and reports that lead to meaningful change was heard.

We acknowledge that the proposed funding of £95million towards workforce and training provided by NHS England and Improvement is a major stride in the right direction. However, we are equally conscious that this is only the start of the journey and state that what is required in order to continually improve safety in maternity services is a multi-year funding increase for workforce expansion and training, in forthcoming years.

Our **Immediate and Essential Actions** from this report, based on our findings from the clinical reviews and listening to the voices of both families and staff, identify that the wider system must invest further in staffing across the whole maternity team to ensure that there are sufficient numbers, and that the workforce is equipped with the right skills and is able to deliver care in the right place at the right time.

Until proposed staffing levels are improved to recognise the increasing complexities of maternity care in the 21st century, NHS maternity services must not, and cannot, focus on the implementation of midwifery continuity of carer. Before continuity of carer is recommenced in any form there must be a thorough review of the evidence that underpins continuity of carer to assess if it is a model fit for the future. Further investment in enhancing staff numbers across the multidisciplinary team will go a long way to improve overall safety in maternity services.

Whilst the review has been heartened by the Trust's progress over the last year, NHS England and Improvement must continue to provide appropriate support and ongoing oversight of its continued progress. Regulators such as the Care Quality Commission together with the Royal Colleges, including those of Midwives, Obstetricians and Gynaecologists, Anaesthetists, and Paediatrics and Child Health must continue to strengthen their collective efforts of collaborative working to hasten the implementation of these further **Local Actions for Learning** and **Immediate and Essential Actions** outlined in this final report.

We are aware that since the inception of this review, there are now at least two other independent maternity service reviews in progress. This may be indicative of some wider systemic issues. At this very moment there may be other maternity services across England which are facing challenges that impact on their ability to provide a safe service as a result of insufficient staffing levels, substandard governance processes, and structures which impede learning.

Over and over, families have expressed their two key wishes for this review. They want answers so that they can understand what happened during the care they received and why. We hope that this report will go some way in identifying and explaining the factors that contributed to the systemic failures which led to the harm they experienced. Secondly, they want the system to learn. We note that as a result of our findings in our first report, through our **Local Actions for Learning** and **Immediate and Essential Actions** the Trust and the wider NHS are beginning to learn and improve. We anticipate that through this report the learning will be sustained. No more families should have to live with the consequences of poor governance systems and structures within the NHS.

We must ensure that for all the families who contributed to this review there continues to be visible, measurable and sustainable change at the Trust and across the wider maternity system in England. That change through the implementation of our **Local Actions for Learning** and **Immediate and Essential Actions** will be the legacy of these families and the terrible loss and harm they have experienced.

Chapter 1

Concerns that led to this review

1.1 The Ockenden Review into the Shrewsbury and Telford Hospital NHS Trust maternity services spans the period from 2000 to 2019 and was commissioned by the then Secretary of State for Health Jeremy Hunt MP at the end of 2016. Donna Ockenden was asked to lead the review, then comprising of 23 families, in the summer of 2017. The following is a chronology of reports and reviews into the Trust's maternity services over this time.

1.2 This timeline shows the failure of the Trust's maternity services to listen to families and to learn from critical incidents spanning the entire period of the review. In 2001, a woman gave birth to a baby in very poor condition who subsequently died at 21 minutes of age. The cause was due to failure to recognise abnormalities in the fetal heart monitoring. The family felt that there was no attempt to be honest with them in subsequent correspondence from the Trust and they claimed that as well as clinical mistakes, there was obfuscation, and a cover-up. The family subsequently took legal action against the Trust in order to get answers that they had been unable to get from the Trust before litigation commenced.

1.3 In 2002 a baby girl named Olivia died following a traumatic ventouse and forceps delivery. The subsequent independent medical report prepared for this family found severe failings in obstetric care. The mother described how at that time she felt like a *'lone voice in the wind'* trying to raise concerns about the Trust's maternity unit. Olivia's mother made multiple attempts to publicise what had happened to her daughter including appearing on national television on the 'This Morning' programme in 2006.

1.4 Olivia's mother told the review chair in late 2018: *'I hope that by speaking out other women who've suffered in childbirth will come forward …to expose the cover-ups that clearly happen…at the time, because I ended up on This Morning as well, talking about this, and the amount of women that day that phoned in, who'd gone through similar things, and it gave me a kind of peace because I knew that they were getting help in the right direction…'*

2007 Healthcare Commission

1.5 In 2004, two babies were born in poor condition which resulted in cerebral palsy. These cases were reported in the local press at the time and the solicitor who represented both families wrote to the then regulator of NHS trusts, the Healthcare Commission (HCC), and the Shropshire and Staffordshire Strategic Health Authority calling for an inquiry. The review team has not seen any evidence that an inquiry took place.

1.6 Three years after the experience of these families in April 2007 the Healthcare Commission wrote to the then CEO of the Royal Shrewsbury Hospital[2] regarding its concerns about the maternity service. The HCC said they had received concerns in March 2006 with regards to poor care resulting in birth injuries. The allegations raised with the HCC were that staff failed to recognise and act upon abnormal cardiotocograph[3] (CTG) tracings, that there was non-adherence to the National Institute of Health and Clinical Excellence (NICE) guidelines and there was a lack of, and inappropriate, staff training.

1.7 The HCC visited the maternity service and said it was satisfied that CTG training for staff and audit had been introduced and that the Trust then used NICE guidance. The HCC considered that the concerns raised with it did not meet its criteria for an investigation and therefore did not undertake one, but suggested areas for improvement with a plan to monitor the implementation of the recommendations until it was satisfied that sufficient progress had been made. The HCC noted the Trust's low caesarean section rate of 14 per cent in 2005 compared to the UK national average of 23.2 per cent. The HCC did not examine unplanned

2 Healthcare Commission Letter to the Trust's Chief Executive Officer 18 April 2007 https://www.sath.nhs.uk/wp-content/uploads/2017/05/Doc-1-Letter-from-Healthcare-Commission-to-Trust-April-2007.pdf

3 See glossary

admissions to the Neonatal Intensive Care Unit (NICU), rates of hypoxic ischaemic encephalopathy (HIE) or relevant other near misses. This was a significant lost opportunity for learning at an already troubled Trust.

1.8 In the letter from the HCC to the Trust dated April 2007, the following recommendations were made:

RECOMMENDATIONS	
CTG	The Trust should send a copy of the latest CTG audit to the Commission and ensure that staff are aware of it for their learning. Trends, learning and improvements should be identified and acted upon.
Lack of/inappropriate staff training	Skills drills training programmes should be evaluated and revised where necessary.
Risk Management Systems (including incident reporting, root cause analysis, actions plans, follow-up and learning from incidents)	The Trust needs to improve the quality of the action plans resulting from clinical incident cases and high risk case reviews, i.e. the actions need to be clearly measurable, the accountable person named and they should have timescales.
How policies and procedures are rolled out to staff and embedded in practice	Policies and procedures should be reviewed in a timely manner, in line with national guidance, and staff should be clear of any revisions.
Clinical Governance	The Trust should share its revised Clinical Governance structure with the Commission.
Clinical Risk Adviser	The Trust should consider the need for permanent additional resource for the Clinical Risk Adviser for the Children and Maternity Service.

2008 Baby Joshua, and baby Kate Stanton-Davies in 2009

1.9 In March 2009 baby Kate Stanton-Davies died following her birth at Ludlow birth centre. Richard Stanton and Rhiannon Davies, Kate's parents have up to the present day voiced their concerns about the circumstances surrounding Kate's death and about the safety of maternity services at the Trust. The Ockenden review team notes that another baby was born the year before, in May 2008, also at Ludlow Birth Centre. Baby Joshua died a few days after birth after also being born in a very poor condition. A review of this case by the review team has noted that there were significant concerns in the care provided to Joshua's mother and that there was not an appropriate investigation. The coroner did not hold an inquest, following receiving information provided by the Trust, but the family explained to the review chair that they were not involved in these discussions between the Trust and the coroner.

1.10 In summary, the births of baby Joshua and Kate Stanton-Davies have similar features. Both mothers presented with antenatal clinical concerns and reduced fetal movements, there were concerns during the labours, there were resuscitation concerns for both babies and both babies required air ambulance transfer. Both families were dissatisfied with the internal investigations and failure to obtain answers to their questions.

1.11 A paediatric death review (an internal investigation by the Trust) occurred in September 2008 following the death of baby Joshua in May 2008. The minutes of the meeting state that all midwives were up to date with neonatal resuscitation and *'advised all midwives to call 999 at the first sign of mother or baby being compromised'.* This was also stated in the action plan which said: *'an ambulance should be called as soon as there are indications that transfer of mother or baby may be required due to the time lag in the ambulance arriving.'* When Kate Stanton-Davies was born 10 months after baby Joshua in the same birth centre an ambulance was not called for 90 minutes, despite signs that Kate was seriously unwell from birth.

1.12 One overarching theme from this review is that over the years there has been a failure within maternity services at the Trust to investigate and learn from serious clinical incidents. It is apparent that baby Joshua's death in 2008 did not result in any actions or learning. It is also noted that when the subsequent death of Kate Stanton-Davies was investigated[4] by Debbie Graham Ms Graham could not locate any definitive guidance for the operating of Ludlow MLU for 2009[5]. This was despite the fact that after the earlier death of baby Joshua these issues were raised as being of importance to ensure the safety of mothers and babies, yet no action appears to have been taken.

1.13 Joshua's parents were scathing of the Trust and their lack of transparency and openness and their failure to learn. In a meeting with the review chair in early 2022 Joshua's mother told of *'phoning and phoning the [Royal] Shrewsbury Hospital for over a year, waiting and waiting for answers, they were always on leave, always in surgery, always not available. No one spoke to me..'* Joshua's father described the Trust as *'ducking and diving, avoiding telling the truth, they've been dodging and weaving all these years..*' Joshua's parents eventually commenced litigation in order to get the answers they wanted from the Trust.

1.14 The Ockenden review team has also searched within the vast amount of information provided by the Trust for relevant guidelines. The SaTH guideline *Resuscitation of the Neonate at a Midwife-Led Unit or a Home Birth by a Midwife and When to Summon Assistance* was first implemented in June 2010. It took just over 2 years after the death of baby Joshua and 15 months after the death of Kate Stanton-Davies to ensure this critically important clinical guideline was introduced.

1.15 In 2015 a woman had a delayed transfer from the midwifery-led unit and fetal monitoring was not undertaken during the transfer period. The baby was delivered in very poor condition and subsequently died. The family were critical of the ensuing investigation, and of correspondence with the Trust, and said during a meeting with the Ockenden review team that they had been *"put off, fobbed off and had obstacles put in our way".*

2013 Clinical Commissioning Groups' (CCGs) review

1.16 In 2013, there was a review into the maternity services at the Trust by the two Clinical Commissioning Groups[6]. This review was commissioned following concerns over an increased incidence of serious clinical adverse events and the safety of the clinical model of maternity care in Shropshire.

1.17 The CCGs' review of risk management focussed on reported serious incidents and near misses in the period April 1, 2012 to March 31, 2013[7]. The review team has found evidence of significant underreporting and cases that should have been investigated not being investigated, so it is our view that the CCGs' review would have underestimated the scale and volume of the incidents at the time. The CCG review also looked at policies, clinical governance systems, care pathways, and training, and concluded that *'there was an openness and transparency in reporting and investigation culture, which has led to a higher*

4 Graham, D. Independent Review of the case of Kate Seren Stanton-Davies at the Shrewsbury and Telford Hospital NHS Trust (2015) https://www.sath.nhs.uk/wp-content/uploads/2016/12/IndependentReview.pdf

5 Ibid n3 p25

6 Telford and Wrekin Clinical Commissioning Group, Shropshire Clinical Commissioning Group. Maternity Services Review The Shrewsbury and Telford Hospital NHS Trust (2013) https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MTU5OTY%3D

7 Ibid n5 p5

reporting of serious incidents than would have been reported elsewhere'. The review stated further *'there is a robust approach to risk management, clinical governance, and learning from incidents'.* The higher reported rate of unexpected admissions to the NICU compared to other local units was attributed in part to *'diligent reporting*[8]' and a thematic analysis was recommended to understand the reasons for this higher NICU admission rate.

1.18 Of note in this CCGs' report is a recommendation for neonatal services that *'measures to implement standards for 'Local Neonatal Units' are actioned immediately so that babies less than 27 weeks gestation receive initial stabilisation and intensive care in Shropshire before being transferred to an appropriate unit for ongoing intensive care'.* There is evidence within this second Ockenden report that this recommendation was not implemented, (see more in neonatal chapter 12). Furthermore a recommendation concerning serious incidents said that the Trust must *'ensure serious incident reporting is congruent with the National Patient Safety Agency (2010) and NHS England (2013) Serious Incident Framework'.* There is no evidence in the documentation provided to the review team by the Trust that this recommendation was actioned, (see more in clinical governance chapter 4). There is also no evidence that the CCG held the Trust to account for meeting these very important recommendations.

1.19 The 2013 CCG review also included comments from 47 women across 13 maternity service user focus groups[9]. It should be noted that this survey took place when the labour ward was at the much older Royal Shrewsbury Hospital prior to a move in 2014 to a new purpose-built maternity unit at the Princess Royal Hospital, Telford, so any negative comments on the condition of the estate could be reasonably disregarded.

1.20 Within the 2013 report there were some very positive comments from women:

All of the staff involved in my care both during my pregnancy and in labour were excellent. The midwife who dealt with my labour was first rate.

The care we had was excellent - the midwives acted swiftly to save my daughter's life, as did the neonatal ward in Shrewsbury.

However, there were also some very concerning negative comments:

I had a terrible experience and ended up being treated for post-traumatic stress following this birth, ahead of my second child. I felt frightened and not listened to during the birth and was 'cared' for by a rude uncaring doctor.

The whole experience of labour and the birth was horrific. The midwife was horrible, the on-call consultant was bad tempered.

I felt the midwives were unprofessional and rude. I had no help with feeding and consequently felt really alone. I thought midwives would be kind and they weren't a bit, they just kept telling me how busy they were. I don't want to have another baby at Shrewsbury.

I had an awful experience giving birth, the midwife was horrible to me, I felt I got no support. Afterwards in the ward I got no help with breastfeeding.

I felt that my concerns during labour were not addressed, that I was made to have a natural birth when an emergency c section was more appropriate just so they didn't dent their precious natural birth rate target. I felt like I was on a butcher's slab.

1.21 Although, as commented by the authors of the CCG report, 90 per cent of the patient feedback was favourable the 10 per cent negative feedback contains some very concerning family stories indicating poor maternity care. The sample size of 47 women was also very small. The report thanks *'the young mums*

8 Ibid n5 p7

9 Ibid n5 p19

who provided valuable feedback[10]*'* It is of note that the families' concerns, which do not appear to have been followed up by the CCG, are very similar to many of those heard by the Ockenden review team.

1.22 The overall assessment from this CCG review was that this was a safe and good quality service. The report states: *'it is clear that Shropshire has a maternity service to be proud of and that the model of service provision is safe and robust…'* The Trust Board reviewed this report[11] and in the minutes it noted '[*some] concern about some families' experiences but this was in the context of generally good services.'*

NHS Litigation Authority

1.23 In March 2014 the Trust was assessed by the NHS Litigation Authority[12]. This assessed the maternity service for organisation, clinical care, high risk conditions, communication, and postnatal and newborn care. The Trust was awarded the Level 3 standard, this was the highest standard available to be awarded. It should be noted that the Clinical Negligence Scheme for Trusts (CNST) standards at the time were assessed almost entirely from self-reporting of guidelines and procedures.

1.24 In 2014 there was a Deanery (medical training) review[13] into the training received by obstetrics and gynaecology staff. Under areas for improvement and with reference to clinical governance it said:

1.25 *'The Trust must integrate Clinical Governance into learning outcomes for trainees and ensure that there are clear and robust mechanisms in place to learn from Clinical Incidents and that any learning points are clearly disseminated to trainees appropriately.'* There is no evidence that has been seen by the review team that this was actioned by the Trust.

2015 Care Quality Commission

1.26 In 2015 there was a Care Quality Commission Quality Report on SaTH[14] which followed on from a visit to the Trust in 2014. The overall rating for maternity services was "good". It is noticeable that in this CQC report other Trust services such as medical care, surgery and urgent and emergency services were rated as 'requires improvement'. The CQC did comment that staffing levels should be improved on the labour ward and also commented that: *'the Trust must ensure that all staff are consistently reporting incidents, and that staff receive feedback on all incidents raised, so that service development and learning can take place'.* However, this comment was a Trust-wide action and not specific to the maternity service.

2015 Debbie Graham independent review

1.27 In 2015 there was an independent review by Debbie Graham[15] which reviewed the high profile case of Kate Stanton-Davies and made some criticisms of the Trust's response to the family.

1.28 The independent review by Graham found that although clinical governance processes were in place in 2009, at the time of Kate's birth there was a disconnect between policy, and the systemic mechanisms in place, which prevented effective clinical governance activity from being embedded into the culture of the organisation. This lack of a safety culture within maternity services at the Trust prevented Kate's death being raised as a Serious Incident (SI). Instead of an SI investigation the death was investigated as a High Risk Case Review (HRCR), and secondly as an unconnected midwifery supervisory investigation, therefore no learning started to occur from Kate's death until the findings of the coroner's inquest in 2015, 6 years after Kate died.

10 Ibid n5 p3

11 2014 Trust Board papers supplied to the review team

12 NHS Litigation Authority Clinical Negligence Scheme for Trusts. Maternity Clinical Risk Management Standards 2013-14. The Shrewsbury and Telford Hospital NHS Trust. Level 3. (2014)

13 NHS Health Education West Midlands. PMET Review Findings Report Summary (2014)

14 Care Quality Commission. Shrewsbury and Telford Hospital NHS Trust Quality Report (2015) https://api.cqc.org.uk/public/v1/reports/0826982d-e4d9-48da-bc92-a78c8fc9b933?20210518113404

15 Ibid n3

1.29 In its conclusions the Graham report stated that *'…the learning from these events, in conjunction with the appointment of key personnel, have led to considerable improvements in the provision of maternity services…In particular the development of advocate roles within the Trust that will work to strengthen the voices of patients and their families so they may be heard in the future'.*

2016 Baby Pippa Griffiths

1.30 Kayleigh Griffiths gave birth to her daughter Pippa Griffiths at home in April 2016. Pippa died the day after her birth due to neonatal meningitis from Group B streptococcus infection. Kayleigh Griffiths had phoned midwifery staff about Pippa's feeding, breathing and other symptoms a number of times overnight after her birth and before she died, but had been reassured. It was established at the coroner's inquest that Pippa would have survived had post-delivery literature been given to Pippa's parents, and had a complete systematic enquiry into her neonatal health taken place.

1.31 Kate's and Pippa's parents (Rhiannon Davies, Richard Stanton, Kayleigh and Colin Griffiths) wrote a joint letter to the Trust Board in April 2017 expressing concern about maternity services at the Trust, discussing their own losses and other cases and saying that nothing had been learned and nothing had changed with regards to maternity services since Kate's death in 2009. At interview with the chair of this review in December 2017 Colin Griffiths, Pippa's father, described the behaviour of the Trust at the time of her death and afterwards as feeling *'like it was a sweep under the carpet, that's what it felt like'.*

1.32 Kayleigh, Pippa's mother, described to the Chair of the review in November 2017 the significant effort the family made to try to get the Trust to investigate her death in April 2016. She said: *'so…I left it until late May, and then it went into June and we'd heard nothing at all from them so I phoned...and said what's happening, surely there's an investigation taking place? And [X[16]] said to me "oh, it's just an internal thing, we're looking into it, but if you've got any questions just send them to me and I'll ask them to look at them…" '*Kayleigh continued: *'I…said "it's not right, you don't just have a sudden, unexplained death and then say there's no investigation and the family's not going to be involved". So I went online straight away and got some NHS England guidance up about involving families and sent it…emailed it…And said there's got to be more to it, and I sent…some questions… And, from there, I contacted…I was just thinking something's not right and I'd seen a lot about Richard and Rhiannon Davies and I made contact with them…I contacted the Chief Exec at SaTH and said, you know, this has got to be investigated…'*

2017 Ovington Review (internal)

1.33 In 2017 the Quality and Safety Committee of SaTH commissioned an internal review into the maternity services following on from concerns raised by bereaved parents and the increased perinatal mortality rate, which had resulted in public attention. This report, Review of Maternity Services 2007-2017[17] was authored by Colin Ovington, then working within the Trust, and published in 2017.

1.34 The Ovington report made recommendations that the maternity service should ensure that governance arrangements are more transparent and open, and should improve the learning from incidents and investigations. It recommended engaging peers from other trusts to assist in the investigation and learning from incidents, and that the Trust should use a standardised process for investigating stillbirths and neonatal deaths. It is unclear whether these recommendations were ever acted upon since the review team has not been provided with or seen any connected action plan or any evidence of completion of the actions following that report.

16 X – identifier removed by review team

17 Ovington, C. Report Review of Maternity Services 2007-2017 Shrewsbury and Telford Hospital NHS Trust (2017) https://www.sath.nhs.uk/wp-content/uploads/2019/12/170629-06-Safety-of-Maternity-Services-2007-17-final-version-June-17.pdf

2017 Royal College of Obstetricians and Gynaecologists Invited Review

1.35 In 2017 there was a Royal College of Obstetricians and Gynaecologists Invited Review and subsequent report into the maternity services based on a visit to maternity services at the Trust carried out from 12-14 July 2017[18]. This report noted the following:

- There were workforce issues, with insufficient numbers of consultants providing obstetric cover. It also noted that middle grade rotas were not always filled by the deanery meaning that the maternity service relied on overseas trainees and locums.
- Risk management and governance systems were inadequate with a lack of resources.
- Incident reporting was inadequate with little evidence of widespread learning from incidents.
- The assessors viewed the allocation of the workforce across the sites as a patient safety issue.
- Current morale among the midwifery workforce was very low.
- The midwifery manager on-call rota required managers to deal with clinical areas they had no experience with.
- The perinatal mortality rates had remained above average compared with rates in similar trusts. The assessors did not see evidence of action plans and resulting changes in practice to act on this concern.

The RCOG report was not presented to the Trust Board until July 2018, and when presented it was prefaced by a report addendum dated 27 April 2018 which reported on interim progress on the recommendations from the original report.

2020 NHS Improvement response

1.36 Concerns were raised by families as to the time taken for this report to be presented to the Trust Board. On 29 November 2019 a letter of complaint was sent to the National Medical Director by two families. The letter alleged that the RCOG report was withheld from the Trust Board for 12 months. Furthermore, it alleged that Trust management sought to 'water down' the RCOG report by requesting a further document (the addendum) to be produced by the RCOG acknowledging improvements that had apparently been made. This addendum document was then added to the original report before being presented to the Trust Board in July 2018.

1.37 In response to this letter, NHS Improvement's Investigation Team conducted a review into these allegations and published the document *Review of the handling of a report produced by the Royal College of Obstetricians and Gynaecologists on maternity services at Shrewsbury and Telford NHS Trust* in July 2020[19].

1.38 This NHSI review noted that twelve months elapsed between the RCOG's site visit and the report being presented to the Trust's Board. It noted that when the draft report was received three months after RCOG's site visit, a number of Trust staff were unhappy with the findings feeling it was not an accurate representation of the service. The CEO, in part guided by maternity staff feedback, initially did not accept the RCOG draft report.

1.39 Following further discussions with RCOG, the Trust did then accept the report in early January 2018 but remained concerned about its tone and content, particularly in relation to the executive summary. The Trust made representations to RCOG to address this, and also proposed a follow-up exercise to evidence improvements the Trust felt it had made. The RCOG declined to make any further changes to the report,

18 Royal College of Obstetricians and Gynaecologists. Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust (2017)

19 NHS Improvement. Review of the handling of a report produced by the Royal College of Obstetricians and Gynaecologists on maternity services at Shrewsbury and Telford NHS Trust (2020) https://www.england.nhs.uk/midlands/publications/review-of-the-handling-of-a-report-produced-by-the-royal-college-of-obstetricians-and-gynaecologists-on-maternity-services-at-shrewsbury-and-telford-nhs-trust/

but did agree to this follow-up exercise, to be conducted as a 'progress review meeting' at the RCOG's premises in London. The RCOG did not visit the Trust to assess the 'improvements' for themselves.

1.40 When the report was finally presented to the Trust Board the covering paper was overwhelmingly positive in tone, with its twelve-point summary reflecting only the most complimentary aspects of the addendum itself. The overall result was a document that gave the impression that issues in the maternity service had been largely resolved, when in fact there was still significant further work to do.

1.41 The NHS Improvement report further found that governance arrangements at the maternity service and care group level were not operating effectively in relation to the report and associated action plan. Although a lot of work was initially done to implement actions and keep the action plan updated, there had been very limited ongoing scrutiny of the plan by local or corporate governance forums. This was concerning given the severity of some of the issues identified in the 2017 RCOG report.

1.42 The NHS Improvement report noted that the Trust was not obligated to commission the RCOG Invited Review but chose to do so and committed from the start to publish the results, knowing that this would open it up to further scrutiny. However, when the outcome was less favourable than hoped for, the primary focus of maternity services and the Trust seemed to shift towards the perceived public reaction to the report, rather than getting the right internal assurance and scrutiny to ensure the necessary improvement of patient services.

1.43 Following the publication of the RCOG report there was significant criticism in the media and from families that the body had not alerted the regulator (the CQC) with regard to its findings. Instead the RCOG had only released the report to the Trust. At the time[20] the RCOG sent reports arising from Invited Reviews to the service/Trust that had been reviewed, without always notifying regulators[21]. The 2015 policy was clear that the RCOG would *'encourage dialogue…with regulatory agencies and authorities'* and *'encourages the sharing of the report with the CQC...'* (RCOG 2015, p3).The RCOG policy was subsequently strengthened in 2020 with the policy stating that *'the RCOG will send a copy of the final report to the organisation's healthcare regulatory bodies'.*[22]

2018 Care Quality Commission

1.44 In 2018 there was a CQC report[23] which rated the maternity service inadequate under the safety domain. Of note there were concerns about cardiotocograph training and mandatory training. The report also commented: *'We found areas of concern that were raised in our last inspection December 2016, for example service wide sharing of learning from serious incidents was not evident, not all staff could give an example of learning'*.

1.45 The review team has been contacted by and interviewed a number of staff who have worked at the Trust over the period of this review. A number of Trust staff at Board level have also been contacted by the review team and interviewed, these have included some current and former Chief Executive Officers, Chairs of the Trust, Chief Nurses and Medical Directors.

1.46 A number of themes have come from these interviews and broadly this feedback forms a consistent picture of the culture in the Trust during the period of this review, with the documentary evidence also considered by the review team.

20 Royal College of Obstetricians and Gynaecologists Invited Reviews a guide (2015) https://www.rcog.org.uk/globalassets/documents/about-us/invited-reviews/rcog-invited-reviews---a-guide-oct-2015.pdf

21 Royal College of Obstetricians and Gynaecologists. Statement regarding an Invited Review by Royal College of Obstetricians and Gynaecologists (RCOG) into maternity services at Shrewsbury and Telford Hospital NHS Trust (2020) https://www.rcog.org.uk/en/news/statement-regarding-an-invited-review-by-royal-college-of-obstetricians-and-gynaecologists-rcog-into-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust/

22 Royal College of Obstetricians and Gynaecologists. Invited Review Service: https://www.rcog.org.uk/en/about-us/invited-review-policy/

23 Care Quality Commission 2018 report Shrewsbury and Telford NHS Trusts https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-report-shrewsbury-telford-hospital-nhs-trust

1.47 It was clear from a number of staff interviews that this was a Trust which had a number of problems. A Board member told the review team that: *'there seemed to be a number of political issues making reform of services difficult'* and there were comments that the populations of Shrewsbury and Telford differed and that *'everybody in Telford wanted all the services in Telford and everybody in Shrewsbury wanted all the services in Shrewsbury'.*

1.48 One staff member said to the review team *'people just didn't do anything… and there just wasn't a culture of accountability for completion..'* and another commented: that *'this wasn't just a maternity unit in chaos and under pressure, this was a whole organisation where it was difficult to find an area which was not under pressure'*. The review team has noted that for many years there have been concerns with regard to safety and performance across the whole of the Trust, including the emergency department.

1.49 One interviewee described the maternity service as the *'Republic of Maternity, where, often, the maternity service seemed to consume its own smoke, and didn't like having oversight by the corporate team'."*The same interviewee commented that *'there was a disconnect both ways actually, I believe, from the corporate team to maternity and maternity to the corporate team'.*

1.50 Over a prolonged period, the Trust Board and executive team were dealing with a situation where the general standard of the whole organisation was poor and according to a staff member *'women's and children's was largely trusted to take responsibility for their own affairs and, to some extent, there was less scrutiny of them by virtue of the fact that they were perceived as being satisfactory to good'.* The impression given from multiple staff interviews with the review team was that the maternity department preferred to manage its service without Trust oversight.

1.51 The Trust had an executive team and Board that had continual change and churn over the period of this review, with documentation provided to the review team by the Trust[24] showing 10 Board Chairs from 2000, with 10 Chief Executive Officers (CEO) from 2000 to early 2020, of which 8 were in post between 2010 and the current day. This lack of continuity at Board and CEO level resulted in a loss of organisational memory and contributed to this "self-management" and lack of oversight of a maternity service that had clearly been in trouble for many years. The overwhelming impression of the staff interviews is that despite significant evidence to the contrary, the maternity unit up until about 2017 was actually not considered to be a trust risk.

1.52 One staff member interviewed stated that following serious incident reports there would have been recommendations made and that often these reports and recommendations were good but what was missing was the follow-up of the actions from the recommendations. It was said that *'there just wasn't a culture of accountability for completion'.*

Concerns from local external bodies

1.53 In late 2021 the review team also spoke to some senior staff of the Clinical Commissioning Groups (CCG) in post between the years 2013 to 2020. We were told that the CCGs did have concerns about maternity services at the time and were aware of the local press reports and family concerns. The CCGs had concerns about the length of time that SIs took to be reported and we were told by a contributor that *'reviews of serious incidents seemed to take a long, long, time to happen and there was an impression of evasiveness around how the learning from those reviews was shared'.* The same contributor told the review team that the CCG did have meetings with the maternity service representatives from the Trust but were assured that *'things were improving',* and were told that the CCGs were in any event *'limited in their power to change things for the better'.* It should be recognised that the CCGs were also concerned about SI investigations and learning from other services across the whole Trust and not just maternity.

24 Who's Who at the Trust – internal document received by the review team on 9 September 2020

Missed opportunities

1.54 In summary this was a Trust which had a number of problems, but the perception was that until 2017 the maternity service was not a major risk. The consistent message coming from both senior maternity staff and from Trust Board members was that external reports into the maternity service were generally favourable and that there were more pressing problems in other services at the Trust. The management of the maternity service was perceived to be competent and able and governance concerns seem to have been managed within the service and not escalated.

1.55 The review team believes that the Trust Board and the CCGs were 'reassured' rather than 'assured' with regards to governance and safety within the maternity service. Although independent and external reports consistently indicated that the maternity service should improve its governance and investigatory procedures this message was lost in a wider healthcare system which was struggling with other significant concerns.

Case Study

Thematic review of three cases at the Trust sharing similar themes within a nine month period (2008-2009)

1a.1 Here we examine the case of Kate Stanton Davies and deaths of two other babies which occurred within a short time period at the Trust. Throughout this report we highlight repeated incidents where maternity services at the Trust failed to investigate, learn and make impactful changes to improve patient safety.

1a.2 Within nine months, between May 2008 and March 2009, there were three neonatal deaths of babies that should have led to a systematic review of governance processes, strong actions and learning as well as a coronial inquiry into safety at the Trust. In all three cases there are significant failings in the care and treatment provided, omissions in the subsequent investigation into care, and failure to learn and establish processes for safe delivery in the midwifery-led unit (MLU) and consultant unit.

1a.3 Most concerning is a lack of transparency and honesty in communication with the families concerned despite internal recognition at the Trust that the investigations were not robust.

Baby Joshua 2008:

1a.4 The maternity review team has found evidence of a case that occurred nine months earlier than that of Kate Stanton Davies. In May 2008 a baby boy called Joshua was born at Ludlow midwifery led unit (MLU) in poor condition. Joshua was transferred by air ambulance to the Royal Shrewsbury Hospital (RSH) Neonatal Unit and died there on day 6 after his care was withdrawn.

1a.5 Joshua's mother was considered low risk with a previous pregnancy and birth and it seems an assumption was made that she would deliver in the freestanding MLU at Ludlow. There was no analysis of risk to ensure normality and whether or not it was appropriate or not to deliver in Ludlow. However, from 31 weeks of pregnancy the maternal risk changed. Joshua's mother reported three episodes of severe uterine tenderness and tightening. One occasion led to an ambulance admission to RSH and this review team believes that concealed abruption should have been considered by clinicians at the time.

1a.6 Joshua's mother reported decreased fetal movements the day prior to labour at 37+5 weeks gestation. No admission CTG was performed; she progressed quickly in labour, and an amniotomy[25] performed at 9cm revealed significant meconium. Seventeen minutes later her baby was delivered with no sign of life. No ambulance had been called in preparation for delivery and no attempt was made to perform a CTG once the meconium was identified.

1a.7 Two midwives at the unit attempted to resuscitate the baby but did not follow UK resuscitation guidance. A paediatrician doing a peripheral clinic took over the resuscitation. An ambulance road crew arrived to help. Joshua was transferred unsecured on a stretcher and ventilated by valve and mask in the air ambulance to RSH where he was ventilated, and remained comatose until treatment was withdrawn on day 6, after a head scan revealed severe widespread damage to Joshua's brain.

1a.8 The review team observes that timely intermittent auscultation was not performed in labour, and what monitoring did occur was not described in an accepted manner. The review team is concerned by alterations added to the notes in a different pen that appear to change the fetal heart rate recordings documented during labour.

1a.9 Placental histology confirmed a significant abruption with an attached and organised blood clot. The pathologist concluded that the abruption was silent and established. Despite this, the explanation given

25 See glossary

to the parents at the bereavement consultation was that the abruption must have been acute in the final 15 minutes of labour, perhaps secondary to a tight umbilical cord causing an unpredicted, acute placental detachment. This is despite no evidence of fresh blood loss at birth or post-partum haemorrhage. The bereavement letter stated: *'nothing could have been done or predicted'* and lacked any apology or reassurance that lessons would be learned.

1a.10 The review team do not accept this opinion of the likely pathology. In addition, we observe from the maternity records supplied by the Trust that the meconium revealed prior to birth was thick and established, indicating that the release was likely to have been some time before, perhaps in the days leading to labour when decreased fetal movements were reported. The review team consider that concealed abruption most likely occurred in the third trimester, contrary to the opinion offered to the parents at the bereavement appointment.

1a.11 There are a number of documents provided to the review team by the Trust which show discrepancies between the factual events and what was actually discussed with the parents. There are also extracts that contain additional information which was not disclosed to the family. This information is found in incident reports filed by members of staff and communications between professionals, provided to the review team by the Trust.

1a.12 The review team conclude that the risk management review of this incident by the Trust failed to follow appropriate local investigation processes to identify the root cause. The Trust also failed to decide on appropriate actions in order to prevent similar harm in the future. It is of concern that a decision to refer to the coroner was reversed by a small number of individuals within the Trust who decided to manage this incident internally.

1a.13 The review team has been aware of internal reports of concern around the lack of vital resuscitation equipment being available at Ludlow. As well as a lack of familiarity with equipment and poor standards of resuscitation, including the failure of midwives to achieve respiratory resuscitation. In addition the lack of ability to monitor oxygen saturation and to monitor the baby during resuscitation, and the lack of facility to thermoregulate and monitor the baby in the air ambulance.

1a.14 Documents shared with the review team by the Trust show that the lack of a portable resuscitaire in Ludlow MLU had been on the maternity risk register since 2005. The Trust did not support this concern and excused the lack of equipment on the basis that it would only be used by a neonatologist. There was an assessment of the resuscitation equipment at the unit but no details were given of the outcome. The review team is concerned by the response to this risk as it demonstrates poor evidence of learning. The additional information around the maternity risk register and the fact that this was a known risk regarding Ludlow MLU was never detailed to the parents during their meeting with the obstetrician or to any other professionals outside the organisation.

1a.15 A few weak action points from this case were circulated via a memorandum suggesting that change in practice was not mandatory and it was optional whether to use CTG monitoring if a woman presented with reduced fetal movements at the MLU. It also suggested it was optional to summon an ambulance when amniotomy was performed with evidence of meconium.

1a.16 A clinician who cared for the baby initially, stated in a letter to the Clinical Director in July 2008 that they had serious concerns regarding the quality of the case review. They pointed out a number of inaccuracies in the findings of the review and wrote: *'I really do wonder whether they have actually read these notes and wonder [about] the quality of the case review'*, and *'I am concerned that there is evidence the parents have not received an accurate explanation of the events leading up to the birth, during the birth and the resuscitation'.*

Baby Thomas 2009

1a.17 In January 2009, after the birth and death of Joshua but before Kate Stanton-Davies was born, a multiparous mother delivered in the consultant unit. Uterine rupture was diagnosed at caesarean section after a failed ventouse and prolonged labour with injudicious oxytocin use. The baby, named Thomas died at 34 minutes of age and was classified as an early neonatal death. The coroner agreed to the stated cause of death as: 1. Multiple organ failure; 2. Severe HIE; 3. Ruptured uterus and placental abruption. No post mortem was performed.

1a.18 The mother was booked for an MLU delivery despite having had a very long previous labour with a macrosomic[26] baby. No gestational diabetes testing was performed in this second pregnancy. Numerous attendances in a long latent phase of labour were apparent and all clinical midwifery reviews highlighted a large for dates baby with poor engagement of the fetal head.

1a.19 The mother was admitted to the consultant-led antenatal ward, contracting at 4cm dilatation. 19 hours later she was taken to the labour ward for amniotomy at 5cm. During the 11 hours following amniotomy there were repeated periods of abnormal CTG and high dose oxytocin infusion was administered for long periods of time leading to and after full dilatation. The contraction frequency was 5 in 10 minutes for long periods and poor medical input was noted. Vaginal examinations revealed classic signs of obstructed labour of a baby in the deflexed occipito-posterior position[27]. An hour prior to eventual birth by caesarean section there were classic signs of uterine rupture including haematuria[28], breakthrough pain, hypotension, and diminished uterine activity, failure to establish between a clear fetal or maternal heart rate. The midwife sought assistance for possible uterine rupture[29]. A ventouse delivery was initiated 35 minutes later and failed after 3 pulls. A caesarean was conducted 10 minutes later and uterine rupture with placental abruption[30] was found. The baby briefly had a heartbeat, but at 34 minutes of age resuscitation was discontinued.

1a.20 A DATIX[31] submission was generated following this event and the outcome of uterine rupture, early neonatal death and major obstetric haemorrhage (4.8 litres) was classified as low harm. It was stated that the case would be discussed in a case review meeting that same month but to date the review team has received no documents from the Trust pertaining to a risk review or outcomes.

1a.21 The review team has graded this incident as Grade 3 (the highest grade of harm) and has major concerns with the management of the incident and the apparent lack of scrutiny.

1a.22 In a bereavement letter, the Trust inaccurately informed the parents that the demise was acute and no one could be certain when the rupture occurred. No reference is made in the letter to the reasons why the mother's uterus was ruptured, or to the chronic hypoxia revealed by the cord ph. There is no reference in the letter to lessons being learned or actions that could prevent such tragedy in the future.

The Stanton Davies family and baby Kate 2009:

1a.23 Two months after the birth and death of baby Thomas and 9 months after the birth and death of baby Joshua, baby Kate died avoidably on 1 March 2009 after her birth at Ludlow MLU. Kate died at 6 hours of age following cardiopulmonary collapse at 90 minutes of life. She was severely anaemic and paediatric help should have been sought earlier.

1a.24 The case has been reviewed extensively: with a highly criticised supervisory investigation, multiple external opinion reports and finally in 2012 a coroner's inquest with jury, all of these occurring after constant pressure from Kate's grieving parents. The inquest concluded that Kate should not have been born at Ludlow. The 2 weeks of reduced fetal movements prior to labour was a factor in Kate being born anaemic, as she had likely suffered repeated episodes of feto-maternal haemorrhage[32]. The MLU staff failed to provide Kate and

26 See glossary
27 See glossary
28 See glossary
29 See glossary
30 See glossary
31 See glossary
32 See glossary

her mother Rhiannon with midwifery expertise. Intermittent auscultation in labour was not adequate and opportunities to manage a baby in difficulty during the first hours of life were missed. Kate died shortly after arrival by air ambulance at a tertiary neonatal unit.

1a.25 There have been numerous specialist opinions on this case over a long period of time. It is clear that the Trust failed to fulfil its responsibility to establish the facts and establish accountability. In particular, the Trust failed to investigate Kate's death appropriately, failed to hold staff to account and failed to address her parent's concerns, and particularly those pertaining to the inadequacy of the supervisory investigation. Further external opinions revealed that midwives did not consider her mother Rhiannon's antenatal care as a whole and did not consider the bigger picture, which would have indicated that Kate should not have been delivered in an MLU. The Trust's investigation into midwifery practice is described as ineffective and half-hearted and the consultant feedback is criticised as being badly considered.

1a.26 Consideration of these three cases of term babies, Joshua, Thomas and Kate who were born and died within 10 months of each other show that by early 2009 there was already a systematic failure within the Trust to investigate its maternity services. Following on from their failure to investigate the deaths of Joshua, Thomas and Kate the Shrewsbury and Telford Hospital NHS Trust completely failed to identify appropriate actions for learning from the deaths of these babies.

1a.27 The review team is particularly concerned by the lack of transparency internally within the Trust and the lack of honesty and transparency with families. This is all the more concerning, when it is clear that major issues in safety were apparent in both MLU and consultant settings during the period leading up to the birth and death of Kate Stanton-Davies, and before her the birth and death of baby Joshua and then baby Thomas.

Chapter 2

How we approached this review

2.1 This Independent Review into Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (SaTH or similar abbreviation) was commissioned in May 2017 by NHS Improvement (NHSI) at the request of the Right Honourable Jeremy Hunt MP, then Secretary of State for Health and Social Care. This was in response to concerns raised with Mr Hunt by Rhiannon and Richard Stanton Davies and Kayleigh and Colin Griffiths about the deaths of their daughters in 2009 and 2016 respectively and about 21 further families which experienced adverse outcomes at SaTH. These concerns were with regards to the maternity care received at the Trust and with the failure of the Trust to provide satisfactory answers to questions asked about the care it provided.

2.2 The first terms of reference in 2018 were written for the planned review of 23 families, but were amended in November 2019 to encompass a much larger number of families. Both the first and the current terms of reference are found in appendices 5 and 6.

2.3 This is the second report published by the Ockenden review team. The original plan was to publish one complete report when the reviews of all the cases had been completed. However in July 2020, following an increase in the number of families included in the review, the then Minister of State for Mental Health, Suicide Prevention and Patient Safety, Nadine Dorries MP, requested a first report focussing on important early actions and learning to improve local and national maternity services. That first report, based on the first 250 clinical reviews, *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Hospital Trust*[33] was published on 10 December 2020.

2.4 For this second report we have reviewed all reported cases of maternal and neonatal harm in the period 2000-2019. As stated in the terms of reference, these comprise cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other complications in mothers and newborn babies. A number of cases were reviewed outside of these years and the earliest case reviewed was in 1973 and the latest in 2020. In total this review has examined the maternity care of 1,486 families resulting in 1,592 clinical incidents involving mothers and babies.

The start of the review in 2017

2.5 When this review began in late 2017 a small team of six obstetricians, midwives, neonatologists and administrative staff were recruited by Donna Ockenden (chair of the review) to begin work as agreed with NHSI. During summer 2017 and early 2018 some original hospital records were transported securely from the Trust to the review's office in Chichester, West Sussex and reviews were undertaken by the clinical team using these records.

2.6 Although this review commenced with 23 families many more came into the review through a number of different channels up until July 2020. This was in response to Trust-led action, word of mouth, social media and press reports. As a consequence the review continued to change and grow throughout the period, as we describe below.

2.7 The period under review has been largely determined by the data the Trust provided to the review team and the terms of reference (TOR) formulated by the review team and NHSI. The year 2000 was identified as a starting point because the first case within the original 23 Secretary of State cohort occurred in 2000.

33 Ockenden, D. Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (2020) https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

2.8 The terms of reference for the review were revised in November 2019 to take account of many further families' cases coming to the review's attention. Many of these additional clinical cases came from the Trust directly reporting families to the review. For instance, a large number of additional cases were reported to the review team by the Trust following a data collection exercise referred to as the 'Open Book', in which the Trust (supported by NHSI) undertook an internal investigation to identify cases of stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3) and maternal deaths. This started as an electronic review in autumn 2018 but further cases were added later in July 2020 (Extended Open Book) after analysis of paper records held by the Trust. The Open Book and Extended Open Book exercises resulted in more than 700 cases of poor outcomes across the four categories within the period 2000-2018 being referred to the review.

2.9 As requested by NHS Improvement, (NHSI) the Ockenden review team drafted an interim report based on early findings and progress which was sent to NHSI in January 2019. Prior to this in autumn 2018 NHSI had formed an oversight committee to scrutinise the work of the Ockenden review team, comprising NHSI, RCOG, RCM and CQC, to which it circulated the interim report. This committee was subsequently withdrawn after concerns were raised by families and in the media.

2.10 The interim report was leaked to the media by an unknown source in November 2019. In response, the number of families contacting the review rose rapidly. Over the course of the review further media coverage resulting from debates in Parliament and from police enquiries resulted in large numbers of families contacting the review.

2.11 In addition, further families were referred to the review by local solicitors representing families and there were additions to the review following contact with the local coroner.

The families within the review have been assigned to a number of different cohorts as shown in Table 1.

Table 1: Family cohorts and timing on entering the review

COHORT	DESCRIPTION	YEAR
Secretary of State (SOS)	The original 23 families at the foundation of the review	2017
Original Direct Contact	Families contacted the Chair having learnt of the review through contact with other families or via social media	2018-2019
Legacy (the Trust named this the 'Legacy' cohort)	Trust-led investigation of further cases identified by the review team following scrutiny of documents pertaining to the Secretary of State cohort of 23	2018
Original post-media coverage	In response to growing media interest	2018-2019
Open Book (Trust-named)	NHSI-led data gathering at the Trust (electronic records only)	May 2019
Post-November 2019 media coverage	In response to the interim status update to NHSI which was leaked to the media	November 2019
Post-parliamentary adjournment	In response to a parliamentary adjournment debate on the review	January 2020
Solicitor	Families approached a law firm in response to media coverage which then referred them to the review team	April 2020
Extended Open Book	Trust-led data gathering (to include all paper copies of medical records)	July 2020
Post-West Mercia Police announcement	In response to West Mercia Police statement regarding the launch of an investigation	July 2020
Coroner	Coronial referrals to the review	July 2020
Saves and Learning (Trust-named)	The Trust identified a number of cases to demonstrate learning within maternity services – a selection of these cases were then passed to the review team	October 2020

Changes to the organisation of the review

2.12 By the time of the first COVID-related national lockdown in March 2020 the review had received only a small number of medical records and associated governance documents from the Trust. There were significant delays in receiving medical records from the Trust throughout 2018 and 2019 with NHS Improvement needing to intervene to try to secure the release of records on an ongoing basis.

2.13 In consequence of the growth in the size of the review's investigation NHSE&I commissioned a company to provide the review with an Electronic Document Records Management System (EDRMS) so that the team could access securely Trust medical records which were scanned and uploaded remotely. This was expedited because owing to lockdown the review team's progress was temporarily halted as the team were unable to travel to the review office. The team commenced accessing the medical records via this secure platform from July 2020. All medical records that had been received from the Trust were securely returned to the Trust once the EDRMS system was up and running.

2.14 The review's internal governance structures were adjusted in response to the high volume of enquiries from families who contacted through emails, social media and telephone calls. All of the initial family contacts were recorded, with follow-up arranged, then an assessment and full clinical reviews were conducted where required. In April 2020 a press statement was released advising the public that the review would close to new families in July 2020.

2.15 The first Ockenden report published on 10 December 2020 was outside the original terms of reference but was requested by the Minister to ensure early learning was disseminated to the Trust and the wider NHS. That first report has occasioned some delay to the publication of the final report.

Closure to new families and progression to final report

2.16 When the review closed to new families in July 2020 it confirmed that 1,862 families came within the review. This was widely reported in the media.

2.17 It should be noted that well over this number of families contacted the review; however the events experienced by some of those families fell outside the review's terms of reference and the review team advised them of the alternative routes they could explore, including approaching the Trust through the email address it had set up for families if they had any concerns.

2.18 Once the screening process had been completed there were 1,815 families for whom the review requested medical records in order to conduct full medical reviews. The reduction of 47 cases arose from a number of duplicate cases, (where for example the Trust and the review team had two different names for a woman following marriage).

2.19 After excluding cases where there were missing hospital records or where consent for participation in the review was not given or could not be obtained the final number of families included was 1,486. Some mothers had more than one incident reviewed over the period of this review and in total 1,592 clinical incidents have been reviewed.

Clinical incident categories and data validation

2.20 Families have been assigned to clinical incident categories. The four clinical incident categories described above (maternal deaths, stillbirths, neonatal deaths, and HIE) were defined by NHSI and the Trust when undertaking the Open Book data collection exercise. The remaining categories (maternal morbidity, cerebral palsy, and the combined category) were defined by the review team to encompass other clinical incidents and issues the families experienced.

Table 2: Clinical incident categories

CLINICAL INCIDENT CATEGORIES
Maternal deaths
Stillbirths
Neonatal deaths
Hypoxic ischaemic encephalopathy
Maternal morbidity
Cerebral palsy
Combined category*

**Combined category: comprises medical termination of pregnancy, missed fetal abnormality, intraventricular haemorrhage, infant death, child death*

2.21 All of the families assigned to the maternal morbidity category self-referred to the review and were largely motivated to do this following reports about the review in the media, or through speaking to other families already within the review. The Trust was aware of a few of these cases, where the family had initially raised concerns through the Trust's complaints process. However, the majority did not have any form of governance investigation, whether initiated through the Trust's clinical incident investigation process at the time of the incident or through the complaints process. The overall conclusion by the review team is that the Trust appeared not to be aware of these families' concerns.

2.22 The majority of the families in the cerebral palsy category also self-referred. Similarly, the majority of these families did not have a Trust investigation at the time of their maternity episode. Many of the families reported being concerned about their baby from the time immediately following their birth and spent a number of years trying to find out from health professionals, or through commencing litigation, why their child had been damaged.Whilst the review spans the years 2000 to 2019 it should be recognised that the review team were contacted by many families whose maternity episode at the Trust occurred before 2000 and the earliest case reviewed was in 1973.

2.23 A total of 170 families from before 2000 and 15 families from after 2019 are included in this review by agreement with NHSE&I as a variation to the original terms of reference. Reviews of these cases have been largely determined by the availability of medical records, with the team being unable to review family cases where there were no medical records. For all the cases under review the standards of care that would have been considered acceptable at the time the incident or concern occurred, and the policies and normal practice at that time, have been used as the benchmark.

2.24 Families included within the review after December 2018 are those who self-referred and a small cohort named by the Trust as 'Saves and Learning'. The families within the Saves and Learning cohort were offered to the review team by the Trust as it wished to demonstrate learning and positive service change in its approach to categorising and investigating serious incidents. Some of these cases had been investigated by the Healthcare Safety Investigation Branch (HSIB). The review team felt that as these cases were offered as examples of change and progression, the governance processes for them should also be reviewed. More detailed commentary on this cohort is included within the clinical governance chapter.

2.25 Families who contacted the review with more recent concerns about their maternity experience were referred back to the Trust to be addressed through the Trust's formal complaints process and timeline. The small number of families from 2019 who self-referred and who remained with the review were those who continued to be dissatisfied with the Trust's response to their concerns. The review includes 15 families

from 2019-2020. Some families from 2021 and 2022 also came forward wishing to share HSIB reports and their experience. The review team advised these families to contact the Trust as we were unable to consider their case due to the review being closed.

2.26 The review received some enquiries and heard accounts from a small number of families with poor maternity experiences at other NHS Trusts across England. Following discussion with NHSE&I the review team advised those families to contact the trusts concerned.

Clinical review methodology

2.27 The core review team comprised obstetricians, midwives, obstetric anaesthetists and neonatologists, with professionals from other disciplines joining the team as and when their specialist expertise was required. Over the course of the review the number of clinical reviewers recruited increased to reflect the growing number of families to be considered. The majority of reviewers retained clinical posts at NHS trusts across England, from Leeds to Plymouth, and all review team members remain on their relevant professional registers.

2.28 As the family numbers grew, the methodology for the clinical reviews underwent several iterations, with the process more efficiently managed once the bespoke electronic platform had been built. Each of the family cases has been reviewed, discussed and graded in accordance with the methodology agreed. The clinical care has been graded using a long-established grading of care[34] scoring system developed by the University of Leicester which was also used in the *Report of the Morecambe Bay Investigation*[35] (2015) by Dr Bill Kirkup.

Governance documentation

2.29 Much of this review centres on the quality of the governance processes in place within the Trust, the quality of clinical incident investigations and any subsequent learning following clinical incident investigations. In our first report, we mentioned that we had received a large volume of governance documentation from the Trust which we had yet to consider. We also reported that in the 250 cases considered to date there was evidence that some serious incidents were not investigated. Subsequently we have found that a number of these cases were investigated, but the governance documentation had not been sent to the review team.

2.30 In the summer of 2021 we were advised by the Trust that it had located many boxes of documents potentially relating to former patients and staff, which had been stored in an unused accommodation block. Subsequently it was confirmed that 171 of those boxes contained information relating to maternity cases. Initially the Trust advised the review team that the maternity governance records found were copies of information already sent to us. This was not correct.

2.31 The review had forecast completion of most of the clinical reviews by mid-August 2021 in order to commence writing the report, which was then planned for publication in December 2021. The Trust provided the review team with information relevant to the families we were aware of, undertaking the screening and sorting of this information themselves, the review team were not involved. Having received this new governance documentation concerning so many families in July 2021, concerns were escalated to NHSE&I as this meant that the reviews already undertaken would need to be reconsidered in light of the new information. Our ability to deliver a second report in December was now severely compromised. The Trust continued to send governance documentation until the end of September 2021, which we agreed as a cut-off date. At this late stage, we had received documentation concerning more than 500 families within the review meaning that each case needed to be reopened and the new documents needed to be reviewed in order to determine whether they changed the reviewer's findings and conclusions following the clinical review which had already been completed.

34 https://pubmed.ncbi.nlm.nih.gov/12390986/

35 Kirkup, B. The Report of the Morecambe Bay Investigation. (2015) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

Family voices

2.32 Many families have been offered the opportunity to meet with the chair of the review. From December 2017 until the beginning of 2020 these meetings were through one-to-one meetings in Shrewsbury. These were supported by telephone and email conversations with senior midwives working as part of the review team. Following severe flooding in the Shrewsbury area, and as the COVID pandemic ensued, video-conferencing platforms were used. Conversations were recorded and transcribed, the families were offered copies of the transcript so that they could review and add to their conversation, and the recordings were deleted.

2.33 The review has contacted the families regularly with an all families update on the review's progress. As the review grew in size and the pandemic lengthened, making travel very difficult, it was clear that the review chair would not be able to offer all families a face-to-face meeting. Instead families were invited to submit their accounts and questions via email, phone call or in writing to the review team.

2.34 Families have been offered support through a collaboration with SANDS, Bereavement Training International, and Child Bereavement UK. There is also a psychological support service provided by Midlands Partnership NHS Foundation Trust which will be discussed in detail later on in this report.

Staff Voices

2.35 The Staff Voices engagement strategy, which will be discussed in detail later in the report, was also significantly delayed. This was firstly and understandably at the request of the Trust due to the enormous pressures that it was facing due to the impact of the COVID pandemic. The Trust then delayed the launch of the Staff Voices process which was scheduled for February 2021, until April and then 11th May 2021. There were several hurdles which the review team had to overcome owing to the way that the Trust launched the process within its organisation. This, alongside the late delivery of significant amounts of governance documentation contributed to further concerns about the ability to publish this report by December 2021.

Data platform

2.36 The review team spent many hours screening telephone conversations and emails in order to ensure that the families included within the review met the terms of reference. From November 2019 it became increasingly evident that maintaining records on a system originally intended for 23 families was no longer viable.

2.37 NHSE&I were unable to either provide us access to a fit for purpose secure electronic platform or suggest any other review or public enquiry which could help with recommending a platform for holding the review data, as a review of this volume appeared to be unprecedented. In August 2020 the review commenced conversations with an external provider and were able to secure a contract for development of a bespoke data platform which could be accessed remotely. This data platform was able to securely hold family details and it enabled the review team to write up their clinical findings directly onto the platform.

2.38 The review team started using the platform in April 2021 and transferred over all data from previously completed reports, including the 250 cases reported on in the first report. This enabled the review team to work more responsively and flexibly as the majority of clinical reviewers were now working remotely.

Limitations with regard to data comparisons

2.39 There are limitations that should be acknowledged when interpreting the data presented in this review. For instance, we are unable to be certain whether all cases which meet the terms of reference between 2000 and 2019 have been identified and shared with the review. We anticipate that, using the approaches described above, most of the cases have been identified. However it remains the case, (especially with so much governance material found stored at the Trust in an inappropriate setting and provided to the review team so late in the review process) that there may have been cases that have not been provided to us.

2.40 Finally, we are also cognisant that the Trust has not provided us with information regarding families who experienced adverse outcomes more recently than December 2018, which is the cut-off date it applied in the Open Book and Extended Open Book exercises.

Working with the Shrewsbury and Telford NHS Hospital Trust

2.41 Throughout, the review has been keen to maintain good working relationships with the Trust. There have been several attempts to establish consistency and good communication by ensuring that the review team have a key point of contact at the Trust to assist with swift responses to requests. These contacts changed over time as staff joined and left the Trust.

2.42 The review team also received a very small number of emails from families who have received good care at the Trust. These were acknowledged and shared with the Trust.

Reporting progress to NHSE&I

2.43 The review team has been conscious of the time this review has taken. Following on from the publication of the first report in December 2020 the review team and NHSE&I both wished to follow this up with the final report in December 2021. As outlined earlier the delay in publication to March 2022 has been due to several factors: introducing new electronic data systems, delays in receiving information from the Trust and delays in engaging Trust staff for their views, the complexities of managing a review of this size, and the fact that most of the reviewers in the team held full-time NHS positions.

2.44 During the national COVID restrictions in January 2021, we became increasingly worried regarding the reduced availability of our clinical team owing to the pandemic pressures and the need for them to quite rightly prioritise their NHS commitments. We raised this concern with NHSE&I and with their assistance, and that of the Royal Colleges, we were able to welcome additional colleagues to the team between March and May 2021. This was essential as our projected plan between January and July 2021 was to complete in excess of 1,200 clinical reviews.

Request to delay publication

2.45 In August 2021, recognising that the December publication date was now compromised owing to the late delivery of the large amount of governance documentation from the Trust and the delay with the staff voices engagement strategy, the review team wrote to the Secretary of State for Health and Social Care raising concerns and suggesting an alternative publication date of March 2022. Following discussions this extension of time was agreed by the Parliamentary Under Secretary of State, Minister for Primary Care and Patient Safety, Maria Caulfield MP.

Family feedback

2.46 It is not possible or appropriate to publish clinical reviews of all individual families' experiences in the report. However it has always been intended that the review team would feedback to families in a way that will help them to understand what happened during their maternity care. In August 2021, the review team wrote to NHSE&I outlining the reasons why giving individualised feedback to families about what had happened in their care was so important and why the feedback should be given by the review team. This process of feedback has been agreed and will take place throughout April, May and June 2022.

Closedown of the review

2.47 The review team has used an independent legal team for advice throughout the review. In particular we have received advice on data protection aspects of the review, and will be closing down the review and archiving its records in accordance with all legislative requirements.

Cost of the review

2.48 From its inception, the review has always been mindful that it has been financed through public funding. The review chair has held senior positions within the NHS and is well aware that large budgets have to be managed accordingly with demonstrable accountability for expenditure. All costs have been clearly accounted for each month and ranged from day to day office costs, to the management of the various secure platforms.

2.49 Since 2017, it is publicly reported that the Trust (via NHS Resolution) has paid out at least £50million to families as compensation for babies who have suffered brain damage or have died. In 2018/19, across England, there were 188 successful maternity claims averaging £9.9million each, amounting to £1.86billion in total (NHS Resolution 2019)[36].

2.50 The additional hidden costs for patients of failures in clinical care include relationship breakdowns, mental health issues and ongoing family suffering, which invariably lead to an increase in demand for resources across health and social care. All of these consequences have been acknowledged, recognised and witnessed through the review team's meetings with families in the course of the review.

2.51 Whilst the review team recognises that the costs for conducting this review are significant, they are a fraction of the cost of one successful cerebral palsy claim. It is intended that our **Local Actions for Learning** and the **Immediate and Essential Actions** are deemed strong enough to continue their positive influence of enhancing the safety culture within maternity services across England, in addition to clearly stating the essential sustainable improvements required within the maternity service at the Trust. They are intended to help with the ongoing repair and restoration of public confidence and trust in maternity services both locally in Shropshire and more widely across England.

36 https://resolution.nhs.uk/2020/07/16/nhs-resolutions-annual-report-and-accounts-2019-20/

Chapter 3

Supporting the families during our review

Three tiers of dedicated family support

The Listening Ear service (Tiers 1 and 2)

3.1 The Listening Ear service, comprising three partner organisations: Bereavement Training International, Child Bereavement UK, and SANDS, was commissioned directly by the review team to be available for all families involved in this review. We recognised that the experience of families coming forward and their case being discussed and revisited with them would reignite difficult and painful feelings.

3.2 Key objectives of the Listening Ear service were as follows:

- To offer a support service, not a counselling service, providing in most cases a one-off listening ear session to families.
- To act as a second tier sign-posting service, providing details of national and regional support services for ongoing or specialist support.
- To provide onward referral to a dedicated team of psychologists offering specialist psychological support (Tier 3) where appropriate, or if requested by the family.

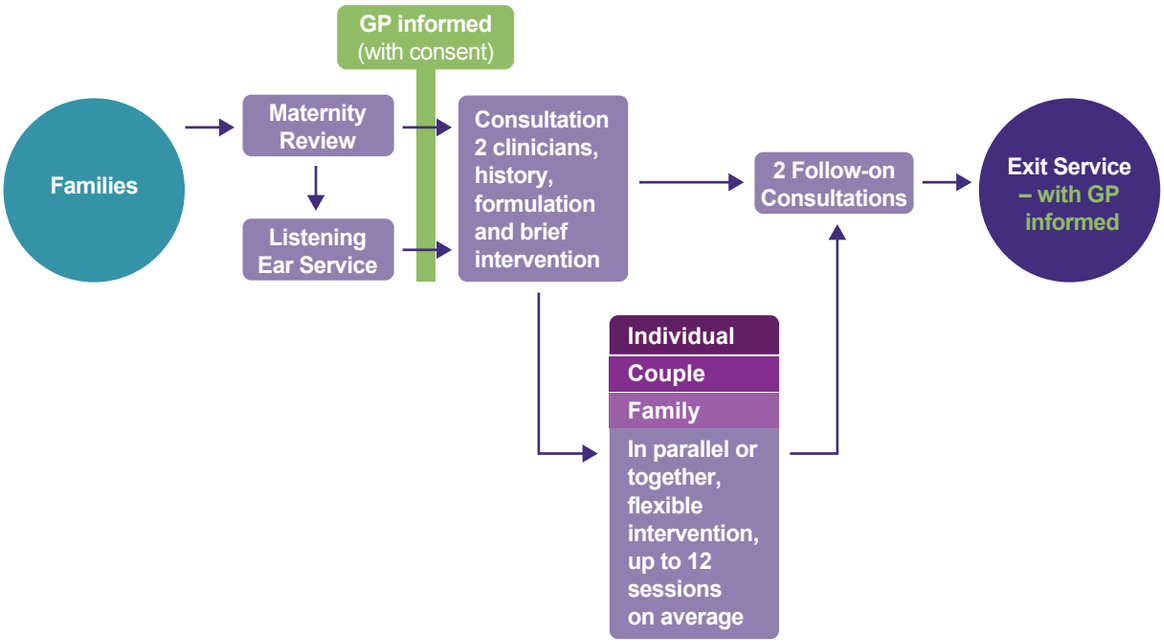
Specialist psychology service (Tier 3)

3.3 As the review team began meeting with families to review their adverse maternity experiences the Chair of the review identified that further support was needed for some families. There was recognition of a gap in service provision for those with complex grief, trauma and emotional distress. This service was beyond the scope of primary care services, but in most cases would not reach the criteria for secondary mental health services. Working in collaboration with the local clinical network and other system-wide stakeholders a specialist psychology service, hosted by Midlands Partnership NHS Foundation Trust (MPFT) and commissioned by NHS England and Improvement (NHSE&I) was established. This dedicated service was designed for families to benefit from an experienced clinician "front-loaded" model, differing from existing services which deliver a stepped model of care.

3.4 A consultant psychologist-led team was recruited to work on a flexible, and at points due to the COVID-19 pandemic remote, basis which also enabled access for those families now living out of the area. Face-to-face provision was also available to any families requesting this, where possible. The duration of support was planned for an 18 month to two year period, with key stakeholders and related care pathways across the local system involved in active, regular review of the emerging clinical data, in order to develop clear plans for transition into relevant care-pathways at the conclusion of this time-limited provision. Extension of the service beyond this timeframe for a period of 3-6 months, to the end of 2022 has recently been requested, in anticipation of the increase in demand following publication of the final report and as families begin to process its findings.

3.5 Access to the specialist psychology service has been via the maternity review team and the Listening Ear service. All families referred were offered a minimum of two consultations (an initial appointment, with the offer of 1-2 subsequent sessions as required) with two psychologists, providing them with an opportunity to feel that their experiences had been listened to and heard. Through embedding this model it was

anticipated that many families would be able to receive support and sufficient intervention at the point of consultation: promoting a positive, strengths-based model, acknowledging the resources families had drawn upon, often over many years, in their own lives to cope with what they had been through. The option of further intervention sessions with two clinicians provided the versatility of either two clinicians working with the whole family, or different parts of a family working in parallel with a different clinician. This model was designed specifically with the importance of continuity of care in mind, in order that families would not have to repeat their story. The diagram below provides an overview of the offer:



3.6 Where initial consultations indicated the need for further psychological interventions, families have been offered a range of NICE recommended treatments based on the individual formulation of their experiences. Treatments have included trauma-focussed Cognitive Behavioural Therapy[37] or CBT, Eye Movement Desensitization and Reprocessing or EMDR[38], couples therapy, and family or systemic interventions. The quality and effectiveness of these interventions has been routinely measured with the use of validated outcome measures, and bespoke client experience measures.

3.7 From the outset the specialist psychology service was developed with a clear exit strategy, remaining responsive to the needs of families, but with the flexibility to adapt the delivery and type of interventions as appropriate, given the time available. Communication with the families has been transparent to explain the scope, access and duration of the service, and with stakeholders preparing for the transition to relevant care pathways both within the NHS and wider local system at the close of this specialist provision.

3.8 Family feedback to the service has highlighted the importance to them of having a dedicated team of specialists with specific knowledge and expertise in the psychological impact of adverse maternity experiences. In particular families have valued the ease of access to the service, with an absence of waiting lists or restrictive referral criteria. Families have also reported how important to them it has been to have the experience of being listened to, understood, and believed, offering the opportunity for a restorative experience of compassionate care.

37 See glossary

38 See glossary

In conclusion

3.9 The provision of a comprehensive package of emotional and specialist psychological support available to all families involved in the review process has been central to helping them navigate the profoundly significant and potentially very painful process of their adverse maternity experiences being reviewed. Many families will have found their maternity experiences to have been life-changing, involving many layers of distress and trauma, with the ripple effects felt by whole families, the wider community, and across generations. The availability of dedicated expert support has meant that families have not had to manage this latest process alone, and have been empowered to have the opportunity to reflect on and understand what they have been through, with professionals committed to facilitating this with care and compassion.

3.10 It is strongly recommended that should any review or investigation be required in the future, this model of family support should be used to inform good practice, drawing on what has been learnt with regards to procedures, protocols and pathways. Above all, there must be recognition that any review of this nature will inevitably impact on those involved, and that the provision of emotional and psychological support should be integral to how the system responds to this need.

LOCAL ACTIONS FOR LEARNING: SUPPORTING FAMILIES AFTER OUR REVIEW IS PUBLISHED

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

3.11 Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.

3.12 There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area.

Section 2

Internal oversight and external scrutiny

- Background information about the Trust
- Chapter 4. Clinical governance
- Chapter 5. Clinical leadership
- Chapter 6. Our findings following review of family cases

Background information about the Trust

Service overview

3a.1 The maternity service at the Trust is provided as a 'hub and spoke' model with a consultant-led maternity unit surrounded by various midwifery-led units within the Shropshire region.

3a.2 The consultant maternity unit was originally based at the Royal Shrewsbury Hospital site (RSH) until 2014 when consultant-led services were transferred to the Princess Royal Hospital (PRH) site at Telford. Throughout the years there have been a number of midwifery-led units, however some of these are temporarily or permanently closed for intrapartum care due to operational reasons. The current five midwifery-led units are based at Royal Shrewsbury Hospital, the Princess Royal Hospital Telford (the Wrekin unit), Bridgnorth, Oswestry and Ludlow. At the time of publication of this report, the only midwifery-led unit providing intrapartum care is the Wrekin unit co-located (or alongside unit) at the PRH in Telford. There are additional community bases at Whitchurch and Market Drayton.

Geographical area

3a.3 The geographical area covered by the service is approximately 2,500 square miles (including the local authority areas of Shropshire, Telford and Wrekin and parts of mid-Wales). A significant amount of the catchment area is rural; this is likely to be a contributing factor to the number of midwifery-led units within the region and the Trust's ongoing community midwifery service provision.

Birth rate

3a.4 The birth rate figures below have been extracted from the Trust's maternity dashboard and are based on financial years (April - March). The birth rate is gradually decreasing; whilst a proportion of this change is recognised as being in line with the national birth rate, some staff also shared concerns with the review team that women are choosing to give birth elsewhere within the region, rather than at the Trust. One staff member told the review:

'We have a lot of women who come under the Trust's locality but they are choosing to birth elsewhere because they do not want to go there.'

Table 1. Annual birth rate at the Trust 2008 – 2020

	YEAR											
WARD	**08/09**	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**	**19/20**
Shrewsbury MLU	503	478	550	478	421	367	235	207	140	120	69	15
Wrekin MLU	477	488	436	435	401	362	336	359	338	351	285	224
Bridgnorth MLU	86	59	98	69	68	75	68	82	75	26	4	0
Ludlow MLU	100	77	81	86	71	62	49	51	37	12	4	0
Oswestry MLU	90	82	83	87	72	74	69	83	46	15	4	0
MLU Totals	1256	1184	1248	1155	1033	940	757	782	636	524	366	239
Home Births	92	90	96	86	91	86	82	63	63	68	75	56
BBA Other	15	11	19	18	21	8	19	14	25	3	8	41
MLU Totals plus Home Births	1348	1274	1344	1241	1124	1026	839	845	699	592	441	295
All Non CU Births (MLU+Home+BBA)	1363	1285	1363	1259	1145	1034	858	859	724	595	449	336
Shrewsbury/Telford CU	3871	3965	3856	3983	4009	3978	3796	4001	4204	4060	4062	4086
TOTAL BIRTHS	**5234**	**5250**	**5219**	**5240**	**5154**	**5012**	**4654**	**4859**	**4928**	**4655**	**4511**	**4422**

Reference: Shrewsbury and Telford Hospital NHS Trust Maternity Dashboard

Demographic

3a.5 The term demographic refers to the structure of a population including (but not limited to) factors such as age, ethnicity, employment and education status. Data was available from a variety of sources including local data from the Trust, as well as large-scale reports such as the Indices of Deprivation[39]. Now more than ever, it is recognised that women from black and ethnic minority backgrounds, and women living in areas with higher rates of social deprivation, are at increased risk of maternal and neonatal morbidity and mortality[40]. Therefore, the continual monitoring of the local demographic is vital in terms of ongoing planning and provision of maternity services[41].

3a.5 The use of electronic maternity information systems (MIS) is now standard in most maternity units in England. However it is important to acknowledge that MIS data is at times incomplete, sometimes because of incomplete data capture as well as individual user input error. Missing data can also be attributed to the constraints and designs of data capture systems, however this is likely to improve with the ongoing development of electronic maternity information systems. It has been recommended that quality improvement indicators should incorporate metrics on data completeness[42].

Ethnicity

3a.6 The majority of women receiving maternity care at the Trust were reported to identify as white British[43]; whilst approximately 10 per cent of the maternity population identified as originating from a Black, Asian or Minority Ethnic background, (BAME) in comparison to a national average of 19-22 per cent[44].

3a.7 Unfortunately, there were 9,276 missing ethnic background details within the data provided by the Trust, which accounts for approximately 9 per cent of the overall data throughout the timescale of the review. It is also evident that the trend of incomplete data on ethnic background is increasing in recent years (Figure 1). The incomplete datasets are also recognised within the Trust's annual perinatal mortality reports between 2013 and 2018[45].

3a.8 Consequently, there are limitations with regard to the correlation of any trends or themes directly linked to ethnicity. However, due to the evidential links of poor maternal and neonatal outcomes of women from ethnic minority backgrounds, as previously stated, it is suggested that all trusts should aim to improve the accuracy of their datasets as part of quality and safety monitoring. Research suggests this is achievable with the use of self-declaration within maternity booking systems[46].

39 Ministry of Housing, Communities and Local Government (2019) 2019 Indices of Deprivation – Telford and Wrekin. https://www.telford.gov.uk/download/dowidnloads//15603/index_of_multiple_deprivation_2019_-_telford_and_wrekin.pdf

40 Knight, M., Bunch, T., Tuffnell, D., Patel, R., Shakespeare, J., Kotnis, R., Kenyon, S. Kurinczuk, JJ. (Eds.) on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19*. (2021) Oxford: National Perinatal Epidemiology Unit, University of Oxford.

41 NHS England and NHS Improvement. *Equity and equality. Guidance for local maternity systems*. (2021) https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf

42 *National Maternity and Perinatal Audit Clinical Report 2017* https://maternityaudit.org.uk/downloads/RCOG%20NMPA%20Clinical%20Report(web).pdf

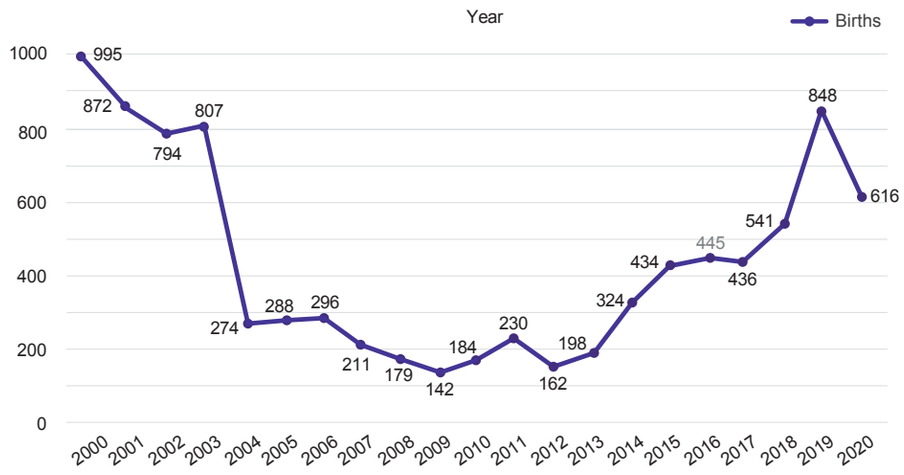
43 Shrewsbury and Telford Hospitals NHS Trust (2020). Deliveries by Ethnic category and age – 2000-2020.

44 MBRRACE-UK. *Perinatal mortality surveillance report for births* (2013-2018)

45 Ibid n7

46 Jardine, JE., Fremeaux, A., Coe, M., Urganci, IG., Pasupathy, D. and Walker, K. *Validation of ethnicity in administrative hospital data in women giving birth in England: cohort study* (2021) British Medical Journal Open, 11(8). doi: https://doi.org/10.1136/bmjopen-2021-051977

Figure 1. Number of records with incomplete ethnicity data at the Trust 2000 – 2020



Reference: Shrewsbury and Telford Hospital NHS Trust[47]

Age

3a.9 The lower and upper ranges of maternal reproductive age are recognised as a risk factor for adverse outcomes in pregnancy. Although research is limited, evidence suggests younger mothers are at increased risk of various complications including preterm birth and are more likely to have a baby with a low birth weight[48]. Mothers of advanced maternal age are recognised to be at greater risk of complications including pre-eclampsia, preterm birth, stillbirth and neonatal morbidity and mortality[49].

3a.10 Upon analysis of national data for younger mothers, it was observed that the age parameters for 'teenage pregnancy' vary. Whilst the Office for National Statistics (ONS) collates data on conception rates of women aged 15 to 17 years old, national reports into perinatal morbidity and mortality categorise 'teenage' pregnancies as mothers under 20 years old[50]. It is therefore not possible to correlate national teenage pregnancies with perinatal morbidity and mortality.

3a.11 Data from the Trust was compared with data from the ONS to identify whether there was a greater incidence of teenage pregnancies, and pregnancies to women of advanced age, within this review than the national average.

3a.12 The review team noted the Trust predominantly covers two local authority areas, Shropshire as well as Telford and Wrekin. Although the local rates of conceptions to younger mothers have fallen in line with the national average, within Telford and Wrekin teenage conception rates were consistently higher than the national average throughout the timescale of the review (Figures 2 and 3). These findings are also recognised within the Trust's annual perinatal mortality reports[51].

47 Ibid n6

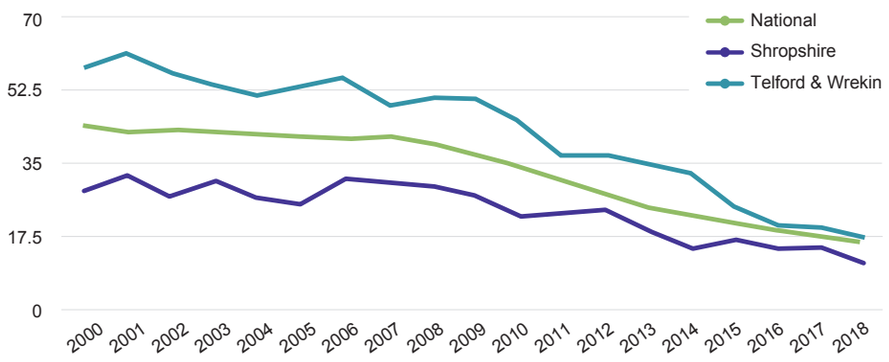
48 World Health Organisation. *Adolescent pregnancy.* (2020) https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

49 Royal College of Obstetricians and Gynaecologists. *Induction of Labour at Term in Older Mothers.* (2013) https://www.rcog.org.uk/globalassets/documents/guidelines/scientific-impact-papers/sip_34.pdfe

50 Ibid n3

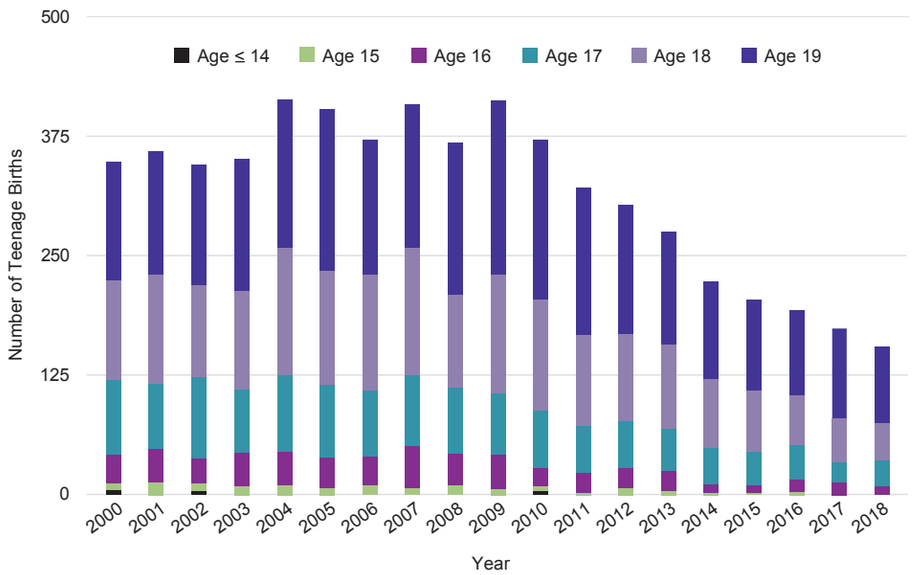
51 Ibid n7

Figure 2: Aged 15 – 17 years of age conception rates per 1000 women



Reference: ONS[52]

Figure 3: Number of teenage births (mothers under 20) at the Trust



**Data from 2019 and 2020 are not reported due to the observed discordance of the annual birth rate reported within the maternity dashboard and birth rate stratified by maternal age provided by the Trust*

Reference: Shrewsbury and Telford Hospital NHS Trust[53]

3a.13 Despite there being a higher proportion of teenage pregnancies at the Trust than the national average, teenage pregnancy cases within the review population (i.e. with adverse outcomes) comprise only 6.4 per cent of cases, which is comparable to the overall proportion of teenage pregnancies at the Trust during the timescale of the review. Consequently, the review team concluded that the increased rate of adverse outcomes observed in the Trust against the national average is unlikely to be due to teenage pregnancies.

3a.14 The incidence of women with advanced maternal age was found to be less than or similar to the national average during the timescale of the review[54]. The lower parameter of advanced maternal age is 35 years old, above which there is a statistically significant increase in the risk of stillbirth and other adverse outcomes

52 Office for National Statistics. *Conceptions in England and Wales:* 2018. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2018#conceptions-by-area-of-usual-residence

53 Ibid n6

54 Ibid n7

listed above. The proportion of women with advanced maternal age at the start of the review was 15 per cent in 2000 and gradually increased to 20 per cent in 2007, after which the proportion did not increase further. This was noted to be in line with national rates of maternities for women aged 35 years and over[55]; therefore, it should not disproportionately affect morbidity and mortality rates at the Trust.

Deprivation

3a.15 Similarly to ethnicity, social deprivation is recognised to be a significant risk factor for morbidity and mortality. MBRRACE-UK reports that women living in the most socially deprived areas[56] are three times more likely to die during or within the year that follows pregnancy than those living in the least deprived areas. Deprivation rates are monitored throughout the country by the assessment of factors such as income, employment, education, living environment, crime, health and barriers to housing.

3a.16 Throughout the time period of the review, a proportion of the geographical area covered by the Trust was regularly ranked within the top 10 per cent of the most deprived areas within the country[57]. Despite this, due to other areas within the region being classified as the 'least deprived', annual perinatal mortality reports consistently highlight the levels of deprivation as similar to the national average[58], therefore morbidity and mortality rates should not be disproportionately affected.

3a.17 The overall conclusion of the review team was that the ethnicity data (though incomplete), the deprivation rates, and the maternal age distribution for the Trust should not have caused any disproportionate effect on morbidity and mortality rates at the Trust when compared with the national average.

55 Office for National Statistics. *Birth characteristics in England and Wales:* 2019. (2020) https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthcharacteristicsinenglandandwales/2019#age-of-parents

56 Ibid n3

57 Ibid n2

58 Ibid n7

Chapter 4

Clinical governance

Introduction

4.1 In line with the terms of reference of the review, this chapter aims to explore whether the local governance within maternity services at the Trust met the standards that would be reasonably expected of it between 2000 and 2019. In doing this, the review team examined a broad range of governance documents supplied by the Trust including, but not limited to, risk management documentation, minutes of meetings, job descriptions, incident notifications, investigation reports, policies, guidelines, audits and complaint responses.

4.2 Whilst acknowledging that the review covers a considerable time frame, and taking account of the fact that governance requirements changed over time, the review team found that the working practices and prevailing attitudes within the maternity service and the maternity governance team at the Trust did not pay sufficient attention to the safety of mothers and babies.

4.3 The key themes identified requiring improvement within maternity services at the Trust were:

- The poor quality of incident investigations
- Poor complaints handling
- Local concerns with statutory supervision of midwifery investigations
- Concerns with clinical guidelines and clinical audit

1. Quality of incident investigation

Background and historical context of incident investigation.

4.4 The definitions and processes for reporting and investigating incidents have changed throughout the time period of the review and therefore the review team has been careful to examine how the Trust reported and investigated incidents in relation to the expected standards at the time.

4.5 A patient safety incident is any unintended or unexpected event which can, or does, lead to harm for one or more patients receiving healthcare[59]. In 2003 the National Reporting and Learning System **(NRLS)**, which is a central database where trusts report incidents, was created and thereafter the culture of reporting incidents to improve safety in healthcare improved nationally. Serious Incidents **(SI)** are acts or omissions in care that results in unexpected or avoidable death or serious harm: 'where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified'[60] to prevent it from occurring again. However it was not until 2010 that a nationally consistent definition of what constituted a SI was published and the use of a specific methodology, Root Cause Analysis[61] **(RCA)**, was recommended for conducting these investigations[62].

59 NHS England, *Report a patient safety incident* https://www.england.nhs.uk/patient-safety/report-patient-safety-incident/

60 NHS England, *Serious Incident Framework*, (2015) https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf

61 See glossary

62 National Patient Safety Agency *National framework for reporting and learning from serious incidents requiring investigation.* (2010) https://www.afpp.org.uk/filegrab/NPSAconsultationdocument.pdf?ref=1064

4.6 In our first report, we identified some of the key issues from the 250 cases we reviewed, which included inconsistent multidisciplinary input to SI investigations which were often cursory and did not identify underlying systemic failings, and failed to learn lessons. In fact we found that some significant cases of concern were not investigated at all.

4.7 Having now considered the care of all families included in the review, in addition to the aforementioned cases for our first report, the review team has identified the following concerns regarding governance in maternity services at the Trust:

a) Incidents that should have triggered a Serious Incident investigation were inappropriately downgraded to a local investigation methodology known as a High Risk Case Review **(HRCR)**, apparently to avoid external scrutiny.

b) When serious incident investigations were conducted many were of poor quality.

c) There was a lack of learning and missed opportunities to improve safety.

d) There was a lack of oversight of serious incidents by the Trust's commissioners.

e) There were repeated persistent failings in some incident investigations as late as 2018-2019.

a. Incidents that should have triggered a serious incident investigation were inappropriately downgraded to a local investigation methodology known as a High Risk Case Review (HRCR), apparently to avoid external scrutiny

4.8 The review team has found a concerning and repeated culture at the Trust of not declaring adverse outcomes as an SI in line with the national framework. Instead, they were inappropriately downgraded and investigated by what the Trust termed a High Risk Case Review (HRCR). This method of investigating incidents, created by the Trust, was less robust, varied considerably in quality and lacked the rigour and transparency of an SI investigation. Notably, HRCRs were not reported to NHS England, the Clinical Commissioning Groups **(CCGs)** or the Trust Board, and therefore avoided external scrutiny.

4.9 In October 2021 during the 'staff voices' 'interviews the review team asked a member of staff for the circumstances in which the HRCR process started appearing within the Trust's local investigation process they responded:

4.10 *One year we were criticised for over-reporting too many Serious Incident investigations. This raised a red flag with the CCG, or the PCT or whatever it was at the time, and they said you've got an awful lot of SIs. We looked back at them and when they were reviewed again, it was decided was that some of them shouldn't have been reported as SIs, we were over-reporting. In our mind these are cases that needed significant review, so we designated them as a High-Risk Case Review, where we will spend quite considerable time looking at them and examining them and trying to learn from them because they are important, but they didn't hit the SI criteria.'*

4.11 The review team saw that frequently an early assessment was made by the maternity service that there was no act or omission in care, which meant that the investigation was downgraded to a HRCR. This meant that the true scale of serious incidents within maternity services at the Trust went unknown over a long period of time.

4.12 The earliest version of the maternity service's Risk Management Strategy available to the review team, version 5, June 2010, correctly defines a Serious Incident (or what was then termed a Serious Untoward Incident) in line with the national guidance[63] and, within section 8.7, includes a clear list of maternity-specific categories that must be investigated as an SI. This list included but was not limited to:

- Maternal death (booked at The Trust and who died up to 1 year following delivery)
- Intrauterine death: over 37 weeks gestation and during an inpatient admission
- Intrapartum death: specifically those that die during labour or during an inpatient admission

63 Ibid n4

- Unexpected neonatal death: from 37 weeks gestation to 28 days post delivery
- Maternal unplanned admission to ITU
- Unexpected admission to NICU: where APGARS[64] are below 4 at 10 minutes and/or the baby has already required intubation.

4.13 Section 8.7.1 said: 'Arrangements for ensuring that all Serious Untoward Incidents undergo a root cause analysis', explains that within the maternity governance meeting 'a decision is made to whether a high risk case review is needed'. Within the document, there is no definition of what an HRCR is. In Version 6.1 from March 2014, section 9.2.9 states that an HRCR will be conducted for those cases 'where there is a poor outcome, patient experience or near miss not fitting the Serious Incident criteria. This additional scrutiny will be an opportunity for transparency, learning and service enhancement'.

4.14 The review team however, found many examples of families who met the criteria to have a full SI investigation, but had an internal HRCR conducted instead. For example, between 2011 and 2019 there were a number of maternal deaths, stillbirths, neonatal deaths and babies born with HIE where an HRCR was conducted. Where these cases correctly underwent a SI investigation, rather than an HRCR, the subsequent investigations were often found by the review team to be of poor quality. Examples of this are found throughout this chapter and other clinical chapters in this report.

4.15 This practice of conducting an internal HRCR when an SI was required is illustrated by a family in **2015**. This involved a baby born by instrumental delivery, which clearly fell outside national guidelines (this delivery occurring with 10 pulls of three sequential instruments). This baby suffered significant skull fractures, brain injury and has ongoing long-term disabilities as a result. Despite this meeting national SI criteria as an act or omission in care which resulted in serious harm[65], the decision was made to conduct an HRCR instead. The HRCR did follow an RCA approach but the quality of the investigation was poor. It did not involve the family, did not identify the root causes but instead concentrated on the incidental findings and the mitigations. Seemingly, the action plan did not offer any learning to the Trust so that similar incidents were prevented from happening again in the future.

4.16 In a typed transcript provided to the review team by the Trust, of a recording of the meeting at which the decision was made to undertake an HRCR instead of an SI for the case of this family, it is stated that an HRCR approach was utilised because *'A high risk case review has a very similar process, but it doesn't get reported to our non-executive, Health England and Tom, Dick and Harry… an SI gets reported all over the patch as far as I can see...'* This approach was taken despite the fact that following its 2014 visit the CQC highlighted its concern to the Trust about an under-reporting of SIs in maternity. There is also evidence from the same meeting that some individual members of staff present were not happy with how the investigation process was being run, with one attendee, (a staff member) insisting that the meeting was recorded. They said: *'My experience of the way that some of the investigations have been run have led me to believe that I should record this'.*

4.17 From the documentation supplied to us by the Trust the review team has been unable to identify when the Trust started using HRCRs or why they were implemented but the 2014 Maternity and Risk Management Strategy, version 6.1 stated that their aim was to *'establish a clear and complete chronology of what happened on the date of the incident and any preceding events that could have impacted on the outcome for the family'.* This is too narrowly focused and so, in many cases, an HRCR failed to identify why the incident occurred, meaning that many learning opportunities were missed. Confusingly, the HRCR investigations often used phrases such as 'Root Cause Outcome', 'RCA meeting' and 'RCA discussion', when in fact a root cause analysis was often not performed. Failing to do this properly meant that families were not given the answers they sought and deserved, the Trust did not identify the underlying issues that led to the incident occurring, and lessons were not learnt, so increasing the risk of further harm to families under the care of the Trust.

64 See glossary

65 Ibid n2

b. When Serious Incident Investigations were conducted many were of poor quality

4.18 When an SI was declared and a full RCA was conducted the quality of the reports was better than for the HRCRs, however many were still not of the standard that would have been expected. The review team has described the specific omissions with regards to serious incident investigation within the chapter on maternal deaths, however the review also found similar themes when assessing other serious adverse outcomes.

4.19 The Royal College of Obstetricians and Gynaecologists **(RCOG)** undertook an Invited Review of maternity services at Shrewsbury and Telford Hospital NHS Trust on 12–14 July 2017. This identified that the Trust's process of investigating SIs was complex and failed to adhere to recommended timescales; in one case reviewed by the RCOG team some 8 months after a stillbirth the report was still incomplete. The RCOG team also identified that the Trust's internal team conducting the investigations was not appropriately resourced or trained in RCA methodology. It also identified that there was no culture of shared learning, that the RCAs often focused on the wrong issues, lacked system wide actions and focused instead on non-specific actions such as 'share report widely' and 'learn from events'. There was no documentation that action plans were completed and recommendations often focused on individuals, rather than recommendations for system changes.

4.20 The Ockenden review team has found similar failings to those identified by the RCOG team in 2017 including long waits for families to be given answers, investigations that focused on describing what happened rather than why, a focus on individual errors rather than systemic issues, and actions that were unlikely to prevent recurrence.

4.21 *A young mother in **2013** had what the RCA described as a 'prolonged pregnancy with intrauterine death' but failed to examine why this occurred and missed causative factors identified by the review team such as lack of fetal monitoring for 15 hours during the induction of labour process. The review team also identified terminology in the Trust report which could be seen as imparting blame on the mother, suggesting that 'patients liked to be left to sleep', putting the emphasis on the mother for not reporting fetal movement concerns, rather than assessing why there was a lack of fetal monitoring. The RCA recommended that fetal viability should be assessed at least once per shift and the Maternity Governance meeting (06.08.13) 'Confirmed with the… manager, [this recommendation was] now embedded in practice and agreed that manager to undertake audit'. The review team however has found no evidence that an audit was undertaken and even within the Trust's 2017 v5.5 Induction of Labour guideline, there is no evidence this practice has been embedded. (2013)*

4.22 *In **2015**, a family did not receive an apology from the Trust, were not involved in the investigation, were not asked to submit questions and waited over 12 months to find out why they suffered an intrapartum stillbirth. The subsequent report focused on individual errors, for example "educational need for midwife – sticker regarding fetal movements absent" and missed the systemic issues contributing to the incident. (2015)*

4.23 *In **2015**, a family waited more than 9 months for an SI to be declared after they suffered an early neonatal death, despite the Trust's 2014 Maternity Service's Risk Management Strategy Version 6.1 stating an SI should have been conducted from the outset. The RCA described the cause of death as a 'sub-acute cord compression leading to acute cord obstruction', but failed to identify why this happened. There was no mention of concerns identified by this review team such as a failure to upgrade intrapartum care to a high risk pathway, and staffing issues and shortages meaning that 1:1 care could not be provided. There was also a failure to monitor the fetal heart rate adequately. This lack of attention to the root cause of the incident meant the systemic issues related to why the incident occurred were not identified and the recommendations that were made did not address the systemic issues within the Trust's maternity services at the time. (2015)*

4.24 In later years there is evidence of improvement in the quality of some SI investigations. In **2017**, a family suffered a similar incident to earlier cases, namely an intrauterine death whilst awaiting an induction of

labour in hospital. The RCA identified multiple systemic and organisational issues resulting in a delay in transferring the mother to the labour ward. The recommendations focused on addressing the issues that created the delay, for example the closure of triage at 8pm putting additional pressure on the labour ward, and how these could be addressed. The report also highlighted that there was *'a culture of normalising long waits for women undergoing induction of labour, who are ready to be transferred to the delivery suite [labour ward] when the delivery suite is busy'*. It should be acknowledged that this was highlighted and multiple recommendations were focused on making improvements. However the review team is of the opinion that the poor investigation of the earlier incident from 2013 represents a missed opportunity to improve and to potentially prevent future incidents, such as this incident in 2017.

c. Lack of learning and missed opportunities to improve safety

4.25 Once investigations were conducted the review team still found there were multiple missed opportunities for the Trust's maternity service to learn, improve and prevent future harm occurring to other women and babies.

4.26 There have been some attempts to improve the safety culture and learn from incidents. In June 2017 the Trust conducted an internal review[66] of maternity services. It considered the history of maternity services between 2007 and 2017, focussed on issues of patient safety, learning, and engagement with bereaved parents. The report further stated that the service must 'create a coordinated approach to the maternity safety improvement plan' and that 'safety in maternity is protected by the efforts of the staff and supported by leaders'. The review concluded that 'all patient safety actions should be in one plan against a framework that makes sense to the staff that run the service'. As of January 2022, the review team has not been provided with this action plan or seen any evidence of its existence in the information provided by the Trust and therefore we cannot comment on the efforts made and any impact of this plan in improving learning and safety at the Trust.

4.27 *In **2010** a woman developed chorioamnionitis[67] and the baby was born in a poor condition, requiring cardiac massage, and subsequently developed brain damage. At the time there was no incident report completed, no review of the care provided, no investigation performed and therefore no learning. In 2018, the Trust asked external experts to review the care provided to the family and they found that the CTG heart monitoring was abnormal for most of the duration of the labour and that there was a lack of obstetric reviews despite midwifery concerns. Oxytocin was started and increased inappropriately when the CTG was abnormal and was also increased despite hyperstimulation in the second stage. They also found that there was a long period of fetal bradycardia not acted upon, and despite performing an instrumental delivery with meconium present the neonatal team were not called to be present at the delivery. This was not one failing in care, but multiple failings. What is clear from the intrapartum section of this report is that issues with the inappropriate use of oxytocin, amongst other failings identified in this case, did continue after 2010.*

4.28 *The lack of investigation in **2010** for a family resulted in a missed opportunity to learn and, due to this it is likely to have resulted in similar situations occurring to other women. Also concerning is that the family were seen a week after the birth of their baby by an obstetric consultant who explained that 'You made good progress in labour and had a very straightforward ventouse delivery for delay in the second stage of labour. Your baby's condition was much unexpected… what is very confusing is that the continuous heart rate monitoring that was performed during labour did not show any signs of your baby becoming distressed and this is unusual'. This was either an unintentional misunderstanding of the clinical situation or a purposeful lack of transparency and honesty. Either way, this follow-up and review was not fit for purpose. The poor governance processes at the time meant that this family waited 8 years to find out there had been significant failings in care that led to their child suffering brain damage. (2010)*

66 Review of Maternity Services 2007 – 2017 by Colin Ovington, on behalf of the Quality and Safety Committee, dated 27th June 2017, provided to the review team by the Trust

67 See glossary

4.29 The review team also found evidence, over many years, of how a failure to investigate harm appropriately at the time meant learning opportunities were missed and subsequently led to other women suffering similar harm. The following three examples over a 12-year period demonstrate exactly this:

4.30 *Firstly, in **2006** a child was born with brain damage (HIE) after the mother developed an infection (chorioamnionitis) due, in part, to multiple inappropriate vaginal examinations after her waters had broken before she was in labour. No investigation was done, no learning identified and therefore no actions were taken to prevent a recurrence. (2006)*

4.31 *Secondly, in **2011** a child developed multiple long term disabilities secondary to inappropriate care in a similar situation (waters breaking before labour). Despite the baby spending 23 days on the neonatal unit there was no investigation performed and again, a missed opportunity for learning. The Trust acknowledged at the time that the 2004 guideline followed at the time was inappropriate and 'very out of date'. Nevertheless, it was still not updated for another three years until 2014. (2011)*

4.32 *Thirdly, in **2015** a very similar incident occurred, with repeated unnecessary vaginal examinations despite the woman's waters having been broken for more than 48 hours before labour and this subsequently led to an infection (chorioamnionitis) and a poor outcome for the baby This poor outcome could potentially have been prevented had investigations been conducted in previous years following competent and appropriate multi-professional governance processes by a team with a willingness to learn. (2015)*

4.33 *In **2016**, the Trust had a second opportunity to review the care provided to a family but this opportunity was again missed. The mother initially made a complaint but after receiving an inadequate response from the Trust, contacted the Parliamentary and Health Service Ombudsman (PHSO[68]), who conducted a review in 2018 and identified failings in care. It was only at this point, three years after this third incident, that the Trust created an action plan to reduce the likelihood of recurrence in the future. The review team however has been unable to find any clear evidence from the information supplied to us by the Trust that the change following the PHSO report has been implemented. (2016)*

4.34 Sadly, the review team encountered many further examples of repeated missed opportunities to learn:

*In **2009** a baby born at the Trust was admitted to the neonatal unit with severe hypoxia and suspected HIE. The baby subsequently died within 12 months of birth due to complications from severe cerebral palsy. There was no investigation performed after the baby was admitted to the neonatal unit with HIE and a missed opportunity for improvement. After the birth the parents met with two consultants who could not identify what went wrong and decided against asking for an external investigation. (2009)*

4.35 *In **2010**, the Trust had a further opportunity to review this case after receiving a complaint letter from the family. However the family have explained to the review team that this response lacked sympathy and compassion and again did not identify any failings in care. The issue of a lack of learning is multi-professional and the neonatal team did not review the care they provided either. Subsequently a letter to the GP from the consultant obstetrician explained that the labour care was 'appropriate' and nothing could have been done differently.*

4.36 *It was only after a second complaint response in **2017**, with a new Chief Executive at the Trust that an external investigation was conducted. In 2018, 9 years after the initial incident occurred, an investigation*

68 See references – various documents on PHSO consulted for this chapter inc:

1. Parliamentary and Health Service Ombudsman (PHSO). Learning from mistakes. 2016.
2. Parliamentary and Health Service Ombudsman (PHSO). A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged. 2015.
3. House of Commons Public Administration and Constitutional Affairs Committee. Will the
4. NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England. 2017.

identified multiple failings, substandard care and that the delivery should have been sooner. Despite the long delay and the multiple failings, the review team could not find any evidence that this report was shared with the family.

4.37 *In **2011** a woman was inappropriately discharged home with severe pre-eclampsia and subsequently had an eclamptic seizure within 24 hours. No incident form was completed, no investigation occurred (2011)*

4.38 *A mother at 36 weeks gestation with diabetes whose antenatal CTG was persistently abnormal for 3 days whilst in hospital, which should have prompted delivery, was discharged home without a plan in place and subsequently her baby died (2011)*

4.39 In the second case above the review team found the care provided to the mother to be significantly suboptimal, however only a cursory internal review was conducted, (notably the CTGs had disappeared) and no clear recommendations for improvement were made.

4.40 The review team also identified that many governance documents between 2009 and 2019 included the following inappropriate images. These images were found on multiple SI reviews, HRCR reviews, minutes of maternity governance meetings, quarterly maternity safety reports, patient safety events, feedback of learning documents and an external letter to the ambulance service. The review team felt that having such images on governance documents was insensitive and demonstrated a lack of professionalism.

d. Lack of oversight of Serious Incidents by the Trust's commissioners

4.41 When an SI investigation is completed locally, it is reviewed by the local Clinical Commissioning Group (CCG) for approval and closure if the investigation and action plan are deemed appropriate. Previous national reports have highlighted concerns that despite closure of incidents, once external scrutiny is applied to the original investigations they are often found to be of poor quality, thereby questioning the oversight of commissioners in this process[69]. The review team also identified extensive and repeated concerns with the quality of SIs undertaken by the Trust, which may indicate a lack of external scrutiny.

4.42 The Telford and Wrekin, and Shropshire, CCGs undertook a review of the Trust's maternity services which was published in 2013 and found the Trust was *'a safe and good quality service, which is delivered in a learning organisation'*[70]. The commissioners' review of risk management focused on reported SIs and near misses in the period 1 April 2012 to 31 March 2013, which was likely to have underestimated the scale and volume of incidents. It also looked at policies, clinical governance systems, care pathways, and training, and concluded that: *'There was an openness and transparency in reporting and investigation culture,*

69 *Magro M, Learning from five years of cerebral palsy litigation claims.* (2017) NHS Resolution https://resolution.nhs.uk/wp-content/uploads/2017/09/Five-years-of-cerebral-palsy-claims_A-thematic-review-of-NHS-Resolution-data.pdf

70 Telford and Wrekin Clinical Commissioning Group, Shropshire Clinical Commissioning Group, *Maternity Services Review: The Shrewsbury and Telford Hospital NHS Trust* (2013) https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MTU5OTY%3D

which has led to a higher reporting of serious incidents than would have been reported elsewhere'. The review stated further *'There is a robust approach to risk management, clinical governance, and learning from incidents'.* The review team has identified failings in a lack of incident reporting, low levels of SIs being declared, poor quality RCAs and investigations where lessons are not learnt and further harm is caused at the same time. These failings beg the question as to whether the CCG review process was fit for purpose.

e. Persistent failings in incident investigations as late as 2018-2019

4.43 The Trust shared with the review team a selection of self-selected maternity incident investigations from 2019 which the Trust entitled 'Saves and Learning.' These maternity cases were submitted to the review team with the aim of demonstrating improvements in maternity investigation methodology during the latter years and as examples of good practice. There were 12 cases in total. The total number of maternity incidents occurring in the Trust during 2019 are unknown. Improvements in investigation processes have been developed since 2018 and there is now more focus on learning and feedback in different forums, however what is not clear from the evidence seen by the review team is whether these forums are open to all staff groups and whether staff are enabled and encouraged to attend. Extracts from the Maternity and Neonatal Collaboration Survey in 2018[71] demonstrate that staff felt that feedback from incidents was still not disseminated as well as it could have been *'Ensure feedback from any incidents is clearly communicated to staff to ensure continued staff learning and development'.*

4.44 The 'Saves and Learning' investigations demonstrated improvements in asking families to contribute to investigations, they were asked to forward their concerns and recollections or attend a meeting if preferred. There was also improved oversight of the recommendations and actions at governance meetings and when actions were delayed, the review team saw evidence that there was timely follow up with action leads. However, the review team identified from the small sample provided by the Trust that the local processes needed to be further improved, in particular:

- There was a lack of consistency in the seniority and staff groups that attended the rapid review meetings and the panels did not comprise of staff members senior enough to decide on the level of investigation.
- There was no oversight or accountability from the Director of Midwifery nor the Clinical Director for obstetrics or the consultant lead for risk.
- There was still a reluctance to declare an SI and in most cases a HRCR was still conducted, when an SI would be the appropriate investigation.
- Actions did not always correlate with the findings of the investigation.
- Action plans were monitored by the quality improvement midwife however there was no evidence in the cases reviewed that they were overseen by the senior leadership team. During the staff voices meetings in late 2021 a member from the senior Trust team raised concerns to the review on the suitability of staff who were responsible for quality improvement and safety. They explained that staff were promoted to roles without previous substantive clinical experience and without any means of formal support.
- Significant delays in completing all of the 12 Saves and Learning cases from 2019 that were shared with the review team by the Trust.
- Despite families being asked to contribute to the investigation they were not actively involved or empowered to do so. This is in stark contrast to the recommendations from NHS Resolution[72] that

71 Maternity and Neonatal Collaboration survey 2018, provided by the Trust

72 Ibid n11

women and their families should be actively involved in investigations. Best practice from HSIB[73] shows that with a dedicated focus on actively encouraging families to be involved, 86% of families within maternity investigations will engage with investigations.

- In discussing the safety of the unit and the robustness of governance processes, during the time they worked there, some staff showed a willingness to bring in changes to improve safety in an unsupportive system. When asked if the unit was safe they responded: *'I don't … I don't even know if I can answer that. I felt it was safe on a day-to-day business basis, based on day-to-day firefighting and operational exhaustion from people trying to do the right thing'.*

4.45 Despite the improvements the Trust believes it has made, anonymised extracts from the Maternity and Neonatal Collaboration Survey in 2018 demonstrate concerns by their own staff regarding an unsupportive culture and one of blame following SI investigations. One extract included *'I am concerned that midwives who have made errors are treated badly, one midwife was on the verge of suicide due to the way she was treated in her involvement in a SI. More support and care, counselling and help needed in these situations so that the practitioner is not pushed to breaking point or self-harm from intense pressure.'* Another contributor to the same 2018 survey said: *'senior management in care group or above not understanding real issues. Not learning from mistakes'.*

4.46 These findings by the review team differ from the publicly presented findings of two external reviews; firstly, the addendum to the RCOG Review of Maternity Services on 27 April 2018[74]. The original report, which was more critical, had been completed in 2017, but was not presented to the Trust's Board until an addendum had been prepared which highlighted a much more positive situation with risk management than actually existed. This is discussed in more detail elsewhere in this report. The 2018 addendum to the 2017 RCOG report stated that: *'The Care Group has strengthened its risk management structure, risk management meetings are held regularly and rapid review meetings following incidents are executive led' and that 'RCA investigations follow the NHS Improvement SI Framework'.* Secondly, the 2019 CQC[75] report of maternity services at Princess Royal which felt that *'the service mostly managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service'.*

4.47 Patient safety relies on maternity services receiving appropriate and timely feedback from regulating bodies to ensure improvements can be made and in these examples above the external systems for review and monitoring of the Trust seem to have failed.

2. Poor complaints handling

4.48 Effective local complaints handling is a part of good clinical governance, enshrined in the NHS Constitution[76]. Done well and in a timely manner, a complaint response can provide patients and families with the answers they deserve, allows areas of concern to be identified and can be used to analyse trends to improve services. In Wales[77] the NHS has published extensively on the benefits of complaints to a service. The review team identified that the Trust performed poorly in all of these areas and identified the following concerns:

a) Lack of senior oversight and input into complaints handling and patient experience

b) Lack of openness and transparency.

73 Healthcare Safety Investigation Branch *Annual Review 2020/21* (2021) https://hsib-kqcco125-media.s3.amazonaws.com/assets/documents/HSIB_Annual_Review_Brochure_2020-21_FINAL.pdf

74 Shrewsbury and Telford Hospitals NHS Trust Board Report (2018) outlining the Royal College of Obstetricians and Gynaecologists review of maternity services. https://www.sath.nhs.uk/wp-content/uploads/2018/07/12-RCOG-Report.pdf

75 CQC report provided by the Trust to the review team, site visits were November 2019 and the report published in January 2020

76 NHS Constitution; NHS Complaints Guide, (updated January 2021). https://www.gov.uk/government/publications/the-nhs-constitution-for-england/how-do-i-give-feedback-or-make-a-complaint-about-an-nhs-service [Accessed on 28 October 2021]

77 NHS Wales Using the gift of complaints (2014) http://www.wales.nhs.uk/usingthegiftofcomplaints

a. Lack of senior oversight and input into complaints handling and patient experience

4.49 The review team identified that there was a lack of input from senior members of the leadership team in the writing, review, approval, quality control and trend analysis of complaints. There is no evidence available that the Head of Midwifery, Director of Midwifery and Clinical Director were ever advisory on complaint responses before they were sent to the Trust's Patient Experience Team for the then CEO's signoff. Neither is there any evidence, that complaint themes and trends were analysed and used proactively to improve the service. Even in the latter years of the review period it was unclear what structure was in place for answering complaints and where the accountability lies.

4.50 The review team identified that in 2009, the Trust created a Patient Experience Midwife post. This role was created to provide an effective and timely complaints and claims procedure framework. One of the main objectives of the role was to develop a patient involvement strategy to contribute to the clinical governance agenda and to maternity service development. This role and scope was innovative for the time, however there is no evidence shared with the review team that the objectives of the role were actually ever met. Despite the creation of this role many years earlier there has been no documentation provided of a patient experience strategy or any evidence seen that the Maternity Services Liaison Committee **(MSLC)** or (from 2017) that Maternity Voices Partnership **(MVP)** meetings were included within the terms of reference for clinical governance meetings.

4.51 Whilst the review team acknowledges that the role and job description was forward thinking, the patient experience midwife post lacked the required experience and authority to lead on patient experience, complaints and claims. This meant that from its introduction the post was undervalued. Additionally, it devolved responsibility and oversight from the divisional senior leadership team to members of staff who had no real influence in changing practice.

4.52 Between 2007 and 2013 it appears from information provided by the Trust that complaints were managed between two members of staff who worked part time, one of them a retired member of staff who returned to work one day a week.

4.53 One staff member described the process of responding to a complaint to the maternity review team as: *'[the second midwife] would look up some of the notes or [they] would get information, [they] would start to put a response together and then I would look at it, tidy it up or ask for more information when I came in. The actual complaint came in and we started to look at the notes, look at all the things that had been written down and then talked to the people that were involved in that case. Then from their comments and from what was written and from the patient's letter, we started to investigate what had happened and understand what had happened and then try to put a response together for the patient. Those all had to go, of course, to the Chief Executive office because they all go out in [their] name, not ours'.* There was no evidence that other members of the maternity department contributed, or that responses were reviewed before being sent to the CEO for approval.

4.54 With regards to trend analysis, the review team has seen evidence that complaint trends were identified at maternity governance meetings but there was no evidence that actions were taken to prevent similar incidents occurring. In 2009, the Clinical Director informed the members at the maternity governance meeting about the existence of a separate monthly meeting where complaint themes were discussed and that monitoring of actions would occur at the maternity governance meeting. The review team however has seen no evidence that this forum was ever formed and no evidence of action plans being presented to the governance meeting.

b. Lack of openness and transparency

4.55 There is evidence that complaint responses lacked transparency and honesty, especially with regards to clinical care. The review team has identified families where care was sub-optimal, where different management would likely have made a difference to the outcome, however the complaint responses

justified actions, delays and omissions in care. In addition, they often lacked compassion and in a number of responses it was implied that the woman herself was to blame.

4.56 There are examples of families whose complaint letters were dismissed, only for external investigations, sometimes many years later, to identify failings which should have been evident at the time, had a thorough complaints investigation been conducted.

4.57 *In one example from **2013** a baby was born in a midwifery-led unit and diagnosed with Hypoxic Ischemic Encephalopathy (HIE) secondary, due to a failure to monitor the fetal heart rate (FHR) appropriately in labour. The complaint response from the CEO stated that the fetal heart rate was normal, and that it was recorded at specified intervals of every 30 minutes in labour. The multi-professional review team did not agree that the heart rate was normal and thinks the response to the family is incorrect. (2013)*

4.58 On a number of occasions parents wrote to the Trust find out whether their case had been investigated, often in situations where an investigation should have been conducted and the family involved from the outset; cases range from intrapartum deaths to severe physical and developmental disabilities.

4.59 *After complaining in **2009** a mother reported to the review team that: 'The response to my complaint made me so angry. It didn't address any of my concerns…and was misspelt.' (2009)*

4.60 *In **2009** another family wrote to the Trust pleading for them to open an investigation into the death of their baby, requesting to be involved in the investigation and asked whether if things were done differently the outcome would have been different. In the response received the Trust said: 'The protocols for dealing with CTGs are clear and laid down for all staff. All staff, both midwives and doctors receive updates on the interpretation of CTG traces every 6 months. The loss of X was unexpected therefore difficult to prevent as [the] CTG trace was not indicative of an at-risk fetus that needed immediately delivery. If every dubious or worrying CTG resulted in an emergency caesarean section then ⅓ of all women would be delivered surgically'.*

4.61 The Trust continued: *'Patients cannot demand a caesarean section. They can request one and discuss the issues with the consultant but if the attending medic does not agree that a caesarean is necessary they will not undertake one'.* (2009)

4.62 This is a tragic case of a neonatal death where an independent investigation undertaken in 2018 identified significant failings in care and also a failure of the Trust at the time to learn lessons and recognise that earlier delivery could have altered the outcome for this family.

4.63 *In **2018** an investigation was started without the woman being told an investigation was ongoing or being asked to contribute. This is despite Duty of Candour[78] being well embedded nationally and being a legal requirement. The family received a written complaint response that outlined actions the Trust had put in place and completed but at a subsequent complaint meeting the parents questioned the honesty and transparency of the written response as the actions had not started at the time of the meeting. The family said: 'It's the fact that, when all this first happened, we went through an awful lot…and to be told that you had spoken to Dr X. Dr X had completed some key learns and due to that, you thought nothing was wrong, so you closed the investigation…but since then, obviously, we've found out that none of that actually took place'. (2018)*

3. Local concerns with statutory supervision of midwifery investigations

4.64 The overarching responsibility of the Local Supervisory Authority (LSA) and Midwifery Supervision was to protect the public by monitoring midwives' fitness to practice and instigate remedial actions where necessary.

78 General Medical Council, The professional duty of candour https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong/the-professional-duty-of-candour

4.65 From 2001, the Nursing and Midwifery Council **(NMC)** gave powers to the midwifery body, composed of trained Supervisors of Midwives **(SoMs)**, in the form of statutory supervision in accordance with the NMC's rules and standards to regulate midwives. Supervision was subsequently removed from statute in 2017 and replaced by a new model which was based on midwifery education and quality improvement. The review team has considered the role of midwifery supervision in-line with what was current practice from 2000 to 2017.

4.66 As a consequence of family complaints there were a number of independent reviews commissioned into the quality of supervisory investigations undertaken by SoMs at the Trust. From the governance documents the review team has received from the Trust there is minimal evidence that investigations were taking place, however there are some SoM updates within the maternity governance reports which indicate that investigations were taking place. We have received a small number of investigation reports which were of poor quality and which, from their dates, appear to have been conducted many years after the incident.

4.67 A significant number of SoM investigations provided by the Trust to the review team were all dated during one week in December 2016 and written by a single SoM. Some of these investigations related to incidents that occurred over 10 years prior. The review team were informed that this was due to a member of staff recognising that the original investigations lacked objectivity, with gaps in their quality.

4.68 This appears to be a conscious attempt to identify any significant practice issues, however it is unclear whether the midwives involved in the older clinical incidents received feedback - although this would have been out of date given the length of time since many of the incidents took place.

Findings from an RCA review and supervisory records:

4.69 A family experienced an unexpected admission of a term baby to the neonatal unit in **2015**, with the baby subsequently dying aged 5 months. A rapid response meeting was held to review the care and identify any immediate learning. At this meeting there were no identified SoMs present.

4.70 This initial review recommended that, due to the potential for long term harm, the RCA level should be undertaken as a serious incident. The supervision, (SoM) team was notified 2 weeks after the incident and a supervisory investigation was undertaken a month later. The investigation went ahead, however there was no chronology to benchmark the midwifery care against the standards of care at the time. From the initial 72 hour review there appeared to be a primary fixation on the lack of differentiation between the maternal and fetal heart rate, contributing to the difficulty in interpreting the fetal heart rate.

4.71 At this first meeting, it is unclear whether the maternity team considered the overall picture of this mother's labour. A further rapid review meeting was held 3 weeks later. The discussion at this stage still failed to demonstrate a detailed understanding of the 66 minute period when the fetal head was on the perineum, at a time when the umbilical cord will have been compressed. (2015)

How staff members described the SoM team:

4.72 Staff members described to the review team that the culture of the SoM team between 2010 and 2016 was discriminatory and non-inclusive. The review team heard from a midwife, in October 2021 who stated that they '*never felt [they} could fit in with the culture of the unit and were made to feel like an outsider by [their] colleagues'.* Though initially supported upon qualification to undertake the SoM Preparation Course [X] was not appointed into a SoM role because 'the existing SoM team did not want [X] appointed'.

4.73 Another member of staff raised concerns that SoM investigations were not transparent or fair and lacked rigour: *'I started to see gaps and I started to point them out and say, "Well actually, look, we've got the same people. The same people are involved in these reviews. The same people did the supervisory investigations, the same people marked them, the same people in the LSA marked them, we've got these patterns".'* It is evident that staff raised concerns about the quality of the investigations at the time, and

some conscious attempts were made to establish some objectivity, the same staff member added: *'There were reviews from a supervisory perspective and we still just about had supervision then [2016] so we did do that and we did some deep dives into…so we did reviews, but if you like, we were still marking our own homework.'*

External reviews of the SoM function at the Trust

4.74 Information provided to the review team indicates that there have been two external independent reviews of a midwifery supervisory investigation previously undertaken by the Trust's SoMs. The Local Supervising Authority Midwifery Officer (LSAMO) – the senior person who was responsible for upholding the standards of midwifery supervision at a regional level - Annual Report April 2014 – March 2015 stated that a complaint was received regarding the LSA function during the 2014-2015 supervisory year. The complaint related to a family who requested a review of a supervisory investigation in relation to the birth of their daughter in 2009. The family were gravely concerned at the lack of quality and accuracy of the initial investigation.

4.75 The external review concluded that the quality of the supervisory investigation was poor. There were a number of inaccuracies in the timeline and events, the facts of the incident were not established and the principles of the midwifery supervisory investigation were not adhered to. In the period between the initial investigation and the external report in 2015, there was no local learning or safeguarding of the public during a 6 year hiatus. Following the external review, the investigating SoM was found to be unsuitable for the role and they were removed from their supervisory duties by the LSAMO.

4.76 The second independent review was of a case of maternal death and intrauterine death. It was commissioned by the regional Chief Nurse in 2016. From information provided to the review team we found that the original investigation is incomplete, and has focused on the methodology of the investigation rather than the actual investigation of the incident.

4.77 The external investigation identified that two of the nine midwives who cared for the family would benefit from more support and development and the remaining seven should reflect on the care they provided. The original Trust investigation had only reviewed the care of one midwife and found no further learning was required. It had concluded that there were not any serious concerns in relation to midwifery practice.

4.78 The review team considered the language used at times in the reports seem to be inappropriate for the tragic outcomes and impact on the whole family. When discussing a meeting with family members as part of the investigation, they used terms such as the family being 'brave'. The external reviewers thanked the family member for involvement in the second review and described their 'graciousness' for taking part in the investigation.

4.79 The review team's opinion is that the external (or second) investigation also failed to identify that with improved care the outcome for the woman could have been significantly different. The first investigation failed to identify any systemic issues around CTG interpretation and sepsis management, which were relevant, factors. It was also felt by the review team that the few recommendations for improvements made would not have prevented a similar situation occurring in the future. The second investigation relied on the presumed cause of death (amniotic fluid embolism) as 'unavoidable' and therefore did not address salient issues particularly around the identification and management of the critically ill mother, sound escalation plans and multidisciplinary team working.

4.80 Two years after the mother's tragic death, the external assessors acknowledged that some of the recommendations for improved care were still *'in progress'.* It is the review team's opinion that despite being a second investigation the LSA (external) investigation still missed significant points for learning, and improvement, specifically that had the sepsis been treated more promptly earlier, that the outcome might have been significantly different.

Causes of supervisory failings and failure to learn:

4.81 The review team identified the causes of supervisory failings as:

- The supervision function was not independent from the management team, therefore the same people scrutinised clinical incidents regardless of whether this was a supervisory review or not.
- The short staffing levels did not appear to provide supervisors with protected time to carry out supervisory activities.
- A lack of involvement of supervisors in risk management and incident reviews which prevented them from identifying the incidents that warranted supervisory review.
- A lack of integration between supervision and clinical governance.
- A lack of leadership within the maternity governance structure.

4. Concerns relating to clinical guidelines and audits

4.82 The writing, review and use of clinical guidelines to inform best practice and the conducting of clinical audits to monitor compliance with these guidelines is an integral part of ensuring a service is safe. The review team has identified the following concerns:

a) A lack of multidisciplinary input into guideline management and audits

b) A lack of a change in practice and monitoring of compliance in response to clinical incidents

c) The repayment of an NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Incentive scheme payment.

a. A lack of multidisciplinary input into guideline management and audits

4.83 Before 2010, and following review of the guidelines supplied to the review team by the Trust, the approach to guideline and protocol management lacked a multidisciplinary approach at the Trust. Guidelines appeared to have been drafted by midwifery staff, with no input or oversight by the obstetric consultants.

4.84 From 2012 onwards the review team identified a named guidelines midwife in post, and identified that subsequent to this, there was a more consistent approach to how guidelines were written, reviewed and then referenced. The review team were unable to find evidence of a named obstetric lead, and obstetric input was not well defined, which meant that there was a lack of multidisciplinary input into guideline management. A member of staff stated '*practice wasn't evidence-based but there was nobody qualified, competent or capable to update guidelines or to even write guidelines. They didn't have very many and what they had weren't evidence-based...I know full well that their guidelines were woefully out of date'.*

4.85 With regard to audits, there is evidence supplied by the Trust of formal registration of women's and children's audits throughout the review period, forming part of the yearly corporate audit plan. This is in line with general practice in maternity units and the majority were conducted by an audit midwife with only a small number, in comparison, having obstetrician involvement. Anaesthetists were involved in audits in earlier years, then no longer featured at the audit meetings and their involvement in maternity audits was not seen in recent years.

4.86 Experience from the multidisciplinary members of the review team is that good practice for most maternity units would be for audit meetings to be multidisciplinary, where all clinicians learn together. The review team noted that the attendance record at audit meetings, especially prior to 2012, demonstrated that, in general, very few midwifery and nursing staff attended, with no midwives present at some. The meetings were often obstetrician-led, attended by the obstetric team and had obstetricians conducting the audits. This shows a culture of exclusion and disparity between the staff groups. After 2012 there was clearly a shift, as most audits were midwife-led, usually by the audit midwife with little involvement by other staff groups. Actions to try to improve obstetric attendance were noted at meetings as late as July 2017.

4.87 For example, in September 2018 the operative vaginal delivery audit was conducted by a midwife and demonstrated that no analgesia was used for ventouse deliveries. The review team felt this was unlikely to be correct, as it would be surprising if none of the women who had a ventouse had an epidural, which is known to increase the risk of instrumental delivery. However, a suggestion was made at audit meetings for this to be investigated and for consultants to supervise future audits with the aim that their presence would promote evidence-based practice and influence a change in practice. The lack of obstetric involvement in the initial audit would have made it difficult for the auditor to develop a robust plan to effect change as it is based on the individual's limited knowledge and experience on the subject.

4.88 Audits were also presented within the maternity governance meetings which to 2012 were mostly attended by midwifery staff. After this time, the review team has noted good attendance by consultant obstetricians and midwives but attendance by junior medical staff was often lacking. The updating of guidelines and leaflets was a regular item on the agenda, however this item was often cancelled when there were more pressing matters being discussed, at the expense of guideline updates.

4.89 Maternity audit action plans were also agreed at these meetings, but discussion when it occurred commonly appeared as perfunctory which was inappropriate as the forum did not have full representation and authority to make decisions. Many action plans merely stated the means of dissemination of findings, rather than addressing the discrepancies identified. Often there was no action plan to improve compliance and then to re-audit. The review team found therefore that management of maternity audits were a significant lost opportunity to improve the quality of maternity care at the Trust throughout the entire period of the maternity review.

b. A lack of a change in practice and monitoring of compliance in response to clinical incidents.

4.90 The review team has identified cases where similar and continuing errors in practice have occurred over the years, which suggests a failure to learn lessons and implement change in maternity practice. When an incident has been investigated and an action plan created, it is vital that these actions are implemented to prevent future harm occurring. The review team has found repeated instances where this has not been the case in maternity services at the Trust.

4.91 *In **2015** a woman with a previous baby on the 5.5th centile was not offered an obstetric review or growth scans. She subsequently suffered a stillbirth at 37 weeks. The baby had a birth weight less than the 3rd centile. The subsequent investigation into this stillbirth recommended that: 'Any previous birth weight between 5.0 and 5.5 centile will be rounded down to 5th centile for the purposes of ascertaining which patients will be offered routine scans at 32 and 36 weeks'. This recommendation however was not written into the Assessment (Antenatal) Guideline Version 11 (2015) nor any versions afterwards. Despite the 2013 RCOG Green Top Guideline[79] recommending use of the 10th centile to determine when ultrasound scans are required, this was not followed at the Trust until 2018. (2015)*

4.92 *In **2016** a woman, for whom English was not her first language, telephoned maternity triage with abdominal pain and was advised to remain at home and sadly attended with a concealed placental abruption and had a neonatal death. The recommendation from the investigation was to update the maternity triage operating procedures to include that women for whom English is not their first language should be invited in for assessment to avoid issues with communication. There is no evidence this occurred. (2016)*

4.93 *In **2018** a woman in early labour telephoned the maternity triage as she believed her 'waters had broken' but she was not invited in for assessment, and the outcome in this case was an early neonatal death. The Latent Phase of Labour and Intrapartum Care on an MLU guideline was updated following this incident and a compliance audit was recorded as being completed, however no evidence of this compliance audit has been supplied to the review team by the Trust. (2018)*

4.94 There is evidence of sharing audit findings at audit meetings. However, there is lack of consistent evidence

79 Royal College of Obstetrics and Gynaecology *Investigation and Management of the Small-For-Gestational-Age Fetus Green-Top Guideline number 31* (2013) https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf

that practice changed as a result of audits. Of particular note is that the majority of audits did not make reference to previous audit findings, hence the opportunity for comparison and therefore learning to improve the quality of maternity care was lost.

4.95 One example is that an electronic training package used by staff for CTG training was discussed at the maternity governance meeting held in February 2016 and it was said to be in routine use. However, in the July 2017 governance meeting, it is reported that staff were unfamiliar with the aforementioned training package. This is inconsistent with the assurances given at prior maternity governance meetings and to external bodies such as the Commission for Health Improvement as far back as 2007. Poor CTG interpretation leading to poor outcomes for babies was a recurring theme among many cases over the period of time considered by the review team.

c. The repayment of an NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Incentive scheme payment.

4.96 The Clinical Negligence Scheme for Trusts, better known as CNST, is an insurance scheme administered by NHS Resolution (previously known as the NHS Litigation Authority), whereby individual NHS organisations pay an annual premium to mitigate against the cost of clinical negligence. In the earlier years the CNST standards were met by auditing practice against prescribed standards and identifying evidence of improvement in practice informed by those audits. Successful achievement of Level 1, 2 or 3 resulted in a percentage reduction of trust payments to the NHSLA for indemnity insurance.

4.97 The review team saw evidence that guidelines were amended and updated based on the CNST assessment reviewer's comments and the maternity unit was successful at gaining Level 1. A member of staff stated in a meeting with the review team that as early as 2009 there were significant concerns amongst individuals about standards of maternity care and governance at the Trust.

4.98 In discussing CNST, a staff member told the review team *'…in 2009, there were signs then that governance was not as it should be and I fought a battle even then just with regard to CNST and I was told we're going to get CNST Level 2, and I said, "We're not", and I was told, "We are", and I said, "We're not", and that was the first time that I experienced having a battle with the…leadership at the time, and the Board…but you know what's right and you can't get beyond that barrier. So I considered that I won that battle, in that we did the right thing…we weren't going to get Level 2 unless we fudged it, so those are my words…but it was met with absolute disdain and I remember…being dragged into [X's] office and told, "Sit there with your laptop, we're going to do this action plan for CNST together..." .'*

4.99 This was also confirmed by another member of staff stating: *'I don't think that anybody on the Board expected me to be finding us non-compliant, because obviously that had gone through the Board, so that was a really difficult time as well. …It was a really difficult time, because we were then saying to the Board that information that they'd signed off six months previously, they didn't have the evidence for it, and then obviously we had to look at year one and then we owed a significant amount of money. I think that, you know, that's an example of where they didn't know how much information they should have.'*

4.100 The Trust subsequently gained level 2 in 2012. The review team saw some of the best conducted audits in 2013–2014, with the Transfer of Women Audit being noted as an example of good practice in its structure and findings.

4.101 During 2013/14 the Trust was preparing for Level 3 assessment. The Trust scored a remarkable 48/50 of the required criteria. NHS Resolution **(NHSR)** stated[80] *'the audit reports were in general of a high quality, with readily identifiable measurable standards'* and *'Particularly impressive was the spread of actions that had been implemented as a result of the audit findings…It was clear to the assessors that each deficit identified had been carefully considered and time and effort had been put into drilling down to the root causes and applying meaningful measures to rectify the issues'.* However, there is a distinct disparity

80 NHS Resolution, NHS Litigation Authority. *NHS Litigation Authority Clinical Negligence Scheme for Trusts: Maternity Clinical Risk Management Standards 2013-14, The Shrewsbury and Telford Hospital NHS Trust*, Level 3, p23 (March 2014)

between those observations of NHSR and the findings of the review team as in subsequent years the audit reports did not lead to sustainable safety improvements in maternity services at the Trust.

4.102 In 2017 NHS Resolution changed the CNST assessment to become an incentive towards improving safety. Maternity services provided self-assessments which were signed off at Board level on 10 safety actions which it was thought, if achieved, would demonstrate that a Trust was providing safer maternity care[81]. By achieving all 10 safety actions Trusts would recover the elements of their contribution to the CNST maternity incentive fund and also receive a share of any unallocated funds.

4.103 The Trust received its rebate in 2018, but after a CQC inspection report in November 2018 rated the maternity services as inadequate[82] the Trust was obliged to return the money it had received. The review team has heard from a member of staff that it was obvious the Trust would not achieve the CNST standard. This is evidenced by the fact that although the Trust declared in 2019 a 90% or more compliance with the multidisciplinary training target in 2018 and 2019 the maternity clinical governance meeting minutes on 25 February 2019 records that there was discussion of the risk that the Trust would not achieve this target.

4.104 In August 2019 the Training Figures document states that the *'maternity incentive scheme training requirements were achieved'*. However the review team has heard evidence from a member of staff that actions were signed off as *'actions met'* without appropriate evidence being either shared with, or requested by, the executive team and Board.

4.105 A member of staff said to the review team: *'...I have thought a great deal since my interview and how things will not change unless we are prepared to push aside feelings of dismay, anxiety and fear and unless we are prepared to act by the very principles we are expecting from others.'* The staff member stated to the review team that *'X advised me when I was undertaking a review of CNST year 2 submission to "be careful what you find" as it will cause "reputational damage" to the Trust'.*

4.106 The review team has identified multiple and repeated failings in maternity governance throughout the timeframe of this review, spanning poor quality incident investigations, poor complaints handling, concerns with how the Trust implemented statutory supervision of midwifery supervisors and concerns with implementation of the systems for guideline development and clinical audit. The review team feel that these serious failings led to unnecessary harm occurring to mothers and babies over a prolonged time period.

LOCAL ACTIONS FOR LEARNING: IMPROVING MANAGEMENT OF PATIENT SAFETY INCIDENTS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.107 Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework.

4.108 The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists and anaesthetists to undertake incident investigations.

4.109 All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession.

4.110 The use of HRCRs to investigate incidents must be abolished and correct processes, procedures and terminology must be used in line with the relevant Serious Incident Framework.

81 NHS Resolution. The maternity incentive scheme year 2 results. Published 13th February 2020. https://resolution.nhs.uk/2020/02/13/the-maternity-incentive-scheme-year-two-results/#:~:text=The%20maternity%20incentive%20scheme%20was%20launched%20by%20NHS,but%20also%20a%20share%20of%20any%20unallocated%20monies.

82 Care Quality Commission, Shrewsbury and Telford Hospital NHS Trusts Inspection report (2018)https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-report-shrewsbury-telford-hospital-nhs-trust

4.111 Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident.

4.112 All SIs must be completed within the timeframe set out in the SI framework. Any SIs not meeting this timeline should be escalated to the Trust Board.

4.113 All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy. These training courses must commence within the next 12 months

4.114 The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.

4.115 Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.

LOCAL ACTIONS FOR LEARNING: PATIENT AND FAMILY INVOLVEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.116 The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.

4.117 All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.

4.118 The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited and encouraged to be involved in incident investigations.

LOCAL ACTIONS FOR LEARNING: SUPPORT FOR STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.119 There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern.

4.120 The Trust must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support the maternity department going forwards.

LOCAL ACTIONS FOR LEARNING: IMPROVING COMPLAINTS HANDLING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.121 Complaint responses should be empathetic and kind in their nature. The local MVP must be involved in helping design and implement a complaints response template which is relevant and appropriate for maternity services.

4.122 Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the MVP.

4.123 All staff involved in preparing complaint responses must receive training in complaints handling.

LOCAL ACTIONS FOR LEARNING: IMPROVING AUDIT PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.124 There must be midwifery and obstetric co-leads for audits.

4.125 Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.

4.126 Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred.

4.127 Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.

4.128 Matters arising from clinical incidents must contribute to the annual audit plan.

LOCAL ACTIONS FOR LEARNING: IMPROVING GUIDELINES PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.129 There must be midwifery and obstetric co-leads for developing guidelines.

4.130 A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use.

LOCAL ACTIONS FOR LEARNING: LEADERSHIP AND OVERSIGHT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.131 The Trust Board must review the progress of the maternity improvement and transformation plan every month.

4.132 The maternity services senior leadership team must use appreciative inquiry to complete the National Maternity Self-Assessment[83] Tool published in July 2021, to benchmark their services and governance structures against national standards and best practice guidance. They must provide a comprehensive report of their self-assessment, including any remedial plans which must be shared with the Trust Board.

4.133 The Director of Midwifery must have direct oversight of all complaints and the final sign off of responsibility before submission to the Patient Experience team and the Chief Executive.

83 NHS England. Maternity self-assessment tool (2021) https://www.england.nhs.uk/publication/maternity-self-assessment-tool/

The NHS Patient Safety Incident Response Framework (PSIRF)

4.134 As has been clearly explained within this chapter, there have been many failings in how maternity incidents were investigated in-line with the national frameworks at the time, namely the 2010 National Framework for reporting and learning from serious incidents requiring investigation[84] and the 2013 and 2015 Serious Incident Frameworks[85]. It is also widely accepted that prior to this review, multiple reports, including maternity specific reports, have already highlighted significant shortcomings in the way patient safety incidents are investigated and learned from[86].

4.135 To improve this situation, NHS England published the 2019 NHS Patient Safety Strategy[87] and will be implementing the Patient Safety Incident Response Framework (PSIRF)[88] which is due for gradual implementation across all organisations from spring 2022. Taking into account that at the time of publishing this report there will be more than 20 organisations working within the PSIRF framework[89] who will continue their work after this report is published, the review team has discussed the PSIRF methodology with NHS England. These discussions have helped ensure that the approaches and principles within the PSIRF are aligned with those of this maternity review.

4.136 The PSIRF differs from the current SI framework, which it will replace, in a number of ways and the review team support the fact that it will have a broader scope, moving away from 'hard-to-define thresholds for serious incident investigations' and that it is committed to engaging and supporting patients, families, carers and staff in accordance with a just culture. The PSIRF Introductory framework , published in March 2020, identifies the process currently being used by early adopter sites and has been published 'so that all parts of the NHS, patients, families and other stakeholders can engage with the proposals and help [NHSE] learn how we best ensure our aim is met'.

4.137 The review team has engaged in dialogue with NHS England based on the findings of this review to receive assurances that the PSIRF works effectively for maternity services. The following issues are of key importance:

PSIRF- Resources and expertise:

4.138 The review team discussed with NHS England that the National Maternity Assessment Tool recommends the following minimum staffing levels for governance teams:

- Maternity governance lead (who is a midwife registered with the NMC)
- Consultant obstetrician governance lead (Minimum 2 PAs[90])
- Maternity safety manager (who is a midwife registered with the NMC or relevant transferable skills).
- Maternity clinical incident leads
- Audit midwife - a lead midwife for audit and effectiveness

84 Ibid n4

85 Ibid n2

86 Royal College of Obstetrics and Gynaecologists. Each Baby Counts: key messages from 2015 (2016) https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/rcog-each-baby-counts-report.pdf

Parliamentary and Health Service Ombudsman. Learning from mistakes. (2016) https://www.ombudsman.org.uk/publications/learning-mistakes-0

Parliamentary and Health Service Ombudsman. A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged. (2015) https://www.ombudsman.org.uk/publications/review-quality-nhs-complaints-investigations-where-serious-or-avoidable-harm-has

House of Commons Public Administration and Constitutional Affairs Committee. *Will the NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England.* (2017) https://publications.parliament.uk/pa/cm201617/cmselect/cmpubadm/743/743.pdf

87 NHS England website. NHS Patient Safety Strategy 2019. https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

88 NHS England. NHS Patient Safety Strategy 2019. https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

89 NHS England. Introductory Patient Safety Incident Response Framework. (2020) https://www.england.nhs.uk/wp-content/uploads/2020/08/200312_Introductory_version_of_Patient_Safety_Incident_Response_Framework_FINAL.pdf

90 A PA or 'programmed activity' is the unit of currency in a consultant contract, each PA broadly equalling 4 hours – see https://www.nhsemployers.org/sites/default/files/2021-06/consultant-contract-faqs_0.pdf

- Practice development midwife
- Clinical educators, to include leading preceptorship programme
- Appropriate governance facilitator and administrative support within the maternity department.

4.139 The review team is assured that these are key team members who will need to understand PSIRF principles and should be involved in planning preparations locally for implementation of PSIRF.

PSIRF and Training:

4.140 The review team is assured that appropriate training in patient safety incident investigations, and safety science more widely, will be a core feature of the PSIRF and that NHSE&I will set minimum levels of training required for investigation leads.

4.141 The review team strongly supports the notion that training must be available prior to PSIRF implementation and are assured that this will be set out within an investigation training framework which will include a straightforward mechanism for providers to commission the training that their staff need.

4.142 The review team is assured that all relevant tools and templates will be available prior to rollout and should further investigation skills training become necessary over time, the minimum training standards requirement will be adapted as appropriate.

PSIRF- What to investigate and ensuring effective oversight

4.143 Maternity and neonatal incidents which meet the Each Baby Counts and maternal deaths criteria will be referred to HSIB for a HSIB-led PSII (or new statutory body). Organisations will also be required to continue to report to NHSR Early Notification Scheme, RCOG EBC project and MBRRACE-UK as well as the PMRT being used for all stillbirths and neonatal deaths. The review team supports this approach of maintaining set criteria for what must be investigated externally.

4.144 The review team also supports the move away from subjective and hard to define thresholds for SI investigations and towards a proactive approach to safety and learning investigations, which can be based on findings from more than one similar completed incident investigation.

4.145 The review team raised concerns that the PSIRF focuses on trusts determining locally what to investigate and although well intentioned to promote a culture of learning, felt this could lead to similar problems as found at Shrewsbury and Telford Hospital NHS Trust, where incidents were downgraded and not appropriately investigated. The review team has been assured that there will be appropriate oversight built into the PSIRF framework with organisations expected to conduct a gap analysis to assess this, whilst also being assured that a training specification for oversight training will be in place before roll out begins. It is the expectation of NHSE&I that the relevant individuals in oversight roles will have received the appropriate training prior to organisations transitioning to PSIRF.

PSIRF and linking complaints to investigations to aid learning

4.146 The review team has been informed that although this is not part of the PSIRF, providers will be encouraged to bring patient safety and complaints teams together as part of the PSIRF implementation and encourage a collaborative and coordinated process. As stated in the IEAs underpinning this final report all trusts must ensure the maternity complaints process is incorporated within the maternity governance team structure responsible for incident investigations to ensure that complaints are not completed and responded to in isolation. The review team states that **NHSE&I must undertake work to provide those dealing with complaints appropriate training in effective complaints handling**.

PSIRF and reducing variation in investigations

4.147 The review team support the notion of a standardised investigation template and are assured that the patient safety incident investigation (PSII) template has been built on the principles developed by HSIB and that the template will be available prior to PSIRF implementation.

Patient and family involvement in investigations

4.148 The review team has been assured that the active involvement of women and families in investigations is fundamental to the PSIRF and that NHSE&I are currently working with HSIB and a group of independent stakeholders (including academics, patients and patient advocates) to develop an involvement guide that will ensure these requirements are covered in detail.

Chapter 5

Clinical leadership

Introduction

5.1 Safe, high-quality maternity care across England is not an ambitious or unrealistic goal and should be the minimum expectation for all women, their families and their babies. Effective clinical engagement and leadership is critical to improving quality, safety and patient outcomes within the NHS[91]. Frontline teams do not operate[92] in a vacuum; leadership is the key determinant of the organisational culture in which frontline teams operate. 'When things go well, it is down to good leadership and when they don't, who takes responsibility? Does it rest with the 'senior' midwife, the trust's chief executive, the board or the midwife delivering the care?'[93]

5.2 Historically, strategic and operational leadership roles within maternity services were held by the obstetric clinical lead, the clinical director and the director of midwifery[94]. These roles have overarching responsibility for the daily operational delivery and strategic management of maternity services locally and are accountable to the trust board for quality, performance, governance and professional leadership. This responsibility includes making positive changes in the workplace where necessary to shape a fair and positive environment, and encouraging a culture which supports improved clinical outcomes for women and their families. The review team has identified that these responsibilities were not always met within maternity services at Shrewsbury and Telford Hospital (SaTH) NHS Trust.

5.3 During a 'Staff Voices' interview with the review team in late 2021 a member of staff reported how the Trust's board did not have oversight of the concerns relating to patient safety, quality and performance or poor clinical outcomes within maternity services.

5.4 The staff member told the review team: *'I don't think that actually the Board knew what was needed in maternity services. I was giving them information that they'd never had before'.*

5.5 The primary influence of clinical leadership is through the expression of clinical expertise, with direct involvement in patient care. A recent RCOG publication[95] (2021) reiterated how the role of the consultant obstetrician is that of the clinical expert, one who influences both clinical decision-making and standards of clinical practice thereby reducing variation in patient care and optimising clinical outcomes in maternity settings by being physically present and visible[96]. The absence of such clinical leadership has been identified by the review team as a contributory factor in the failure of maternity services at the Trust to provide high quality and safe maternity care to women and their families, and is an overarching theme in this report. This has been widely reported in many national maternity reports over many years[97]. These national maternity reports include those by the Department of Health, Royal Colleges and CEMACH.

91 Joseph & Huber 2015, https://pubmed.ncbi.nlm.nih.gov/29355179/ 2015

92 NHS England: *National Maternity Review: Better Births: Improving Outcomes of maternity services in England* (2016) p72: https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

93 Royal College of Midwives (RCM) (2012). Leadership - what's that got to do with me? Midwives Magazine Issue 2 2012 [online]. Available at: https://www.rcm.org.uk/news-views/rcm-opinion/leadership-what-s-that-got-to-do-with-me/ [Accessed 24th November 2021].

94 Royal College of Obstetricians and Gynaecologists (2007) *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.* Available at: https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf [Accessed 01 December 2021].

95 Royal College of Obstetricians and Gynaecologists (2021) *Workplace Behaviour Toolkit.* Available at: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/workplace-behaviour/toolkit/ [Accessed 01 December 2021].

96 Ibid n4 RCOG (2007 and 2021)

97 Department of Health *Why Mothers Die. Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1994–1996.* (1998). RCOG, 2004, CEMACH, 2007, Kirkup, B. (2015) *The Report of the Morecambe Bay Investigation.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf [Accessed 01 December 2021]. Knight et al, 2016 and NHS, 2019.

Review of independent reports

5.6 It is acknowledged that the assessment of maternity services has continually evolved over the 20-year span of this independent review, and that different standards and priorities have been expected of maternity services at different times. Key national reports continued to highlight poor leadership as the reason that maternity services were failing women and hampering continued development of the professions[98]. In assessing the quality of leadership within maternity services at the Trust, the review team has considered the most recent external reports reviewing maternity services at the Trust and whether the leadership team were responsive in making effective changes following the recommendations made in those reports.

5.7 A review of maternity services at the Trust was undertaken by the two local clinical commissioning groups[99] (CCG's) in 2013. This was in response to concerns regarding the increased number of serious incidents (SIs) at the Trust, and the safety of the 'hub and spoke' model[100] of maternity care. The findings from the CCG's were favourable, with the overall assessment noting that maternity services provision at SaTH was a safe and good quality service. The Trust board reviewed this report noting: *'There had been concern about some families' experiences but this was in the context of generally good services'.*[101]

5.8 In March 2014, the Trust was reviewed by the NHS Litigation Authority and awarded Level 3, the highest standard under the Clinical Negligence Scheme for Trusts (CNST). The Trust was benchmarked against the requirement to demonstrate good leadership, with an open and supportive culture, providing a service that can fulfil the needs and expectations of women and their families. A maximum score of 10 out of 10 was awarded in 2014, suggesting there were no concerns regarding leadership and management at that time.

5.9 Following the successful submission of CNST data, a staff member explained to the review team that they had voiced concerns regarding the accuracy of the data submitted, suggesting there was no evidence to support that the service was ever compliant in meeting the criteria. The staff member told the review team:

5.10 *'We were then saying to the Board that information that they'd signed off six months previously, they didn't have the evidence for it.'*

5.11 In 2014, a Deanery review of medical training was undertaken. Clinical governance was identified as an area for improvement. The Deanery report stated:

5.12 *'The Trust must integrate clinical governance into learning outcomes for trainees and ensure that there are clear and robust mechanisms in place to learn from clinical incidents and that any learning points are clearly disseminated to trainees appropriately.'*

5.13 An independent review in 2015 by Debbie Graham which considered the case of a family who had suffered the death of their baby daughter criticised the Trust's response to the family. However the report concluded *'…the learning from these events, in conjunction with the appointment of key personnel, have led to considerable improvements in the provision of maternity services and the strengthening of the Trust's clinical governance and complaints processes. In particular the development of advocate roles within the Trust that will work to strengthen the voices of patients and their families so they may be heard in the future'.* Graham (2015) does not state the basis upon which this conclusion was reached. When considering a number of cases after 2015 and through until 2019 the review team has not seen evidence that this belief came to fruition.

5.14 For instance, in 2018 a family in conversation with the review's Chair described the approach of the Trust at listening to families following critical incidents as *'tinkering at the edges'*. In reviewing the SI report into the

98 RCM 2012

99 See glossary

100 See glossary

101 2014 Trust Board papers supplied to the review team

death of their baby the family (who had significant professional experience in risk management and root cause analysis) said of the Trust's SI report: *'It's not getting down [to the detail]…it says here root cause analysis, they're fine words but the words don't mean anything because they don't understand…and, again with all due respect to them, as I say, from my world I live, eat, sleep and breathe root cause analysis…'*.

5.15 The 2017 Ovington report compiled internally within the Trust stated how *'safety in maternity is protected by the efforts of the staff and supported by leaders'.* It concluded that governance arrangements should be more transparent and open. It also highlighted how learning from incidents and investigations should be improved. No action plan to meet these recommendations in Ovington (2017) has been provided to the review team at the time of writing this report in spring 2022.

5.16 In 2017, there was an invited review of the maternity services by the RCOG. This review found that while there was evidence of strong leadership and good working relationships between the various staff groups, concerns relating to workforce numbers and insufficient numbers of consultants providing obstetric cover were identified. There was evidence of middle grade rotas not always filled by the Deanery, resulting in maternity services relying on overseas trainees and locums. In accordance with other previous reviews, the RCOG report identified a lack of resources and inadequate incident reporting, risk management and governance systems. This report was subsequently not presented to the Trust Board until May 2018. The Trust's 2018 Care Quality Commission report concluded within the 'Well Led' domain that leadership required improvement and also raised governance concerns stating:

5.17 '*Staff were overwhelmingly positive regarding the local management of the service in the hospital. They told us that the senior team were visible and they were approachable and able to raise issues and concerns. However, they were not certain that these issues were then heard at board level. We were not assured that the executive team had engaged well with staff to develop the vision for the service.'*

5.18 *'We found areas of concern that were raised in our last inspection in December 2016, for example service-wide sharing of learning from serious incidents was not evident, not all staff could give an example of learning.'*

Obstetric services, workforce and clinical leadership

5.19 It is clear from the evidence provided by the Trust to the review team that prior to 2012 the obstetric medical staffing at both consultant and junior doctor level at the Trust was inadequate for the size of the unit at around 5,000 births per year. The number of consultants, and the number of women that they were responsible for meant that timely reviews of women on the labour ward, or in other inpatient areas would have been very difficult, if not impossible, to provide at times. Therefore, midwives wishing to escalate clinical concerns would have been regularly working in an environment in which it would have been difficult to obtain a timely senior obstetric review.

5.20 The poor provision of medical staffing resulted or certainly contributed to delays in the instigation of appropriate medical management. This created an environment in which it was accepted within maternity services at the Trust that it was normal practice to wait for an obstetric review, thus leading to clinical risks, which ultimately contributed to poor maternity outcomes. The review team has heard from one member of the medical staff who confirmed that for many years the registrar had to cover both gynaecology and obstetrics clinical areas.

5.21 This staff contributor told the review team:

'One of the problems...in this sort of context that I've been describing, was a very, very overburdened and thinly stretched middle tier in the obstetric team. I was, frankly, flabbergasted at what I was being told, you know, doctors were being asked to cover services that, it was manifestly clear, you couldn't possibly do that on your own.'

5.22 There is evidence within business plans to the Board (provided by the Trust to the review team) that the Trust was working to increase the number of doctors at both middle grade and consultant level. The number of hours of consultant presence on the labour ward subsequently increased from 40 hours in 2011 to 76 hours in 2013. These plans included evidence that solutions were being sought to support this, including better provision of elective caesarean section lists, for example. In spite of these efforts, in 2016 the Trust had difficulty in being able to appoint the required number of middle grade doctors, resulting in the staffing levels being below the recommended standard for both consultant and middle grade staff. At the time of writing this report in early 2022 there has been further consultant expansion at the Trust supporting an increase in resident consultant hours on the labour ward.

Neonatal services, workforce and leadership

5.23 It is clear from the majority of medical records reviewed that involvement of the consultant neonatologists in clinical decision-making, in the provision of neonatal care and in communication with parents and other family members was of a high quality. The medical records suggest that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. They often wrote discharge summaries themselves and were also usually involved in the long-term follow-up of their patients, providing continuity of care for their parents. For some of the clinical cases reviewed, the consultant providing cover for the neonatal unit was also covering the general paediatrics service. This may compromise the availability of skilled care, and, given the size of the neonatal service at the Trust, it would be important to have separate consultant cover for the neonatal and general paediatrics services. This has now been achieved.

5.24 Advanced neonatal nurse practitioners (ANNPs) played an important role in the management of sick infants on the NNU and of babies on the postnatal ward. As far as can be judged it appeared that their practice was appropriate and likely to have made an important contribution to neonatal practice within the Trust. For some of the cases reviewed it was clear that, out-of-hours, middle-grade neonatal medical staff were covering the paediatric unit as well as the neonatal unit. This can compromise the availability of skilled care in both units. The employment of ANNPs has undoubtedly provided some mitigation of this but it was not clear whether the service was adequately covered to this level at all times.

5.25 The review found some evidence of senior neonatal leadership within maternity and perinatal governance processes, and on occasions in raising concerns about individual cases in the perinatal service. We heard evidence of attendance by a neonatologist at Perinatal Mortality and Morbidity (M&M) meetings. In interviews with the review team, we were told of neonatologists attending joint mortality meetings from the early 2000's. Neonatologists contributed data to the national neonatal audit project, which collects important neonatal outcomes. Neonatologists and obstetricians told the review team that they usually met bereaved parents independently, but the review team found some evidence of correspondence between them, including selected cases where a neonatologist wrote to the consultant obstetrician requesting a case review after an adverse outcome.

5.26 Some of the neonatologists told the review team that they raised concerns in the early 2000s about a perceived higher than expected incidence of hypoxic ischaemic encephalopathy (HIE). They also raised concerns about lack of recognition of IUGR and of trauma secondary to instrumental delivery. At interview members of the neonatal team told the review team that these concerns were raised with clinical colleagues and the divisional management team, however the outcome remains unclear.

5.27 A staff member told the review team: *'We have been always very closely involved because we have regular monthly perinatal mortality reviews, meetings every third Wednesday, third Friday of every month and we would actually attend all the late fetal losses, stillbirths, everything, it's not just neonates…so we would robustly challenge them…and those were very well attended meetings, including midwives, obstetric, neonatal teams, perinatal pathologist and geneticist etc.'*

5.29 They continued:

'I think the consistent feature from the neonatal side for us for many stillbirths etc. was the lack of recognition for fetal growth restriction and I think that's another part we repeatedly brought out. I think that led to the introduction of the customised growth centiles as well as the GROW programme.'

Midwifery roles, workforce and leadership

5.30 Frontline midwifery leadership incorporates a myriad of midwifery roles across maternity services including midwives[102], matrons, senior midwifery managers, labour ward coordinators, community clinical leads and specialist midwives. It is notable that, in spite of the RCOG safety recommendations from 2007 on standardising an approach to clinical leadership roles, the Trust did not have any consultant midwife posts for all of the time period considered for this review. The Trust has informed the review team that their first consultant midwife is due to take up employment in early 2022. The national recommendation remains that midwifery-led units (MLU) have one full-time consultant midwife post and obstetric-led units have one additional full-time consultant midwife post to every 900 births, based on 60 per cent low risk women receiving midwifery-led care[103].

5.31 The review found no evidence that there was a consideration of developing the role of the consultant midwife, during the time period under consideration. In conjunction with the consultant obstetrician, the consultant midwife could have provided the balance of professional and effective clinical leadership to ensure the improvement of both quality and safety across maternity services.

The labour ward co-ordinator

5.32 The role of the labour ward coordinator is multi-faceted and central to ensuring the safety of pregnant and labouring women and babies. It encompasses the role of midwifery clinical expert; to inform and challenge practice, and to escalate clinical concerns whilst prioritising and managing the complex demands of contemporary midwifery and maternity care in the high-risk clinical setting of the labour ward.

5.33 Maintaining oversight and knowledge of the management of all clinical cases, the coordinator acts as a source of clinical support for junior midwifery and obstetric staff and a professional conduit across multidisciplinary teams thereby ensuring appropriate use of resources to enable the effective and safe provision of care. While there were some examples of good midwifery leadership seen, staff within maternity services at the Trust shared with the review team their own lived experiences of when this was not always the case.

5.34 A staff member told the review team:

'I was, I think, three months into my labour ward rotation and I kept pressing the call bell saying she's bleeding a lot quicker than I'd like, you know, I think we're up to 500mls now, and the coordinator kept coming in saying I'm on [the] ward round, it'll have to wait…I felt like I'd let that woman down because my skills weren't good enough, that's how I was made to feel when, actually, that was a situation I should have had help in…if she was bleeding that much I should have had help.'

5.35 Each labour ward must have a team of experienced senior midwives rostered as labour ward coordinators, who have supernumerary status; this is defined as having no caseload of their own during a shift and is fundamental to the effective running of the labour ward, which is a high risk clinical area. This is also a recognised requirement in the CNST safety standards[104].

102 Ibid n4 RCOG (2007) & Kings Fund, 2008https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/safe-births-everybodys-business-onora-oneill-february-2008.pdf

103 Ibid n4 RCOG (2007) RCM, RCA, RCPCH, 2007 and Kings Fund, 2008

104 NHSR, 2020

5.36 The review team found that the Trust allocated one band 7 labour ward coordinator per shift who had overall responsibility for coordinating the care throughout a clinical shift, and for the allocation of staff (Labour Ward Staffing v2, 2015). Out-of-hours in the absence of the management team, the coordinator was also responsible for overseeing the clinical activity across the whole of maternity services, including the distant MLUs, and community activity across Shropshire, with escalation to the on-call manager at home, according to the Future Model of Care, 2016 document, shared with the review team by the Trust.

5.37 Reports by the CCG in 2013 and the RCOG in 2018 found that due to midwifery staffing shortfalls, the coordinator was supernumerary for only 50% of the time (RCOG, 2018). This mirrored the findings of the review team who identified that, in many instances, the coordinator had their own women for whom they were responsible for providing clinical care and were therefore not able to fulfil their required role, in particular the provision of support for junior midwives and doctors. Nor were they able in these circumstances to achieve and maintain the necessary 'birds eye' view of the labour ward.

5.38 A staff member told the review team:

5.39 *'The shift leader was constantly having a patient and from the time that I was working on their labour ward, ...you sometimes couldn't get hold of the shift leader because she was in looking after a woman.'*

5.40 Another staff member told us:

5.41 *'I was frightened about putting in…being put into an area that I just, just wasn't my area of expertise and not having support. But it wasn't just lack of support, it was actually, I was just frightened of going past a labour ward; I didn't want to do it, it wasn't my area of expertise and at the time if you voiced those concerns that was probably going to mean you were going to go there full time…'*

Midwifery matron

5.42 The role of the midwifery matron is deemed to be the cornerstone for improving the quality of clinical care through visible, compassionate and inclusive leadership and management. The role has evolved considerably since the publication of The Matron's 10 Key Responsibilities in 2003, and the Matron's Charter in 2004. However, the fundamental aspects remain the same: this includes promoting professionalism in the workplace, ensuring good patient safety and service-user experience, control of infection responsibilities, and monitoring the cleanliness of the clinical environment. It is widely acknowledged that midwifery matron roles also encompass workforce management, budgetary responsibilities and effective resourcing of equipment and maintenance of estates. The recommended minimum requirement for presence is one full-time equivalent, with additional on call and out-of-hours cover, ensuring 24-hour managerial cover[105].

5.43 The review has identified that as late as 2015 the Trust did not meet these recommendations, as the labour ward manager was found to be a hybrid of roles consisting of two shifts working as a labour ward coordinator and three shifts as a matron according to Labour Ward Staffing v2, 2015. In addition, the lead midwife/clinical risk co-ordinator role for consultant inpatient service also had responsibility for leading midwifery care and management on the labour ward. This combination of roles would have resulted in a workload that was not manageable and would have led to key issues being overlooked.

Statutory supervision of midwifery

5.44 Prior to its removal as a statutory function in March 2017, the West Midlands Local Supervisory Authority (WMLSA) had overarching responsibility for statutory supervision of midwifery at the Trust. While there were many professional principles for midwifery supervision, in terms of clinical leadership its purpose was to maintain and improve quality, and to protect women and babies by actively promoting a safe standard of

105 bid n4 RCOG (2007) and RCM, RCA, RCPCH, 2007

midwifery practice, which contributed to the protection of the public. The role of a supervisor of midwives (SoM), who was appointed by the WMLSA was intended to play an important part in providing expert, professional leadership for midwifery at both local and regional level[106].

5.45 A SoM timeline produced by the review team consisting of information extracted from documentation provided to the review including WMLSA audit reports, identified a high level of confidence in the supervisors of midwives at both Trust executive and clinical levels. The supervisors were said to be 'cohesive', had a 'very good team dynamic', and were said to be actively involved in staff training, which included participating and leading in obstetric emergency drills.

5.46 In 2012, a WMLSA visit reviewed the Trust's SoMs' investigation process, which concluded that the team would benefit from further support and guidance around report writing. This training was said to be provided in a supplementary visit to the Trust, however there is no evidence in the documentation provided to the review team that the WMLSA ever returned to the Trust to ensure improvement had occurred.

5.47 Until 2017, the caseload numbers of SoMs at the Trust were repeatedly identified as being above the then recommended ratio of one SoM to 15 midwives. To address these concerns, four of the current supervisors held a double caseload (i.e. 30 midwives) and received double financial remuneration and 15 hours of time in which to manage the additional workload. Similarly, appropriately qualified staff who had retired or previously left the Trust were recruited on a bank basis to provide further support to the supervisory team. There is also evidence which suggests the SoMs were supporting the CNST team; while the context of this is unclear, this may have given rise to a perceived conflict of interest as documented in the Midwifery Regulation in the United Kingdom report (Kings Fund 2015).[107]

5.48 In response to a complaint from a family, an external review was commissioned by the Trust to review an original investigation, which had been conducted by the Trust and signed off by the Local Supervisory Authority Midwifery Officer (or LSAMO) in 2009. The external review concluded that the quality of the supervisory investigation was poor, noting that the principles of root cause analysis were not applied, resulting in key events not being investigated. A repeat investigation by two midwives independent of the Trust made a number of recommendations relating to midwives involved in the clinical care; these included consideration of supervised practice, development support and referral to the Nursing and Midwifery Council (NMC). Furthermore, a significant number of systems issues were identified, that had not been identified in the original investigation including the escalation of staffing issues during times of increased activity/emergency. The absence of a systematic root cause analysis and the lack of support available to the investigating SoM, in particular when interviewing midwives, was also highlighted.

5.49 An independent review was instigated of WMLSA governance and assurance arrangements to determine whether the management and oversight of midwifery supervision was adequate. The review, which was carried out by NICHE patient safety[108] identified a lack of rigour around oversight of the investigative process, best practice was not followed and the quality of reports was not sufficient to prevent reoccurrences. With the purpose of statutory supervision of midwifery being to maintain and improve quality, and to protect women and babies by promoting a safe standard of midwifery practice, these were lost opportunities to achieve these objectives over a long period of time.

5.50 In late 2016, the WMLSA instructed the Trust to review a number of its cases internally. These appear to be some of the cases of the original 23 families, from 2000 onwards which make up the cohort that was highlighted to the Secretary of State and began the process of this review. This task appears to have been undertaken by one SoM at the Trust. The Trust found that none of the nine case investigations, which have been made available to the review required further investigation, thereby missing valuable opportunities for wider organisational learning and further improvement to processes. None of the families were contacted to be involved. Despite the complexity of some of the cases, this was a single professional review, failing

106 NMC, 2015

107 https://www.kingsfund.org.uk/projects/midwifery-regulation-united-kingdom

108 NICHE 2016 Independent Review of West Midlands local Supervising authority (LSA) Supervisory Investigations Governance arrangements dated 31st August 2016, ref 2031-16, supplied by the Trust

to involve other key colleagues who could have potentially provided significant assistance; for example obstetric, neonatal or anaesthesia colleagues. The review team believes that the WMLSA's instruction to undertake a further internal supervisory review of the investigations is questionable as we have not been able to evidence that assurance had been sought arising from the LSA's initial concerns regarding the quality of supervisory investigations, originally identified several years before.

Concerns regarding governance and concerns from families

5.51 Independent reports into maternity services at the Trust, including Graham (2015), identified governance issues, concerns from families and failure to learn from incidents and investigations. There is often a clear disconnect between the issues raised by the families and the findings in the subsequent investigations report. It is also clear that the maternity department, the Trust and the CCG were aware of these issues raised by families. The governance chapter of this report reviews this in more detail, but the evidence available and seen by the review team is that whilst the various reports made recommendations these did not translate into consistent improvements. As indicated in the first Ockenden Report (page 15) there were examples in 2016 and 2017 of families' dissatisfaction with investigation reports. Further examples were found in multiple interviews with families by the review chair throughout 2018 and 2019.

5.52 The RCOG undertook an invited review of maternity services at the Trust during July 2017, which was commissioned by the Trust's Medical Director to evaluate the culture within the service and to assess the safety and effectiveness of maternity and neonatal services.

5.53 The review team was provided with documentation updating on the progress of actions against the recommendations of the RCOG review; including an addendum to the report received during June 2018. This addendum had been prepared following a visit to the RCOG in London by a Trust team. The RCOG had not returned to the Trust to assess the accuracy of the evidence submitted. Quotes from the 'addendum' include the following: *'Review had been undertaken of the manager on-call rota and the rota is now "working better". The escalation policy is firmly in place and was referred to on many occasions, particularly during times when an MLU is closed and services are diverted to another unit.'*

Team working, culture and civility

5.54 The complexities and challenges of team working are not exclusive to healthcare settings, however unlike in some specialities, the effect of poor relationships and collaboration can have catastrophic long-term consequences for individuals, teams and organisations[109].

5.55 National reports into failing maternity services over a number of years have highlighted conflicting agendas and poor teamwork as significant contributory factors towards adverse maternal and neonatal outcomes[110]. Whilst there was some evidence of multidisciplinary team working at the Trust, there was often a notable lack of leadership, accountability and situational awareness.

5.56 *'In **2015** a woman in labour with a twin pregnancy at 36 weeks gestation did not receive an obstetric review on arrival to the labour ward. The neonatal unit were not informed of the admission. No progress in cervical dilatation was escalated to the labour ward coordinator, however there was no change to the management plan or escalation for obstetric review.'*

5.57 *'At full dilatation, an obstetrician attempted to perform a ventouse delivery of twin two. The ventouse cup came off after four pulls. Keilland's forceps were subsequently applied and five pulls were attempted. Neville Barnes forceps were then applied and the baby was delivered in poor condition with one further pull (ten with an instrument in total). The baby had moderate to severe hypoxic ischaemic encephalopathy.' (2015)*

109 Fatolitis, P. and Masalonis, A. 'Human Factors in Aviation and Healthcare: Best Practices, Safety Culture and the Way Ahead for Patient Safety', Journal of Ergonomics vol 11 issue 5. (2021) Available at: https://www.longdom.org/open-access/human-factors-in-aviation-and-healthcare-best-practices-safety-culture-and-the-way-ahead-for-patient-safety.pdf [Accessed 01 December 2021].

110 Kirkup, B. (2015) The Report of the Morecambe Bay Investigation. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf [Accessed 01 December 2021].

5.58 Due to the requirement for 24/7 cover of a significant proportion of service provision, teams within maternity units increasingly involve various practitioners of different clinical expertise[111]. Teams are also rarely constant, resulting in a number of individuals practising their specific roles within interchangeable groups. As such, training should enable maternity practitioners to function effectively in whichever team or environment they find themselves working in.

5.59 Furthermore, the labour ward can be a particularly challenging environment for even the most cohesive teams or groups due to its acute, unpredictable and specialist nature.

5.60 A staff contributor told the review team in late 2021:

'The fear was being pulled to somewhere else in the middle of a nightshift or being on-call for homebirths or midwife-led units. Being on-call perhaps having worked the day before, working the next day and then being called in to the labour ward to work a whole night shift because it was lacking in staff and that was very fearful…'

5.61 *'Yes, I certainly wasn't equipped because I was a community midwife…those were my areas of expertise, and I was expected to go in and act as a manager on labour ward and I was terrified. I was terrified and much stressed, and very emotional all the time about it.'*

5.62 Throughout the years, there have been multiple reports and research detailing the intricacies of team working and its direct relationship with safety outcomes and patient experience[112]. Additionally, there have been recommendations from leading organisations over a long period of time with the aim to improve safety through the standardisation of minimum multidisciplinary staffing requirements[113]. Despite this, the overall team working at the Trust remained suboptimal, which contributed towards many preventable incidents and adverse outcomes.

5.63 A staff contributor told the review team in autumn 2021:

'Culture is a big thing because I feel there's a reluctance to change there. Yes, they do need to change because this has resulted in lots of families having a terrible event happen in their lives that shouldn't have happened and I'm a midwife, and I know that things don't always go to plan. I don't believe that anybody has set out to go to work to cause harm or anything like that, but I think that probably some processes, some attitudes have definitely been a reason as to why things have not gone to plan.'

5.64 Another staff member said the following to the review team in early 2022:

'If I could say anything to the families it would be that there were people who tried to make changes, we tried to escalate our concerns and be heard but every process we used was set up not to acknowledge our voices or the problems we were highlighting. We were ignored and made out to be the problem but ultimately we failed to make ourselves heard....'

5.65 Many different factors affect the dynamics of team working which are well illustrated within various national programmes including Each Baby Counts. The following feature as contributory factors in adverse incidents:

- Individual human factors (present within 58 per cent of cases)
- Team communication issues (present within 53 per cent of cases)
- Lack of team leadership (present within 24 per cent of cases)
- Poor intra- or inter-professional communication (present within 43 per cent of cases).[114]

111 Flin, R., O'Connor, P. and Crichton, M. Safety At The Sharp End. (2008) CRC Press; Florida.

112 Ibid n20 and Liberati, E., Tarrant, C., Willars, J., Draycott, T., Winter, C., Chew, S. and Dixon-Woods, M. (2019) *How to be a very safe maternity unit: An ethnographic study*. Available at: https://www.thisinstitute.cam.ac.uk/research-articles/safe-maternity-unit-ethnographic-study/ (Accessed 01 December 2021).

113 National Institute for Health and Care Excellence Safe *midwifery staffing for maternity settings*. (2015) Available at: https://www.nice.org.uk/guidance/ng4 [Accessed 01 December 2021] and Ibid n4

114 Royal College of Obstetricians and Gynaecologists (2020) Each Baby Counts. 2020 Final Progress Report.

5.66 Similarly, Civility Saves Lives (2017)[115] articulates how negative behaviour such as rudeness or bullying results in a significant decrease in a clinician's performance and/or cognitive ability. Furthermore, incivility is recognised to not only affect an individual recipient, but also bystanders, patients/relatives and the wider team within healthcare settings[116].

5.67 A staff member told the review team that:

'There is culture of bullying on labour ward 24. Staff don't always feel supported by the shift co-ordinators. As I have said previously even though I am experienced I still felt I needed support and didn't always get it. I was told that I was a band 6 midwife so I should have no problems. I also got told by one shift co-ordinator that I was qualified longer than her and why was I asking her to support me with what was a difficult delivery?'

5.68 Whilst the identification of human factors will always remain integral to patient safety, there is more recent emphasis on addressing and preventing such issues from occurring in the first instance. Consequently, there is an increasing recognition of the importance and value of workplace culture and civility.

5.69 Workplace culture can be defined as 'shared ways of thinking, feeling and behaving within an organisation'[117]. The Trust consistently demonstrated negative behaviours and practices, resulting in many staff learning to accept poor standards as it became the cultural norm; this constitutes organisational abuse, similar to that found in the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013).

5.70 It is imperative to ensure the 'culture' within all healthcare settings is one that promotes openness, transparency and the psychological safety to escalate concerns. Yet the review team found evidence of disempowerment, with staff encouraged not to complain or raise awareness of poor practice within both personal and professional capacities.

5.71 A staff contributor told the review team that:

'You feel like you're penalised constantly in this organisation. I'm keeping my head down now. I have raised it before, I went to HR and it was almost as though I was causing trouble.'

5.72 Another staff member told the review team:

'Whilst reviewing the governance and assurance processes, I was approached by a consultant [obstetrician] who said be careful what you find.'

5.73 Reflecting on the harm caused to families a current staff member told the review team in early 2022:

'I am sorry and I know that sorry is not enough but by engaging with this review we hope that our voices will finally be acknowledged and that change will happen so that there are robust and independent places for clinicians to speak out that acknowledge what we are saying, what needs changing and act on this without fearing reprisals..'

5.74 Positive behaviour strategies have been designed to address negative cultures within healthcare, to improve the working environment for staff and so promote the delivery of safe and compassionate care for patients. Some of these strategies include the implementation of a Workplace Behaviour Toolkit (RCOG, 2021), Civility Toolkit (HEE, 2021) and the creation of national patient safety movements such as Civility Saves Lives (2017) and Learning from Excellence (2014).

5.75 Whilst it is of equal importance for all staff within maternity settings to demonstrate positive behaviours in their everyday practice, it is vital that leaders, such as the labour ward coordinator and senior obstetricians,

Available at: https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/each-baby-counts/ebc-2020-final-progress-report.pdf [Accessed 01 December 2021].

115 Civility Saves Lives (2017) Civility Saves Lives. Available at: https://www.civilitysaveslives.com/ [Accessed 01 December 2021].

116 Youngson, G. and Flin, R. Patient safety in surgery: non-technical aspects of safe surgical performance (2010). doi: 10.1186/1754-9493-4-4.

117 Mannion, R. and Davies, H. Understanding organisational culture for healthcare quality improvement, British Medical Journal (2018) doi: 10.1136/bmj.k4907.

are acutely aware of their own behaviour and how this influences other members of the wider team. Where negative workplace practices or behaviours are identified, leaders should ensure they take proactive steps to support individuals, address concerns and prevent the creation of a systemic negative culture similar to that described by staff at the Trust.

5.76 During the staff voices interviews some staff stated to the review team that there was a culture of bullying within the leadership team, and that this was not confined to the senior maternity management team but went across the Trust management structure.

5.77 A staff member told the review team:

'At a study day in 2016/2017, following the Kirkup report, a senior manager made the comment "we (SaTH) are not a Morecambe Bay". I made the comment that we absolutely were a Morecambe Bay - a trust full of unhappy staff with ineffective poor leadership, looking to hide or ignore poor care and poor management. I have worked for [another NHS Trust] which learned from its mistakes and supported its staff for the past [number of] years'.

5.78 *'I didn't realise how bad things were in SaTH until I left. The bullying culture from top down breeds bullying. I used to be proud to work there, but that changed from 2006.'*

5.79 Another member of staff told the review team of events within maternity services in 2019:

5.80 *'SaTH was managed with a big…stick from behind, there was no forward thinking leadership. We had changes in policy imposed on us, we did not contribute to changes. We were bullied, everything was done under the guise of 'clinical need' or 'your contract says.' We had issues with pay being withheld, managers not happy to reconcile hours/wages. The on-call rotas and change lists were both used as bullying tools. [An] entire team of five experienced midwives left the Trust in less than 18 months…I tried to raise a concern and instead of being listened to I was referred straight to occupational health. It seemed that as I dared raise a concern I must obviously be mentally unwell (this was in 2019)…this whole conversation was held in public unbeknown to me. Other midwives sitting in the office were listening to the way the manager spoke to me. I was and am still absolutely appalled by that action. I resigned…There are a lot of, I would say, home grown midwives, there are cliques there and, you know, they are Band 6s, Band 7s, Band 8s and they are a little gang, and, yes, they will make your life hell'.*

5.81 They continued: *'It's very hard to speak up because despite what anybody will tell you, there are consequences to speaking up and the consequences are your life gets made very difficult or you get subtle … you can't really pinpoint it as bullying, it's like subtle, made to feel uncomfortable when you go to work…'*

5.82 The staff interviews with the review team also highlighted that there was a lack of respect and role appreciation between the consultant unit staff and the community teams.

5.83 A staff member told the review team that *'There was a…bit of a feeling that because they were the consultant unit, they knew better than you, but actually, we're in the outlying units because we're experienced and we know what we're doing, but…we didn't feel like that respect was always there. Often our decisions were questioned as to, "Well, try this, try that", "Well no, actually, I'm sending her... [the mother in]" '.*

5.84 They continued:

5.85 *'Actually, they need to know our role; they need to know what it's like half an hour, 45 minutes. ...Nearly an hour away from the consultant unit, and they forget that you have to think that far ahead because of what might happen. We don't have an emergency buzzer to have the whole team in, so we have to think ahead and I think they forget that.'*

Conclusion

5.86 External reviews of the maternity services at the Trust between 2013 and 2017 gave the overall message that this was a safe maternity service. This review is concerned that some of those messages gave false reassurance and as a consequence opportunities were lost to have improved maternity services at the Trust sooner. For example, there were a number of concerns arising from these reports regarding governance issues and concerns raised by families, however these issues did not appear to have been prioritised.

5.87 The workforce is a cause for concern, and there were missed opportunities to address the shortfalls in staffing. It is clear that there were insufficient numbers of consultant obstetricians and junior obstetric staff and that there was inadequate anaesthetic support to the maternity unit. It is clear that the midwifery staffing across the service was poor and resulted in the service constantly working in escalation. This impacted on staff confidence and morale, creating a culture of fear and anxiety. There is also evidence of a lack of role appreciation across the service, particularly with those providing maternity services in the community.

5.88 The review team found evidence from documents provided by the Trust (2013-2016) that the local leadership had identified and escalated workforce issues and business plans had been drawn up to increase consultant and middle grade staffing. In recent times there has been a significant expansion in consultant obstetrician staffing.

5.89 Overall, there is a picture of external, independent and internal reports not being critical of clinical leadership at the Trust. However, the review team is concerned that even where recommendations were made, there is no evidence of who was accountable for their implementation or who, within the context of leadership, was responsible for maintaining oversight of these. Because of this, there was no effective strategy for meaningful change within maternity services at the Trust which further perpetuated the cycle of harm to women and families accessing maternity services at the Trust over an extended period of time. Staff who are currently employed in maternity services at the Trust and who engaged with the maternity review team as recently as early 2022 told us of a fear of speaking out in maternity services that persist to the current time. This is of very significant concern to the review team and has been shared with the Trust in advance of publication of this report.

Chapter 6

Our findings following the review of family cases

6.1 A total of 1,862 cases were either reported by the Trust or self-referred to the review. After the closure date for referrals the database was reviewed and 47 duplications were identified and removed leaving 1,815 cases.

6.2 The review was intended to span the years 2000-2019. However, as discussed in previous chapters, some earlier and later cases were reviewed in line with the updated terms of reference. The earliest case reviewed occurred in 1973 and the latest in 2020.

6.3 After excluding cases for which hospital records were missing, or where consent for participation in the review was not given or could not be obtained, the **final number of families whose cases were reviewed was 1,486**. It is important to note that some families had more than one clinical incident reviewed, as some mothers had more than one pregnancy during the review period. **In total 1,592 clinical incidents were reviewed.** Table 1 outlines the number of families and clinical incidents throughout the review period.

Table 1: Time period of family cases included in this review

YEARS	FAMILIES	CLINICAL INCIDENTS
Pre-2000	170	181
2000-2019	1,305	1,393
Post-2019	15	18
Totals	**1,486***	**1,592**

** Four families had clinical incidents that fell both within the 2000-2019 years and outside these years. Therefore there are 1,486 unique families in total.*

6.4 In line with the terms of reference underpinning this review we reviewed all 1,592 clinical incidents and analysed two aspects. Firstly, we graded the care provided by the Trust as set out overleaf. Secondly, we reviewed all the maternity governance documentation provided to the review team and graded the quality and appropriateness of the incident investigation in line with national frameworks at the time.

Grading of care

6.5 All the clinical incidents were reviewed by members of the review team which comprised obstetricians, midwives, neonatologists, and other specialists where appropriate. The clinical care was graded using an established grading of care scoring system (Table 2) developed by the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI), which was similarly used in the Morecambe Bay investigation report by Dr Bill Kirkup, OBE. Further details on the findings and the Immediate and Essential Actions recommended by this review are described in the accompanying chapters.

Table 2: Grading of maternal and newborn care provided

GRADE	SUMMARY DESCRIPTION OF CARE	DETAILED DESCRIPTION OF CARE
0	Appropriate	Appropriate care in line with best practice at the time
1	Minor concerns	Care could have been improved, but different management would have made no difference to the outcome
2	Significant concerns	Suboptimal care in which different management might have made a difference to the outcome
3	Major concerns	Suboptimal care in which different management would reasonably be expected to have made a difference to the outcome

6.6 Table 3 shows the grading of care for the major incident categories. For the incident categories HIE, neonatal death and cerebral palsy / brain damage the investigation into mother and baby is considered as one family. **It is important to note that a mother or baby can be in more than one category and this includes the maternal morbidity category and the combined category.**

Table 3: Clinical review findings for each of the major incident categories

INCIDENT CATEGORY	REVIEW TYPE	NUMBER OF REVIEWS*	GRADING OF CARE SCORE				PERCENTAGE OF CARE AT GRADE 2 AND 3
			0	1	2	3	
Maternal Death		12	0	3	6	3	75.0%
Stillbirth		498	193	174	93	38	26.3%
Hypoxic Ischaemic Encephalopathy	Mother**	44	10	5	16	13	65.9%
	Baby***	41	26	13	2	0	4.9%
Neonatal Death	Mother**	251	107	74	38	32	27.9%
	Baby***	237	182	38	13	4	7.2%
Cerebral Palsy/ Brain Damage	Mother**	147	35	47	45	20	44.2%
	Baby***	139	99	30	8	2	7.2%

**Some mothers had more than one pregnancy where a clinical incident occurred during the period of the review (for example a stillbirth in one pregnancy followed by another incident in a subsequent category).*

***Review of the care provided to the mother*

****Review of the neonatal care provided to the baby after birth*

Maternal deaths

6.7 There were 12 maternal deaths reviewed and in nine of the 12 cases (75 per cent) the review team identified significant or major concerns in the care received. Maternal deaths are further discussed in chapter 10.

Stillbirth

6.8 498 cases of stillbirth were reviewed and graded. One in four cases were found to have significant or major concerns in care which if managed appropriately might, or would have, resulted in a different outcome.

Hypoxic Ischaemic Encephalopathy (HIE)

6.9 HIE is a newborn brain injury caused by oxygen deprivation to the brain. There were significant and major concerns in the care provided to the mother in two thirds (65.9 per cent) of all cases. After the baby had been born, most of the neonatal care provided was considered appropriate or included minor concerns however these were unlikely to influence the outcome observed.

Neonatal death

6.10 Most of the neonatal deaths occurred in the first 7 days of life. Nearly a third of all incidents reviewed (27.9 per cent) were identified to have significant or major concerns in the maternity care which might or would have resulted in a different outcome.

Cerebral palsy

6.11 All of the families in this group self-reported to the review. The diagnosis of cerebral palsy was often made some years following their maternity episode. On reviewing the medical records, where it was found that the neonatologists at the Trust had recorded a diagnosis of HIE in the early neonatal period, a small proportion of families were subsequently transferred to the HIE incident category. From the remaining cases of cerebral palsy, more than 40 per cent were identified to have significant or major concerns in maternity care which might have resulted in a different outcome. The grading of neonatal care in most of the cases was either appropriate or with only minor concerns.

Maternal morbidity

6.12 Within this group were families who did not meet the incident categories identified in the NHS England and Improvement (NHSE&I) and Trust-led Open Book exercise conducted in the autumn of 2018 (maternal death, stillbirth, neonatal death and HIE). There were 614 women in this group, and they included women who experienced morbidity such as admission to intensive care, women who had had a caesarean hysterectomy, women who had severe sepsis or major haemorrhage or reported having experienced rare adverse outcomes such as eclampsia, amniotic fluid embolus or a cardiac arrest. Our reviewers identified significant and major concerns in the care provided to one in four women in this group. The care provided to the baby was considered appropriate in more than 90 per cent of records reviewed.

Combined category

6.13 This group included families who were outside the other categories. Some of these families self-reported. This category included medical termination of pregnancy, missed fetal abnormality, neonatal intraventricular haemorrhage, infant death and child death. There were 58 cases reviewed in this group. Most of these cases were graded as receiving appropriate care or care with only minor concerns.

Quality of investigation

6.14 We graded the quality and appropriateness of clinical incident investigations undertaken at the Trust throughout the time period of the review. Nationally, investigative processes have improved over time and this is described further in Chapter 4. Table 4 outlines the grading system used for the clinical incidents from 2011 onwards.

Table 4: Grading of investigations from 2011 onwards

GRADE	INVESTIGATION	FAMILY INVOLVEMENT
Appropriate	Incident investigated by team of clinicians Appropriate collection of evidence (statements, notes, policies etc.) Appropriate care and service delivery problems identified Strong recommendations for improvement with clear plan for implementation.	Families involved in investigation by compassionate communication with family at time of incident. Feedback to family once investigation concluded.
Poor	Any of the above missing (state which).	Very little family involvement, or feedback to family lacking after investigation.
None	Incident not investigated.	No family involvement.

6.15 The tables below show the results for stillbirths and neonatal deaths for the period 2011-2019. The maternal death investigations are discussed more fully in Chapter 10. Where there was no Trust investigation this is shown. In some cases the review team reported "unable to grade" which was usually due to incomplete documentation. Only where there was sufficient documentation for a review was a grading of appropriate or poor given.

Table 5: Stillbirths (2011-2019)

Total number of cases	GRADING OF INVESTIGATION				GRADING OF FAMILY INVOLVEMENT IN INVESTIGATION			
	Total number of cases where an investigation took place	Appropriate	Poor	Unable to grade	Total number of cases where an investigation took place (with enough data)	Appropriate	Poor	Unable to grade
168	100	36%	49%	15%	85	32.9%	40.0%	27.1%

6.16 In the period 2011-2019, 68 (40 per cent) of the 168 stillbirths reviewed did not have an investigation. Of those where an investigation occurred 36 per cent were found to be appropriate. Family involvement was graded as appropriate in 33 per cent of cases.

Table 6 Neonatal Deaths (2011 – 2019)

Total number of cases	GRADING OF INVESTIGATION				GRADING OF FAMILY INVOLVEMENT IN INVESTIGATION			
	Total number of cases where an investigation took place	Appropriate	Poor	Unable to grade	Total number of cases where an investigation took place (with enough data)	Appropriate	Poor	Unable to grade
77	44	54.5%	34.1%	11.4%	41	41.5%	31.7%	26.8%

6.17 In the period 2011-2019, 33 (43 per cent) of the 77 neonatal deaths reviewed did not have an investigation. Of those where an investigation occurred 55 per cent were considered to have been appropriately investigated. Family involvement was graded as appropriate in 42 per cent of cases.

6.18 In the hypoxic ischaemic encephalopathy group there were 12 cases reviewed for the period 2011-2019 and of these eight were investigated by the Trust. This group was considered too small to draw conclusions on the quality of the investigation.

Section 3

Our findings of what happened to the families

Chapter 7

Antenatal care

7.1 Safe and individualised antenatal care must be the foundation underpinning a woman's pregnancy and birth journey. From the point at which a woman notifies her pregnancy, often to her GP, and then attends a booking appointment with a midwife, a detailed and thorough risk assessment must be undertaken. Comprehensive, individual and woman and family-focussed questioning permits an accurate risk assessment so that care can be personalised and women can be signposted to the most appropriate antenatal care pathway.

7.2 For many women antenatal care is provided by a wide group of professionals including midwives, doctors and sonographers, as well as individuals from external agencies such as social care. This relies upon the sharing of accurate information between primary care and hospital maternity services and on occasion other medical specialities. Throughout antenatal care provision there is a necessity for close interdisciplinary working between these groups to ensure optimal and safe antenatal care is delivered. This chapter focuses on aspects of antenatal care that were not previously addressed in the first report and aims to highlight areas within the maternity service provided by the Trust which the review team felt warranted further attention.

Good practice in antenatal care and missed opportunities for learning

7.3 Throughout the time period of the review our multi-professional review team found a number of examples of good practice, of compassionate and safe antenatal care. However, also throughout the entire period of the review our team found poor standards of antenatal care, showing a lack of consistency and significant opportunity for improvement. Unfortunately there were significant numbers of poor standards of investigation when things went wrong or investigations that should have taken place which did not. Overall, the Trust continued to miss significant opportunities for significant learning throughout the entire time period of the review.

Care of vulnerable women

7.4 Pregnancy is a well-documented catalyst that may increase maternal vulnerability and inequalities already present in the lives of some women[118]. Vulnerability can be seen in women that have previously or are currently experiencing poverty, homelessness, domestic abuse, learning difficulties, seeking asylum, substance misuse, poor mental health, complex co-morbidities and teenage pregnancy. It is widely recognised that pregnancy carries a great deal of uncertainty. Women who are vulnerable in pregnancy are more likely to be exposed to additional harm, stress and anxiety.

7.5 The review team found evidence of missed opportunities to further investigate women from vulnerable groups. There was a lack of professional concern and in some cases a lack of appropriate referral in cases where further exploration was warranted. It is recognised that vulnerable women who receive appropriate support and intervention have improved outcomes[119].

7.6 *In **2009** a young woman in her first pregnancy was booked for consultant-led care due to her age and was diagnosed as having a baby with fetal gastroschisis[120]. She was not referred for additional support from the teenage pregnancy midwives but instead was seen by multiple midwives. As a result there were missed opportunities to explore her possible complex social needs as her care continued to be focused largely on the fetal gastroschisis (2009).*

118 NHS England. Better Births (2016) https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

119 Centre for Maternal and Child Enquires. Perinatal Mortality 2008 (2010) https://www.publichealth.hscni.net/sites/default/files/Perinatal%20Mortality%202008.pdf

120 See glossary

7.7 *A very young woman was booked for her first pregnancy in **2013**. There was no referral to the teenage pregnancy service nor any further exploration relating to her social circumstances, particularly as her partner was significantly older than her. She was not offered appropriate additional support and care. (2013)*

7.8 *In **2013**, a young teenage woman presented with a history of three previous pregnancies, all of these ending in miscarriage. Whilst she was appropriately referred to the teenage pregnancy midwife there was a lack of professional exploration or questioning around her social background, support networks and mental health. Appropriate signposting and referrals were not made in the pregnancy, and she did not receive the necessary additional offers of care and support. (2013)*

7.9 National guidance for women with complex social factors was updated in 2010[121] and emphasised the need to improve support for women with additional needs. The Trust has guidance available with care pathways and referral processes for specialist practitioners such as the safeguarding team and teenage pregnancy midwife. The review team considered many cases where guidance was followed and referrals had been appropriately made

7.10 *In **2018**, the review team had concerns around a lack of appropriate safeguarding and domestic violence screening- not completed at the booking visit. There were a number of missed opportunities to follow up the questions about domestic violence. It is appreciated there is always a possibility that an individual may not disclose any concerns. Following what was thought to be a domestic violence incident there was significant maternal morbidity and stillbirth. The review team subsequently saw evidence of learning from the Trust and changes to practice following this case. (2018)*

Good practice

7.11 *In **2008** a young teenage woman in her first pregnancy received appropriate input and referrals from the teenage pregnancy midwives and additional input and investigation from the fetal medicine consultant. Bilateral talipes[122] were identified on an ultrasound scan. The baby was born at term and had an extended stay on the neonatal unit for nearly 1 month due to its inability to feed and the need for nasogastric feeding. There were extensive investigations for a possible neuro-muscular disorder and the family were counselled and supported by a geneticist about this. (2008)*

7.12 *A young woman in her first pregnancy in **2016** was appropriately referred to the teenage pregnancy team. The review team observed use of interpreters and the offer of a comprehensive assessment which would have resulted in an holistic consideration of the family strengths and needs. This was declined by the mother and the family (2016).*

7.13 Whilst highlighting these examples of good practice, the review team found that overall there was a lack of consistency, potentially exposing women and their babies to increased risk and potentially unnecessary harm.

Fetal growth assessment and management

7.14 Monitoring fetal growth is an integral component of safe and effective antenatal care. Over the last 20 years there has been increasing evidence that fetal growth restriction (FGR) is associated with stillbirth, neonatal death and increased perinatal morbidity. The Perinatal MBBRACE report in 2015[123] on term antepartum stillbirths found that 'about one in three term, normally formed, antepartum stillbirths are related to abnormalities of fetal growth'.

121 National Institute for Health and Care Excellence. Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (2010) https://www.nice.org.uk/guidance/cg110

122 See glossary

123 MBRRACE-UK. Perinatal Confidential Enquiry. *Term, singleton, normally-formed, antepartum stillbirth* (2015) https://www.hqip.org.uk/wp-content/uploads/2018/02/perinatal-confidential-enquiry-term-singleton-normally-formed-antepartum-stillbirth-report-2015.pdf

7.15 In November 2015, the Department of Health[124] announced a new ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030. The National Maternity Review, Better Births[125] (2016) highlighted a range of measures which can enhance the safety of care for women and babies, and identified a 'care bundle' as good practice in reducing stillbirths.

7.16 NICE (2003, 2008)[126] and RCOG (2013)[127] guidance advocates the use of symphysis fundal height (SFH) measurement and plotting these on a growth chart in the maternity handheld notes as essential to the care of low risk women. A referral for an ultrasound growth assessment is indicated where thresholds are reached or for women who are deemed to be high risk.

7.17 In 2016 NHS England produced the Saving Babies Lives Care Bundle Toolkit for maternity units to reduce the risk of stillbirth. The 'toolkit' was a range of measures that could be deployed to improve safety for mothers and their babies. One element of this has been the detection and surveillance of fetal growth restriction (FGR); (version 2 published 2019)[128]. However, it must be acknowledged that historically, national guidance for monitoring of fetal growth has been conflicting and this has been a contentious issue across the UK over the last 20 years. There remains extensive regional variation in the adoption of guidance and practice.

7.18 In 2007-2008 the Trust introduced customised growth charts as part of the national Growth Assessment Protocol (GAP)[129] and Gestation Related Optimal weight (GROW)[130] programme with the West Midlands being one of the first regions to introduce the programme. Prior to this time the non-customised SFH and ultrasound growth charts were in use within the Trust's handheld antenatal notes.

7.19 The review team found many instances where fetal growth restriction occurred but was not identified. Whilst it is recognised that despite following guidance it is not always possible to detect FGR (given the limitations of available methods including ultrasound) there were definite themes that emerged from review of these cases:

- The SFH measurement was not always completed and documented at each antenatal visit from 24 weeks.
- The SFH measurements taken were both inconsistently and inaccurately plotted onto the growth chart.
- A lack of appropriate referral when SFH measurements would have triggered an ultrasound scan.
- Failure to monitor growth by ultrasound in babies at high risk of FGR (e.g. women with underlying hypertension).
- Lack of recognition, action and wider learning by the Trust when babies were born growth restricted, including those who died.

7.20 *In 2017 a nulliparous[131] women was assessed at her an antenatal visit at 27 weeks and it was noted that the symphysis fundal height (SFH) plotted above 90th centile when plotted on the customised growth chart. Following this fetal growth appeared to be reducing in trajectory. According to local guidance a fetal growth scan should have taken place .This did not occur. At 35 weeks gestation a stillbirth occurred of a grossly fetal growth restricted baby (birthweight at delivery on the 1st centile). The Trust recognised that*

124 https://www.england.nhs.uk/mat-transformation/saving-babies/

125 Ibid n1

126 National Institute for Health and Care Excellence. Antenatal Care Clinical Guidance 6 (2003) https://www.nice.org.uk/guidance/cg6 and Antenatal Care for uncomplicated pregnancies Clinical Guidance 62 (2008) https://www.nice.org.uk/guidance/cg62

127 Royal College of Obstetrics and Gynaecologists *Investigation and Management of the Small-For-Gestational-Age Fetus Green-Top Guideline number 31* (2013) https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf

128 NHS England. Saving Babies' Lives Version 2: a care bundle for perinatal mortality (2019) https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

129 Clifford, S., Giddings, S., Southam, M., Williams, M., Gardosi, J., *The Growth Assessment Protocol: a national programme to improve patient safety in maternity care*. (2013) https://www.perinatal.org.uk/wwwroot/pdf/nz/GAP_article_MIDIRS_Dec_2013.pdf

130 Gestation Network. Growth Charts GROW https://www.gestation.net/growthcharts.htm

131 See glossary

there were missed opportunities to detect IUGR and refer appropriately. There was confusion from staff about guidance and when a woman should be referred for a scan. Had this severe IUGR been detected earlier delivery may have been expedited prior to stillbirth occurring. (2017)

Staff voices on fetal growth:

7.21 A staff contributor told the review that that they had encountered problems with women being referred for growth scans and had found that some clinical colleagues were uncertain of SFH measurement technique:

'When I was doing some of the clinics, I would be seeing antenatal women who should have had a scan… and in one clinic session, there were three women who should really have been referred for a growth scan and obviously, I did refer them, but I mean even the one partner had plotted the growth on the chart because they said the midwife hadn't plotted it…'

7.22 *The staff member continued: 'I was even asked the one time, "How do you measure fundal height?" by a midwife? I don't know, having a joke or something, I says, "How do you mean?" and [midwife] said, "Well…" literally [they] described how they measure the fundal height, I said, "Well, it's clear on the growth chart how to measure it you know, this is how you do it; it's on the growth chart itself how to measure it," and [they] says: "I do it the opposite way", which wouldn't give you the correct measurement'.*

7.23 Incorrect assessment of fetal growth was repeatedly observed by the review team. Some examples of this include:

*In **2011** a woman had continuity of care with the same midwife during her antenatal care, however the SFH measurements were incorrectly documented at some visits (not written in centimetres), and were incorrectly plotted in their position and mark used on the growth chart. The plots, if correct should have alerted referral for an ultrasound scan to assess growth. The pregnancy ended in a stillbirth of a baby with growth restriction. (2011)*

7.24 The Trust's initial investigation in June 2011 did not recognise that there had been missed growth restriction. The governance documentation reviewed was poorly completed and there was no indication that any of the actions had been achieved. Following a complaint from the family in October 2011 a further investigation took place and it was acknowledged that the growth measurement and plotting did not identify growth restriction. An action plan was made and evidence subsequently supplied to the family that the actions had been completed. However the learning only took place after a family complaint and not before. Families consistently told the review team of investigation only commencing after receipt of a complaint or commencement of litigation. The review team has seen this was a regular feature during the whole time period of this review. (2011)

7.25 *At 36 weeks' gestation in **2013** a woman experienced an intrauterine death. Following birth it was found the baby was significantly growth restricted. On case review it was established the SFH was not plotted on the GROW chart. The SFH was persistently measured as >90th centile (when retrospectively plotted) but the baby was profoundly growth restricted, and weighed 1.53kg at birth (1st centile). This case highlights poor SFH measurement techniques by several different antenatal care providers. (2013)*

7.26 Governance documents supplied by the Trust to the review team for the above case recognised that growth was not plotted appropriately and there had been missed FGR. Actions stated by the Trust were to ensure GROW training was being accessed by all, including GPs. GAP training was due to start in 2014. A further meeting in 2015 found that the CCGs had not progressed these actions and the GPs had not accessed the GAP training. Following this meeting the action was for the patient safety manager to highlight the need for the GAP training with the CCGs in conjunction with the recent MBRRACE report. The target date was February 2016, 3 years after the case. The review team has not been provided with evidence by the Trust to demonstrate this actually happened despite the significant passage of time.

7.27 *In **2015**, a woman became pregnant who had previously had a small baby with a birth weight just above the threshold in the local guideline to merit referral for an ultrasound scan. She was a current smoker and in this current pregnancy missed antenatal appointments due to issues with scheduling and non-attendance. Despite these risk factors, in the pregnancy in 2015 the complete clinical picture was not considered and she was not appropriately referred for an obstetric review or serial growth scans. (2015)*

7.28 *Her baby was stillborn at 37 weeks, with a birth weight less than the 3rd centile. The investigation by the Trust recommended a change to guidelines, to clarify exactly which centiles must be included in the risk assessment guidance for referral for scans in a subsequent pregnancy. The following two versions of the guidance did not change and the antenatal risk assessment was not updated until **2018**, a gap of 3 years following the incident.*

7.29 *A woman who was known to have large uterine fibroids had midwifery-led care throughout her pregnancy in **2016**. There were errors in the interpretation of the baby's growth, fetal and growth restriction was not detected and an obstetric opinion on the ultrasound scan was not obtained. The baby was born at 31 weeks and was severely growth restricted with a birthweight less than the 1st centile. The baby died the same day from a severe hypoxic birth injury. Local investigation recognised there was a missed opportunity for earlier specialist ultrasound scanning. (2016)*

7.30 Staff interviews undertaken during late 2021, as part of the Staff Voices initiative, supported the view that the Trust remained slow in implementing recommended changes. A staff member told the review team: *'so we're going to put that into our protocols and policies and before it was just 'mañana', we'll do it tomorrow. Tomorrow never comes. There's no urgency to address or change or do anything. They'll do that and if it works for them, we'll do it. No, we have to do it. We're answerable, we're accountable'.*

Specialist antenatal care

7.31 Some aspects of antenatal care require the input of specialised services. The review team identified the following areas of concern with specialist services that were being delivered at the Trust.

Fetal medicine care

7.32 A number of cases were considered where fetal medicine care was provided at the Trust. The review team identified incidences where a baby was born with an abnormality which was not detected until after birth or where a fetal abnormality was detected during the pregnancy and the review team had concerns about the care provided. From review of clinical records, in most cases the quality of fetal medicine care at the Trust appears to have been appropriate or good for the year that the pregnancy occurred. Some fetal abnormalities would not necessarily have been expected to be diagnosed antenatally and for those diagnosed it was evident that appropriate, kind and compassionate care had been provided both during the pregnancy and following a pregnancy loss.

Good care

7.33 *In **2007** a woman had a pregnancy complicated by multiple abnormalities found on the anomaly scan. She was seen by the fetal medicine consultant at the Trust and counselled regarding the increased chance of a chromosomal abnormality and she had an amniocentesis. The baby was confirmed to have a chromosomal abnormality and a referral to the genetics team was made. The parents decided to terminate the pregnancy. There was documented evidence of good communication with the parents and GP antenatally and postnatally and evidence of compassionate antenatal and bereavement care. (2007)*

7.34 *In **2012**, a baby was diagnosed with a significant brain abnormality at the anomaly scan. There was referral to the tertiary centre and the parents were counselled by the geneticists and paediatric neurologists at the tertiary centre and the neonatal and fetal medicine team at the Trust. The woman had regular scans and thorough investigations during the pregnancy with good multidisciplinary antenatal care and*

communication noted. The baby was delivered at 37 weeks and the baby died at a few hours of age. There was appropriate follow-up with the neonatal and genetic teams. (2012)

7.35 *A woman had a pregnancy in **2016** complicated by multiple fetal abnormalities identified at the anomaly scan at 19 weeks. She was seen by a fetal medicine consultant and offered an amniocentesis (invasive testing) and possible termination of pregnancy which she declined and had a stillbirth at 36 weeks. She was seen regularly by the midwives and obstetricians throughout the pregnancy and offered bereavement support. (2016)*

7.36 These cases demonstrate that there was often appropriate multidisciplinary care, support, counselling and bereavement care for the parents, including care at the tertiary centre where appropriate, following the diagnosis of a significant fetal abnormality.

Poor care

7.37 However, the review team found a number of cases where care was substandard. For fetal abnormalities such as cardiac abnormalities, babies that require surgery immediately post birth, babies with multiple abnormalities suggestive of a genetic syndrome or babies with severe early onset FGR, then referral to a tertiary fetal medicine centre during the antenatal period is the appropriate care pathway expected. This would ensure multidisciplinary counselling and expert care and for many babies birth in a unit with a Level 3 neonatal unit would be appropriate. There appeared to be a reluctance by some clinicians to refer some women for tertiary centre fetal medicine care for advice and counselling, or to transfer care to a Level 3 centre as a more appropriate place for birth. In cases where a fetal abnormality was detected postnatally or a baby died with abnormalities there was often no Trust investigation of the screening process or care. Thus opportunities for learning were lost.

7.38 When interviewed by the review team a member of staff at the Trust agreed that there was sometimes a reluctance to refer fetal medicine cases for an external review.

7.39 The contributor told the review: *'I think I'd probably, in retrospect, agree…to some extent. I think there was a degree of fetal medicine clinical overconfidence…but there are other things that you thought perhaps ought to have been referred elsewhere earlier on, yes'.*

7.39 *A woman booked in her third pregnancy in **2015**; although the 20/40 week anomaly scan was normal, significant fetal abnormalities were diagnosed at a later scan, which were likely to be associated with a poor outcome for the baby. She was counselled by a Trust fetal medicine consultant; although documentation of the discussion and possible outcomes were poor. The plan was made for the baby to be delivered at the Trust and for the neonatal team to be at the birth. The baby was delivered at 36 weeks and died within the first 24 hours of life. (2015)*

7.40 This case highlights the importance of appropriate antenatal communication and consideration for best place for birth. Although in cases, such as this, where the outcome is likely to be poor and the pregnancy is continuing, the outcome may be unchanged by referral to a tertiary centre, appropriate practice would be offering referral to a tertiary fetal medicine unit to ensure the provision of detailed counselling regarding the prognosis, including counselling from the wider multidisciplinary specialists. The specialist team would comprise geneticists, neonatal surgeons and speciality paediatricians to plan appropriate antenatal surveillance and postnatal care and ensure informed decision making by the parents.

7.41 Ongoing antenatal care following referral can be shared between the local and tertiary centre but at least one visit to the tertiary centre will ensure that key expertise is sought. Consideration must also be given to birth in the tertiary centre in complex cases, where the abnormality is likely to require early surgery and where level 3 neonatal care may be required to ensure optimisation of care at birth. With all of this information provided to the woman and her family they are then able to make an informed choice.

7.42 *In **2008** a women in her sixth pregnancy was identified as having a baby with a significant congenital abnormality at the anomaly scan. She was counselled by a Trust obstetric consultant, the neonatal team and neonatal surgeons at the tertiary centre. She decided to continue her pregnancy and delivered her baby at the Trust. The baby was transferred to the tertiary centre postnatally and died aged four days. Following review of this case it was agreed that referral to tertiary fetal medicine service should have been made and consideration given to the appropriate place of birth. (2008)*

7.43 *In **2019**, a woman had a pregnancy affected by severe early onset fetal growth restriction. There was no referral to a tertiary centre for specialist review, counselling or advice, particularly when the woman was reluctant to consider local advice regarding birth. The review team found there was limited evidence, pointing to inadequate counselling, and fetal medicine management was not in keeping with best practice. (2019)*

7.44 In the chapter focussing on neonatal care the review team discuss the change in designation of the neonatal unit in 2006 from level 3, (neonatal intensive care unit or NICU) to level 2, or a 'local' neonatal unit. Staff interviews supported the culture of reluctance to transfer women in utero or neonates to a Level 3 tertiary unit following the Royal Shrewsbury Hospital being designated a Level 2 or local neonatal unit, (LNU) in 2006. Staff described a gap of circa 8 years before the changes introduced in 2006 were actually implemented, but some were reluctant to be quoted within the report. Some staff members from the Trust stated that there was a lack of capacity at the designated level 3 units in the surrounding area, leading to the Royal Shrewsbury Hospital continuing to care for babies outside its designation. However this was disputed by the neonatal network.

7.45 One staff contributor told the review: *'Part of the sense of futility is that we have raised concerns, you know, sometimes we've actually had quite heated debates about…if on the obstetric side they feel that they don't want to send to Stoke or Birmingham, and…want...to keep the patient, and you're made to feel that you're letting the side down by not agreeing to proceed…I think for some of them there is a reluctance, and I don't know if that is a cultural thing because I think for a long time, particularly while based at RSH, there was a feeling that it was a very standalone unit and it did its own thing. So I think culturally there's been that feeling…'.*

Multiple pregnancies

7.46 About 1 in 60 pregnancies is a twin or triplet pregnancy (NICE 2015). A unit with approximately 5,000 births a year such as the Trust would expect on average 65-75 pregnancies resulting in multiple births a year. Multiple pregnancies are known to be at greater risk of adverse obstetric outcomes and so additional antenatal care is required.

7.47 NICE guidelines on twins and triplet pregnancy were first published in 2011 and have since been updated in 2019[132]. Guidance has emphasised the importance of detailed antenatal counselling for women with twins or triplets especially with regards to intrapartum management. This is best facilitated through a specialist clinic. The review found multiple cases where limited or no counselling was evident with regards to management of twin pregnancies.

7.48 *In **2013**, a multiparous[133] woman booked with a DCDA[134], twin pregnancy. At 31 weeks she was seen by a registrar and requested birth by caesarean section. She was told this was not necessary but there was no documented discussion regarding the risks associated with vaginal birth for the second twin. Twin 2 experienced a complicated birth and suffered HIE Grade 3. The child is now profoundly disabled and the mother suffered post-traumatic stress disorder. (2013)*

132 National Institute for Health and Care Excellence. Twin and triplet pregnancy NICE Guideline NG137 (2019) https://www.nice.org.uk/guidance/ng137

133 See glossary

134 See glossary

7.49 *In **2014**, a 41-year-old first time mother who conceived through assisted conception was advised an induction of labour at 36+ weeks as her twins were small. There was no evidence of any antenatal counselling. Labour was induced and she required an assisted vaginal birth for both twins in theatre. The second twin had a very complicated birth and as a consequence suffered HIE. (2014)*

7.50 *In **2017**, a primiparous[135] woman was induced at 37 weeks and 5 days as she had a DCDA[136] twin pregnancy, this was in accordance with local guidance. There was inadequate documented antenatal discussion with regards to the process of induction of labour, consideration of epidural analgesia and the potential risk of caesarean section for twin 2. Furthermore, at the time of induction prostaglandin (medication given to start the labour) was given without an obstetric review or an ultrasound scan to confirm presentation of the twins. An emergency caesarean section was undertaken for a fetal heart rate abnormality. There was a postpartum haemorrhage of 2500mls which was appropriately managed. (2017)*

7.51 Further cases of concern regarding the management of multiple pregnancies were seen by the review team. In conclusion, the review team found that multiple pregnancy management at the Trust gave cause for concern across the entire review period.

Diabetic Care

7.52 The care of women with diabetes encompasses women with both pre-existing diabetes and women who develop diabetes during pregnancy, known as gestational diabetes mellitus (GDM). UK rates of GDM have steadily increased over the last decade with Diabetes UK estimating that about 1 in 16 women will develop GDM. Women with pre-existing diabetes make up a smaller proportion of the women requiring diabetes care, but pregnancy complications are greater in this group.

7.53 UK guidance for the management of diabetes in pregnancy was first published by NICE in 2008 (revised in 2015 and updated 2020)[137]. Prior to NICE guidance CEMACH[138] published a landmark report in 2007 that highlighted women with pre-existing diabetes had a fivefold increased risk of stillbirth and a threefold increased risk of perinatal mortality. All these reports emphasise the importance of multidisciplinary care for women with diabetes and that women must have ready access to specialists with expertise in the care of diabetes in pregnancy.

7.54 Diabetes care at the Trust must be led by a named consultant obstetrician who acts as a lead for the service. This lead consultant must have sufficient time in their job plan to lead the diabetes service effectively. This can be benchmarked against other similar sized trusts. The lead consultant must work in conjunction with a consultant diabetologist, specialist nurses, midwives and also a diabetes dietician. It is imperative that these individuals work together in a collaborative manner. The diabetes service at the Trust was created in 1999 and has increased in size over the last 20 years. The number of women presenting with diabetes has been increasing significantly.

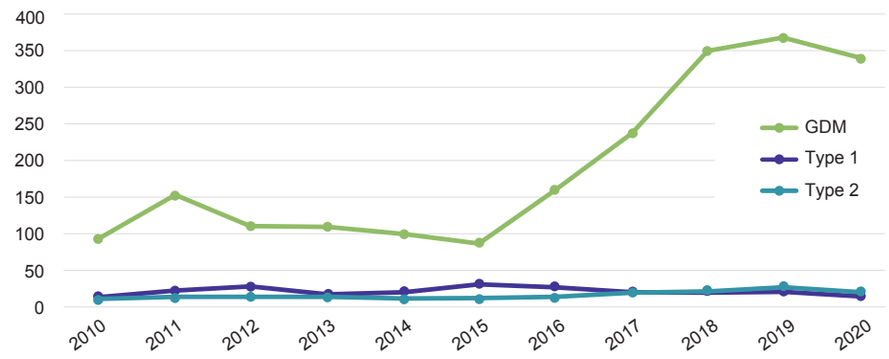
135 See glossary

136 See glossary

137 National Institute for Health and Care Excellence. *Diabetes in pregnancy: management from preconception to the postnatal period NICE guideline NG3* (2020) https://www.nice.org.uk/guidance/ng3

138 Confidential Enquiry into Maternal and Child Health. Diabetes in pregnancy: are we providing the best care? (2007) https://www.publichealth.hscni.net/publications/diabetes-pregnancy-are-we-providing-best-care

Diabetes yearly breakdown



Source: Shrewsbury and Telford Hospital NHS Trust

7.55 *In **2016**, a woman had appropriate multidisciplinary team antenatal care that involved senior obstetric, diabetic specialists and midwifery input. However there was failure not to act or further investigate increasing ketonuria[139] and fetal macrosomia[140] in a diabetic smoker all of which are individual risk factors for intrauterine fetal death. An antepartum stillbirth occurred at 34 weeks and 6 days. There was no evidence provided to the review team that this case was discussed at a governance meeting or that any learning was identified. (2016)*

7.56 *In **2016** a women with Type 1 diabetes who had poor control prior to pregnancy, suffered a stillbirth at 34 weeks' gestation. There were multiple missed opportunities to improve diabetic control and care sometimes seemed fragmented. The risks of the pregnancy were not shared with the patient. The patient had a pregnancy the following year where the care was much improved with evidence of better multidisciplinary team working. (2016)*

Staffing of the maternity diabetic service at the Trust

7.57 The Trust has advised the review team that the present diabetic service consists of two consultant obstetricians, and two endocrinologists. There is one Band 7 midwife and two band 6 midwives who both provide less than 0.5 full time equivalent cover. The service also has access to diabetes nurse specialists. The review noted current problems with staffing and capacity within the diabetic service, especially given the increasing workload. Firstly, there is no current provision for consultant cover during periods of annual leave, study leave and other absences, meaning women have limited access to the correct specialist during their antenatal care.

7.57 Furthermore, from the documentation provided to the review team there appears to be only one fortnightly clinic run for women with GDM. This is inadequate for the number of women managed with GDM in the service, which is on average 29 women a week (based on the Trust's data for the last 3 years). Having such limited appointments available for complex pregnancies means that an appropriately detailed assessment is unlikely to be made, which increases the likelihood that omissions will occur and errors will be made.

Good practice

7.59 Whist the review had concerns regarding the maternity department's ability to support the diabetes service it saw good practice, in that the department had invested to develop a midwifery non-medical prescriber. This model of care means a specialist midwife has a greater depth and understanding of diabetes and also continues to manage women with gestational diabetes when medical therapy is required.

139 See glossary

140 See glossary

Preconception care and diabetes

7.60 An important facet of diabetes management is access to preconception care for women with pre-existing diabetes. Women with very poor diabetic control must be advised against becoming pregnant until better diabetic control is established and must have access to appropriate advice on contraception and medications to avoid when embarking upon pregnancy. The review found evidence of numerous cases of women with pre-existing diabetes who had not had access to preconception care. This includes the case below, which is relatively recent.

7.61 *In **2019** a woman with underlying type 2 diabetes and an elevated BMI booked with an average blood glucose level of 117 prior to pregnancy (desired upper level for pregnancy is 48). Whilst she was first seen prior to 10 weeks of gestation, she unfortunately suffered an intrauterine death at 16 weeks, which may have been related to her pre-pregnancy diabetic control. (2019)*

7.62 Cases such as this evidence the disconnect between diabetes care, general practice and maternity services and the need for greater emphasis on preconception care. With better access to preconception care and provision of appropriate contraception services, this will help reduce or minimise cases of pregnancy loss associated with a woman's diabetic status.

7.63 As pregnancies in women with underlying diabetes are at elevated risk of poor fetal outcome it is imperative that women undergo thorough clinical and risk assessment at all antenatal visits. This includes assessment of blood pressure, urine and measuring and plotting the SFH.

7.64 A further important component of antenatal care for women with diabetes is that of birth planning. Women with diabetes are far more likely to require induction of labour or birth by planned caesarean section, particularly in the presence of fetal macrosomia or fetal growth restriction. There was evidence that this failed to occur in several cases leading to poor fetal outcome at the Trust.

7.65 *In **2014** a woman with type 1 diabetes was seen at 35 weeks and a plan was made for induction of labour at 38 weeks. There was no assessment of fetal growth beyond 35 weeks, but it was noted the abdominal circumference plotted above the 95th centile. At the time of induction, it was noted that the SFH measured 46cm and yet this was not acted upon. The patient underwent induction of labour which culminated in a vaginal birth complicated by a shoulder dystocia and abnormal fetal blood gases. Unfortunately, an early neonatal death occurred which was related to fetal hypoxemia at birth. (2014)*

7.66 When planning the place and mode of birth, maternity team members must provide women with evidence-based advice and recommendations. This will enable women to make an informed choice about their pregnancy and birth. This discussion must be fully documented in the maternity notes.

Good practice

7.67 There is evidence within the diabetes service that the Trust has made efforts to enhance antenatal care for diabetic women. The Trust has invested in the use of smartphone technology to allow remote reviews and telephone consultations for women with gestational diabetes. Additionally, NHS England recently mandated funding for all women with type 1 diabetes to have access to continuous glucose monitoring (CGM) in pregnancy. This funding stream has commenced after the period of the review but it is nevertheless important that the Trust ensures women have equity of access to CGM early in pregnancy.

Hypertension management

7.68 Gestational hypertension (also referred to as pregnancy induced hypertension) is a common disorder and may affect up to 1 in 10 pregnancies. It describes new onset hypertension in pregnancy occurring after 20 weeks gestation where maternal blood pressure is greater than 140/90 on two separate readings more than 4 hours apart. Hypertension identified prior to this point is known as chronic hypertension and affects about 1-2% of women. Gestational hypertension as well as chronic hypertension are known to be

risk factors for the development of complications in pregnancy and so women must undergo assessment of blood pressure at every antenatal visit. Furthermore, women who develop hypertension may require antihypertensive treatment during pregnancy to reduce the risk of developing severe hypertension.

7.69 National guidance for hypertension management was first published by NICE 2010 with collaboration from the RCOG and the RCM. It has since undergone revision in 2019[141]. Prior to 2010, the UK confidential enquiry in maternal deaths (CEMACH)[142] emphasised the importance of treating severe hypertension which may have contributed to cases of maternal death. Given how common hypertension is, all healthcare professionals working in maternity services must be aware of the need for monitoring and onward referral of woman with hypertension for obstetric review.

7.70 The Trust shared with the review team its first guidance for hypertension in pregnancy. This appears to have been created in 2006. The document is entitled Hypertension Severe (it has no implementation date but was due for review in 2008). It is noteworthy that the guidance stated that the initiation of antihypertensive medication for high blood pressure was only required if the systolic was 170 or greater, and they acknowledge that the Confidential Enquiry recommendation (published 2007) stated a lower blood pressure of 160 systolic required treatment. This potentially indicates a reluctance within the Trust's maternity service to treat severe hypertension according to national guidance. It must be noted these thresholds are much higher than the current guidance set out from NICE where blood pressure requires treatment when it is 150/100 or greater.

7.71 This review covers an extended period over 20 years and underpinning the review is a methodology acknowledging that assessment of cases must utilise the national guidance in use at the time. When reviewing the management of hypertension, the review team has focused on cases from 2009 onwards so that maximum learning could be established for the Trust as regards current service provision from the cases reviewed. Nevertheless, it must be acknowledged that there were many significant cases that were encountered where there was suboptimal management of hypertension prior to 2009. One example is:

7.72 *In **2001**, a woman developed severe hypertension with a blood pressure 165/100 and proteinuria at 36 weeks' gestation. A 24 hour urine collection was raised at 0.5g/l. No treatment was started, instead her elevated blood pressure was attributed to anxiety, despite clinical signs of severe hypertension. Over a week later induction of labour was finally decided upon when she developed epigastric pain and felt very unwell. There was no long term harm to mother or baby in this case. (2001)*

7.73 Following publication of the 2010 NICE guidance the review team found continued deviation from NICE guidance in the treatment of women with hypertension at the Trust.

7.74 *In **2011** a woman developed hypertension at 38 weeks' gestation in her first pregnancy, despite multiple elevated blood pressure readings that would have justified treatment, no treatment was started. She suffered an intrapartum stillbirth during the induction of labour, (IOL) process. The review team felt this was a high risk case, and a scan should have been carried out prior to IOL. In addition, assessment should have been made by an experienced midwife, not a student. If the CTG had been normal at the beginning of induction, then it is more likely than not that with adequate and ongoing observation and assessment, the outcome would have been different. (2011)*

7.75 *A woman developed hypertension and proteinuria at 33 weeks gestation in **2011**. She was admitted to the antenatal ward and started on treatment and given intramuscular steroids in anticipation of early birth. She had persistent vomiting and an ongoing headache. A consultant review occurred and it was decided she could have outpatient management. The woman was discharged but had an eclamptic seizure at home and was transferred and delivered by emergency caesarean at another hospital. The review team have not been provided with any documentation by the Trust that indicated any investigation or subsequent learning occurred as a result of this case. (2011)*

141 National Institute for Health and Care Excellence. Hypertension in pregnancy: *diagnosis and management NICE guideline NG133* (2019) https://www.nice.org.uk/guidance/ng133

142 Confidential Enquiry into Maternal and Child Health. *Saving Mothers' Lives 2003-2005* (2007) https://www.publichealth.hscni.net/publications/saving-mothers-lives-2003-2005

7.76 *In a **2013** pregnancy a woman with type 1 diabetes was reviewed as an inpatient at 37 weeks as she had developed hypertension and proteinuria. Her blood pressure was elevated at 162/98mmhg. Her case was escalated to a consultant who despite clinical signs of hypertension and proteinurea indicated that no treatment was required. The review team found had concerns that such a high risk case had induction of labour started on the antenatal ward. There was poor management of her pre-eclampsia; earlier medication/treatment for pre-eclampsia would be recommended in this case. The review team notes with concern the management of a high risk IOL on the antenatal ward. Due to the complexity of this case, IOL should have been managed on the labour ward. There were also concerns regarding the management of this woman's diabetes with a delay in starting an insulin 'sliding scale'. (2013)*

Chronic hypertension

7.77 Another key element to managing hypertension in pregnancy is the recognition of women who have chronic hypertension. This cohort of women are at greater risk of developing severe hypertension in pregnancy as well as pre-eclampsia, having a preterm birth or a baby born small for gestational age. Women identified with chronic hypertension must be cared for throughout their antenatal period on a consultant-led care pathway. Current evidence suggests women should be advised to take aspirin from 12 weeks' gestation[143]. Additionally, women may require additional fetal growth scans to assess for growth restriction, which is more common in this cohort of women.

7.78 *A 42-year-old woman with a history of previous pregnancy affected by pre-eclampsia had a booking blood pressure of 140/80 with dipstick proteinuria in **2015**. She was appropriately referred to see a consultant at 11 weeks. However, there was no consideration that this might be chronic hypertension with an underlying renal disease. Unfortunately, the woman developed superimposed pre-eclampsia and experienced a stillbirth at 27 weeks' gestation. (2015)*

Inpatient antenatal care

7.79 It is estimated that about 12 per cent of all pregnant women are admitted to the antenatal ward during their pregnancy[144]. Women admitted for hospital care antenatally are more likely to need extra surveillance for an existing or new condition during their pregnancy. As a review team we acknowledge that there is an absence of national guidance that sets thresholds for when a woman must be admitted. Nevertheless, when women are admitted to the antenatal ward a clear consultant obstetrician-led plan of care is required as a standard.

Obstetric ward rounds

7.80 The Trust's Maternity Clinical Operation Policy (2015) describes the cover and support for the wards (wards described as labour ward; antenatal ward; postnatal ward and other pregnant women in hospital such as ITU) with a consultant on site from 08.30 to 20.30 from Monday to Friday and 08.00 to 16.00 on weekends and bank holidays. However, there is no clear description of what this 'support' entails. There is no mention of dedicated ward rounds on the antenatal ward. The RCOG Roles and Responsibility of a Consultant[145] (published 2009 and updated 2021) has identified that obstetric ward rounds enable staff to monitor, anticipate and respond in a timely way to emerging problems. They permit women to voice their concerns and enable them to ask questions and receive answers with regard to their care.

143 Ibid n25

144 Tracy, K. et al. *Caseload midwifery care versus standard maternity care for women of any risk: M@NGO*, A randomised controlled trial. (2013) Lancet. Vol 382, Issue 9906 p1,723-32

145 Royal College of Obstetrics and Gynaecologists. Roles and Responsibilities of a Consultant – Workforce Report (2021) https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

7.81 Handovers must also include high risk women in the antenatal ward, enabling the out of hours team to be aware of concerns and possible reviews needed during their shifts (RCOG 2010[146], NHS1 2019[147]).

7.82 The review team found many incidents of high-risk women admitted to hospital not being reviewed by consultants. There was a lack of consultant presence on the antenatal ward and no evidence seen of a structured antenatal ward round. Medical assessments of antenatal inpatient women seemed to happen when a midwife asked for a clinical review rather than being part of the daily routine in maternity services.

7.83 When a plan for treatment or intervention was decided, documentation of detailed discussions with the women and their partners was rarely found within the records supplied to the review by the Trust.

7.84 *In **2005**, a woman with a complex pregnancy had an amniotic fluid drainage (removal of excess amniotic fluid around the baby) on the ward. There was no mention of a discussion of the procedure with the woman or any record of the procedure itself. The only documentation in the medical records provided to the review team by the Trust is the amniotic fluid biochemistry. (2005)*

7.85 During the staff voices interviews in autumn 2021, staff were asked about inpatient care and if registrars couldn't get hold of consultants to see high-risk antenatal patients, whether they would make it known that it was a concern. A staff member replied: *'No, they wouldn't, they would just act on whatever... they would just do whatever they can'.*

7.86 *In **2017** a woman was booked in for low risk midwifery care, but placed on aspirin as there was a family history of pre-eclampsia. The woman presented as large for her dates, had oedema and reduced fetal movements on presentation at 39 weeks and 6 days gestation. She was booked for an induction of labour. Following Propess[148] times 1 and Prostin[149] times 3, when ready for artificial rupture of membranes (ARM) the labour ward was too busy to accept her transfer, so the mother remained on the antenatal ward. Approximately 12 hours later, she was transferred to the labour ward. However, on attempting to auscultate the fetal heart, intrauterine death was identified and confirmed on ultrasound scan. (2017)*

7.87 Additionally, the review team encountered multiple instances where women who were admitted for induction of labour did not have a clinical review at all prior to commencing the induction process.

7.88 *A woman was admitted for induction of labour at 40+1 weeks in **2013**. Through the documentation provided by the Trust to the review team the indication for induction was not clear. Prostaglandins were given as the cervix was unfavourable. No obstetric review is documented in the notes until 48 hours after admission. Baby was born delivered by emergency caesarean section. Parents report their experience around induction, labour and the immediate postnatal experience being 'horrific.' (2013)*

Escalation of concerns

7.89 The RCOG Each Baby Counts (2020)[150] documented that 'failure to escalate/act upon risk/transfer appropriately' occurred in 36 per cent of reviewed reports. Factors affecting escalation nationally included site-based or professional team alliances, and skill gaps within specialisms and wider teams.

7.90 The review team identified many cases where midwifery staff appeared reluctant to escalate their concerns regarding care and treatment to obstetric and neonatal colleagues. High risk and complex cases were not escalated to the right person in a timely manner. Sometimes, there was recognition by the midwifery team of the need to escalate but as the junior doctor was often busy, they just waited despite their concerns.

146 Royal College of Obstetrics and Gynaecologists. Improving patient handover: Good practice no. 12 (2010) https://www.rcog.org.uk/en/guidelines-research-services/guidelines/good-practice-12/

147 NHS Improvement. Implementing huddles and handovers 0- a framework for practice in maternity units (2019) https://www.pslhub.org/learn/patient-safety-in-health-and-care/transitions-of-care/handover/nhs-improvement-implementing-huddles-and-handovers-%E2%80%94-a-framework-for-practice-in-maternity-units-25-march-2019-r136/

148 https://www.medicines.org.uk/emc/files/pil.135.pdf

149 https://bnf.nice.org.uk/drug/dinoprostone.html

150 Royal College of Obstetrics and Gynaecologists. *Each Baby Counts: 2019 progress report* (2020) https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/reports-updates/2019-progress-report/

In other cases, they did not recognise a sick or deteriorating women and failed to escalate. The cases below are examples from across the timespan of the review. In addition, frequently women with confirmed preterm pre-labour ruptured membranes were not given antibiotics in keeping with national guidelines.

7.91 *In **2002** a woman was admitted with repeated episodes of antenatal bleeding. Her waters then broke at 25 weeks' gestation. She reported tightenings but was asked to go for a walk and given some analgesia. It was eventually realised that the so called tightenings were labour and she experienced a vaginal breech birth just 75 minutes later. (2002)*

7.92 *A woman with a history of ruptured membranes for 3 days in **2011** was admitted feeling unwell and had a raised pulse. Despite raised inflammatory markers on her admission bloods, there was a delay in recognising how unwell the woman was and she was transferred to labour ward with overwhelming sepsis 14 hours later. (2011)*

7.93 *In **2016**, a woman with preterm pre-labour ruptured membranes was admitted at 35 weeks' gestation. Antibiotics were not given. She was seen by several different doctors and advised to try for a vaginal birth if her labour started spontaneously even though the baby was breech. She experienced an intrapartum stillbirth with evidence of E.coli sepsis. (2016)*

7.94 The review team also saw multiple cases where women who were considered high risk were admitted to the antenatal ward to commence an induction of labour when induction should have occurred (or it should at least have been considered) on the labour ward. Lack of senior review or awareness meant that care provision happened in the wrong place and often without full consideration of the clinical risks involved in the care provided.

7.95 *In **2010** a woman was transferred from the midwife-led unit, (MLU) by ambulance to the consultant-led unit. There was high clinical activity at the time and yet there was no escalation to the labour ward consultant. The registrar was unable to make a full assessment because they were conducting a twin delivery with another patient at the time. This case sadly resulted in the baby needing to be cooled and developing HIE. (2010)*

7.96 *In **2012**, a 25-year-old mother with a history of previous caesarean section for breech decided to attempt vaginal birth after her membranes ruptured at 36 weeks. Prostaglandin was given on the antenatal ward. There was no documentation in the records provided by the Trust with regard to information given on the increased risk to the mother or her baby. The mother suffered a uterine rupture and the baby was born in poor condition. The baby died at 7 days of age. (2012)*

7.97 *In **2014**, a woman with preterm pre-labour ruptured membranes was admitted at 35 weeks' gestation however antibiotics were not given. She was seen by several different doctors and advised to try for a vaginal birth if her labour started spontaneously, even though the baby was breech. Her baby was born showing no signs of life. Resuscitation was initiated, but neonatal death was confirmed at 27 minutes of age. (2014)*

7.98 *A woman who was 25 weeks' gestation in **2016**, was admitted to the antenatal ward with preterm pre-labour ruptured membranes, she developed a MEOWS score of 7 indicating that she was severely unwell. The midwife contacted the registrar who was busy, but there was no escalation to another clinician until almost an hour later. At this point the women was severely unwell and a decision was then made for an emergency caesarean section. (2016)*

7.99 *In **2019**, a 35-year-old woman in her third pregnancy was induced as her baby was severely growth restricted, with absent end diastolic flow[151]. She also had gestational hypertension. A decision was made to commence the induction on the antenatal ward. The CTG was deemed suspicious on admission and she was transferred to the labour ward. The consultant review was at first to prescribe prostaglandin, but*

151 See glossary

fetal monitoring remained suspicious and a category 2 caesarean section was performed. The review team is of the view that induction should have been started on the labour ward in the first instance due to consideration of the mother's known hypertension and a severely growth restricted fetus (placental pathology). This baby therefore needed frequent monitoring. (2019)

Delay in transfer of women to the labour ward

7.100 The review team found many incidences where there was a delay in transfer of women in established labour to the labour ward. Women were frequently not monitored appropriately despite being identified as high risk. There were also several cases of women experiencing induction of labour where following delays in transferring to labour ward an intrauterine death occurred. In other cases, the delay subsequently led to a category 1 caesarean section.

7.101 *In **2003**, a 28–year-old woman was admitted to the antenatal ward at 29 weeks with abdominal pain. On the ward she collapsed with a tender abdomen. It took nearly 50 minutes to transfer her to the labour ward and conduct an emergency caesarean where a placental abruption was confirmed along with the death of her baby. (2003)*

7.102 *In **2013**, a woman undergoing induction of labour on the antenatal ward was delayed in transfer to the labour ward. When the family requested for the fetal heart to be monitored as it had not been for an hour, the fetal heart could not be located. The midwife asked the woman to go for a walk and have a drink as it was handover. An intrauterine death was diagnosed on her return an hour later. (2013)*

7.103 *A type 1 diabetic mother had a high risk pregnancy in **2013** and was admitted having evidence of pre-eclampsia. There was delay in planning induction of labour (IOL). When IOL commenced it was conducted on the antenatal ward and transfer to labour ward was not arranged until the mother had reached 4cm cervical dilatation. The baby was born by emergency caesarean section and initially responded well to resuscitation, but required transfer to the neonatal unit at seven hours of age. The baby remained an inpatient for three weeks, and is now doing well. However, as well as a delay in transfer to the labour ward the review team also has concerns regarding the care provided in labour once transfer occurred. (2013)*

7.104 *In **2015** a woman who experienced an antepartum haemorrhage in late pregnancy was inappropriately advised by the consultant obstetrician that her plans to birth in a midwifery led unit (MLU) did not need to be reconsidered or changed. When problems were identified in labour there was a delay in transfer to the labour ward, and fetal wellbeing was not adequately monitored during the transfer period. The baby was delivered in very poor condition and hypoxic ischaemic encephalopathy (HIE) was later confirmed. The baby subsequently died. The family were critical of the ensuing investigation and correspondence with the Trust. (2015)*

7.105 *In **2017**, a woman whose transfer to labour ward was delayed during the induction process as the unit was very busy experienced an antepartum stillbirth whilst on the antenatal ward. During their investigation into what happened, the Trust through their Root Cause Analysis (RCA) recognised there were delays in transfer primarily due to maternity unit activity. In the RCA analysis section of the report the causes were identified as a lack of capacity on the labour ward, increased activity and emergency caesarean sections being undertaken. It also found that there was a 'culture of normalising long waits for women undergoing induction of labour when labour ward is busy'. (2017)*

7.106 Various versions of the Trust's Escalation of Maternity Services policy have been provided to the review team by the Trust since version 1 from June 2010 to version 5 in 2018. The policy repeatedly states that if the labour ward is busy, this must be escalated to the highest level and if women are waiting more than eight hours to be transferred to continue induction of labour then a senior obstetric review must occur. The review team found numerous cases where the trust did not follow its own escalation policy.

Misinterpretation of the antenatal cardiotocograph (CTG)

7.107 Fetal well-being assessments are a significant component of antenatal inpatient care and this will frequently be through CTG monitoring. Typically, women admitted to the antenatal ward may need enhanced fetal monitoring so it is imperative that CTG monitoring is undertaken appropriately and interpreted correctly. Delaying action or misinterpreting an antenatal CTG may lead to a poor fetal outcome. This is especially true in high risk women, such as those with pre-eclampsia, diabetes or severe fetal growth restriction.

7.108 The RCOG 'Green Top' guidelines Reduced Fetal Movements[152] advises that all women have an antenatal CTG from 28 weeks (pre-computerised CTG) if they are not in labour. CTG monitoring for at least 20 minutes provides an easy and accessible means of detecting fetal compromise. The presence of a normal fetal heart indicates a healthy fetus with a functioning autonomic nervous system. Interpretation of the CTG must be according to the NICE classification of fetal heart patterns.

7.109 The review team found there were many cases where an antenatal CTG was incorrectly classified, or there was a delay in acting upon a clearly abnormal CTG leading to poor fetal outcome.

7.110 *In **2003**, at 37+4 weeks gestation, a woman reported to the maternity triage unit with reduced fetal movements. The CTG was reported as having a baseline rate of 90 beats per minute (grossly abnormal) but there was no escalation made to an obstetrician, an intrauterine death was confirmed 30 minutes later. (2003)*

7.111 *In **2011**, a woman at 34 weeks' gestation attended the day assessment unit with reduced fetal movements and symptoms of pre-eclampsia. She was sent home and informed to return at a later time. When she was eventually seen by a locum registrar four hours later the CTG was interpreted as being abnormal but was not correctly classified and immediate escalation did not occur. Even when the case was reviewed by the consultant there was a delay in expediting birth to a category one caesarean section, instead, opting to perform an obstetric ultrasound scan. The baby was born requiring admission to the neonatal unit and was later diagnosed with hypoxic ischaemic encephalopathy grade 3. (2011)*

7.112 *In **2010**, a woman with a complex social history was admitted to the antenatal ward with preterm pre-labour ruptured membranes, (PPROM) at 29 weeks gestation. The review team found a failure to obtain adequate CTG's and a failure to perform additional fetal wellbeing tests such as a fetal biophysical profile whilst the woman was an inpatient. The review team also found no use of prophylactic use of antibiotics once there was confirmed PPROM, which may have reduced the risk of maternal infection and its complications. There was a lack of communication to the woman and her family and a lack of a clear obstetric plan. An intrauterine fetal death occurred 4 days after ruptured membranes occurred. Examination of the placenta showed there was histological evidence of acute chorioamnionitis[153] and funisitis[154]. There was a complaint made by the family regarding treatment and plans were made with lessons to be learned but there is no evidence from the documentation shared with the review team by the Trust of these actions having been put in place. (2010)*

152 Royal College of Obstetrics and Gynaecologists. Reduced fetal movements: Green top guideline 57 (2011) https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg57/

153 See glossary

154 See glossary

LOCAL ACTIONS FOR LEARNING: CARE OF VULNERABLE AND HIGH RISK WOMEN

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.113 The Trust must adopt a consistent and systematic approach to risk assessment at booking and throughout pregnancy to ensure women are supported effectively and referred to specialist services where required.

LOCAL ACTIONS FOR LEARNING: FETAL GROWTH ASSESSMENT AND MANAGEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.114 The Trust must have robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height (SFH) measurements and audit of the documentation of it, at least annually.

7.115 Audits must be undertaken of babies born with fetal growth restriction to ensure guidance has been followed. These recommendations are part of the Saving Babies Lives Toolkit (2015 and 2019).

LOCAL ACTIONS FOR LEARNING: FETAL MEDICINE CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.116 The Trust must ensure parents receive appropriate information in all cases of fetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for birth in the tertiary centre as the best option in complex cases.

7.117 Parents must be provided with all the relevant information, including the opportunity for a consultation at a tertiary unit in order to facilitate an informed choice. All discussions must be fully documented in the maternity records.

LOCAL ACTIONS FOR LEARNING: DIABETES CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.118 The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.

LOCAL ACTIONS FOR LEARNING: HYPERTENSION

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.119 Staff working in maternity care at the Trust must be vigilant with regard to management of gestational hypertension in pregnancy. Hospital guidance must be updated to reflect national guidelines in a timely manner particularly when changes occur. Where there is deviation in local guidance from national guidance a comprehensive local risk assessment must be undertaken with the reasons for the deviation documented clearly in the guidance.

LOCAL ACTIONS FOR LEARNING: CONSULTANT OBSTETRIC WARD AND CLINICAL REVIEW

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.120 All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHSE 2017). These consultant reviews must occur with a clearly documented plan recorded in the maternity records.

7.121 All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021.

7.122 The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR to enable all staff to escalate and communicate their concerns.

LOCAL ACTIONS FOR LEARNING: ESCALATION OF CONCERNS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.123 The Trust's escalation policy must be adhered to and highlighted on training days to all maternity staff.

7.124 The maternity service at the Trust must have a framework for categorising the level of risk for women awaiting transfer to the labour ward. Fetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward.

7.125 The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents such as Each Baby Counts and Saving Babies Lives. The Trust has used computerised CTGs since 2015 with local guidance to support its use. Processes must be in place to be able to escalate cases of concern quickly for obstetric review and likewise this must be reflected in appropriate decision making. Local mandatory electronic fetal monitoring training must include sharing local incidences for learning across the multi-professional team.

Chapter 8

Intrapartum care

Multidisciplinary working

Failure to escalate and lack of senior obstetric input

8.1 Effective communication between healthcare professionals and women is an integral component of safe maternity care, this is absolutely vital during intrapartum care. Maternity services should foster a team approach based on mutual respect, a shared philosophy of care and a clear organisational structure for both midwives and medical staff, with explicit and transparent lines of communication[155].

8.2 In our first report[156], which was a review of 250 cases across the timespan of the review, evidence was provided that concerns were not appropriately escalated, leading to direct impact on the safety and quality of care provided to women. In this second report the review team has selected vignettes from more recent years to highlight both a failure to learn and a lack of progression at the Trust in terms of governance and learning.

8.3 All midwives and medical staff have a duty to call for help if they consider that a clinical situation requires the direct input of a consultant. The consultant should be responsive and attend in person in complex situations such as the cases outlined in the vignettes below[157].

8.4 *In **2014**, a pathological CTG in the second stage of labour failed to attract the attention of the obstetric team for too long. The trainee was busy but even during the daytime, there was no apparent attempt to call the consultant obstetrician despite a complicated operative delivery of a baby in the operating theatre. This baby now suffers cerebral palsy and no governance review was conducted. (2014)*

8.5 *In **2016** a woman was taken to the operating theatre for an attempted forceps delivery. The baby's head was in the posterior position and the delivery was undertaken by a junior registrar. No attempt was made to rotate the baby's head to the correct position and during the forceps delivery the woman sustained a 4th degree tear. There was no evidence of duty of candour being performed and the issue does not appear to have been raised with the junior doctor as a training issue. (2016)*

Consultant presence on labour ward

8.6 The requirement for consultant obstetricians to be directly involved and lead in the management of all complex pregnancies, labour and delivery, with planned twice daily consultant-led ward rounds was identified as a local action for learning for the Trust within our first report. As the review team has continued to review all of the cases for this report we have found little evidence of planned consultant level reviews throughout the time period of this review. There were many cases which demonstrated that the supervision of trainee doctors during day and night time did not meet the required standards. Many high risk women received minimal obstetric care during the induction of labour and intrapartum period, until a point of midwifery request for review.

155 Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. *Safer Childbirth Minimum Standards for the organization and delivery of care in labour (2007)* https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf

National Institute for Health and Care Excellence Safe midwifery staffing for maternity settings (2015) https://www.nice.org.uk/guidance/ng4

156 Ockenden, D. *Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust.* (2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

157 Royal College of Obstetricians and Gynaecologists Safe Staffing (2021) https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/safe-staffing/

8.7 *In **2007**, in the death of a woman who was a practicing Jehovah's Witness and who laboured and gave birth to twins, no middle grade or more senior review was received until the final stages of her second stage of labour. Consultant input into her care was only sought when an extensive perineal haematoma was discovered many hours after the birth. (2007)*

8.8 *In **2012** a woman who did not initially want a vaginal birth after a previous caesarean section birth was advised to undergo an induction of labour after pre-labour preterm rupture of membranes with signs of infection. The registrar advised oxytocin to be administered after 2 hours of pushing and the woman pushed in the second stage of labour as the oxytocin continued to be increased for over 4 hours until she suffered a uterine rupture and her baby died. No consultant input was evident within this birth or during the immediate postpartum period. Oxytocin was prescribed by the registrar during advanced labour when there were signs of obstructed labour without first performing a medical review. No apology was given for the mismanagement of this case and the conclusions of the subsequent Trust risk review were not appropriate or relevant to the real issues at the time. (2012)*

8.9 One midwife spoke to the review team in autumn 2021, describing that in a previous trust they had been familiar with a system in which a senior trainee, anaesthetist and obstetric consultant would lead a ward round after handover twice a day. The midwife was concerned that there were no ward rounds at the Trust however when questioning this, the response they received was: *'No, no, no, you are the Band 7 coordinator, you should know when the doctor needs to see the patient'.* The midwife described to the review team how she was laughed at and ridiculed for suggesting that multi professional ward rounds were necessary.

8.10 Evidence was found by the review team that when care was escalated at the Trust there was a failure of the senior clinical team to respond appropriately:

*In **2016**, a woman was admitted to the labour ward with evidence of excessive uterine contractions with a reassuring CTG and severe hypertension. This was escalated to the registrar who decided upon no further intervention. The midwife's written statement indicated unhappiness with this response however these concerns were not escalated further. The CTG was pathological for one hour before delivery of a large for dates baby with significant shoulder dystocia and postpartum haemorrhage (PPH). The baby was later diagnosed with grade 3 hypoxic ischemic encephalopathy (HIE). Escalation and obstetric involvement in this case was poor throughout. (2016)*

8.11 *In **2016**, a woman spent approximately 8 hours on the labour ward, where she received minimal medical input despite midwifery requests for a medical review of her raised blood pressure (BP). At numerous times during the late first and second stages of labour the woman's BP was recorded as 160/105 mmHg or higher which is a medical emergency. Repeated attempts to have the woman reviewed due to her high BP were unsuccessful and when the consultant was informed, nothing was written in the notes and the consultant did not review the woman, instead prescribing an anti-hypertensive which had little effect. During a subsequent major postpartum haemorrhage this same consultant attended, advised on drug use and again documented nothing. The governance review failed to address these issues of lack of consultant review and action. (2016)*

Midwifery leadership and culture on the labour ward

8.12 A lack of documentation regarding decision-making by the labour ward coordinator was often evident when the labour ward coordinator was asked to attend a room for review of a case. Although the role of the coordinator is challenging, with contemporaneous documentation sometimes difficult when dealing with emergency situations, many cases reviewed have failed to demonstrate even any good quality retrospective documentation. The verbal and written communication between the coordinator and obstetrician is paramount and there is evidence that it failed in numerous cases.

8.13 *In **2015**, a woman with a raised BP had her labour augmented with oxytocin for 12 hours without an obstetric review. The labour ward was so busy that the labour ward coordinator was caring for another*

labouring woman and did not perform a 'fresh eyes' assessment on a CTG when asked. The midwife had previously attempted to escalate clinical findings of raised maternal BP, significant proteinuria and an abnormal CTG with no documented evidence that she was supported by senior obstetric or midwifery staff even when the emergency buzzer was pulled due to fetal bradycardia. Eventually a decision was made to expedite the delivery using forceps and the baby required admission to the neonatal unit for suspected infection. (2015)

8.14 It is not ideal for the coordinator to be caring for a woman in labour, although the review team appreciates this can happen occasionally in an emergency situation. This role must be supernumerary so that the labour ward remains safe and there is senior presence available to assist midwives and to facilitate escalation to the obstetric team[158]. Midwives also have a duty to escalate care and challenge decisions when there is a concern about safety[159].

8.15 *In **2016**, a woman who laboured at the birth centre was not adequately monitored as 'the unit was busy'. When problems were eventually identified in labour there was a delay in transferring the mother to the labour ward, where her baby was delivered in a very poor condition having suffered a brain injury. The baby subsequently died. (2016)*

8.16 There is evidence that over a long period of time midwives may have been reluctant to ask for help when working on the Trust's labour ward. One midwife explained to the review team in late 2021 how *'you just tried to keep your head down...asking for help was seen as a bad thing. People were derided for asking for help. Even something simple like a junior midwife asking for support suturing, they were like … [ridiculed]...'.*

8.17 Midwives providing intrapartum care outside the labour ward described facing reproach from labour ward colleagues when they telephoned regarding a possible need to transfer the woman to labour ward. One midwife outlined the challenges midwives faced when transferring women into labour ward or planning ahead when the clinical picture of the woman they were caring for started to change stating that there was *'a bullying culture'* on the labour ward.

8.18 The same midwife explained to the review team how the general culture on the labour ward was to joke that the transferring midwife did not know how to look after a woman in labour, for example, *'Do you not know how to look after a woman in labour? So that was the culture. It started off as being a little bit more of a jokey sort of thing, then it became really quite insidious so that I used to dread it, I would dread ringing. In the end I would say…this is the situation I am bringing the lady up, expect me in an ambulance in forty five minutes, and then I would always get, well if you bring her up, you would have to look after her yourself'.*

8.19 Another midwife told the review team in autumn 2021 of a culture of bullying on labour ward. *'Staff don't always feel supported by the shift co-ordinators. As I have said previously even though I am experienced I still felt I needed support and didn't always get it.'*

8.20 A further example was provided by a midwife who described being belittled when asking for support on the midwifery-led unit due to an excessive and complex workload. *'I said: "I can't accept somebody in labour because there are nine women, nine babies, a midwife who's not familiar that needs my support as well and I don't feel it's safe…" [A manager] came storming down and said, "You've got no authority to close this MLU", and I was like, "I'm not closing the MLU, I'm saying that we need further support to be able to safely do this." [The manager] belittled me in front of a group of staff there and told me, "You're taking this woman".'*

8.21 The same midwife also commented on how midwives were belittled when transferring women to the labour ward: *'You'll hand over care to somebody on the consultant-led unit and the comments that they make*

158 Ibid n1 and Royal College of Midwives. *RCM guidance on implementing the NICE safe staffing guideline on midwifery staffing in maternity settings* (2016) https://www.rcm.org.uk/publications/publications/rcm-guidance-on-implementing-the-nice-safe-staffing-guideline-on-midwifery-staffing-in-maternity-settings/

159 Nursing Midwifery Council. *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*. (2015, updated 2018) https://www.nmc.org.uk/standards/code/

in front of the woman, can be very belittling and degrading to your face in front of a family and that's not cohesive. That's not putting the woman first'.

8.22 It is evident from considering numerous reviews and hearing staff voices throughout the autumn and winter of 2021 that there continues to be some major issues relating to the culture of intrapartum care at the Trust. Influencing factors include human factors, leadership from senior clinicians, lack of escalation, locum doctors working for many years with little supervision, lack of robust governance processes and a lack of multi-professional working.

8.23 The culture of intrapartum care at the Trust may have resulted in harm to mothers and babies due to failure in escalation to the most appropriate professional in a timely manner. This starts with the allocated midwife not escalating to the labour ward coordinator. The coordinator in turn fails to escalate to the consultant, when the trainee is either busy or is performing practice against guidance (for example unsafe operative delivery and, in particular, a number of inappropriate breech deliveries). These examples continue throughout the period of the review to the very end. Examples of these are detailed throughout this report.

8.24 The direct links between incivility and patient safety have been well documented. Civility Saves Lives[160] sets out the detrimental impact uncivil behaviours have on team functioning, decision-making, performance and safety. The consultant obstetrician and labour ward coordinators have an integral role to play in role-modelling the professional behaviours and personal values that are consistent with positive team working, including the demonstration of respect for colleagues and women[161].

Use of medical locums at obstetric middle grade

8.25 The review team found that there appeared to be a high reliance on the locum medical workforce working at middle grade at the Trust without evidence of documented supervision and governance.

8.26 *During the birth of twins in **2015**, a family told the review team the doctor was 'so aggressive, he was shouting. The midwives didn't like him; that was obvious'. The doctor conducted a poorly managed twin delivery and walked out of the room (not to return) during a postpartum haemorrhage and episode of extreme hypotension. The Trust has not shared any evidence of learning or the development of actions following this case with the review team. (2015)*

8.27 *In **2016** a locum doctor failed to recognise or intervene during a 40 minute terminal bradycardia resulting from acute intrapartum hypoxia. After alienating both the midwife and woman, he was told to leave the room and did so without any further delivery of care. The baby was born with HIE and severely acidotic cord blood results. The Trust risk review process was not robust and there was no evidence of internal reflection. The RCA report failed to investigate and recognise that this incident occurred due to gross lack of team working, failure in escalation, failure to monitor the actions of locum staff, failure to recognise acute bradycardia in labour and failure to document to an expected standard. The report concluded that, 'it is difficult to understand the team dynamics'. (2016)*

8.28 The review team found several examples where locum doctors acted unsupervised, leading to poor outcomes for mothers and babies. Equally it appears that there were not clear escalation plans to the consultant or midwife in charge. In cases of adverse outcomes there is evidence that these were not investigated in line with the incident framework utilised at the time and individuals were not held to account.

8.29 Consultants must be visible, approachable and demonstrate effective leadership skills, enabling other team members to speak up when something is wrong, ensuring good information flow and clinical prioritisation[162].

8.30 The widespread shortage of suitably qualified obstetricians who can safely undertake the role of senior resident doctor out-of-hours with indirect supervision from a consultant who is non-resident has been well documented. The RCOG has highlighted the need for adequate support and supervision of locums

160 Civility Saves Lives. Civility Saves Lives (2017) https://www.civilitysaveslives.com

161 Ibid n3

162 Ibid n3

who enter the workplace and has recently released guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland and Wales[163].

8.31 Locum doctors are employed to cover staffing shortfalls and trusts should have appropriately robust recruitment processes in place including assessment of their skills and knowledge, with structured feedback and support before they are released to work independently.

LOCAL ACTIONS FOR LEARNING: MULTIDISCIPLINARY WORKING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

8.32 The labour ward coordinator must be the first point of referral and be proactive in role modelling the professional behaviours and personal values that are consistent with positive team working and providing timely support for midwives when asked or when abnormality in labour presents.

8.33 The labour ward coordinator at the Trust must be supernumerary from labour care provision and provide the professional and operational link between midwifery and the most appropriately trained obstetrician.

8.34 There must be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week.

8.35 Senior clinicians such as consultant obstetricians and band 7 coordinators must receive training in civility, human factors and leadership.

8.36 All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out and feel able to speak out when they have concerns about safe care.

Fetal Assessment and Monitoring

8.37 National intrapartum guidelines[164] recommend intermittent auscultation (IA) of the fetal heart rate (FHR) in low-risk pregnancies and continuous FHR monitoring if there are abnormalities such as tachycardia or decelerations, meconium, bleeding, or interventions such as epidural analgesia or oxytocin administration.

8.38 Intrapartum monitoring of the baseline FHR, presence of decelerations, and visually determined FHR variability are used to assess the risk of fetal acidaemia[165] via a set of clinical guidelines. However, FHR abnormalities during labour rarely correlate with fetal compromise because the FHR is highly sensitive to hypoxaemia/hypoxia (both common during labour), but lacks specificity for fetal acidosis, the end point of intrapartum hypoxia.

8.39 On the one hand this mismatch results in increased operative delivery of non-acidotic babies; whilst clinicians on the other hand may miss fetal compromise because current guidelines remain silent on the adverse role played by intrapartum factors, which impair fetal adaptation to the challenges of labour such as fever, chorioamnionitis, meconium, abnormal fetal behavioural states, and excessive head moulding. National perinatal audits and quality improvement programmes such as the Confidential Enquiries into

163 Royal College of Obstetricians and Gynaecologists *Guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland and Wales*. (2021) https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/safe-staffing/rcog-guidance-on-the-engagement-of-long-term-locums-in-maternity-care.pdf

164 National Institute for Health and Care Excellence *Intrapartum care for healthy women and babies* (2017) https://www.nice.org.uk/guidance/cg190

165 See glossary

Stillbirths and Deaths in Infancy (CESDI) and Each Baby Counts (EBC) have highlighted the significant contributions of these conditions to adverse perinatal outcomes.

8.40 In our first report we found significant problems with the conduct of intermittent auscultation and the interpretation of CTG traces. The review team found problems with intermittent auscultation of labour throughout the entirety of the review period right up to the very end of the review timeline. Vignettes from the cases considered by the review team are presented below which continue to illustrate significant knowledge gaps and examples where the care of complex cases was left in the hands of inexperienced staff.

Failure to recognise and/or escalate the abnormal CTG in early labour

8.41 *In **2012**, a woman presented to the MLU in labour. A CTG was performed on admission, which was reassuring, and early labour was diagnosed. The woman described her pain as constant, but the midwife did not perform an abdominal examination. Intermittent auscultation (IA) showed a significant drop in the baseline fetal heart rate (FHR) although remaining within normal parameters. The FHR was not auscultated for 1 full minute following a contraction. The FHR was auscultated prior to the lady entering the pool and found to be 90bpm. There was a delay in escalation. The baby was born in very poor condition and was later diagnosed with cerebral palsy. The family had concerns that the FHR was not listened to enough. The Chief Executive's letter to the family incorrectly stated that the FHR would be auscultated every 30 minutes during labour. (2012)*

8.42 Fetal bradycardia should be reviewed urgently by an experienced obstetrician to exclude irreversible obstetric emergencies (abruption, cord prolapse and uterine rupture) and to correct reversible causes such as supine or epidural hypotension and uterine hyperstimulation due to excessive oxytocin use. Urgent delivery should be undertaken where indicated if the bradycardia does not improve.

8.43 *In **2012**, a multiparous woman with an uneventful pregnancy had a membrane sweep at 41^{+2} and at 41^{+4} weeks and later admitted to the MLU contracting regularly. The woman presented with a temperature of 37.7^{0}C, maternal heart rate (MHR) 120bpm, and cervix 3cm dilated. Following concerns the woman was transferred and arrived on the labour ward 2 hours later. A female baby was delivered in poor condition by ventouse with an Apgar score of 1[166] at 1 minute and 1 at 5 minutes. Despite intensive resuscitation the baby died after 40 minutes. Post-mortem findings were consistent with infection as a cause of the death. (2012)*

8.44 Clinicians should always consider factors which can influence the fetus. Antenatal factors such as placental insufficiency, intrauterine infection, meconium aspiration, hypoglycaemia, recreational substance abuse or fetal brain injury can all influence fetal heart rate patterns. Where suspected, these cases should all be escalated urgently to make an appropriate plan for delivery.

8.45 *In **2018**, a woman in labour had meconium stained liquor and fetal tachycardia. The family were given the option to 'carry on' with the labour or opt for immediate caesarean. There is no evidence of discussion with the consultant regarding an appropriate plan of care. The CTG was not considered pathological by the maternity review team and therefore to give the woman 'an option' to have a category 1 caesarean is not the standard practice. There is also no evidence that a further vaginal examination was performed prior to the caesarean to exclude or confirm full dilatation, in which case an emergency caesarean may not have been necessary. (2018)*

8.46 Fetal heart rate tachycardia associated with meconium staining of the amniotic fluid raises the likelihood of fetal infection significantly. The team should involve a consultant in the management as soon as possible to set out a plan of care, and the family should be involved in a Montgomery[167] compliant manner.

166 See glossary

167 https://www.rcog.org.uk/globalassets/documents/members/membership-news/og-magazine/december-2016/montgomery.pdf

Augmentation

8.47 Augmentation of labour is the process of increasing the frequency, length and strength of uterine contractions after the onset of labour. This can be achieved either by intravenous oxytocin infusion and/or artificial rupture of membranes.

Use of oxytocin

8.48 Oxytocin can be used to increase uterine contractions when they are reduced, particularly during prolonged labour and to facilitate cervical dilatation and vaginal birth.

8.49 Many examples of the injudicious use of oxytocin were highlighted in our first report. The review team has found further examples of inappropriate oxytocin use which impacted upon fetal wellbeing and neonatal outcomes suggesting that sufficient learning from previous cases had not occurred. A common theme identified by the review team was the inappropriate commencement and continuation of oxytocin despite evidence of deterioration of the baby's condition.

8.50 Oxytocin should only be used when there is a valid indication and potential benefit for its use and appropriate guidelines and equipment available to support its safe administration. One-to-one midwifery care must be provided and the FHR rate and maternal contractions must be closely monitored. The identification and escalation of any concerning features relating to CTG changes should occur promptly and oxytocin reduced or discontinued in the presence of excessive uterine contractions or fetal heart rate concerns.

8.51 Appropriate risk assessment should be carried out before oxytocin use in the first stage of labour, and again before use in the second stage of labour. Decision-making regarding the plan of care and mode of birth should consider any additional risk or intrapartum factors which impair fetal adaptation to the challenges of labour and the stage of labour that has been reached.

8.52 *In **2012** a woman presented in spontaneous labour at 30 weeks' gestation. After an hour of pushing in the second stage, the fetus remained high in the pelvis with a pathological CTG. An oxytocin infusion was commenced. After a further hour of pushing, the woman consented to a trial of instrumental delivery in theatre. A manual rotation was undertaken followed by the application of Wrigley's forceps with a presenting part level with the ischial spines. No descent was noted after one pull. An emergency caesarean section was undertaken, and the infant was delivered in poor condition. The infant was resuscitated, but later died due to complications of severe hypoxic ischaemic injury and massive hypoxic damage to multiple organs. (2012)*

8.53 *In **2014**, a woman who had a previous caesarean section was in active labour. Despite FHR abnormalities, oxytocin was commenced and was continued despite evidence of deterioration of the baby's condition. The baby was born in poor condition and died a few months later. A case review was undertaken by the Trust but it failed to identity or address the errors in the management of the mother's labour thus leading to a complete failure to learn lessons or change future clinical practice. (2014)*

LOCAL ACTIONS FOR LEARNING: FETAL ASSESSMENT AND MONITORING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

8.54 Obstetricians must not assess fetal wellbeing with fetal blood sampling (FBS) in the presence of suspected fetal infection.

8.55 The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work.

8.56 Midwives and obstetricians must undertake annual training on CTG interpretation taking into account the physiological basis for FHR changes and the impact of pre-existing antenatal and additional intrapartum risk factors

Midwifery-led units

8.57 There are five Midwifery-led-units (MLUs) that have provided antenatal, intrapartum and postnatal care in addition to the consultant maternity unit at the Trust, during most of the time period of this review. The Royal Shrewsbury Hospital, (RSH) in Shrewsbury, provided consultant-led care until 2014. Consultant obstetric services were relocated to the Princess Royal Hospital (PRH) in Telford in 2014. An overview of births by each MLU is provided in table 1 below. The review team is advised that Wrekin MLU has recently moved to a new location adjacent to the Shropshire Women and Children's Centre at the PRH.

Table 1: Births by MLU Overview (Source: SaTH Clinical Dashboards)

MLU	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bridgnorth	69	68	75	68	82	77	26	4	0
Oswestry	87	72	74	69	83	52	15	4	0
Ludlow	86	71	62	49	51	36	12	4	0
Shrewsbury	478	421	367	235	207	142	120	69	15
Wrekin	435	401	362	336	359	337	351	285	224

8.58 Issues relating to MLU closures and staffing availability have been highlighted within the local press and Telford and Wrekin CCG's Quality and Safety Report in 2013. Staff shortages within maternity are also raised as an issue within the Trust's 2021 CQC report[168] and remain an urgent wider issue for maternity care on a national basis.

8.59 Evidence from staff who have contacted the review team suggest that there was an expectation for midwives working on the MLU to manage with reduced staffing. A midwife who had worked at the Trust until 2021 commented that: *'historically, whilst working in the MLU, there was an expectation to stretch the boundaries of what was considered normal…MLU staff are seen as less important, less valuable, and less skilled. There can be poor conversations between teams frequently but teams working together stick together and support one another. This remains to this day. There is a very toxic culture within the place and it seems impossible to break despite some individuals trying to raise as an issue - myself included and part of the reason I have now left'.*

8.60 Another long term community midwife reflected on the impact this had on safe care provision on the MLU where there were *'...incidents where we are caring for a woman and the second midwife has been told to leave the unit to move to another area. This is unsafe practice as there should be two midwives on the unit when a woman is birthing at all times'.*

168 Care Quality Commission Inspection (2021) https://www.cqc.org.uk/provider/RXW?referer=widget3

LOCAL ACTIONS FOR LEARNING: SPECIFIC TO MIDWIFERY-LED UNITS AND OUT-OF-HOSPITAL BIRTHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

8.61 Midwifery-led units must complete yearly operational risk assessments.

8.62 Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.

8.63 It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.

Delay in escalation and taking appropriate action

8.64 The review team found evidence of failure to appropriately document the FHR and undertake continuous electronic fetal monitoring (CEFM) using a CTG when abnormal FHR changes were detected on the MLU. Evidence of this has also been presented above. Information gained from any investigations performed after a birth were not always shared with women and families, and evidence of appropriate governance and shared learning from such incidents is frequently unavailable.

8.65 *In **2006**, a multiparous woman was noted to have an abnormal FHR whilst in labour on the MLU. This was not acted upon, a CTG was not performed nor was the case escalated. The woman suffered a stillbirth. In the bereavement follow-up appointment the consultant gave incorrect information and initially withheld information from the parents about the possible cause for their baby's death. (2006)*

8.66 *In **2010**, a primiparous[169] woman attended the MLU in labour. Intermittent auscultation (IA) was started, however there was a delay in starting CEFM when this became abnormal. Eventually the CTG was started and a further examination was undertaken which revealed a cord prolapse. Emergency transfer was arranged and delivery by caesarean section. The baby was born in poor condition and required cooling. There were missed opportunities for earlier transfer. (2010)*

8.67 *In **2010** there was a failure to appropriately document intermittent auscultation (IA) of the fetal heart and commence CTG monitoring for a woman labouring in the pool with meconium. There was a significant delay from the time of decision to transfer to the Royal Shrewsbury Hospital (RSH) to calling the ambulance for transfer. The midwife failed to ascertain the fetal wellbeing during transfer. Following admission to labour ward a CTG was commenced and was abnormal. The midwife escalated her concerns to the registrar and prepared the woman for an emergency caesarean section. Due to the workload of the labour ward the registrar was called away to attend a twin birth and there should have been escalation to the on-call consultant, who should have attended. The baby was born in poor condition, intubated and received cardiac compressions before receiving hypothermic cooling. (2010)*

8.68 A number of the MLU cases reviewed by our team reflected some of the wider issues found on the labour ward relating to failures in appropriate escalation and consultant obstetric review once transfer to the consultant-unit was achieved. In a number of cases there was inappropriate risk assessment and management of labour when women presented with a history of reduced fetal movements. The wider clinical picture was not always appropriately assessed and acted upon. Evidence of poor teamwork and communication during transfer has also been presented elsewhere in this and other chapters of this report.

169 See glossary

8.69 *In **2010** a mother self-referred to Wrekin MLU with absent fetal movements and abdominal pain. There was a failure of the two midwives working there to recognise the evident clinical signs of placental abruption: an obstetric emergency. There was no attempt to cannulate the mother and it took 80 minutes to assess her and order a "blue light" ambulance transfer from Telford to Shrewsbury. No paramedic crew were requested. Arrival time at the consultant-unit from initial admission was 1 hours 45 minutes. Following arrival there was appropriate assessment and whilst the baby's death appeared unpreventable there are many care delivery issues that suggest that learning from this event was required. Postnatal care was not appropriate and there was no obstetric documentation in the notes until 09.45 the next day. There is no evidence of a governance review or learning from this case by the Trust. (2010)*

8.70 *In **2013** a woman with a history of multiple miscarriages attended the MLU for a post-term membrane sweep at 40+5 weeks gestation. A fetal bradycardia was noted prior to the procedure and the woman walked over to the consultant-unit and was in theatre within 20 minutes for a category 1 caesarean section. There followed a delay of 17 minutes after the consultant arrived in theatre where he discussed the possibility of not performing a caesarean section. The parents opted to proceed and the baby was born in poor condition and developed severe cerebral palsy. Neonatal care at all points within this case was excellent. The SI investigating team was solely made up of midwifery staff with no evidence of inclusion of an obstetrician, neonatologist or Trust executive all of whom would be expected to have involvement in this level of investigation. (2013)*

8.71 *In **2016** a primigravid[170] woman called Wrekin MLU at 09:18 stating that she did not think things were right as her baby was not moving as much and the pattern of movements had changed. She was advised to lie on her side, have a cold drink, and focus on the baby's movements over the next two hours. The woman responded that she had done all of that already and still had reduced fetal movements. The MLU staff member responded that they had a lot on that morning so to wait until lunchtime before coming in. On arrival there was difficulty ascertaining the FHR, an ultrasound scan (USS) performed and urgent transfer to the consultant-unit was arranged where a category 1 caesarean section was performed. The baby was born in poor condition and died the following day. The parent's comments suggest that they were put off attending the MLU earlier that day when they phoned with concerns because the unit was busy. The parents expressed many concerns about the bereavement care, the lack of information and their belief that the emphasis was on damage limitation for the hospital. (2016)*

8.72 A midwife employed at SaTH for many years who left in recent years[171] told the review team that: *'The MLU's practice needed to be standardised and updated as practice was not evidence-based. There was nobody competent to update guidelines, what guidelines they had were not evidence-based'.* In relation to learning from incidents the midwife emphasised that there was a reluctance to rotate staff to different clinical areas for updating for fear of upsetting people and *'When an incident happened, once the cause had been identified and the actions agreed it took too long to implement change'.* The review team notes that many guidelines have since been reviewed and updated.

8.73 Recent findings from national perinatal surveillance data which focussed on intrapartum stillbirths and intrapartum-related neonatal deaths in planned births at freestanding MLUs and those alongside consultant-led units found that in 75 per cent of deaths improvements in care were identified that might have made a difference to the outcome for the baby[172]. The authors conclude that these findings do not address the overall safety of midwifery-led settings for healthy women with straightforward pregnancies, but suggest areas where the safety of care can be improved. Issues with care were identified around risk assessment and decisions about planning place of birth, intermittent auscultation, transfer during labour, resuscitation and neonatal transfer, follow-up and local review.

170 See glossary

171 Date of leaving provided to review team but not stated to maintain confidentiality of staff member

172 Rowe, R, Draper, ES, Kenyon, S, Bevan, C, Dickens, J, Forrester, M, Scanlan, R, Tuffnell, D, Kurinczuk, JJ. I*ntrapartum-related perinatal deaths in births planned in midwifery-led settings in Great Britain: findings and recommendations from the ESMiE confidential enquiry*. (2020) BJOG 127

8.74 Findings published from a national cross-sectional survey of all 122 UK maternity services found that 92 per cent of local admission guidelines varied from national guidance[173]. These findings suggest that variation in admission criteria for MLUs exists nationally which presents a potentially confusing and inequitable basis for women making choices about planned place of birth. An earlier study also found that local guidance for transfer of women from MLUs to consultant units were of poor quality[174].

8.75 *In **2018** a woman made numerous contacts with Wrekin MLU triage throughout her pregnancy and early labour due to concerns about reduced fetal movements, bleeding and spontaneous rupture of membranes (SROM). Based upon national guidance it would have been appropriate for the woman to have been transferred to the consultant unit. Local Trust guidance did not align with national guidance. The baby was born in poor condition on the MLU and despite extensive resuscitation and neonatal support a decision was made to withdraw care and the baby subsequently died. (2018)*

8.76 National guidance recommends that when there are maternal concerns about fetal movements, the woman and the baby should be assessed (NICE, 2021). It is important that this assessment takes into consideration the full clinical picture and previous history of reduced fetal movements.

8.77 The importance of ensuring that women undergo a risk assessment at each contact throughout the pregnancy pathway was presented as an essential action in report 1. The review team continued to find evidence that this did not always happen. All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made.

Vaginal breech birth

8.78 Further evidence of poor escalation, failure to involve the consultant obstetrician and to respect women's wishes in relation to mode of birth were evident within the vaginal breech cases reviewed across the timespan of the review. Women reported to the review team that they were persuaded to have a vaginal breech birth without the associated risks being explained or there was a failure to make decisions regarding mode of birth in a timely way. There is a lack of evidence that governance processes were fully implemented which may have provided the Trust the opportunity to refine its decision-making processes, define the personnel needed for a safe breech vaginal delivery and refine the escalation pathways on the labour ward.

8.79 *Request for consultant advice or attendance was never made for the vaginal breech birth of a woman at 36/40 weeks gestation in **2003**. There was a lack of formal documentation regarding the mother's birth wishes and advantages and disadvantages of mode of birth. The middle grade doctor was asked by the midwife to examine for footling breech but declined to do so. It was inappropriate for the most inexperienced member of the medical team (SHO) to be conducting a footling breech delivery alone in the labour room without registrar or consultant attendance. During the birth an emergency caesarean section was arranged. There is no documentation of involving the consultant in any way and when the consultant attends in theatre [they] appear surprised in [their] notes at the impending situation. The baby was born with no signs of life and after extensive resuscitation died at approximately 3 hours of age. (2003)*

8.80 *There was a failure to appropriately plan and escalate care for a woman at 31 weeks' gestation in labour with prolonged premature rupture of membranes in **2011**. On the day of delivery, there was a failure to escalate for consultant decision-making, failure to make definitive decisions regarding the mode of delivery, failure to have adequate and highly trained individuals at the delivery, and failure to understand that a footling breech delivery at 31/40 weeks is relatively contraindicated by local and national guidelines. There was also no internal investigation of this case and so no evidence of lessons learned. (2011)*

173 Glenister C, Burns E, Rowe R. *Local guidelines for admission to UK midwifery units compared with national guidance: A national survey using the UK Midwifery Study System (UKMidSS).* (2020) PLoS One. Oct 20;15(10):e0239311. doi: 10.1371/journal.pone.0239311. PMID: 33079940; PMCID: PMC7575094.

174 Rowe RE. *Local guidelines for the transfer of women from midwifery unit to obstetric unit during labour in England: a systematic appraisal of their quality.* (2010) Quality and Safety in Health Care19 (2):90-4.

Management of twin pregnancies and births

8.81 Some of the issues within this section reflect the findings presented previously in this chapter, namely unsafe operative delivery, inappropriate use of oxytocin and a failure to escalate care with the added complication of a twin delivery to consider. The review team found significant concerns with the management of twin labour and births throughout the whole of the review period right to the very end of the review.

8.82 *In **2013**, a primiparous woman with an IVF conceived twin pregnancy was induced at 36+5 weeks gestation as the second twin was found to be small. After one hour of pushing a decision was made for trial of instrumental delivery in theatre under spinal anaesthetic by a consultant and registrar. The first twin was born in good condition following a Keilland's forceps rotation. The second twin was born 37 minutes later by Neville Barnes forceps, after a total of 9 attempts at delivery by ventouse and Keilland's forceps. The baby was born in very poor condition and required resuscitation and transfer to the NNU where he underwent cooling and had multiple blood transfusions. He was subsequently diagnosed with moderate to severe HIE, subgaleal and subdural haemorrhage with depressed bilateral skull fractures. The administration of second stage oxytocin did not follow any guideline or regime. There was no concluded Trust investigation provided to the review team. (2013)*

8.83 *Inappropriate use of oxytocin and poor CTG management was noted with no escalation during the labour of a woman with a twin pregnancy at 35+4 weeks gestation in **2013**. The second twin's birth was not expedited when it should have been and the baby was diagnosed with HIE 2. There was no obstetrician or neonatologist in the room for the birth of twin 1 despite twin 2 being breech, they were called to assist with twin 2 following a placental abruption and the baby required a vaginal breech extraction. (2013)*

8.84 *A woman was admitted to hospital in **2014** at 34+6/40 weeks gestation with a suspected urinary infection with uterine tightenings. It was found that that both twins had died in utero. Placental abruption was noted at birth, with partial dehiscence of the uterine scar. Brown liquor was also noted which was mildly offensive. (2014)*

8.85 *The antenatal care was complex as the woman had numerous admissions to hospital for abdominal pain and tightenings, urinary symptoms and back ache. It was noted that the CTGs during admissions often had loss of contact or poor quality interpretation that was not escalated. The woman's voice was not heard as it was documented that there were reduced fetal movements but no action was taken. The woman met with the Trust who made promises around improving bereavement support, but the mother told this review that it felt that this was not actioned. (2014 until 2020)*

8.86 *In **2016** a woman who had a twin pregnancy, complicated by twin to twin transfusion syndrome, developed pre-eclampsia and was allowed to go home despite signs of evolving pre-eclampsia. Subsequently one twin died and the governance review documentation leans towards blaming the woman for the outcome, as she decided to go home rather than accept the 'offer' to remain in the unit as an inpatient. (2016)*

Management of high-risk and complex mothers

8.87 In a significant number of cases the review team found evidence that the poor outcomes in mothers and babies were caused mainly because clinicians failed to recognise women at high risk of medical complications. They failed to respond adequately to problems arising during labour, failed to make appropriate clinical decisions and failed to respond in a timely manner to signs of impending serious complications such as severe hypertension and significant antepartum haemorrhage. There were many instances of poor communication between doctors and midwives which led to inappropriate and delayed clinical decision-making.

8.88 *A woman presented on multiple occasions around term with hypertension and proteinuria in **2009**. There were missed opportunities to manage hypertension appropriately with the woman returning at least four times for assessment of blood pressure, when there could have been consideration for delivery. During this time she saw a relatively junior member of medical staff and there was a failure to consider the worsening*

picture of pre-eclampsia and no involvement of the labour ward coordinator. There appeared to be no urgency to treat the severe hypertension and there was little thought as to whether to give magnesium when this was appropriate. The baby was born in poor condition with Apgar scores 1 at 1 minute and 6 at 5 minutes. (2009)

8.89 *In **2017** a primigravid woman in spontaneous labour developed mild intrapartum hypertension. She required emergency caesarean delivery and received ergometrine intraoperatively. Subsequently, she developed significant postnatal hypertension and required treatment. Her medical records and subsequent correspondence indicate significant friction between the midwives and the registrar over the administration of ergometrine and its subsequent effect. The parents' concerns and communication about investigation of the drug error were poorly handled, leading to a formal complaint. (2017)*

Psychological birth trauma

8.90 The degree of life-long psychological trauma revealed by families in this report is harrowing and profound. Women and families have given graphic written and verbal accounts describing their recollection of events that have led to long-term depression, anxiety, distressing memories and post-traumatic stress disorder (PTSD). Some have sought psychological treatment, whilst others have remained silent until now.

8.91 Descriptions of physical trauma, pain, lack of attention, vulnerability, unkind words, swearing, sarcasm and bullying towards women as well as unkind treatment of colleagues, amongst midwives and obstetricians have been found to be widespread throughout the review period.

8.92 *A woman who gave birth in **2009** told the review team: 'I was lying on the table and was prepared for surgery but they couldn't find the anaesthetist. The senior midwife said to the assistant who was there "If this baby dies it's on his head". I reminded her I was still awake and she said "sorry no it will all be fine...". After the anaesthetist was found I was put under. My husband who was waiting outside was told 'go and walk round the car park for 45 minutes. But I have to prepare you don't hold out much hope for the baby' I had counselling after the experience but still felt I needed to complain as I knew how lucky we had been that our daughter was not only alive but well. I wrote my concerns down and the response I had just made me so angry. It didn't address any of my concerns…it was so bad that to be honest I gave up and just tried not to think about it.' (2009)*

8.93 There were many cases reviewed in which the care provided aligns with national standards and where there is evidence of the maternity team at the Trust going above and beyond the usual expectations in an attempt to support women. It is evident that for many women, any deviation from the expected progress of events, such as passage of meconium, bleeding of any degree or suspicious features on CTG is recalled by them years later as a failure of appropriate care.

8.94 Sometimes, despite documented good quality care and reassurances, the woman's recollection is terror, guilt, suspicion and feelings of Trust cover up. In addition, many women perceived any deviation from normality to be an indicator that a caesarean section was needed and that this was subsequently denied to them by the Trust. Despite this, the review team has seen many cases of meconium stained liquor, marginal placental abruption and mild infection that were managed appropriately with a trial of labour and outcomes that have been satisfactory.

8.95 *In **2017**, a woman whose baby presented in the occipito-posterior position laboured for 15 hours having experienced a small antepartum haemorrhage. The woman received very good care during labour with ongoing and appropriate efforts to address her anxiety and analgesia requirements. A caesarean section was performed within a standard timeframe and both mother and baby were well following this. Despite good care, the woman's recollection of labour has developed into ongoing treatment for PTSD. (2017)*

8.96 Formal diagnosis of PTSD is a common finding in the review and despite the evidence of some good care as detailed above, there were also many cases reviewed that demonstrate poor management in labour that resulted in ongoing physical and psychological harm for women as detailed in the following vignettes.

8.97 *In **2011**, a woman suffered psychological harm after being accused of 'being lazy in labour'. Also, as an employee of the Trust, she was advised against making a complaint. (2011)*

8.98 The review team has heard recollections from women relating to feelings of loss of control and power, **(2016)**, excessive and painful vaginal examinations **(2003)**, not being listened to **(2002; 2004; 2015; and 2016)** which resulted in psychological trauma for themselves and on occasion their birth partners.

8.99 *In the case of a forceps delivery and a missed recto vaginal fistula in **2009**, a woman told the review team: 'Following my daughter's birth by forceps, I was passing wind through my vagina. My wound was never checked whilst I was a patient in the hospital. It was only when I got home that a midwife asked me how I was and I said I felt something wasn't right. She did then check me at home but found no problem. A couple of weeks later I went to see my GP about it and I was referred back to the hospital.*

8.100 *I saw a consultant obstetrician. After examining me the doctor informed me that I'd had a large baby and that had caused in her words "a baggy fanny". To say I was upset is an understatement and despite telling her that I could tell the wind was coming from my back passage and passing through to the front, she said no further investigation was required. My issues got worse and the anxiety of going outside and embarrassing myself by having no control of passing wind meant I became nervous, anxious and depressed which seemed to exacerbate the situation. All of which resulted in upset stomachs and loose stools which resulted in my passing faeces through my vagina. Feeling that I should have pushed this matter further in the hospital made me feel inadequate as a mother. With the fistula causing personal care issues for me, the depression got worse. It wasn't diagnosed for quite some time. The emotional effects of all this still affect me 10 years on.' (2009 -2019)*

8.101 *A consultant said to a woman with physical disabilities in* **2008***: 'How do people like me get pregnant, who would do that [have sexual intercourse] to me, and did I know what I was doing?'. (*2008*)*

8.102 *Many women describe how they moved to different units for subsequent births or even to other countries. One woman in **2013** described to the review team how she could never contemplate giving birth in the UK again and found her experiences in the USA far more acceptable. (2013)*

8.103 *After not feeling listened to in **2016** another woman described: 'not having the courage to stand up and advocate for herself'. (2016)*

8.104 The few cases of maternal ICU admission for life-threatening illness are strongly associated with ongoing psychological morbidity and PTSD and women have expressed their strong desire for professional psychology services to be available to them.

8.105 *In a case of chorioamnionitis and failure to act on a pathological CTG in **2012** a woman told the review team: 'They spent half an hour trying to resuscitate my daughter in the corner of the room, didn't say anything to us until it was: "I'm sorry, but we couldn't save her". [I said] "But you were telling us everything was fine". On top of that, the aftercare was absolutely appalling as well. They left us in the [delivery] room for I don't know how long and then they put me in a wheelchair, gave my daughter to me, put us in a room and left us there basically. What was even worse, they put us on the maternity ward so we could hear babies crying. We could hear people being congratulated'. (2012)*

8.106 *Following a cardiac arrest in **2014**, a woman still finds it difficult to come to terms with her condition and feelings she could still die. She described to the review team unhelpful comments from an unknown doctor saying, ' "Hi, I was the guy that restarted your heart". I couldn't cope with that. I was really struggling with the gratitude I felt for the people that had saved my life but also needed some counselling.' (2014)*

8.107 *There were failings within the MDT in **2014** to manage a woman's history and experience of childhood sexual violence. There was evidence of a disconnect between the midwifery notes and the woman's recollection of events. Following her birth experience, the mother contacted the review team to help her to determine if her PTSD, and a birth injury which took years to heal, and left her unable to work is 'normal and acceptable'. The woman explained to the review team that she had been unable to leave the house between 2014 and 2018.*

8.108 Evidence that staff at the Trust often try to settle fears and anxieties is present in many case reviews yet long term psychological harm has still occurred. Postnatal discussion meetings have routinely been offered to women at the Trust over many years but a debrief with a midwife is often not enough for women who have harboured deep seated anxieties and memories and have complex clinical questions that require answers. Most midwives in the UK are not trained to provide professional counselling and may not have the clinical knowledge to adequately explain clinical scenarios that require the input of an obstetrician, neonatologist or anaesthetist.

8.109 It would seem that women receiving their maternity care at the Trust may require the opportunity to review their birth experience more often and in a different way than is currently provided, even if the care was perceived as good. In cases where clinical care was below optimal or complications occurred, ongoing psychological support for women is necessary.

8.110 The NHS Long Term Plan[175] renewed the commitment for the NHS to improve specialist perinatal mental health services. The Perinatal Mental Health Programme and the Maternity Transformation Programme are working together to fulfil this ambition to enable maternal mental health services to be improved by establishing nationwide Maternity Outreach Clinics by 2023/24. This service will help provide support for women with moderate to severe complex mental health problems resulting from their maternity experience and is expected to address issues such as PTSD, perinatal loss and tocophobia (fear of childbirth).

8.111 In July 2020, NHS England and NHS Improvement invited proposals for pilot areas for the testing and development of a maternal mental health service. Shropshire Telford and Wrekin were selected as an early implementer and have revised and updated their Maternity Mental Health guidance. There is evidence that the Trust is working towards improving access to perinatal mental health services.

Conclusion

8.112 This second report builds upon our first report[176] published in December 2020. In that first report, evidence was provided that concerns were not appropriately escalated, leading to a direct impact on the safety and quality of care provided to women and their babies. In this second report which concludes our review of family cases the review team has highlighted both a failure to learn and a lack of progression at the Trust in terms of governance and learning across the timespan of the review.

8.113 In this chapter the review team has highlighted the essential need for effective communication between all healthcare professionals providing maternity care and the women they provide that care for. We have highlighted numerous examples where communication was not at the standard expected or required. As with other chapters in the report there is an ongoing concern from maternity staff at the Trust feeling unable to speak out and raise concerns about care at the Trust. This is an issue that requires urgent action and resolution at the time of publishing this report.

175 NHS England. *The NHS Long Term Plan* (2019) https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

176 Ockenden, D. *Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust.* (2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

Chapter 9

Postnatal care

9.1 There is a need for continuing midwifery and multi-professional observation of the mother and her baby during the postnatal period since serious events or deterioration of already known conditions can occur in this time. The time after the birth of a baby is often when new mothers report they feel most vulnerable, with vulnerability increased where a woman already experiences social disadvantage or pre-existing medical co-morbidities. It is essential, therefore that postnatal care is safe, supportive and compassionate.

9.2 The importance of senior (consultant) involvement in acute care, including postnatal care, was emphasised by the RCOG 2021[177] when it noted that 'consultants must ensure that they fulfil the standard that all women should be reviewed within 14 hours of admission' and that 'this standard also applies to postnatal admissions'. This is not new advice, and reiterates Keogh[178] standard 2 first published in 2015 and emphasised by MBRRACE UK 2019[179]. MBRRACE advised a 'review of guidance [was] needed to ensure that deviation from the usual clinical pathway, with unexpected, or unexplained, symptoms [then] triggers a consultant review'. MBRRACE also noted 'These enquiries have emphasised repeatedly the importance of senior review in relation to abnormal postnatal symptoms'.

9.3 Overall improvements in postnatal care across the wider maternity system require significant investment in both workforce, and technology, especially the improved availability of information technology on postnatal wards and across the community too. Midwifery and support staffing on postnatal wards is often poor, and across England maternity teams will recognise that staff are moved from postnatal wards and the community when there are staff shortages in those areas considered to be more acute, such as the labour ward. Across postnatal care the staff at the Trust have described to the review team how they are stretched beyond capacity. This can then lead to poor physical, social and emotional care provision for mothers and their babies.

9.4 Early postnatal discharge from hospital to home is not always appropriate, despite pressure (which can be from families or the maternity service) for women to leave hospital soon after birth. It must therefore only occur if clinically appropriate, and there must be appropriate support in the community after discharge. Across England, improved midwifery and support staffing levels in postnatal care will improve the safety of that care and lead to an increase in family satisfaction. Consultant job planning must also be considered to ensure that postnatal reviews are a timetabled activity.

Lack of consultant involvement in the management of complex postnatal cases at the Trust

9.5 The review team noted many cases where there was no consultant review, or inadequate consultant involvement, in the management of complex postnatal problems in maternity services at the Trust. For example:

9.6 *In **2002** a woman spent 17 postnatal days in critical care, and sadly died. During that time she was only reviewed on four occasions by an obstetric consultant. There should have been greater consultant obstetrician input into her ongoing care. (2002)*

9.7 *In **2006** a woman with known cardiac problems was discharged home soon after birth without consultant review, despite having been fluid overloaded in labour requiring treatment with diuretics and oxygen. She was admitted some three weeks later in significant heart failure and died. (2006)*

177 Royal College of Obstetricians and Gynaecologists, Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology (2021) https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/roles-and-responsibilities-of-the-consultant-workforce-report-june-2021.pdf

178 Keogh B, *Seven Days a Week*, NHS England (2015) https://www.england.nhs.uk/seven-day-hospital-services/the-clinical-case/

179 Knight M, Bunch K, Tuffnell D, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17.* Oxford: National Perinatal Epidemiology Unit, University of Oxford (2019). https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf

9.8 *In **2007** there was no postnatal consultant review after a difficult caesarean section, even though the registrar who performed the surgery informed a consultant that they were concerned that there might have been bladder damage during the operation. The consultant simply advised an indwelling catheter for 14 days, however, after the woman was discharged home on day five she was readmitted on day 12 but was not reviewed by a consultant until day 15 when she was finally diagnosed with a ureteric injury which occurred during her caesarean section. (2007)*

9.9 *In **2011** a woman with known pregnancy induced hypertension, who required a prolonged postnatal stay in hospital because of labile blood pressure, had no postnatal consultant review. Earlier consultant review could have identified seriously deteriorating HELLP[180], from which the mother subsequently died. (2011)*

9.10 *In **2018** a woman who underwent a caesarean hysterectomy because of a placenta accreta[181] had her surgery performed by a consultant, who also reviewed her the day after surgery, but there was no further consultant involvement in her care after this. (2018)*

Complex postnatal care requiring readmissions

9.11 Postnatal readmissions, for maternal complications, are uncommon, and are by definition complex. Management should therefore include review by a consultant. However, there were several cases where timely consultant review did not occur:

9.12 *In **2006** a woman was admitted with postnatal faecal incontinence, but was not seen by a consultant until 4 days after admission. (2006)*

9.13 *In **2009** a woman remained on the postnatal ward for 15 days after a caesarean hysterectomy for placenta accreta. In the first week she had regular obstetric review, including consultant reviews on days 1, 3 and 8. In the second week recording of maternal observations was very ad hoc and all the reviews were by very junior doctors. This woman was discharged home on day 15 by a junior doctor but was readmitted later the same day with severe sepsis, requiring ITU admission. Adequate observations, and thorough review before discharge, should have alerted clinicians to the developing sepsis, and would have allowed more timely management, possibly avoiding the need for ITU care. (2009)*

9.14 *In **2018** a woman was admitted with postnatal endometritis[182], but did not have any consultant reviews. In this case the management was not timely, as it was not recognised that she had retained placental tissue requiring removal under anaesthetic until 3 days after admission. (2018)*

Observations and appropriate responses

9.15 Observation of vital signs, and appropriate response if they are not normal, underpins the provision of safe maternity care. This should occur at all stages of pregnancy, including the postnatal period. The review has noted many cases where this did not occur across the timespan of the review.

9.16 *In **2000** there were very limited postnatal observations recorded of a woman who had experienced a stillbirth, with abruption, and a 3 litre blood loss, which required a blood transfusion. (2000)*

9.17 *In **2008** there had been abnormal observations recorded but the midwife simply discontinued observations without explanation. This resulted in a delay arranging the blood transfusion this woman required. (2008)*

9.18 The review team has also noted a number of cases where women with known pregnancy-induced hypertension either had few postnatal observations recorded, or had hypertension recorded but there was no response to the abnormal readings (both on the postnatal ward and in the community). These cases include examples seen in **2008** and in **2011**.

180 See Glossary
181 See Glossary
182 See glossary

9.19 *In **2008** when a woman reported severe rectal pain after a forceps delivery there was little consideration that she may have a serious complication. She was given analgesia, but very few observations of her vital signs were made, even when it was noted that she had only passed small volumes of concentrated urine. It was eventually realised, when it was noted that her heart rate was 140–160 bpm that an internal haemorrhage was likely, and her management was discussed with the on-call consultant who advised examination under anaesthetic (EUA) in theatre. Initially no plans were made for the consultant to attend theatre, but as the woman had still not gone to theatre 90 minutes after the decision for EUA, the consultant did attend. The woman went on to have a laparotomy[183], and drainage of a large retropubic haematoma[184]. She also required a 6 unit blood transfusion. Earlier recognition of her blood loss should have led to more timely management. (2008)*

9.20 Shock in the postnatal period should be recognised by all members of the multidisciplinary maternity team. The team must be aware that as most pregnant women are fit and healthy they can compensate for blood loss, and therefore may not show all the classic signs of hypovolaemia[185], which are an increasing heart rate with a fall in blood pressure, usually secondary to blood loss. The review team noted a number of cases where there was a significant delay in either recognising postnatal shock, or a slow response to the situation by clinicians. These are discussed below:

9.21 *In **2006** a woman was admitted with a significant secondary postpartum haemorrhage (PPH). Fluid resuscitation was slow, as was the decision for an examination under anaesthetic (EUA) during which the mother required a hysterectomy. (2006)*

9.22 *In **2006** the midwife noted excessive blood in the drains after an emergency caesarean section with an associated tachycardia and fall in oxygen saturation. The midwife did inform both the registrar and consultant of her concerns. A litre of colloid fluid did not improve the mother's tachycardia, and her oxygen saturation deteriorated, but the obstetric team did not appear concerned as the blood pressure remained normal. It was not until approximately 2.5 hours after leaving theatre that a bedside blood test was performed which revealed a life threateningly low haemoglobin level of 3.3g/dL. She was then rapidly transfused and returned to theatre where she underwent repair of a bleeding left uterine artery. (2006)*

9.23 *In **2008** a woman with known severe pre-eclampsia developed pulmonary oedema some 36 hours after an emergency caesarean section. This is a recognised potential complication, which is why her postnatal care should have been multidisciplinary (obstetrics and anaesthetics) and should have included a clearly documented postnatal MDT[186] management plan of fluid restriction, careful monitoring of fluid balance and regular MDT clinical review including chest auscultation[187]. In this case the care was not multidisciplinary, and did not involve appropriate fluid management. Had this occurred she would certainly have been better managed, and the pulmonary oedema possibly avoided, or managed earlier, so that admission to the medical HDU where her pulmonary oedema was well managed might have been avoided. (2008)*

9.24 *In **2016** a consultant obstetrician ignored clinical signs suggesting an ongoing problem. After a normal birth a woman had a high uterus and ongoing bleeding, this was managed with an oxytocin infusion but the heavy trickle of blood continued. She developed symptoms of light headedness, as well as a fast heart rate, and low blood pressure. Her blood loss was recognised, and managed with one unit blood transfusion. As her bleeding was still ongoing 7 hours after birth the registrar planned for her to have an examination under anaesthetic (EUA) to check for any retained placental tissues, or unrecognised tears. When she was reviewed by a consultant, some 9 hours after the birth, the consultant decided that EUA was not needed. The woman was transferred to the postnatal ward, where she had a further 3 unit blood transfusion the*

183 See glossary
184 See glossary
185 See glossary
186 See glossary
187 See glossary

next day, and was discharged home on day 3. She was readmitted 20 days later with heavy bleeding, and when she did undergo the EUA a large (9 x 5 x 3cm) piece of placental tissue was removed. Clearly the initial management controlled the immediate symptoms, but did not treat the underlying cause of retained placental tissue. Had the EUA occurred 7–8 hours after the birth, as planned by the registrar, then this woman would not have been exposed to the increased risk of infection and secondary haemorrhage. (2016)

Escalation

9.25 The review team has noted many cases where abnormal findings by midwives have then not been escalated to the midwife in charge of the ward/unit or to appropriately senior medical staff.

9.26 *In **2008** a postnatal woman, with known pre-eclampsia, had her blood pressure taken 5 times over a 20 minute period with all readings showing significant hypertension with no further escalation. A junior doctor came to review, but on attending found the woman asleep so the review did not occur until she woke up very confused, and with a headache about 2.5 hours after the hypertension was first noted. She was subsequently managed with a magnesium infusion and antihypertensive medication. (2008)*

9.27 In some cases midwives appropriately escalated concerns to medical staff, but the response to the escalation was poor.

9.28 *In **2019** a midwife escalated concerns about a woman's one-sided weakness the day after a manual removal of placenta was performed under spinal anaesthetic. The midwife's concerns were raised after the woman had been reviewed by an anaesthetist on a routine ward round, when no issues had been identified. The anaesthetist had not documented their clinical review in the medical records. The midwife's concerns led to a further review by an anaesthetic registrar who concluded that the woman's weakness could be explained as "prolonged effects from spinal". This was incorrect as spinal anaesthetic does not cause one-sided weakness. The midwife again raised her concerns, and the woman was then reviewed by a consultant anaesthetist who arranged a head CT scan which diagnosed a subarachnoid haemorrhage. In this case there was a delayed diagnosis of a serious condition. (2019)*

What Trust staff have told the review team

9.29 In late 2021 a number of maternity staff from the Trust, including current and past employees, spoke to the review team:

9.30 One contributor told the review team that '*There wasn't really much working together at all, it was very much we're midwives, they're obstetricians…if you knew certain obstetricians were on [duty] you would be fearful of calling them…because of their way with women…not very nice to the women'.* Another contributor, also noted *'A midwife couldn't ring the consultant on-call…afraid to ring with any concerns'.* A further staff member told the review team: *'It seems to be [with] processes, protocols, guidelines, some are using it, and some are not…policies and guidelines are all there…but not being followed'.*

9.31 A staff member described *'a very, very overburdened and thinly stretched middle tier in the obstetric team… doctors were being asked to cover services that you couldn't possibly do on your own'.*

9.32 Another staff contributor described: *'There were one or two, or even three, consultants that would intimidate the midwives and junior doctors, and make sure they were not approachable…many registrars have been intimidated not to contact the consultant during the night, and if they contact they get told off'.* The same contributor also commented on the relationship between consultants and midwives: *'They don't get on well…there is a barrier'.* Another contributor, commented on the relationship between consultants and midwives and said: *'Some you were seriously on your guard with… [would] bite your head off…I wouldn't have phoned a consultant lightly… [They] weren't particularly approachable'.*

9.33 Some staff also shared with the review team the lack of a supportive culture for junior or inexperienced staff that they had experienced very recently but declined to have their words used directly. It was explained to the review team that asking for help was seen as a bad thing and that junior staff at the start of their careers were often too frightened to ask for support when needed.

9.34 Overall staff feedback to the review team in late 2021 describes poor team working, failure to follow guidelines and an overstretched middle tier of obstetricians. This undoubtedly influenced the ability of postnatal ward midwives and junior doctors to be able to escalate potential clinical complications appropriately. These issues with lack of escalation were found within our first report and feedback directly to the review team from current maternity staff supports the findings in report 1.

9.35 There were however some encouraging reports from staff that the culture has started to change within maternity services at the Trust over recent years. A member of staff, interviewed in October 2021, who had only been with the Trust for a short period reported: *'Overall I think the culture is good…on the postnatal ward'.* The same contributor reported: *'Two new consultants [are]…trying to update the MEWS (modified early warning system) charts'* in reference to escalation from the postnatal ward, a recommendation from our first report.

9.36 Another staff contributor, referring to previously poor escalation at night commented *'Doesn't happen now…consultant now covering labour ward at night'.* The same contributor also commented that the relationship between doctors and midwives was *'improved now'*. Another member of staff, commented on the appointment of an individual consultant in 2018 who changed the culture *'in terms of consultant engagement…is engaged, approachable, woman-centred…and was the start of potentially the tide turning with what was quite an old and staid consultant body…it's much better now…24/7 consultant cover on labour ward'.* The same contributor said *'that is a good thing to come out of all this scrutiny'.*

Clinical follow-up in the postnatal period:

9.37 Clinical follow-up is comprised of two main aspects: firstly, follow up of results of investigations with potential amendments to already existing plans of care. Secondly, follow-up discussion and debriefing of care especially for families who have experienced perinatal loss, or a serious adverse event. This is essential to help women and their families understand, and begin to come to terms with, what has happened to them.

9.38 Follow-up discussions should address ongoing care needs, and discussion about any implications that events within the current/most recent pregnancy may have for care in a future pregnancy. In some cases it may be appropriate for this discussion/debrief to occur before discharge from the postnatal ward, but in others a formal follow-up appointment is required.

9.39 Such discussions require effective and timely communication with both the mother and her GP. It is therefore vital that the appointment occurs in an appropriate setting, within a reasonable timescale and is accurately documented and that the appointment is with a senior doctor who gives the family time for adequate discussion. The doctor also needs to listen to the family, who may hope that any investigation of their case could lead to learning and changes that might avoid another family experiencing a similar event. When a stillbirth occurs MBRACE-UK 2017[188] advised that *'All parents should be offered a follow-up appointment, in an appropriate setting, with a consultant obstetrician to discuss events leading to their baby's stillbirth, the actual or potential cause, chances of recurrence and plans for any future pregnancy'.* The same report also advised that *'A summary of their follow-up appointment, written in plain English, should be sent to the parents, and their GP'.* The review team found many examples where this did not happen:

9.40 *Failure to address the mother's ongoing care needs were noted by the review team when in **2007** a woman was discharged from maternity care still on antihypertensive medication, which had been started during the pregnancy, but with no instructions to either the GP or the woman, about ongoing blood pressure management. (2007)*

188 MBRACE-UK Perinatal Mortality Surveillance Report: *UK Perinatal Deaths for Births from January to December 2015* (2017) https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK-PMS-Report-2015%20FINAL%20FULL%20REPORT.pdf

9.41 *In **2014** a mother's membranes ruptured well before 24 weeks, and she went on to have a very pre-term birth and neonatal death after a few hours. In her pregnancy she had been informed of a positive test result, and advised to collect a prescription for treatment, which she did not do. This test result was noted when she was admitted, and appropriate treatment prescribed, but it was never given. This information was not relayed to the GP, nor was it addressed when the mother saw the consultant for follow-up. (2014)*

9.42 Similarly there are cases of women who experienced serious physical trauma at birth with potential implications for future births, where they and their GP do not appear to have been advised about these implications. One example is the following:

9.43 *There was a lack of information given to a mother in **2018** when a woman had an 'inverted T incision' on the uterus at caesarean section for the birth of the second very pre-term twin (25 weeks gestation). Sadly both twins died in the neonatal period. In the records provided by the Trust there was no evidence that the parents were made aware of the unusual incision on the uterus which does have implications for a future pregnancy: if this woman were to labour in the future there is a high risk of uterine rupture, which can be catastrophic for both mother and baby. The discharge summary to the GP did not include any information about the 'inverted T' incision. (2018)*

9.44 The review noted many perinatal loss cases where there was no evidence in the medical notes that the family had been offered a follow-up appointment; this was noted across the years of the review (2000–2019). For most of the last 20 years the majority of maternity units have arranged that these follow-up appointments take place away from any clinic associated with maternity care, but the Trust was still seeing these families in the gynaecology clinic as late as 2014.

9.45 These appointments are often distressing for the families, and must therefore be conducted sensitively. The written summary of the discussion must also be both sensitive, accurate and easily understood by the family. This was often not the case for the families considered by the review team.

9.46 *A family told the review that they felt that the consultant was 'unprofessional' during their post-stillbirth appointment in **2006**, as he was ill-prepared, had not read the post-mortem report, and sent a letter with multiple factual errors after the appointment. The family explained to the review team that the consultant exacerbated their distress in an already extremely difficult situation, and they then had to write back to the consultant to get the factual errors in the letter corrected. (2006)*

9.47 *A family described their post-stillbirth consultant appointment in **2011** as 'very brief in and out in less than five minutes, and 'did not give [them] any answers'. The consultant was described to the review team as 'inattentive' and he is said to have 'sat on the table swinging his legs'. (2011)*

9.48 *A family who suffered a neonatal death in **2013**, after a traumatic birth, reported that at the follow-up appointment the consultant 'showed no compassion or understanding of the trauma experienced'. (2013)*

9.49 In some cases the letter sent to the family after the follow-up appointment did not offer condolences, or was written using a lot of unfamiliar medical terminology. The review team has seen examples of this in both **2016 and 2018**. In other cases the letter used inaccurate wording that the family found upsetting for example in **2018** the consultant's letter after a stillbirth noted that the mother had *'gone through labour and delivered a very healthy girl'* which is inappropriate given that the baby was stillborn. (2018)

9.50 It is expected that families are given complete and honest information both before discharge from the hospital and at the follow-up appointment. The review team found a number of instances where the information given was either incomplete, or misleading:

9.51 *In **2002** after an intrapartum stillbirth, the consultant's postnatal letter stated 'all the findings would probably suggest there was a little bit of growth restriction at the end, and that labour on top of a compromised baby caused the ultimate demise'. However, the letter failed to mention that the CTG was grossly abnormal for nearly 90 minutes before the stillbirth, that there was thick meconium, and that earlier birth by caesarean section would probably have resulted in a live birth. (2002)*

9.52 *In **2005** after a stillbirth there was appropriate discussion of the family's concerns, but no discussion about the growth restriction noted at post-mortem (not detected in the antenatal period) as a cause of the stillbirth, as well as an infection after probable pre-labour rupture of membranes. (2005)*

9.53 *In **2006** a family whose baby died at 3 days of age with severe HIE[189] and bleeding into an arachnoid cyst, noted that at post-mortem they were given the impression that 'haemorrhage into the cyst had caused the HIE' rather than hypoxia during labour. The multi-professional review team concluded there was clear evidence of a pathological CTG prior to birth and that the resulting features of HIE would be consistent with an intrapartum hypoxic insult which was likely to be due to cord compression worsened by injudicious use of oxytocin. (2006)*

9.54 *In **2008** a woman who experienced an abdominal wound dehiscence 5 days after caesarean section was told that 'the suture had snapped, and this was an equipment failure, not a medical issue'. (2008)*

9.55 *In **2013** after an intrauterine death that occurred in hospital during induction of labour, the family and GP were told that the cause of death was that the labour ward was too busy for her to be transferred for artificial rupture of the membranes (ARM). The Trust RCA did not consider that failure to monitor the fetal heart for 15 hours, (which contravened Trust policy), was the true cause. (2013)*

9.56 *In **2014** following IUD of 28 week twins, the consultant told the family that the scan a week before fetal demise showed that 'Doppler assessments of flow in the cord and brain were normal'. However, there was no evidence in the medical records that they measured Doppler flow in the brain when performing this scan. (2014)*

9.57 *In **2015** after a traumatic operative vaginal birth of the second twin, using 3 sequential instruments, a consultant discussed issues around the birth with the mother, on the postnatal ward, and explained that the baby was 'short of oxygen' during the birth, but did not mention the skull fractures that the baby had sustained. (2015)*

9.58 *Similarly in **2018** a family were told that there was no evidence of pre-eclampsia before a mother was admitted with an abruption and intrauterine death. However the review team noted that in the 2 weeks prior to the abruption the mother was being managed as an outpatient with proteinuria (measured by urinary PCR) and blood pressure that was increased from that recorded at booking. This does indicate that this mother did have known pre-eclampsia, which was a risk factor for abruption. Abruption cannot be predicted, or prevented, but if this woman had been managed as an inpatient, then urgent delivery as soon as the abruption was recognised might have achieved a different outcome. (2018)*

9.59 In a number of cases families felt that the Trust was reluctant to undertake investigations, or to change practice.

9.60 *After experiencing a neonatal death in **2005** a family told the review team: 'We just wanted to understand and maybe work with the hospital to try to change practice to avoid any parents having to go through the same painful ordeal. However, this certainly wasn't an option. It was like the door had been slammed in my face'. (2005)*

9.61 *In **2012** a family were told that there was a Trust investigation after the mother had to return to theatre because of intra-abdominal bleeding after an elective caesarean section, and that nothing different could have been done. However, the Trust has not given the review team any evidence of an internal investigation. The review team is critical of the care this woman received after her elective surgery. (2012)*

9.62 *In **2014** a meeting with the family to discuss the findings of the Trust investigation did not occur until more than 2 years after the birth, and the baby's neonatal admission, from an MLU with severe sepsis. After this meeting the Medical Director did send the family a letter outlining the results of the investigation, but also indicated that the letter had been composed from the Head of Midwifery's notes and transcription (it was obviously 'cut and pasted'). The letter concludes that there were still questions to be answered and confirmation was still required as to whether actions from the investigation had been undertaken.*

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This was 2 years after the case occurred. The review concluded that this letter was unprofessional and reinforced the apathy shown towards the case. The review team considers there appeared to have been little involvement with or support shown to the family. (2014)

Compassion and kindness

9.63 Many families reported to the review team a lack of compassion and kindness shown to them by Trust staff.

9.64 *In **2002** a woman with pre-eclampsia discharged herself 36 hours after delivering 25 week stillborn twins as she felt her care 'was appalling'. (2002)*

9.65 *In **2008** a woman reported her distress about the care she received on the postnatal ward after undergoing a postnatal laparotomy for a retropubic haematoma. She felt that on the ward 'There was no communication at all. I was shouted at, ordered about and forgotten…I was made to feel like an inadequate mother and made to feel like I was making up how poorly I was and I like I shouldn't have rung the bell or asked for help'. (2008)*

9.66 *In **2011** two families commented that 'midwives didn't care', 'showed no kindness [and] support' and 'there was no caring involved'. One mother told the review that she felt unsupported after suffering a cardiac arrest and was not offered any psychological support. She told the review that she was made to feel 'I was in the way and they wanted rid of me, they were in no way subtle about it once they decided that I had spent enough time in the unit'. (2011)*

9.67 *Another woman in **2015** told the review that she felt she had received poor care that also lacked empathy. (2015)*

9.68 The review team heard from families who felt unsupported and uncared for when their babies were unwell:

*In **2010** a baby was readmitted with significant jaundice. The family felt that their baby was 'starving to death' and complained about lack of feeding support. A review of the medical records indicated that inconsistent advice had been given to the parents. (2010)*

9.69 *In **2012** a mother felt ridiculed for having followed another staff member's advice on how to put on her daughter's nappy. (2012)*

9.70 *In **2014** a mother reported , whose baby was on the neonatal unit, that she was 'told off' for 'worrying about her pain too much'. The woman reported to the review team that she was told by staff 'what we tend to find is that those women who have babies next to them have more important things to think about. People like you who do not, are only concerned with themselves'. (2014)*

9.71 *In **2015** two families described the postnatal care as being 'truly awful' and that they 'felt like a burden' and 'not listened to'. One of these families also described a midwife calling the mother 'a princess' for asking for formulafeed for her baby. (2015)*

9.72 *In **2016** a mother reported being left alone in the birth room, with the call bell out of reach, just 40 minutes after giving birth. (2016)*

9.73 Concerning attitude issues towards families were also reported by some staff. One contributor to the staff voices process, reported to the review team that *'some staff [on the wards] ignored buzzers unless it was "their buzzers".'* This meant that some women asking for help could not access any support if their own midwife was busy, off the ward, or on a break. This contributed to some families feeling that *'midwives didn't care'.* The same contributor also commented that postnatal ward staff were probably quite unhappy and described *'not much understanding between labour ward and the postnatal ward'.* The same member of staff also stated: *'I wouldn't have wanted to go there as a patient'.*

9.74 Staff members told the review team that asking for help was seen negatively but were unwilling to be quoted directly as having said this, despite assurances of anonymity. This was not an attitude likely to foster a good working environment for staff, nor likely to lead to good care for families. Another member

of staff, stated that the Trust was *'a dreadful place to work…practice wasn't evidence based …guidelines woefully out of date…I tried to raise concerns unsuccessfully'.*

9.75 Whilst the review team noted that the Trust had a perineal follow-up clinic for women who had experienced 3rd and 4th degree tears, or other perineal problems, they also noted issues with some staff communication in this clinic.

9.76 *In **2009** a woman was referred to this clinic because of persistent perineal symptoms, despite no known history of significant perineal trauma at birth. In the clinic the consultant who saw her dismissed her symptoms, and said that no further investigation was required, without even examining the woman. This woman was subsequently seen in another hospital where a rectovaginal fistula was diagnosed, which must have occurred because of significant trauma at birth, probably a missed 3rd or 4th degree tear. (2009)*

9.77 *In **2014** when a woman was reviewed in this clinic after a 3rd degree tear the doctor wrote in the notes: 'Well, but fat and very anxious. Can try for a vaginal birth – risk of re-occurrence low'. (2014)*

Receiving postnatal care in the correct location

9.78 Care in the postnatal period for mother and babies must take place in an appropriate setting, according to clinical need.

9.79 *In **2012** there was inappropriate transfer to midwifery-led care in the postnatal period which led to poor management. The transfer of care, to a distant MLU, occurred 3 days after birth despite a complex caesarean section, massive obstetric haemorrhage, anaemia, postpartum pyrexia, persistent tachycardia and persistent pain. The mother was eventually transferred back, very unwell, to the consultant-led unit (inappropriately by car) on day 8 with severe sepsis, with both a pelvic abscess and a lung empyema[190]. (2012)*

9.80 *In **2017** a woman with known pre-eclampsia was transferred to a distant MLU for ongoing postnatal care on day 3, despite her blood pressure remaining elevated. (2017)*

9.81 *In **2017** a mother and baby who had been transferred to a standalone midwifery-led unit (MLU) for postnatal care after birth was advised by a midwife: 'Don't tell them the baby is 'grunty' or they will send you back to the consultant unit'. A family member subsequently highlighted their concerns and the mother and baby were transferred back to the consultant-led unit (2017)*

9.82 *In **2018** a mother and baby were discharged home 4 hours after vaginal birth but the baby's temperature was 36.1°C with no evidence of repeat measurement, the review team felt this was inappropriate. (2018)*

9.83 Follow-up appointments by community midwives after postnatal discharge from hospital should aim to both support the mother, and to detect and appropriately refer any maternal, or baby problems identified. In some cases this did not occur.

9.84 *In **2011** when a woman reported 'very little bowel control' on day 10, the midwife advised her to report this to her GP, rather than referring her to the obstetric team for review and management, or continuing to* review the situation herself. (2011)

9.85 In other cases women who had experienced pregnancy loss were advised to see their GP to get a prescription for therapeutic lactation suppression. It is normal practice to offer women lactation suppression after perinatal loss. The review noted evidence that lactation suppression was discussed with parents, but from the records of a **2016** early neonatal death it appears that Cabergoline was not stocked on the labour ward. This suggests that the management for families experiencing loss was not holistic.

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Staffing

9.86 Poor staffing levels, both midwifery and obstetric, will affect both the quality of patient postnatal care, and staff morale. It would appear that staffing levels and staff morale were an issue for some time at the Trust.

9.87 When contributing to the Staff Voices initiative in late 2021 one contributor graphically described the stress staff felt because of poor staffing levels, with postnatal ward midwives regularly being *'pulled to labour ward'* and described the way this affected care as: *'you … try and just do the work as quickly as possible, and there wouldn't be any quality of care'.* The same contributor also described that this prioritisation of the labour ward, leaving the postnatal ward understaffed *'really increased our stress levels because obviously, it's upsetting when you can't give the care that you want to give…especially on a postnatal ward where it led to healthcare assistants or the women's services assistants doing most of the clinical care with midwives just running in with some painkillers or IV antibiotics, or doing a quick check'.*

9.88 The response from the staff member, when asked about escalation of concerns regarding staffing levels on the postnatal ward, was *'you know, you can escalate, but you know if there's nowhere to pull, there's nowhere to pull. You're just left and you just have to get on with it'.* The contributor also reported pressure for early discharge *'they [postnatal women] can't even stay in for breastfeeding support'.*

9.89 Many staff contributors also reported significant staffing issues. They described: [a] '*shortage of midwives… needing to pull in staff (from wards and community)…robbing Peter to pay Paul,'* and *'[being] concerned about safety and staffing'.*

Bereavement

9.90 It is sadly inevitable that many of the families included in this review have experienced the loss of a baby, which can have a huge impact on their long-term wellbeing. As noted by SANDS (2021) *'Good care cannot remove the pain and devastation that bereaved parents experience, but poor or insensitive care makes things worse, both immediately and in the months and years that follow'.*

9.91 Compassionate bereavement care must begin when a family are told that their baby has died (or before death if the baby is known to have an abnormality incompatible with survival), it is therefore vital that all staff communicate compassionately with families at this very difficult time. Below are some cases from across the timespan of the review identified by the review team where families felt this did not happen:

9.92 *In **2002** a family complained about the way that a midwife sonographer informed them that one of the twins had died when the mother presented with ruptured membranes at 37 weeks gestation. (2002)*

9.93 *Similarly in **2009** a family complained about the manner of the doctor who diagnosed the absence of fetal heart activity, which they felt was insensitive. (2009)*

9.94 *In **2018** the review team noted that a family wished to continue a pregnancy with known abnormalities incompatible with survival and they were seen by the bereavement midwife and consultant neonatologist together during the pregnancy to plan care at the time of birth. After these meetings a letter outlining the plans for care was sent to the family. However, this information was inadequately conveyed to the labour ward staff, who were unaware of the agreed plans. This led to the inappropriate repeated discussion of the issues when the mother was in labour, and after the baby was born. It was also noted that some of the agreed plans were not followed, such as the family spending as much time with the baby as possible before discharge from the hospital. It is clear from the documentation that at the time of birth there was little, or no, discussion with the family with regards to meeting their individual requirements, nor to fulfil their required cultural and religious practices despite these having been agreed at the pre-birth meetings. (2018)*

9.95 In most maternity units it is routine practice to suggest that women go home after being given oral mifepristone following the diagnosis of an intrauterine death, to return after 36-48hrs for further management to induce labour. It is however very important that staff ensure that parents are given the option of staying in the hospital if they prefer, or that they are clearly informed that they can return to the hospital at any time if they wish.

9.96 *A mother described how she felt in **2010** 'When I left the hospital on the day I found out that my baby had died [at a scan]. I was told that they wouldn't expect me to return for 48 hours, from when the tablet was taken'. This family reported that they felt unsupported. (2010)*

9.97 *Similarly a mother raised concerns regarding staff attitudes after the very early neonatal death of a very premature baby in **2014**, who was born at 21+ week's gestation. She explained that she had to 'wait for the corridors to be empty before carrying her son back to the birth suite'. In her notes there was minimal documentation regarding postnatal bereavement care. (2014)*

9.98 Women who experience perinatal loss need to be cared for in a clinically appropriate area, so that both their physical and emotional needs can be addressed.

9.99 *In **2012** a family reported that their care after an intrapartum stillbirth was upsetting. Firstly the family were 'left in the room for I don't know how long…then put me in a wheelchair, gave baby to me (to hold), put us in a room and left us there'. This family also reported 'what was worse they put us in the maternity ward so we could hear babies crying'. Families have clearly explained to the review team how both compassion and an appropriate place of care can help make the unbearable more bearable. (2012)*

Consent to post-mortem examination

9.100 Post-mortem is the most useful investigation in supporting the determination of cause of death and its value is frequently underestimated by health professionals[191]. Deciding on whether to have a post-mortem investigation conducted can be one of the most difficult decisions bereaved parents face in the period immediately after their baby dies. It is essential that this is dealt with in a sensitive way by a professional trained to take post-mortem consent. The review team noted cases where discussion with families about having a post-mortem examination was insensitive or unhelpful. Below are two examples:

9.101 *A family in **2009** told the review team that: 'The doctor who went through the consent process for the post-mortem examination was observed by the midwife who documented "Noted that he went through documents very quickly and with little empathy. Family distressed by this and told me they were not happy with this when he left. Apologies given".' (2009)*

9.102 *Also in **2009**, a family reported that following the stillbirth of their daughter 'there wasn't time or space to make the important and difficult decision about consenting to, or declining, a post-mortem examination'. In this case the post-mortem consent was discussed only 6 hours after an unexpected stillbirth, and the family felt that the consultant obstetrician counselled them against having a post-mortem, and this was their 'largest concern about the care' the family received. (2009)*

Ongoing care after bereavement

9.103 Not surprisingly parents are very fragile at this difficult time, something all maternity staff should be aware of. Some families reported experiencing a lack of sensitivity to the review team. A family told the review team that in **2009** they found a consultant's attitude to be *'rude and completely dismissive of [their] concerns'.* (2009)

9.104 A family in **2011** felt deeply about *'the lack of compassion and empathy exhibited by the midwife'*. Also from **2011** the review team noted poor bereavement care and support and that there was evidence of a breach of confidentiality as there had been disclosure of the death of the baby to the woman's father without her consent. This had caused a strain in their relationship ever since. (2011)

9.105 It is reasonable to expect that maternity staff are careful to obtain accurate information when caring for bereaved families, or those with sick babies on the neonatal unit.

9.106 *A mother complained about the postnatal care she received in **2009** following a bereavement saying that the staff appeared unaware of the issues and she had to keep explaining distressing details at every shift change. (2009)*

191 https://www.sands.org.uk/professionals/sands-post-mortem-consent-package

9.107 *In another instance in **2014** a bereaved family reported seeing a different community midwife at each postnatal visit. (2014)*

Specialist bereavement care

9.108 Families who have experienced baby loss must have ongoing support, either from their own community midwife, or from a bereavement midwife. The review team noted a lack of support for bereaved families in many cases, over a long period of time.

9.109 *From a case in **2003** the review team noted that one woman said she was happy with the antenatal and intrapartum care she received but when she needed support following her term stillbirth this was 'sadly lacking'. In this case there was no information in the medical records about bereavement care apart from a checklist and mention of counselling in the bereavement follow-up letter. It is unclear whether this was ever arranged. (2003)*

9.110 *Following the loss of her baby in **2010** the clinical records indicated that the mother was discharged from maternity care on day 8 and advised to 'call if further support needed'. (2010)*

9.111 *In **2011** the review team noted an apparent lack of bereavement support after a stillbirth. The only evidence of involvement from the Trust was a single telephone call some four weeks after the birth. The notes from this call, provided by the Trust, indicate that the mother was advised to contact other healthcare professionals for support if she wished. (2011)*

9.112 *In **2012** one family reported that the bereavement care they received was 'appalling' and another family felt that the bereavement support was 'very tick box' and that they found the maternity bereavement service 'of no help'. (2012)*

9.113 *In **2016** the review team heard from parents of a lack of care and compassion in bereavement care following the neonatal death of their baby shortly after birth. (2016)*

9.114 Another important aspect of care at this difficult time is ensuring that parents receive all the information they require, or request, and that all appropriate services are informed of the bereavement.

9.115 *A family reported that in **2010** when they requested that the community midwife follow up the missing photographs of their stillborn baby that this did not occur. As the photographs had still not been sent to her months later the woman had to phone the ward herself to obtain them. (2010)*

9.116 *A family reported that in **2011** there was a delay in them being told that their baby had been returned following the post-mortem, which led to a significant delay in arranging the funeral. (2011)*

9.117 *In **2016** a health visitor was unaware of the neonatal death and provided congratulations and Bounty literature continued to be sent to the family, which they found distressing. (2016)*

Good bereavement care

9.118 In some cases, there was evidence of kind and compassionate support given to families after bereavement. The following are examples of that kind and compassionate care.

9.119 *In **2006** the community midwife was praised by the family for her care and compassion and they specifically asked for her in subsequent pregnancies. (2006)*

9.120 *In one case in **2011** the obstetric registrar offered condolences and gave a detailed discussion about post-mortem and the parents opted for a limited one with the knowledge that there was a limit to the information they would receive. (2011)*

9.121 *There was evidence in some cases that the maternity staff tried to help families with stillbirth registration. In **2014** a couple with English as a second language were escorted to the registry office to register their stillborn twins. It was also arranged for an interpreter to be present when the couple came to see their consultant for a follow-up appointment. (2014)*

9.122 *In **2012** the family reported that through bereavement support it was ensured that the family's concerns and questions were addressed in the Trust investigation.*

9.123 *In **2017** the parents reported effective information sharing, good levels of care including continuity of care after bereavement. (2017)*

Good postnatal care

9.124 Whilst the review has identified poor postnatal care it should be acknowledged that in the cases the maternity review team considered we also found examples of women receiving good, safe and supportive postnatal care.

9.125 *In **2011** there was evidence of effective team work with appropriate referral and involvement of social services, GP and health visitors. (2011)*

9.126 *In **2014** the review team also noted that 'the immediate midwifery care provided during the postnatal period was of good standard and aligned with local and national guidelines'. (2014)*

9.127 *In **2014** evidence was noted of extra postnatal community visits to provide more emotional support to a new mother. (2014)*

Good record keeping and good care planning

9.128 Good record keeping is fundamental to safe and high quality maternity care, and remains so in the postnatal period. Whilst the review has criticised poor record keeping, examples demonstrating appropriate and good quality postnatal record keeping were identified in **2010** and **2013**. The review team also identified sensitive documentation in the care of a family in **2008** and in another case involving a family in 2016 documentation was described as having a *'detailed midwifery record'* by the review team.

9.129 The review team also identified examples where problems likely to lead to a difficult outcome were identified during the pregnancy with evidence of good care planning in 2008. In cases from **2011** and **2015** the review team also noted evidence of family involvement in the planning of care.

9.130 Some cases of good clinical care were also noted. In **2011** timely multidisciplinary management was noted when a woman was readmitted with a severe wound infection after a caesarean section. The infection was promptly recognised as the severe life threatening condition of necrotising fasciitis, which was managed well.

9.131 In **2013** when a woman informed her community midwife that she felt 'unwell' at a routine visit, the community midwife recognised the severity of her condition and arranged prompt referral directly to the labour ward. When this woman arrived on the labour ward the midwives ensured that she was seen promptly by the obstetric registrar, who rapidly diagnosed sepsis and appropriately administered intravenous fluids and antibiotics within 30 minutes of her arrival in the maternity unit. She then went on to have good multidisciplinary management, including a short spell in ITU, and made an excellent, and fairly rapid, recovery. (2013)

LOCAL ACTIONS FOR LEARNING: POSTNATAL CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

9.132 The Trust must ensure that a woman's GP is given complete, accurate and timely, information when a woman experiences a perinatal loss, or any other serious adverse event during pregnancy, birth or postnatal continuum.

9.133 The Trust must ensure complete and accurate information is given to families after poor obstetric outcome. The Trust must give families the option of receiving the governance reports, which must also be explained to them. Written summaries of any debrief meetings must also be sent to both the family and the GP.

Chapter 10

Maternal deaths

The impact on families when a mother dies

10.1 Families have explained to the review team that the impact of a maternal death and thus losing a mother, wife, daughter, sister, or grandchild is far reaching across a whole extended family and the effect of this remains with them forever. Here are some of the ways families who have spoken to the review team about maternal death have described this to us:

10.2 'It never goes away…you just kind of…and it's a natural thing, you just kind of withdraw within yourself a little bit. Usually, for me, that's like a month, six weeks, two months.' (**2002**)

10.3 'It's just sad, I ache for her every day, every day.' (**2007**)

10.4 'I think her Mum and Dad, they're still grieving now…Even now like, I mean you go round the house and there's always a candle lit, you know, they've got our wedding photos still up, you know, it's just a constant reminder when you go round to their house.' (Husband talking about his wife who died in **2011**)

10.5 '…she was having some problems and eventually she said to her step mum that she felt bad that her Mummy had died because she'd wanted to have a brother or sister.' This example is from a bereaved husband, talking about his first-born daughter whose mother died during a later pregnancy. His daughter believed that her wanting a sibling was the reason her mother had died in **2016**.

10.6 The review team noted that several families felt their questions surrounding the maternal death had not been addressed by the Trust. Bereavement support after the event was also described by families as inconsistent:

10.7 When asked as to whether an investigation into the death had been performed a husband whose wife had died in **2002** responded: *'There was no…it was just the…it was pulmonary oedema and obviously pre-eclampsia was like mentioned, or part of it. Yes, fluid on the lungs. No, they never gave an explanation for that, for why'.*

10.8 Another family member said to the review chair: *'It's what makes me angry, because I feel like the Trust got off lightly at the time with me, because I feel that they recognised, in that meeting, how desperately distraught I was and they just decided…like everything was done, you know…We can't find any reason for, but if you want to take a complaint elsewhere that's up to you…but as far as we're concerned there's no case to answer…is what they basically said. And I came out flabbergasted because I think I'd expected them to offer me a big apology, you know, and say oh yes, we've made loads of failings here, and all this, that and the other...And of course they didn't and when they didn't do it I just thought I can't do any more, like I haven't got the energy to do any more. So I think they got off lightly really, and it makes me feel bad that I didn't have the energy to do it, but it would have been too much for me to go through…because I want to go through this process [the Ockenden review] to get some answers for my own peace of mind as to what happened, because I laid a lot of blame on myself afterwards…'*

10.9 The family member further recalled: *'one doctor that wasn't so pleasant or helpful…when I rang him to ask some of the questions, his exact words to me were "if you keep digging into this you'll just find things you don't want to find". That's what he said to me, and then he put the phone down'.* (This feedback is from the partner of a mother who died in **2002**)

10.10 A partner of a woman who died in **2014** told the review chair: *'I was actually told that I would get to see [the investigations], they did an independent review on their midwives and then they did another one, I saw another lot…so the ones above them also went back on her case and went through all that, I was also told I would get them...[investigation reports] and we've never had them'.*

Number of maternal deaths reviewed

10.11 At the time of concluding this review, in total 19 maternal deaths were noted by the review team. Three of these occurred prior to the core review period (before 2000) and one death in **2015** occurred after the mother was transferred in labour to another trust. This woman's pregnancy care was reviewed by the team as the majority of the pregnancy care occurred at the Shrewsbury and Telford Trust's maternity services, but her death was not.

10.12 Of the 16 cases that occurred within the core review period, there were eight direct[192], and seven indirect maternal deaths[193], plus one accidental death resulting from a road accident, which was not investigated further by the review team.

10.13 One death which occurred at the Trust during pregnancy in **2019** was comprehensively investigated by the regional Healthcare Safety Investigation Branch[194] (HSIB) as per NHS policy. This case was not reviewed further by our team.

10.14 One mother who delivered at the Trust died in another hospital in **2019** and the family declined the HSIB review. It was not possible to obtain permission from the family regarding inclusion into our review. In cases such as this, there is ultimately learning for the whole maternity system and trusts involved must learn together through digital or remote means if necessary. The review team is not aware of any such joint learning in this case.

10.15 Clinical notes were unavailable for one woman who died in **2001**, despite recommendations that all maternity records should remain available for 25 years after the birth of the last child[195]. An external governance review was arranged after the family complained to the Trust and provided to the review team by the Trust. The review team was therefore able to review the quality of the Trust's internal investigation after the death, but not the clinical care.

Analysis of the maternal deaths

10.16 The remaining 12 maternal deaths were each reviewed by a multi-professional team of midwives, consultant obstetricians, a consultant obstetric physician and a consultant anaesthetist, with special interest in obstetric and cardiothoracic anaesthesia. Further experts (including experts in intensive care, cardiology, neurology and others) joined the team to give expert opinion or answer specific clinical questions where required.

10.17 As with all other reviews, for each maternal death review the team adopted a holistic and multi-professional approach, including access to all available governance documentation provided by the Trust and communication with the family of the deceased mother.

10.18 Although statistical analysis of the maternal deaths is limited due to the small numbers, the review team noted the relatively high number of direct maternal deaths at the Trust. This is in contrast to the overall national trend, where direct deaths have been declining since 2004[196]. This may be an indication that the care for pregnancy related conditions such as pre-eclampsia (PET), sepsis and major obstetric haemorrhage needs to be further improved locally.

10.19 The review team noted that all but one woman who died were of white ethnicity, a patient group which usually has a lower risk for mortality in pregnancy. Seven of the women who died were classified as obese at booking for maternity care (BMI> 30 kg/m2) and therefore were of higher risk for pregnancy related complications.

192 See glossary

193 See glossary

194 See glossary

195 Department of Health, Records Management: NHS Code of Practice: Parts 1 and 2: 2006, revised 2009 and 2016, include reference to HSC 1998/217: Preservation, Retention and Destruction of GP General Medical Services Records Relating to Patients (Replacement for FHSL (94) (30))

196 MBRRACE-UK, Saving Lives, Improving Mother's Care (2020)

10.20 Two maternal deaths did not have a coroner's inquest. In three cases where there was a coroner's inquest the review team commented further on the cause of death as stated by the coroner:

*In **2002** a woman with pre-existing lung disease developed pre-eclampsia and had inappropriate fluid management with significant fluid overload, over many days. She later died from acute respiratory distress syndrome (ARDS). The pathologist at the inquest speculated that very high oxygen levels during ventilation on the intensive care unit led to the ARDS. The underlying respiratory condition and inappropriate fluid management were not identified at the inquest. The review team is of the opinion that this was a missed opportunity for learning from the death of this woman.*

10.21 *In **2014** a woman with poorly managed sepsis and prolonged resuscitation efforts was found to have squamous epithelial cells in the pulmonary vessels at the post-mortem investigation and the cause of death was determined as amniotic fluid embolism (AFE). The review ream is of the opinion that fetal squamous cells in the systemic or pulmonary circulation of the deceased is not necessarily proof that she died of AFE and that sepsis was a significant contributing factor. The review team is also of the opinion that this was a missed opportunity for learning from the death of this woman.*

10.22 *The post-mortem investigation in a woman who died of major obstetric haemorrhage in **2017** found evidence for an undiagnosed cardiac condition, which was classified as contributory to the death The review team is of the opinion that there is no evidence that the woman was affected by the cardiac condition in any way and that this did not contribute to her death.*

10.23 The clinical care and quality of the subsequent investigation were rated by agreement between the review team members as per below:

GRADING OF CARE	DEFINITION
0 Appropriate	Appropriate care in line with best practice at the time.
1 Minor Concerns	Care could have been improved, but different management would have made no difference to the outcome.
2 Significant Concerns	Sub-optimal care in which different management might have made a difference to the outcome.
3 Major Concerns	Sub-optimal care in which different management would reasonably be expected to have made a difference to the outcome.

10.24 The quality of the incident investigation root cause analysis or RCA at the Trust was rated differently depending on the year the incident occurred, to reflect the national developments in incident reporting and investigation.

For cases up to and including 2010:

	INVESTIGATION	FAMILY INVOLVEMENT
Appropriate	Incident investigated by team of clinicians. Evidence of recommendations for improvement.	Compassionate communication with family at time of incident.
Poor	Any of the above missing.	Very little or non-compassionate communication with family.
None	Incident not investigated.	No family involvement.

For cases from 2011:

	INVESTIGATION	FAMILY INVOLVEMENT
Appropriate	Incident investigated by team of clinicians. Appropriate collection of evidence (statements, notes, policies etc.) Appropriate care and service delivery problems identified. Strong recommendations for improvement with clear plan for implementation.	Families involved in investigation by compassionate communication with them at the time of incident. Feedback to the family once investigation concluded.
Poor	Any of the above missing.	Very little family involvement or feedback after the investigation.
None	Incident not investigated.	No family involvement.

Grading of care

10.25 The review team reviewed the maternal death cases individually prior to agreeing the grading at multidisciplinary team discussions. With hindsight, one will often judge a past decision by its outcome instead of based on the quality of the decision at the time it was made, given what was known at that time. The review team is conscious of the fact that there is a danger of judging past care decisions by the outcome, instead of based on the quality of the decision made at the time, which can lead to outcome bias when applying any grading of care. It is important to note that all cases were reviewed in accordance with best clinical practice and guidelines available at the time of the incident, to avoid outcome bias as much as possible.

10.26 The reviewers found none of the maternal death cases had received care in line with best practice at the time (grade 0). Three cases were found as requiring improvement in care, however, the eventual outcome would not have changed (grade 1). In six cases the care was rated as 2, meaning the reviewers found suboptimal care of the women and different management might have changed the eventual outcome. Three cases were graded as 3, where the eventual outcome could have reasonably been expected to be avoidable, had the care been different.

Grading and analysis of internal investigations

10.27 In line with the Terms of Reference of the review, all available governance documentation and family communication were reviewed in the context of best practice at the relevant time. A total of 11 incident investigations were considered. However, in some cases no comprehensive serious incident (SI) report was available (as would have been the expectation), but rather an abbreviated High Risk Case Review (HRCR), in the form of a spreadsheet. This appears to have been an internal Trust review process that has not been seen outside the Trust by review team members. It was not always clear to the review team whether, and if so how, these were shared with the families of the deceased women.

10.28 One maternal death in **2017** was investigated by an external provider. The review team agreed that the standard of the investigation was appropriate.

10.29 A maternal death that occurred in **2002** was not investigated by the Trust as the care was rated by them as appropriate, a finding with which the review team fundamentally disagree. The Trust maternity governance team noted *'This case was reported as a serious untoward incident and also a full report sent to CEMD (Confidential Enquiry into Maternal Death). It was also discussed at the mortality meeting, but it was felt*

that there were no lessons to be learned. This was a high risk pregnancy and Mrs X was aware of the potential effect this could have on her future. The staff were extremely saddened by her death'.

10.30 The review team acknowledges that the pregnancy in this case from **2002** was high risk, however there were multiple missed opportunities and a lack of understanding in regard to the mother's underlying condition and poor management of developing complications. The family in conversation with the chair of the review has explained how they felt the Trust 'blamed' the mother and her husband for her death, because had the mother not got pregnant she would not have died.

10.31 In another case in **2001** the family made three requests via the NHS complaints procedure for an external review into the death of the mother. It was finally arranged by the Trust's lay chairman and complaints convenor two years after the death in 2003 and identified significant issues in the care. In their letter to the family it is stated *'The lay chairman and I agree that there has been a long period of local resolution, including a meeting with the consultant in charge…and several letters from the chief executive. In fact, this is the third request for an independent review. The independent clinical advice supports your view that there are still significant issues which need to be addressed concerning the standard of care provided…'* From the available documentation the review team can conclude that the initial investigation into the death by the Trust was poor.

10.32 The review team rated all available Trust investigations into these maternal deaths as poor. We found repeatedly that significant omissions in care were not identified by the Trust investigators, leading to missed opportunities for learning that could affect the outcome for other women and babies in the future.

Findings

10.33 Many RCAs did not involve a multidisciplinary team, even if there were multiple professions involved in the care of the woman (for example there was usually an absence of specialities such as obstetric anaesthesia, intensive care, infectious diseases, cardiology and/or haematology). Frequently only a few internal maternity staff performed the investigations and even at mortality and morbidity review meetings a truly multidisciplinary discussion did not happen.

10.34 It appears that all these cases of maternal deaths were investigated purely internally, with no external expert opinion sought, except in the one case mentioned above.

10.35 If and when post-mortem results became available during the investigation that seemingly pointed to a direction of an 'inevitable outcome', the direction of the investigation changed in such a way that detailed scrutiny and holistic review of the entire care did not happen.

10.36 Issues in care that were identified were frequently treated as individual failings and actioned by 'internal reflection' of involved staff. The investigations did not follow the appropriate systems-based approach as outlined in the relevant NHS incident frameworks and significant learning opportunities for the Trust and the wider maternity teams were lost. These frameworks are discussed further in the report chapter focussing on clinical governance.

10.37 The review team noted that frequently the women themselves were blamed or held responsible for the adverse outcomes, without identifying underlying and obvious failings in care. A husband recalled how in **2011** his deceased wife was blamed when he was told: *'[it was] difficult for the midwives to listen to baby's heart beat due to her size'.* This was also recorded in the maternity records. Trust documentation pertaining to a maternal death in **2002** stated *'…she knew of the risks [related to pregnancy] and accepted these'.* In another case in 2002 the following was said *'...she must have been responsible for some of that because she clearly did not complain very much and tended to ignore many of her symptoms…'.*

10.38 In one case in 2014 there was a significant discordance between what was discussed with the relevant clinicians involved in the incident by email and the stated outcome of the internal incident investigation. The Trust investigation concluded *'no deviation in care and management identified relating to root cause'.* However, in emails that were sent by one of the lead investigators to individual staff involved in the care

of the mother, it is clear that significant omissions in care were identified: '*…none felt that discharge to the antenatal ward at that point was the correct action'.* This case highlights significant cultural problems in the Trust at the time. There appeared to be a lack of ability to come together and examine why this happened. There was no insight into the problem resulting in a poor investigation, which later informed the coroner's inquest. This affirms the overall findings of the review team that significant contributory factors and/or the root causes for poor outcomes were not identified, or to the extent they were identified, were not addressed with a robust action plan; demonstrating a lack of rigour and transparency in the RCA investigations.

10.39 There is also evidence from the available governance documentation and conversations with families that in some cases failings in care were not communicated in an open and transparent way, once the investigations were completed.

10.40 *In **2006** a woman with an underlying cardiac condition, developed significant tachycardia and low blood pressure after the delivery. In a meeting with the family after the investigation they were told that 'The ECG of a pregnant woman can be misleading to a junior doctor with general medical experience; as it can appear to suggest the heart is not coping; which is incorrect and a normal rhythm in pregnancy.' At no point was it discussed with the family as to whether this complication should have been escalated to a more senior doctor or cardiologist. There was also a missed opportunity to manage and treat the underlying causes of the tachycardia.*

10.41 *In **2014** another family who questioned the appropriateness of treatment for maternal sepsis were told in a debriefing meeting that 'she did not have signs of profound infection' which is not corroborated by the clinical notes. The internal discussion at the Trust regarding the serious incident found that the sepsis treatment had been not well coordinated, but this was not disclosed to the family.*

Learning from maternal deaths

Local Actions for Learning and Immediate and Essential Actions from report 1:

10.42 The review team re-emphasises the importance of the previous Local Actions for Learning for the Trust and Immediate and Essential Actions for the wider maternity system from their first report regarding the learning from the maternal deaths at the Trust. They can be found in Appendix 2 and form a vital part of the ongoing learning for the Trust and wider maternity system. In particular continued focus must be around timely escalation to an appropriately senior level and multidisciplinary team working. MDT training involving maternity teams working with ITU, anaesthetic and other colleagues in management of the deteriorating pregnant woman is needed. This will ensure the right team are always available with the skills to manage complexity.

LOCAL ACTIONS FOR LEARNING: MATERNAL DEATHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

10.43 In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.

Chapter 11

Obstetric anaesthesia

11.1 Expert advice was sought from anaesthetist colleagues within the Maternity Review Team for a number of cases. Criteria for anaesthetic review for this report were the presence of severe pre-eclampsia or HELLP; eclampsia; postpartum haemorrhage of 3000ml or more; significant pre-existing maternal medical disease; and concerns regarding the management of obstetric anaesthesia. As a consequence, 68 cases were referred to anaesthetists within the Review Team. This is a small percentage of the overall number of cases reviewed in this report and an even smaller proportion of the overall number of maternities taking place at the Trust during the past two decades. Consequently, there is a limit as to how representative of anaesthetic provision at the Trust these cases can be considered to be. However, there were a number of recurring themes that are worthy of comment to facilitate further learning.

Anaesthetists and the multidisciplinary team

11.2 The role of the anaesthetist on duty for obstetric anaesthesia is much broader than being merely a technician for provision of pain relief and anaesthesia. They must also work as part of the multidisciplinary team in the management of women experiencing pregnancies or childbirth, complicated by certain obstetric issues or pre-existing medical disease. As described in the first report, the review team again found evidence that anaesthetic input on the labour ward was often task-focussed and lacking consideration of the wider clinical picture of the women in their care.

11.3 *In **2012**, ten days after emergency caesarean a woman was displaying florid signs of sepsis and a decision was made to reopen her wound. The specialty doctor anaesthetist gave appropriate intraoperative care at laparotomy which revealed pus in the caesarean wound and pus within the peritoneum[197]. However, there was no evidence of discussion regarding where the patient would be best managed postoperatively and no postoperative instructions were documented by the anaesthetist. She was discharged back to the labour ward overnight and stepped down to the postnatal ward the following day despite the patient's concerns about her breathing. A respiratory examination was not undertaken until the second postoperative day when the patient was experiencing chest pain and had a significant oxygen requirement. She was later found to have a loculated empyema[198] for which she was admitted to the high dependency unit and later transferred to another hospital for surgical management. There was no anaesthetic input into the subsequent high risk case review. (2012)*

11.4 *In **2019**, a woman developed severe intraoperative hypertension under spinal anaesthesia. Early the following morning the midwife noted unilateral arm and leg weakness and requested an assessment by the anaesthetist who suggested that this was a residual effect of the spinal anaesthetic, but did not document their review. Later in the day, after no improvement, a further review was requested and documented and the anaesthetist escalated their concerns to the consultant anaesthetist and medical team. A CT scan ten hours after initial concerns were raised revealed a subarachnoid haemorrhage[199] an internal Trust review of the case by a consultant anaesthetist found no problems with the anaesthetic care. (2019)*

11.5 As well as occasions where anaesthetists failed to involve themselves in the care of critically ill women, there were cases where the obstetric and midwifery teams failed to involve or inform the anaesthetist on duty about women with significant morbidity. Often the anaesthetist was only called to review a patient once a decision had been made to take them to theatre, sometimes for very urgent surgery, thus denying the anaesthetist the opportunity to make a considered assessment of the patient and to take steps to optimise the patient's condition prior to anaesthesia.

197 See glossary
198 See glossary
199 See glossary

11.6 *In **2004**, at 0520h, 50 minutes after a vaginal delivery, a woman had bled in excess of 1000ml. The midwife did not escalate this to the obstetric team until 0550h who, in turn, did not alert the anaesthetist until 0730h, just prior to transferring the patient to theatre for an examination under anaesthetic. Local guidelines regarding key personnel to be notified in the event of post-partum haemorrhage were therefore not followed. The woman raised concerns about her care when she subsequently attended an obstetric outpatient appointment. There is no evidence that her case was reviewed by the maternity governance team even though the consultant obstetrician stated in his letter from that appointment that it should be. The consultant mentioned that she would have a midwifery debrief appointment in order to address 'her various anxieties'. (2004)*

11.7 *In **2006**, ten days after an emergency caesarean section a woman was readmitted with collapse and blood loss in excess of a litre. Despite a decision within 20 minutes of admission by the consultant obstetrician that the patient would need an examination under anaesthesia, there is no evidence that the anaesthetist was notified for more than 4 hours (contrary to the Trust's postpartum haemorrhage guidance at the time). The anaesthetist assessed the patient 9 minutes before she was transferred to theatre. She was so unstable that she required a general anaesthetic, hysterectomy, and a blood transfusion of 11 units. An incident report was submitted but a consultant obstetrician decided that a high risk case review was not required. The consultant wrote to the obstetrician who performed the caesarean section stating that 'care throughout [the readmission with postpartum haemorrhage] seems to have been appropriate and decision making made at the appropriate level' but queried the possibility of injury to the uterus at caesarean section. (2006)*

11.8 *In **2008**, a multiparous woman was admitted with raised inflammatory markers[200] after premature rupture of membranes at 33 weeks of pregnancy. A scan the day after admission showed the baby was in a footling breech position. Despite a recognised high probability of the need for early delivery, the anaesthetist was not called to review the patient until a decision was made for a category 1 caesarean section when the patient had reached 7cm cervical dilatation 6 days later. There is no evidence of learning arising from this case. (2008)*

11.9 *In **2018**, despite repeated previous admissions with antepartum haemorrhage in a woman with known low anterior placenta accreta[201], the duty anaesthetist was not alerted to the presence of the woman in the hospital until the decision was made that she required a category 2 caesarean section, almost 36 hours after her admission with a further antepartum haemorrhage. Escalation by the duty anaesthetist to senior anaesthetic staff and involvement of additional theatre staff was then swift and her overall anaesthetic care good and safe. There is no governance documentation relating to this case. (2018)*

11.10 Failure of anaesthetic and obstetric resident on-call teams to escalate promptly to senior staff during times of high workload or when managing deteriorating or very ill women was noted in this review's first report and seen again in further cases reviewed for this current report. In response to a Local Action for Learning point from the first report, the Trust now has a specific guideline advising when the on-call consultant anaesthetist must be contacted by the resident anaesthetist. However, as with all guidelines advising on escalation to specific personnel (including the ones that were not followed in the vignettes below), this will only result in service improvement if its advice is adhered to, and if the consultant on-call is free to attend. Anaesthetic staffing at the Trust remains a concern which is discussed later in this chapter.

11.11 *In **2004**, the resident anaesthetist was called at 0530h to see a woman in labour following an intrauterine death thought to be due to placental abruption. He was unable to attend for an hour and a half due to workload, by which time the patient had bled 1400ml and was tachycardic[202].There is no evidence that this incident was reported or that any investigation or learning occurred.(2004)*

11.12 *In **2013**, a woman had labour induced due to pre-eclampsia. She had significant oedema, headache and visual disturbance. Her blood pressure was 166/115mmHg and she was struggling to cope with the impact*

200 See glossary
201 See glossary
202 See glossary

of an oxytocin infusion on her labour pains. 2h 25min elapsed between the duty anaesthetist being called and their attendance to site the epidural as they were busy in theatre. During this time the oxytocin infusion had to be switched off due to the woman's distress. Once the epidural was sited, the anaesthetist left the midwife to administer the initial doses, contrary to Trust guidance, as they were called for a category 1 caesarean section for another patient. There is no evidence that efforts were made to contact another resident anaesthetist or the consultant on-call to assist with the workload. An incident report was submitted about an unrelated aspect of her peripartum care, but no action plan or investigation was documented or made available to the review team. (2013)

Anaesthetic services, workforce and leadership

11.13 The first report raised concerns about anaesthetic staffing at the Trust, in particular at consultant level. The 2017 RCOG report[203] commented that anaesthetic consultant staffing was non-compliant with the 2013 Obstetric Anaesthetists' Association/Association of Anaesthetists of Great Britain & Ireland (OAA/AAGBI) Guidelines for Obstetric Anaesthesia Services[204] which recommended 12 consultant anaesthetist sessions per week to cover just the emergency work of the labour ward, with additional sessions required for management of clinics and elective caesarean list workload.

11.14 The Trust has a document reflecting its anaesthetic staffing and plans: Strategy for Staffing Levels – Obstetric Anaesthetists and Assistants. Its first iteration was in 2010 and it has been amended over the years in response to service changes, audits, and a Clinical Negligence Scheme for Trusts (CNST) report, with a full review and update in 2015. At that point, the Trust self-evaluated that it required 14 sessions of anaesthetic consultant cover in order to comply with the OAA/AAGBI guidance but that it had a shortfall of three consultant sessions. Prospective cover for leave involved cover by another consultant or a specialty doctor.

11.15 By 2018 the self-evaluated number of sessions that required cover had risen to 16 but actual staffing remained static at coverage of 11 sessions only, a deficit of 5 sessions. Since the publication of the first report, the Trust has advised the review team that elective lists and clinics are almost always staffed by a consultant grade anaesthetist but that the labour ward only has dedicated consultant cover 50% of normal daytime hours. This falls short of current guidance from the Royal College of Anaesthetists (RCoA) as detailed in the Guidelines for the Provision of Anaesthetic Services (GPAS)[205].

11.16 The review team has been advised by the Trust that, out-of-hours, the anaesthetic consultant on-call at The Princess Royal Hospital, Telford, has responsibility for general theatres, intensive care, paediatrics, and the head and neck surgical service as well as obstetrics. This results in situations where, understandably, they are unable to be in more than one place at a time. The review team has been advised by staff that attempts to recruit new consultant anaesthetists in order to provide a separate rota to cover intensive care have so far been unsuccessful. The required training and skillset of the obstetric anaesthetists and also that required for the non-obstetric anaesthetists who cover the maternity service out-of-hours is not specified in RCoA's guidelines. The Trust's Strategy for Staffing Levels – Obstetric Anaesthetists and Assistants document states that *'Staff are made aware of the availability and access to all guidelines, protocols and policies during their induction'* but does not give any more detail on any measures taken to assure staff training and updates. A list of consultants who provide input to the on-call service has been provided by the Trust and it is notable that a significant proportion are locums. There is a nominated lead obstetric anaesthetist who has an active role in leading and managing the service, and this is reflected in their job plan.

11.17 A team of specialty doctors provide the out-of-hours and much of the within hours resident cover to the maternity service. They are described by the lead obstetric anaesthetist as a 'senior stable workforce'.

203 The RCOG report -Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust July 2017

204 OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, June 2013, London

205 Guidelines for Provision of Anaesthesia Services (Chapter 9 Guidelines for Provision of Anaesthesia Services for an Obstetric Population 2020). RCoA. (https://rcoa.ac.uk/gpas/chapter-9)

Doctors in training spend daytime hours on obstetrics but have not contributed to out-of-hours provision since 2011. The Trust has provided no detail to describe the training and ongoing development of the specialty doctor group of anaesthetists upon which the service relies so very heavily. Access to learning and development opportunities can be limited for staff grade, associate specialist and specialty doctors (SAS) generally within the NHS, specifically in comparison to consultant colleagues or doctors in formal training programmes. This may be due to the role of SAS doctors in managing service pressures and their lower supporting professional activity (SPA) allowance compared to consultant staff.

11.18 A member of staff talking to the review team in the autumn of 2021 told us; *'We're just about functioning but we are having to use locums and every week you look at the system and it's just a mess of extra people doing different lists, slotting in. So we're getting by, you know, week to week. It's quite a challenge…you raise your concerns and everybody says yes, yes, this is a big concern but nothing really happens'.*

Management of common obstetric conditions

11.19 In a surprisingly large proportion of the cases reviewed for this report, common obstetric conditions were not recognised or not managed in line with established guidelines. There is evidence of women receiving excessive volumes of intravenous fluid prescribed by both anaesthetists and obstetricians. This took place in the presence of severe pre-eclampsia, contrary to local and national guidance regarding fluid restriction in such circumstances, and also after post-partum haemorrhage. In some cases, the women were displaying clear signs and symptoms of fluid overload over a protracted period before it was noted by medical staff.

11.20 *In **2004**, after discharge to recovery following examination under anaesthesia for post-partum haemorrhage, the patient continued with 100-150ml intravenous fluids per hour despite plentiful oral intake. Some 3.5 hours later she was noted to be desaturating and an hour after that she complained that her hands felt 'tight' and they were documented as oedematous. Her urine output overnight peaked at 320ml/h. An obstetric SHO prescribed a further two units of blood as there was a decrease in the woman's haemoglobin. The following morning, with oxygen saturations of 88% on air, she was finally diagnosed as being fluid overloaded. She passed 1600ml of urine in the hour after she was given intravenous furosemide[206] and shortly afterwards was able to stop oxygen therapy. (2004)*

11.21 *A woman who had symptoms and signs of severe pre-eclampsia in **2008** had her baby delivered by caesarean section after failed induction of labour. She was diagnosed with left ventricular failure[207] and pulmonary oedema[208] in the postoperative period when she had a positive fluid balance in excess of 2000mls. Fluid administration was consistently in excess of the nationally advised limit of 80ml/h with 1500ml being given in theatre alone. A handwritten note in the patient's hospital records stated that her case had been discussed at a governance meeting, but no documents reflecting this were supplied to the review team by the Trust. (2008)*

11.22 Obstetric haemorrhage is a common condition that all staff involved in the care of obstetric patients must be confident in recognising and managing. However, there were a number of instances where the obstetric and anaesthetic teams seemed slow to diagnose bleeding as the underlying cause of a woman's deterioration. For example:

11.23 *In the early hours of the morning after an elective caesarean section in **2012**, a woman became progressively tachycardic and hypotensive[209] feeling hot, clammy and dizzy, with a sense of ringing in her ears, vomiting, and loss of consciousness with a brief seizure. Despite a 30g/l drop in haemoglobin on blood gas sample analysis, raised lactate, and uterine tenderness, the staff grade anaesthetist who was called to see her (and the obstetric on-call team) did not recognise that the patient was bleeding as there was 'no excessive*

206 See glossary
207 See glossary
208 See glossary
209 See glossary

blood loss seen'. The medical registrar was called to comment on the seizure and suggested bleeding as an underlying cause. She was finally diagnosed as such once the obstetric consultant was contacted. An incident report was submitted, but there are no other documents available related to the case. (2012)

11.24 *Following a vaginal delivery in **2016** a woman suffered a postpartum haemorrhage which resulted in tachycardia, hypotension, and the administration of 3.5 litres of crystalloid[210] by the obstetric team. The haemoglobin pre-delivery was 123g/l and at its lowest was 60g/l. The obstetric registrar estimated blood loss as 1000ml and wanted to take the patient to theatre for an examination under anaesthetic. The consultant anaesthetist estimated blood loss as 2000-3000ml. The consultant obstetrician estimated blood loss as 1200ml and overruled the plan for examination under anaesthesia. After a unit of blood that day and three the following day, the haemoglobin improved to 89g/l. A blood loss of just 800ml was later documented on the woman's discharge summary. When the woman was readmitted a month later she had a large remnant of placenta removed under anaesthesia and required a further blood transfusion. There was no incident reporting concerning these events. (2016)*

11.25 Local Actions for Learning from our first report highlighted the need for development of evidence-based guidelines and multidisciplinary training for developing and maintaining staff skills in the diagnosis and management of obstetric conditions. The Trust's anaesthetists have worked to create a full range of obstetric anaesthesia guidelines in response to the first report, and now acknowledge the challenge in embedding them into clinical practice and monitoring adherence to them. It is reassuring to hear from staff interviews that obstetric skills and drills are now undertaken regularly on the labour ward and involve the multidisciplinary team, including the anaesthetists.

Postnatal follow-up

11.26 In the process of undertaking reviews of clinical records for the purposes of this report, it is apparent that many women who experienced complications did not have the opportunity to have a proper discussion with clinicians about their peripartum care. On occasion there has been poor practice and care on the part of the Trust that has not been adequately discussed, and on other occasions women have had a complicated and difficult childbirth. From the communications between women, their families and the review team it is clear that a sense of not being listened to, as well as a lack of understanding about peripartum events, has persisted for some women and families for many years, impacting negatively on their psychological state, even now.

11.27 With the power of retrospection, it is clear that many women would benefit from postnatal discussion with clinicians who can actually give individualised answers about their care. Such discussion can occur at the time of events taking place but must be reinforced after discharge, when women are more able to gather their thoughts and questions in advance of a meeting, be supported by the presence of a friend, relative or advocate if they so choose, and take notes of answers.

11.28 Outpatient postnatal follow-up by an anaesthetist must be offered for women for whom significant issues have occurred, especially where they may impact on anaesthesia management or anxiety during future childbirth. Such issues include inherent anaesthetic complications such as intraoperative pain, including where conversion to general anaesthesia became necessary, suboptimal epidural pain control with significant consequent distress, and postdural puncture headache. More serious complications such as awareness under general anaesthetic and neurological complications related to anaesthesia must also be followed-up in an outpatient setting. Clinicians must also recognise situations where women would benefit from a conversation and explanations regarding their anaesthetic care even when nothing has actually gone wrong. Provision of such appointments must be seen as part of a culture of openness and willingness to maximise improvement of patient care, rather than as an admission of failure on the part of the Trust.

210 See glossary

11.29 *A woman made contact with the Review Team regarding her 'horrendous' experience of pain during caesarean section under epidural top-up with intraoperative conversion to general anaesthesia in **1999**. Despite the passage of time, the experience still causes the woman distress to this day. On review of the medical records it is clear that the epidural never offered adequate pain relief in labour and there is no evidence that the top-up for surgery was checked for adequacy. Twenty minutes after arriving in theatre the patient was given a general anaesthetic with a note documenting 'switch to GA after initial incision for surgical reasons'. After a midwifery debrief, the patient's notes were passed to a consultant anaesthetist who wrote a note saying that 'bar reassurance, probably there is no specific reason to see her'. Although this case occurred before the main period of the review, it is included here as a reminder to all clinicians involved in maternity care how psychological injuries may persist for years afterwards. Efforts must be made to minimise such occurrences and to provide adequate help to manage the consequences of such events when they do occur.*

11.30 *Two days after an emergency caesarean in **2017**, a woman was admitted to HDU with acute lung injury. A confusing and conflicting range of underlying diagnoses were reflected in the notes and discussed with the patient by the obstetric, anaesthetic and respiratory teams. At discharge, the patient asked about the possibility of a debrief with an obstetrician. She later had a debrief with a midwife only, where no further insights on the woman's underlying medical diagnoses were discussed and she remained unclear as to what had caused her significant illness. Over a year later she was still requiring psychological support. In this case a multi-professional meeting with clinicians who had been involved in her care would have been more appropriate than a midwife-only debrief. (2017)*

Documentation

11.31 On performing reviews of medical records for this report, midwifery documentation has tended to offer the most consistent evidence for understanding the development and timing of events. Brief reviews by both obstetric and anaesthetic doctors are often not documented by the doctors themselves despite being of clinical significance, and anaesthetic documentation is commonly restricted to an anaesthetic chart only. Documentation on the anaesthetic charts was frequently patchy, lacking detail of block adequacy achieved before surgery, or medication administered.

11.32 *Despite attending a patient with massive antepartum haemorrhage, the duty anaesthetist in **2004** did not document their actions or plan. The patient was reviewed a number of times over the course of the subsequent day by a consultant anaesthetist who again did not document anything. Their reviews, actions and advice were documented by the midwife only. (2004)*

11.33 *Following a category 1 caesarean section for antepartum haemorrhage complicated by massive obstetric haemorrhage in **2015** the patient remained cardiovascularly compromised for a time period in recovery, as evidenced by low blood pressure and high heart rate on her observation chart. The healthcare worker who completed the observation chart also documented the presence of the consultant anaesthetist for the full 45 minutes of that instability, although the anaesthetist made no entry in the notes. (2015)*

Learning from adverse outcomes

11.34 An important part of the purpose of reporting adverse events is in order to inform staff about the possibility of risks, to learn from the adverse outcomes of the practice of others, as well as oneself, and to take steps, where possible, to minimise similar occurrences in future. Failure to learn from such occurrences and share reflections with colleagues, risks a failure of 'institutional memory' and may result in repeated and needless patient harm. Staff of all grades and specialties benefit from continual peer and self-review of their practice in the form of morbidity and mortality meetings. Just 39 incident reports concerning obstetric anaesthesia were submitted in the Trust during the time period 2008-2021. The Trust must consider whether such a low reporting rate indicates staff acceptance of poor practice and complications, or a lack of faith that reporting can effect change.

11.35 *A spinal anaesthetic was sited for a forceps delivery in **2010**. Documentation on the anaesthetic chart stated 'no pain on insertion/injection'. The woman developed foot and leg pain the following day but the anaesthetist declined to review the patient as they 'thought it unlikely to be related to spinal anaesthesia'. An MRI requested by the orthopaedic team showed oedema[211] of a low-lying and tethered conus[212]. Documentation of subsequent discussion between the anaesthetist and the woman reflects that she had actually experienced 'electric shock' pains on initial spinal insertion but the anaesthetist wrote that they had withdrawn the spinal needle when this had occurred. There was no explanation as to why there was a discrepancy between the documentation on the anaesthetic chart and the subsequent conversation. The patient needed ongoing management for neuropathic pain and foot drop after discharge. The chief executive's response to a complaint letter included the statement: 'Training is not an issue as [the anaesthetist's] main activity is undertaking epidural and spinal anaesthetics in the maternity department'. (2010)*

11.36 *In **2012**, a woman experienced non-postural headache and focal neurological symptoms after an epidural for labour by a staff grade anaesthetist (which took a number of attempts to insert, worked sub-optimally, and was sited more than five hours after it was requested due to labour ward workload). It was only on her fourth readmission with symptoms that brain imaging was undertaken and bilateral subdural haemorrhage diagnosed. In the Trust's response to her complaint letter, it stated that the anaesthetist had said that the subdural haemorrhage could not have related to an accidental dural puncture as none was noted at the time of epidural insertion, thus failing to acknowledge that unrecognised dural puncture may take place. Possible causes suggested in the letter were high blood pressure in labour, the stress of her baby being admitted to the neonatal unit, and a pre-existing neurological susceptibility. (2012)*

11.37 *In **2018**, a root cause analysis into the management of a woman with what was considered to be an atypical presentation of pre-eclampsia (drowsiness, reduced level of consciousness in conjunction with elevated blood pressure, headache, vomiting and epigastric pain) looked at statements from three midwives and an obstetric middle grade. It did not involve the consultant anaesthetist or consultant obstetrician involved in the patient's care at the time culminating in her emergency caesarean section and seizure. Nor did it address the failure of the obstetric and midwifery teams to check on blood results taken in triage the night before, when the woman was assessed and discharged home, which would have shown her to be severely hypercalcaemic[213]. Nor did it investigate how an incorrect (elevated) value of INR[214] was verbally reported to the team caring for her, resulting in unnecessary administration of blood products, a decision not to perform a planned lumbar puncture, and a decision not to manage a fibroid at the time of caesarean section. (2018)*

11.38 Anaesthetists should be included in and engage fully with the multidisciplinary team, both clinically, and in maternity governance activity. The Trust's Women's and Children's Root Cause Analysis planning proforma in use in 2018 has a list of job roles with the option of indicating who should be present. None of the 17 job roles listed is that of consultant anaesthetist.

11.39 Involvement of the anaesthetic team in governance activity requires a change in culture and attitude but also requires time and planning. Departmental leads and the executive team must address the resource requirements necessary for anaesthetists to take an active role in obstetric governance and ensure time away from clinical commitments is allowed for this purpose in anaesthetic staff job plans. This will necessarily have cost and recruitment implications. Conflicts of demands on the time of consultant anaesthetists must be addressed at executive level and not left solely to individual anaesthetists to resolve.

11.40 The terms of reference for the Trust's maternity governance meetings from January 2018 state that an anaesthetist is required to attend every three months – minutes of attendance suggest that even this low benchmark is not being achieved. It is important that, even in times of high clinical workload, anaesthetic presence at governance meetings must be maintained to ensure the safety and the integrity of the service in the longer term. This is certainly challenging if, as Trust staff advised the review team, there are still considerable issues with consultant anaesthetic staffing.

211 See glossary
212 See glossary
213 See glossary
214 See glossary

Local Actions for Learning

11.41 The review team re-emphasises the importance of the Local Actions for Learning and Immediate and Essential Actions for obstetric anaesthesia services from the first report. These can be found in Appendices 5 and 6 and form a vital part of the ongoing learning for both the Trust and maternity services nationally.

11.42 The following Local Actions for Learning are based on themes recognised whilst undertaking the current review and must be addressed by the Trust as a priority. The RCoA 'Guidelines for Provision of Anaesthetic Services' (GPAS) document stipulates the key requirements in the provision of obstetric anaesthesia services and these Local Actions for Learning address requirements where the Trust currently falls short. We place a responsibility on the Trust's executive team to support the anaesthetic department in achieving compliance. They are also applicable to hospitals experiencing similar issues and should therefore be used to inform wider improvements in obstetric anaesthesia care.

LOCAL ACTIONS FOR LEARNING: OBSTETRIC ANAESTHESIA

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

11.43 The Trust's executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.

11.44 The Trust's executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust's services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service.

11.45 The Trust's executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by GPAS in 2020.

11.46 The Trust's anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be undertaken to ensure evidence-based care is being embedded in day-to-day practice.

11.47 The Trust's department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting.

Chapter 12

Neonatal care

Introduction

12.1 In this chapter we focus primarily on the clinical care provided by the neonatal team to babies delivered at the Trust. The majority of the care reviewed took place on the neonatal unit (NNU), but the neonatal team were involved in resuscitation of babies on the labour ward as well as managing some babies on the postnatal wards.

12.2 It is important to emphasise that in line with the terms of reference the cases reviewed only represent less than two per cent of the total births at the Trust and a small minority of neonatal admissions over the review period. Cases were ascertained due to either parental concerns about the quality of maternity care or due to poor outcomes - specifically neonatal death or brain injury. In addition, some cases came to light in the Open Book exercise arranged by the Trust which considered HIE and neonatal death as factors for referral to the review.

12.3 As well as identifying areas for improvement and learning, the review team also noted many examples of good neonatal practice and often excellent communication. The number of complaints by families about the care they received in the neonatal unit was quite low.

Organisation of neonatal services in the UK (2000-2019)

12.4 In 2001 the British Association of Perinatal Medicine (BAPM) updated its 1996 standards for hospitals providing neonatal intensive care. There was a recommendation that hospitals work together in networks and care of the smallest and sickest infants be centralised into larger centres, neonatal intensive care units (or NICU), known as level 3 units. This led to the development of managed neonatal networks and was incorporated into the Maternity Services National Service Framework in 2004. It was also recognised that clinical skills needed to be maintained in the local neonatal units (LNU), known as level 2 units, to provide short term intensive care (usually up to 48 hrs) for more mature babies in close liaison with their designated level 3 NICU.

12.5 In 2009 a Department of Health taskforce of neonatal professionals and parent representatives published a Toolkit for High Quality Neonatal Services[215] with service specifications to standardise special care, high dependency care and intensive care. In 2010 the National Institute for Health and Care Excellence (NICE)[216] published quality standards for neonatal specialist care. In most trusts compliance with these standards is reviewed through clinical governance processes.

12.6 NHS England commissions all levels of neonatal critical care. The commissioning of care is usually agreed with the neonatal network but ultimately is a formal agreement between the commissioners and the provider unit trusts.

Neonatal transport

12.7 Babies should ideally be delivered in the most appropriate setting for their predicted care needs. In utero (before delivery) transfer is preferable to postnatal transfer and has been shown to improve outcomes. However babies do sometimes need to be transferred after birth for escalation of care, or to access

215 Department of Health. Toolkit for High-Quality Neonatal Services (2009) https://webarchive.nationalarchives.gov.uk/20130123200735/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107845

216 National Institute for Health and Care Excellence. Neonatal specialist care Quality Standard (QS4) (2010)

specialist care (e.g. for neonatal surgery). Over the period of this review, neonatal transport services, which were traditionally provided and staffed by the larger NICUs, were centralised in all networks so that a dedicated transport team is responsible for moving babies between units, and since 2015 most services have had a centralised telephone triage system. In the West Midlands, a centralised team has provided transport services 24/7 since 2008. Teleconferenced triage has become available in very recent years.

Organisation of neonatal services at the Trust (2000-2019)

12.8 Following the establishment of neonatal networks in England in 2004, the Trust's neonatal services initially formed part of the Staffordshire, Shropshire and Black Country Neonatal Network (SSBCNN) becoming an operational delivery network in 2013 (SSBCODN). The NNU and the obstetric services at the Trust are located within the Shropshire Women and Children's Centre, based at the Princess Royal Hospital (PRH) in Telford, having moved there from the Royal Shrewsbury Hospital (RSH) in late 2014.

12.9 Prior to 2006 the neonatal service at the Trust provided intensive care. Since 2006, when unit categories were first defined, it has been designated as a Local Neonatal Unit (LNU) of level 2. This means that it is commissioned to provide special care and high dependency care for newborn babies, as well as intensive care for periods of up to about 48 hours. Babies requiring longer-term intensive care and singletons born at less than 27 weeks gestation, if not transferred in utero, should be discussed with and transferred to a level 3 unit (NICU).

12.10 The neonatal unit at the PRH in Telford has 22 cots and is busy compared to other LNUs with above average numbers of preterm babies admitted. In 2018-19 it provided 7,425 care episodes, which was in the top quartile of critical care activity for neonatal units providing critical care in England.

12.11 The review team heard that the neonatal service at the Trust disputed its revised designation and did not work in line with the new scope of its responsibilities. There is debate why this was. Some at the Trust felt that due to the unit's size, expertise and geographical location (including receiving babies from Wales) it should have been designated as a level 3 unit. Others at the Trust have stated that there were insufficient cots and expertise elsewhere throughout the region, although this is disputed by the neonatal network[217]. The West Midlands Neonatal Operational Delivery Network confirmed in correspondence with the Chair of this review that *'capacity in both University Hospital North Midlands (which is the care pathway for SaTH and Royal Wolverhampton Hospital NHS Trust) has rarely been so that they would not take a baby that required NICU care'.* Despite this, the review team found evidence of non-compliance by the Trust with its 2006 level 2 designation until at least 2015.

12.12 The review team noted that for a period of nine years after the designation to a level 2 unit, transfer of babies from the Trust that required intensive care did not consistently occur in line with the national and network guidelines. According to the neonatal network capacity issues were not causative. The review team is of the clear opinion that NICU care relies on a properly resourced multidisciplinary team and that the designation as a level 2 unit after 2006 should have been respected and adhered to.

12.13 Following the contested designation as a level 2 unit in 2006, the review team has been advised that network leadership and the commissioners met with the Trust on several occasions, especially after the publication of a network care pathway document in 2011 to try to ensure that neonatal care within the Trust followed the guidance.

12.14 The Royal College of Paediatrics and Child Health (RCPCH)[218] carried out an invited review in 2013. They noted that *'given the availability of experienced and dedicated neonatologists, at the time of the visit the unit cared for a number of babies under 27 weeks and provided an enhanced range of intensive care services'.* They noted that this intensive care activity was not supported by the neonatal network and that the unit would in future work as a standard level 2 local neonatal unit. The Trust continued to deliver some aspects of intensive care outside the agreed care pathway until the unit moved to the Telford site in 2014.

217 Letter to Donna Ockenden from West Midlands Neonatal ODN dated 3rd September 2021

218 Report provided to the review team by the Trust

Cases considered by the review team also demonstrated that this progressive change in neonatal care took many years to be embedded into clinical practice:

12.15 *In **2011** a baby was delivered at 26 weeks gestation after threatened preterm delivery from 23 weeks with no record of consideration of in utero transfer Senior staff were closely involved in care at the Trust with a good relationship with the family and evidence of compassionate care was seen after the poor outcome. (2011)*

12.16 In the next revision of the network care pathway in 2015, it was made more explicit that advanced therapies should not be delivered at the Trust, unless in exceptional circumstances and after discussion with a neonatologist at the Royal Stoke Hospital (now University Hospitals of North Midlands) NICU. Sometime after the move to the new unit in Telford the neonatal unit started operating at the designated level 2.

Perinatal and neonatal mortality

12.17 The perinatal mortality rate (PMR) and the neonatal mortality rate (NMR) are measures which are used as benchmarks of the quality of obstetric and neonatal care, although other factors such as socioeconomic circumstances and maternal age also have an important influence on these measures.

12.18 The MBRRACE-UK perinatal surveillance annual reports have been available since 2013, and they have provided PMR and NMR data, 'adjusted and stabilised' with regard to key contributory factors, for individual trusts from 2014[219]. The neonatal mortality rate (NMR) for the Trust was above the average for similar providers (similar numbers of births LNUs) for the years 2014–2016, but in 2017 it dropped to below the average. In 2018 and 2019 it was 'red' (more than 5 per cent above the group average). It should be noted that in all these years the NMR and PMR were comparable to many similar units and were not statistical outliers. Mortality rates for preterm babies born between 2015 -2018 were also high for babies born within the SSBCODN network and for two of its neighbouring networks.

12.19 In 2009 the neonatal service at the Trust described itself in the National Neonatal Audit Programme (NNAP) report as a NICU, despite having been designated as a level 2 NNU in 2006. This review has also been provided with documentation of a presentation to the CCG in 2018 where a Trust representative outlined that one of the reasons that the Trust felt its neonatal unit had higher perinatal mortality than its peers was because it was being compared with level 2 units (LNUs) when it had in fact been operating as a level 3 unit (and therefore accepting and continuing to care for more complex cases) until 2016. In this presentation the Trust representative made the case that therefore the figures were not representative. They stated the reason for operating at level 3 was due to capacity issues elsewhere in the network. There has been no evidence seen by the review team that capacity in other units was an issue and this has been confirmed by the neonatal network. The review team note that the data is difficult to interpret as the Trust had consistently not worked at the level it had been allocated and that it should not have taken in excess of eight years for the Trust to have worked at the level it had been designated.

National Neonatal Audit Programme

12.20 The National Neonatal Audit Programme (NNAP) has measured the quality of care delivered by neonatal units since 2006. NNAP reports available online (2014-2019) indicate that, for the limited number of quality indicators, the NNU at the Trust was performing at above the average for LNUs in the UK. In particular, the Trust NNU achieved one of the best scores compared with other LNUs for communication (the proportion of parents who meet with a senior member of the neonatal staff within the first 24 hours of admission). Temperature control of babies was also above average and eye-screening was excellent for this period.

12.21 The length of stay on the NNU at the Trust for late preterm babies and more mature babies was reported to be longer than in other NNUs - this may reflect a need to improve transitional care facilities at the Trust. In 2018 and 2019 the proportion of neonatal nurses working in the NNU at PRH who had a specific

219 MBRRACE Perinatal mortality surveillance reports 2013-2016 https://www.npeu.ox.ac.uk/mbrrace-uk/reports/perinatal-mortality-surveillance
MBRRACE Perinatal mortality surveillance report 2017 https://www.npeu.ox.ac.uk/mbrrace-uk/reports

qualification in the care of sick newborn infants was lower than the average for LNUs in the UK and appears to be falling.

Review of neonatal clinical care at the Trust

12.22 During our reviews we identified a number of cases where individual errors were made or there was poor practice. However, these were very much the exception and we have found no evidence of systemic poor neonatal practice or lack of care or compassion in the neonatal service. The review found evidence that identified failings in care were addressed by the Trust with the development of appropriate guidelines, but the review team does not know if the development of these guidelines then led to improvements in care. However, some incidents occurred with sufficient frequency, or were sufficiently important, that we feel there is scope for wider learning on a national level.

12.23 It appears from the majority of the medical records reviewed that involvement of the consultant neonatologists in the provision of neonatal care and in communication with parents was of a very high quality. The medical records invariably record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. There were frequent examples of the consultants being called to assist with resuscitations of newborn babies on the labour ward and in many cases their interventions led to an improvement in the short-term outcome.

12.24 Review of the medical records shows that the Trust was an early adopter of the Advanced Neonatal Nurse Practitioner (ANNP) model and that ANNPs played an important role in the management of sick or premature infants at delivery, on the neonatal unit and on the postnatal ward. We noted their practice to be appropriate and that the ANNPs formed an important part of the neonatal staffing model. The quality of their entries in the medical records was generally noted to be of a very high standard. During the reviews we did not identify any systematic concerns about nursing care.

Transfers, referrals and escalation of care

12.25 Neonatal care is most effective when delivered in close partnership with other services as discussed above. When reviewing individual cases we found evidence of effective joint working:

12.26 *In **2005**, after an uncomplicated term delivery a baby became progressively seriously ill with breathing and neurological problems. On the first day of illness the problem had been recognised as a very severe metabolic disorder and advice on care was obtained from regional and national specialist services. Despite transport to the national centre being arranged sadly it was not possible for the baby to survive. Successful genetic diagnosis allowed counselling about future risk to be provided to the family. (2005)*

12.27 *In **2010** antenatal scans had suggested the possibility that a baby might have problems and a plan was in place for assessment and care at birth After delivery it became clear that the baby could not manage to breathe strongly enough on their own and needed support from a ventilator. Specialist reviews were arranged in Shrewsbury and the required investigations quickly carried out with close involvement of regional and national services. A definitive diagnosis of a neuromuscular disorder was very quickly established and palliative care agreed with the family. We found good evidence of highly effective and compassionate care with input from multiple specialists. (2010)*

12.28 We found evidence of appropriate communication with tertiary specialists when babies required escalation for specialist care, including surgical or cardiac care and good liaison with Alder Hey and Birmingham specialists regarding MRI scans and post-mortem reports. However, in some other cases we found planned deliveries being arranged at the Trust which had not had the involvement of specialist services as would have been expected.

12.29 *In **2008**, a baby was diagnosed with significant spina bifida[220] (lumbar myelomeningocoele) with severe hydrocephalus in the antenatal period. There was no evidence of tertiary fetal medicine or neurosurgical*

220 See glossary

discussion regarding appropriate tertiary referral. The baby delivered at the Trust. There were challenges delivering respiratory support in head box oxygen[221] and baby needed support with a ventilator when the transport team arrived at 30 hours of age, before they could be moved to Birmingham Children's Hospital, (BCH). Despite continuing intensive care in the regional unit the baby developed worsening respiratory distress at BCH as well as a coagulopathy[222] and remained too ill for surgery and died. (2008)

12.30 During the period when the neonatal service continued to operate as a NICU, despite its designation as a neonatal unit, some babies were delivered with major congenital anomalies requiring high level intensive care.

12.31 *In **2008**, there was an antenatal diagnosis of diaphragmatic hernia[223]. The parents were seen by a neonatologist and plans for delivery in Shrewsbury were discussed. An antenatal appointment was offered at Alder Hey. Parents declined this as they felt they had too many appointments to attend. The surgical service were aware of the plan to deliver locally and to transfer the baby after stabilisation. No major difficulties were encountered with the baby's initial care at Shrewsbury and baby was transferred but at the tertiary unit the baby progressively deteriorated and did not survive. (2008)*

12.32 In the same year another baby with the same major anomaly was delivered in Shrewsbury:

*The baby was diagnosed in the antenatal period in **2008** with a diaphragmatic hernia. The neonatologist wrote a letter to the parents and another to the paediatric surgeons in the local surgical centre at Birmingham Children's Hospital (BCH). This states 'baby has diaphragmatic hernia, booked to deliver at RSH and as a unit that is able to perform all levels of intensive care we feel that we are in a position to offer neonatal resuscitation and stabilisation pre-surgery at Shrewsbury. One of the neonatologists will personally be on call for the lady's delivery'. (2008)*

12.33 *The regional surgical service were aware of the planned delivery with no evidence seen by the review team that that they suggested any alternative plan. The baby died after three hours after challenges in delivering aspects of intensive care. Whilst the outcome might not have been different it was not clear that the parents had been offered the opportunity to discuss options with the specialist surgeons in Birmingham prior to delivery.*

12.34 Babies found to have diaphragmatic hernia during antenatal scans are now transferred for delivery in Birmingham Women's Hospital or Liverpool Women's Hospital. In our review of the medical records it was not always apparent that early consultation with a tertiary centre, to consider planning of transfer of care where appropriate, had taken place. It is possible that such consultations did take place but were not documented in the medical records to which we had access.

12.35 *In **2011** a woman presented at 25 weeks, with a twin pregnancy complicated by twin to twin transfusion syndrome[224]. There was antenatal discussion with Birmingham but the babies were born at RSH. The first twin needed prolonged resuscitation at birth. Later in the first week he required exceptionally extensive intensive care after a large brain bleed. There was no recorded discussion with a NICU and missed opportunities to transfer out in the first 2 days before baby became critically unstable. Sadly, the baby died. The other twin died at 5 months of age in a specialist centre, with airway problems. (2011)*

Management of babies with Hypoxic-Ischaemic Encephalopathy

12.36 Hypoxic-Ischaemic Encephalopathy (HIE) is due to impaired delivery of oxygen to the brain. Until around 2010 treatment was largely supportive, although clinical trials of brain or body hypothermia were undertaken in the early 2000s and published in 2005-2009 and cooling therapy was initially offered in a limited number

221 See glossary
222 See glossary
223 See glossary
224 See glossary

of centres participating in these trials. By 2009 it was established that therapeutic hypothermia significantly reduced the incidence of death or disability from HIE and the BAPM issued a position statement on its use. At this time therapeutic hypothermia (cooling) was normally delivered in NICUs although some larger LNUs in the UK still undertook this therapy on a transitional arrangement if agreed by the network.

12.37 To be most effective, cooling should be commenced (either passively or actively) by 6 hours of age. It is important that cooling therapy follows evidence-based pathways wherever possible. We found some examples of cooling outside this pathway.

12.38 *In **2010,** a baby born after cord prolapse with an umbilical cord pH 6.8 was cooled quickly and effectively, required full intensive care including inotropes to support blood pressure and mechanical ventilation to support breathing. The baby was not discussed with or transferred to a NICU. (2010)*

12.39 The review found that the clinical management of HIE in many cases was of a good quality but found that the cooling therapy delivered at the Trust was outside the agreed network pathway for this provider which stated: *'Newly born infants who require cooling for treatment of perinatal asphyxia will have active cooling initiated at RSH prior to being transferred with continued active cooling to UHNS or New Cross Hospital the Network Lead Centres or an appropriate neonatal intensive care unit'.*

12.40 *In **2011** a baby was cooled because of HIE. The seizures were very difficult to control despite anticonvulsants and so there was a documented discussion with a NICU outside the network but with a strong research reputation for cooling, who suggested it could be extended by 24 hours. The cooling in fact continued for a total of 6 days. Whilst there was no evidence of direct harm from this, it was unusual practice and outside the advised practice. The child continued to have epilepsy through early childhood. (2011)*

12.41 We did however find evidence of good practice in that the Trust diligently reported babies receiving therapeutic hypothermia for HIE to the 'cooling registry' which gathered data after the TOBY[225] study on hypothermia was published.

Resuscitation and stabilisation at birth

12.42 The review found a number of cases where the Newborn Life Support algorithm was not followed in the correct order. In particular, where cardiac compressions were started before lung inflation had been achieved. It is vital that an airway is established and effective lung inflation achieved before moving on to cardiac compressions as they otherwise will not be effective.

12.43 Intubation of small babies is a difficult skill, and one that is increasingly hard to gain competence in as intubation opportunities have become less frequent with greater use of non-invasive ventilation. We found in general that babies were intubated on the labour ward appropriately. The Trust appeared to be relatively late adopters of CO_2 detectors (which can help confirm the endotracheal tube is correctly placed). In some cases babies had multiple extubations and intubations in the first minutes of life, either due to uncertainty about their position or due to accidental extubation.

12.44 *In **2007**, an extremely preterm baby weighing just over 500g was in poor condition at birth, and had five intubation attempts including the use of a bougie. When successfully inserted, the ET tube was inserted too far. (2007)*

12.45 *In **2008** a baby at 23 weeks born in the Trust had two accidental extubations within the first hours of life, so required three intubations in four hours. The baby deteriorated on day 10 for which they were given a third dose of surfactant (unusually late). Deterioration was found to be secondary to intestinal perforation and they were then transferred to a surgical NICU. (2008)*

225 TOBY study group. Whole body hypothermia for the treatment of perinatal asphyxial encephalopathy: A randomised controlled trial (2008) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2409316/

Communication during neonatal resuscitation

12.46 In the cases considered by this review we sometimes found that a structured approach to communication to a senior doctor in a crisis situation did not always happen. Our view is that there should be a shift in expectations such that, when it is known that senior help cannot attend immediately, a formal two-way telephone dialogue, based on the SBAR (Situation, Background, Assessment, and Recommendation) structure, should take place at the time of calling for the senior help. This two way conversation directly with the resuscitation team should involve a review of the interventions which have been tried and advice from the senior help concerning the actions to be taken pending their arrival. This situation is not unique to this Trust.

Management of hypoglycaemia (low sugar levels)

12.47 The review identified a number of cases where there was prolonged hypoglycaemia without effective or timely intervention. In some instances this was due to the need to transfer from the midwife-led unit (MLU) to the neonatal unit.

12.48 *In **2018**, a term baby was born at the MLU in Princess Royal Hospital, Telford, at 03:44 with a very slow heart rate. After the neonatal team arrived and baby was intubated the heart rate improved. On arrival at the NNU at 04:55 the baby was hypotensive, hypothermic (planned) and had an apparently unrecordable blood glucose at 05:26 and 05:43. There is no evidence of it having been measured prior to this. An emergency blood transfusion was given for low haemoglobin, but the glucose was not addressed (even having been measured) until a bolus and infusion of dextrose were given at 07:05. This is 3 hours and 20 minutes after a major resuscitation (known to deplete glucose stores) and 1.5 hours after the glucose was first noted to be unrecordable. This may have contributed to the failure of the heart to respond to inotropes, fluids and other resuscitation measures. The first dose of antibiotics was not administered until 3 hours after admission to NNU and 2 hours after it was prescribed, despite IV access being in place. This is an unacceptable delay. Sadly, the baby died. (2018)*

12.49 *In **2007**, a growth restricted term baby had very low cord pH at birth (but the baby quickly recovered with Apgar[226] scores of 8 and 10), and required only facial oxygen. A paediatrician appropriately requested to keep baby warm and establish feeds. On review at 30 minutes, they noted profound hypoglycaemia. The paediatrician instructed "commence feeds as soon as mum ready and if concerned to inform NNU". A doctor was called to review the baby when it was noted to be dusky aged 1 hour. The requested senior review said baby did not need admission. No further glucose levels documented until admitted at 13 hours, when they were normal. This baby was later diagnosed with HIE. (2007)*

Management of sepsis

12.50 In general the management of babies with suspected sepsis was in line with national recommendations and common practice. However, in the majority of cases reviewed where infection or suspected infection were part of the clinical picture, it did not seem that the use of infection markers such as C-reactive protein[227] (CRP) for 'tracking' of the progress of the infection was standard practice. This was an active decision on the part of the neonatal consultants. We have not been able to identify a situation where the absence of these measurements was likely to have had a significant influence on the clinical outcome. However, infection markers can be useful in both the identification of infection and in guiding treatment and are widely used in neonatal practice. In more recent years the Trust has adopted the use of CRP.

226 See glossary

227 See glossary

Communication with families and documentation

12.51 Case reviews almost invariably showed evidence of good communication with the parents, especially by the ANNPs and consultants. There was evidence of compassionate care for the babies and their families, especially at the end of life or when considering reorientation of care towards comfort-orientated care.

12.52 *In **2002** a baby was born at full term and unexpectedly found to have severe respiratory problems from birth. The baby was diagnosed on the neonatal unit at Shrewsbury with severe pulmonary hypoplasia, (under-development of the lungs) and sadly this was untreatable and the baby died on the first day of life. There was extensive consultant involvement in the baby's short life, including the involvement of a second consultant in reviewing an unexpectedly serious case, a consultant doing the summary letter and, most importantly, sometime after the sad death, when all results were back, the consultant visited the family at home to go through the results of the baby's post-mortem examination and other specialised tests. The review observed this as an example of exceptionally good practice. (2002)*

12.53 We also found evidence that some parents had confidence in the quality of the consultant-led neonatal follow up:

*In **2001**, a baby was delivered by forceps after an eight hour 2nd stage of labour and developed HIE. The baby was discharged home well on day 9. The parents moved to Leicestershire but declined transfer of care to a local consultant and chose to come back to Shrewsbury for each neonatal follow-up visit to maintain continuity of care. (2001)*

12.54 We found some examples where neonatologists requested that obstetricians at the Trust review a baby's care when they perceived there were unexpectedly poor outcomes.

12.55 *In **2009**, a baby was born at 42 weeks, 50 hours after rupture of membranes with the cord tightly round its neck and thick meconium, and with a low cord pH of 6.5. Fortuitously the baby had a normal MRI brain scan and was said to be developing normally at 2 years of age. After seeing the family at an outpatient appointment the neonatologist wrote first to the risk manager in August suggesting the case was reviewed. The neonatologist also wrote to the obstetrician requesting a parental meeting and wrote again in November chasing this up as the family had still not heard anything. The long term outcome of this case is not known. (2009)*

12.56 In another case the neonatologist had concerns about the care of a baby after transfer between other NICUs:

12.57 *In **2008**, a baby was born at 23+1 weeks in RSH after in utero transfer and received 11 days intensive care before being transferred to a surgical NICU due to intestinal perforation. Having received surgery the baby was repatriated to a third neonatal unit and apparently arrived in a 'shocked' condition, hypotensive and hypothermic and died 1 week later. The neonatal consultant at RSH wrote to the neonatologist at the receiving hospital suggesting they raise this with the referring surgical centre as this was 'unacceptable'. This represents evidence of concern for governance and ensuring quality of care. These examples were infrequent, but evidence a desire to ensure good quality of care for patients and their families. (2008)*

Combined medical and nursing notes

12.58 The clinical records that were reviewed had separate medical and nursing entries. This has the potential for important information not being accessed by key members of staff involved in the care of individual babies. The standard of medical and ANNP note-keeping was generally good and the admission clerking in particular was generally very comprehensive. However, there was no obvious systematic approach for daily ward round reviews, which meant that continuity of potentially important information was sometimes lacking.

12.59 Although by no means universal, prior to the introduction of electronic clinical records many NNUs had moved to having combined medical and nursing notes. The Trust now uses joint neonatal and medical notes and are moving to an electronic patient record.

Middle grade or Trust Tier 2 neonatal staffing

12.60 For some of the cases reviewed it was clear that, out of hours, middle-grade neonatal medical staff were covering the paediatric unit as well as the neonatal unit. This can compromise the availability of skilled care to both units. It is for this reason that it is a service specification for level 3 NICUs that there is separate middle-grade cover for neonatal and paediatric units and why level 2 LNUs should not undertake prolonged intensive care.

12.61 The review found evidence that in some cases this led to a delay in middle-grade attendance at deliveries and in reviewing sick babies on the neonatal unit. As already discussed the Trust were early adopters of the ANNP model and this undoubtedly provided some mitigation but it was not clear whether the neonatal unit was adequately covered at middle-grade level at all times.

Consultant neonatologist staffing

12.62 It is clear from the majority of case notes reviewed that involvement of the consultant neonatologists in clinical decision making, in the provision of neonatal care and in communication with parents and other family members was of a very high quality. The case notes usually record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. They were usually involved in the long-term clinic follow-up of their individual patients, providing continuity of care. Information sharing was aided by the neonatal discharge summaries often being written by a consultant. Having met with staff it is apparent to the review team that this high level of direct consultant input may have been at some personal cost and may have been offered in part due to a desire to continue as a NICU after designation as a LNU in 2006.

12.63 For some of the cases reviewed the consultant providing cover for the neonatal unit was also covering the general paediatrics service. This can also compromise the availability of skilled care. Given the size of the maternity and neonatal service at the Trust, if it was aiming to provide ongoing neonatal intensive care at the time, it would be essential to have designated neonatal consultants on call 24/7. This was highlighted by the RCPCH invited review in 2013:

12.64 *'The neonatal rota is not compliant with BAPM staffing arrangements given the level of intensity of services provided at the RSH site. There is an enthusiastic staff team keen to develop their skills and care for babies locally, and a consultant group that provides prospective cover out-of-hours, coming in to support juniors and general paediatric consultants even when not on call. This is not sustainable and must be addressed when the service moves. The current enhanced status is not supported by the network following a CCG-commissioned review of maternity services and will in future operate as a standard level 2.'*

12.65 It is the review team's understanding that separation of the neonatal and paediatric consultant on call rotas has now been achieved, and we found evidence that the neonatal service has, since the move to Telford and publication of the updated care pathway by the neonatal network in 2015, largely been operating appropriately as a level 2 Local Neonatal Unit.

LOCAL ACTIONS FOR LEARNING: NEONATAL CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

12.66 The Trust must ensure that there is a clearly documented, early consultation with a tertiary NICU for babies who require, or are anticipated to require, continuing intensive care. This must be the subject of regular audit.

12.67 As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention and training of ANNPs.

12.68 The Trust must ensure that sufficient resources are available to provide safe neonatal medical or ANNP cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU.

12.69 The number of neonatal nurses at the Trust who are 'qualified-in-specialty' must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review.

Section 4

Our call for essential action following completion of this review

Chapter 13

What happened in maternity services across England after our first report

13.1 Our first report Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust was based on a review of 250 family cases and was published on 10 December 2020. The report outlined seven Immediate and Essential Actions, (IEAs) for maternity systems across England and 27 Local Actions for Learning, (LAfL) for the Trust.

13.2 Since the publication of the first report, trusts and maternity services across England have shared their plans to ensure full implementation of the seven IEAs takes place. The NHS has been working with regions, systems and Royal Colleges to implement the IEAs. Significant funding has been provided by the NHS, although we all recognise that much more is needed. The NHS has also reviewed the Maternity Transformation Programme to ensure future plans are in line with the seven IEAs.

13.3 All trusts have now assessed their position against the IEAs and submitted evidence to demonstrate compliance which has been independently quality assured. The commitment to system-wide improvement in maternity services has also seen all NHS standard contracts include conditions whereby any provider delivering maternity services must provide and implement an action plan, approved by its governing body, describing, with timescales, how it will implement the immediate and essential actions set out in the Ockenden Review.

Additional funding for maternity services

13.4 Our first report highlighted that the amount of improvement required must be backed by real investment in maternity services.

13.5 In March 2021[228] the Government made available £95.6million of investment for maternity services across England for:

- 1,200 additional midwifery roles
- 100 whole-time equivalent consultant obstetricians
- Backfill to allow for multidisciplinary team training
- An additional midwife in every unit to support newly qualified midwives as they begin their careers.

13.6 Alongside this, in July 2021 the Government announced £2.45m[229] to be invested into maternity services. These funds were allocated to the Royal College of Obstetricians and Gynaecologists (RCOG) to find the best ways of spotting early warning signs of infants in distress.

13.7 For 2021/22, more than £80m of additional funding has been allocated to be distributed as targeted System Development Funding (SDF)[230]. This funding will be focused on areas where it will have the biggest impact on delivering the immediate and essential actions and ensuring the safety of women, babies and their families.

228 NHS England and NHS Improvement Board Meeting November 2021. Agenda Item 6: Maternity and Neonatal Services Update https://www.england.nhs.uk/wp-content/uploads/2021/11/board-item-6-251121-maternity-and-neonatal-update.pdf

229 Gov.uk press release. Government pledges £2.45million to improve childbirth care (2021) https://www.gov.uk/government/news/government-pledges-245-million-to-improve-childbirth-care

230 NHS England. Guidance on finance and contracting arrangements for H1 2021/22 (2021) https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-h1-21-22-guidance-on-finance-and-contracts-arrangements.pdf

13.8 With a shortage of midwives, and concerns around continuing attrition of midwives and obstetricians, actions have been taken to increase the workforce by recruiting midwives internationally and £4.5m funding for 2021/22 has been allocated. Additional investment has also been made in Professional Midwifery Advocates, who provide educational and psychological support for midwives, increasing the number to 800 in England. To support retention of midwives, NHSE&I has also funded a pastoral care midwife[231] role in every maternity unit during 2021/22.

13.9 With midwifery and obstetric staffing numbers continuing to cause significant concern and attrition from the midwifery profession, midwives and doctors remaining on the frontline are working tirelessly to support mothers and their babies in achieving a safe outcome.

Our call to action

Funding

13.10 Whilst the funding announcements we have seen have already made significant strides in the right direction in improving maternity services for all, much more still needs to be done. The Health and Social Care Committee report[232] on maternity safety in England, published in June 2021, stated that NHS maternity units in England needed an investment of £200-£350m to prevent women and babies dying or sustaining avoidable harm. This view was supported by the NHS Confederation[233] and we state this level of investment must be forthcoming.

Continuity of carer (CoC)

13.11 We recognise the original aim of CoC which seeks to ensure a mother receives safe and personalised care from the same midwifery team with a named midwife who coordinates the care and takes responsibility for ensuring that the needs of the woman and her baby are met through all stages of maternity care. The CoC model was introduced with little recognition of its potential impact on an already pressured maternity system across England.

13.12 Recent guidance[234] has aimed to address the concerns expressed that CoC will lead to unsafe and inconsistent staffing and provides guidance for local planning and implementation of CoC. At a time of unprecedented stress on NHS resources we continue to hear concerns relating to attempts to support this model, which can lead to inequities in care provision. The CoC model must be reviewed and suspended until all Trusts demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that CoC models of care place on maternity services already under significant strain. The reinstatement of CoC should be withheld until robust evidence is available to support its reintroduction

13.13 As a multi-professional clinical review team comprising midwives, obstetricians, neonatologists and other specialist colleagues who work within (and closely with) maternity services in trusts across England, we strive to ensure that all women receive high-quality, safe care throughout their pregnancy pathway which is tailored to their individual needs. We all recognise the challenges faced by maternity services across England as they work to ensure that the maternity care provided leads to the best possible outcomes for mothers and their babies.

13.14 In our interactions with families, we have seen clearly that the Shrewsbury and Telford Hospital NHS Trust failed to learn, failed to improve and failed to safeguard families over a prolonged period of time. This is a Trust that was also failed by the wider maternity system which did not act, and this must not happen again.

231 Ibid n1

232 Ibid n2

233 NHS Providers letter to Rt. Hon Jeremy Hunt MP Chair, Health and Social Care Select Committee (2021) https://committees.parliament.uk/publications/6290/documents/69337/default/

234 NHS England/ I (2021) *Delivering Midwifery Continuity of Carer at full scale Guidance on planning, implementation and monitoring 2021/22* Available: https://www.england.nhs.uk/wp-content/uploads/2021/10/B0961_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf

13.15 We urge maternity services across England to continue their work in implementing the IEAs from our first report. We have seen so much excellent practice and a real desire to improve. Now, the NHS across England and the Shrewsbury and Telford Hospital NHS Trust must make ambitious plans to ensure timely implementation of the additional Local Actions for Learning, (LAfL) and Immediate and Essential Actions, (IEA) from our final report.

13.16 As difficult decisions loom about NHS funding post the COVID-pandemic, maternity services in England **must not slip down the priority list.** The scale of this review is unprecedented in NHS history and after listening to so many families, we have been given an unrivalled opportunity to change and improve maternity service provision for all parents and their families now and in the future. Together the changes we have outlined, and the demand for better funding will ensure safer outcomes for more women and families, reducing the risk of unnecessary loss of life, injury and resultant heartbreak.

Chapter 14

Local Actions for Learning (LAfL) - the Trust

Clinical governance

LOCAL ACTIONS FOR LEARNING: IMPROVING MANAGEMENT OF PATIENT SAFETY INCIDENTS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.1 Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework.

14.2 The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists and anaesthetists to undertake incident investigations.

14.3 All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession.

14.4 The use of HRCRs to investigate incidents must be abolished and correct processes, procedures and terminology must be used in line with the relevant Serious Incident Framework.

14.5 Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident.

14.6 All SIs must be completed within the timeframe set out in the SI framework. Any SIs not meeting this timeline should be escalated to the Trust Board.

14.7 All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy. These training courses must commence within the next 12 months

14.8 The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.

14.9 Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.

LOCAL ACTIONS FOR LEARNING: PATIENT AND FAMILY INVOLVEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.10 The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.

14.11 All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.

14.12 The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited and encouraged to be involved in incident investigations.

LOCAL ACTIONS FOR LEARNING: SUPPORT FOR STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.13 There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern.

14.14 The Trust must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support the maternity department going forwards.

LOCAL ACTIONS FOR LEARNING: IMPROVING COMPLAINTS HANDLING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.15 Complaint responses should be empathetic and kind in their nature. The local MVP must be involved in helping design and implement a complaints response template which is relevant and appropriate for maternity services.

14.16 Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the MVP.

14.17 All staff involved in preparing complaint responses must receive training in complaints handling.

LOCAL ACTIONS FOR LEARNING: IMPROVING AUDIT PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.18 There must be midwifery and obstetric co-leads for audits.

14.19 Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.

14.20 Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred.

14.21 Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.

14.21 Matters arising from clinical incidents must contribute to the annual audit plan.

LOCAL ACTIONS FOR LEARNING: IMPROVING GUIDELINES PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.22 There must be midwifery and obstetric co-leads for developing guidelines.

14.23 A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use.

LOCAL ACTIONS FOR LEARNING: LEADERSHIP AND OVERSIGHT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.24 The Trust Board must review the progress of the maternity improvement and transformation plan every month.

14.25 The maternity services senior leadership team must use appreciative inquiry to complete the National Maternity Self-Assessment[235] Tool published in July 2021, to benchmark their services and governance structures against national standards and best practice guidance. They must provide a comprehensive report of their self-assessment, including any remedial plans which must be shared with the Trust Board.

14.26 The Director of Midwifery must have direct oversight of all complaints and the final sign off of responsibility before submission to the Patient Experience team and the Chief Executive.

235 NHS England. *Maternity self-assessment tool* (2021) https://www.england.nhs.uk/publication/maternity-self-assessment-tool/

Antenatal care

LOCAL ACTIONS FOR LEARNING: CARE OF VULNERABLE AND HIGH RISK WOMEN

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.27 The Trust must adopt a consistent and systematic approach to risk assessment at booking and throughout pregnancy to ensure women are supported effectively and referred to specialist services where required.

LOCAL ACTIONS FOR LEARNING: FETAL GROWTH ASSESSMENT AND MANAGEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.28 The Trust must have robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height (SFH) measurements and audit of the documentation of it, at least annually.

14.29 Audits must be undertaken of babies born with fetal growth restriction to ensure guidance has been followed. These recommendations are part of the Saving Babies Lives Toolkit (2015 and 2019)[236].

LOCAL ACTIONS FOR LEARNING: FETAL MEDICINE CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.30 The Trust must ensure parents receive appropriate information in all cases of fetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for birth in the tertiary centre as the best option in complex cases.

14.31 Parents must be provided with all the relevant information, including the opportunity for a consultation at a tertiary unit in order to facilitate an informed choice. All discussions must be fully documented in the maternity records.

LOCAL ACTIONS FOR LEARNING: DIABETES CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.32 The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.

236 Ibid n11

LOCAL ACTIONS FOR LEARNING: HYPERTENSION

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.33 Staff working in maternity care at the Trust must be vigilant with regard to management of gestational hypertension in pregnancy. Hospital guidance must be updated to reflect national guidelines in a timely manner particularly when changes occur. Where there is deviation in local guidance from national guidance a comprehensive local risk assessment must be undertaken with the reasons for the deviation documented clearly in the guidance.

LOCAL ACTIONS FOR LEARNING: CONSULTANT OBSTETRIC WARD ROUNDS AND CLINICALREVIEW

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.34 All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHSE 2017[237]). These consultant reviews must occur with a clearly documented plan recorded in the maternity records.

14.35 All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021[238].

14.36 The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR[239] to enable all staff to escalate and communicate their concerns.

LOCAL ACTIONS FOR LEARNING: ESCALATION OF CONCERNS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.37 The Trust's escalation policy must be adhered to and highlighted on training days to all maternity staff.

14.38 The maternity service at the Trust must have a framework for categorising the level of risk for women awaiting transfer to the labour ward. Fetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward.

237 NHS England. *Seven day services clinical standards* (2017) https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf

238 National Institute for Health and Care Excellence. Inducing labour NICE Guideline 207 (2021) https://www.nice.org.uk/guidance/ng207

239 See glossary

14.39 The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents such as Each Baby Counts[240] and Saving Babies Lives[241]. The Trust has used computerised CTGs since 2015 with local guidance to support its use. Processes must be in place to be able to escalate cases of concern quickly for obstetric review and likewise this must be reflected in appropriate decision making. Local mandatory electronic fetal monitoring training must include sharing local incidences for learning across the multi-professional team.

Intrapartum care

LOCAL ACTIONS FOR LEARNING: MULTIDISCIPLINARY WORKING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.40 The labour ward coordinator must be the first point of referral and be proactive in role modelling the professional behaviours and personal values that are consistent with positive team working and providing timely support for midwives when asked or when abnormality in labour presents.

14.41 The labour ward coordinator at the Trust must be supernumerary from labour care provision and provide the professional and operational link between midwifery and the most appropriately trained obstetrician.

14.42 There must be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week.

14.43 Senior clinicians such as consultant obstetricians and band 7 coordinators must receive training in civility, human factors and leadership.

14.44 All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out when they have concerns about safe care.

LOCAL ACTIONS FOR LEARNING: FETAL ASSESSMENT AND MONITORING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.45 Obstetricians must not assess fetal wellbeing with fetal blood sampling (FBS) in the presence of suspected fetal infection.

14.46 The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work.

14.46 Midwives and obstetricians must undertake annual training on CTG interpretation taking into account the physiological basis for FHR changes and the impact of pre-existing antenatal and additional intrapartum risk factors.

240 Ibid n32

241 Ibid n11

LOCAL ACTIONS FOR LEARNING: SPECIFIC TO MIDWIFERY-LED UNITS AND OUT-OF-HOSPITAL BIRTHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.47 Midwifery-led units must complete yearly operational risk assessments.

14.48 Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.

14.49 It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.

LOCAL ACTIONS FOR LEARNING: MATERNAL DEATHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.50 In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.

LOCAL ACTIONS FOR LEARNING: OBSTETRIC ANAESTHESIA

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

The review team re-emphasises the importance of the Local Actions for Learning and Immediate and Essential Actions for obstetric anaesthesia services from the first report. These can be found in Appendices 5 and 6 and form a vital part of the ongoing learning for both the Trust and maternity services nationally.

The following Local Actions for Learning are based on themes recognised whilst undertaking the current review and must be addressed by the Trust as a priority. The RCoA 'Guidelines for Provision of Anaesthetic Services' (GPAS) document stipulates the key requirements in the provision of obstetric anaesthesia services and these Local Actions for Learning address requirements where the Trust currently falls short. We place a responsibility on the Trust's executive team to support the anaesthetic department in achieving compliance. They are also applicable to hospitals experiencing similar issues and should therefore be used to inform wider improvements in obstetric anaesthesia care.

14.51 The Trust's executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.

14.52 The Trust's executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust's services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service.

14.53 The Trust's executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by RCoA in 2020.

14.54 The Trust's anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be undertaken to ensure evidence-based care is being embedded in day-to-day practice[242].

14.55 The Trust's department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting.

LOCAL ACTIONS FOR LEARNING: NEONATAL

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.56 The Trust must ensure that there is a clearly documented, early consultation with a tertiary NICU for babies who require, or are anticipated to require, continuing intensive care. This must be the subject of regular audit.

14.57 As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention and training of ANNPs.

14.58 The Trust must ensure that sufficient resources are available to provide safe neonatal medical or ANNP cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU.

14.59 The number of neonatal nurses at the Trust who are "qualified-in-specialty" must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review.

LOCAL ACTIONS FOR LEARNING: POSTNATAL

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.60 The Trust must ensure that a woman's GP is given complete, accurate and timely, information when a woman experiences a perinatal loss, or any other serious adverse event during pregnancy, birth or postnatal continuum.

242 RCoA Raising the Standards: RCoA Quality Improvement Compendium. Chapter 7 Obstetric Practice. 4th Edition September 2020

14.61 The Trust must ensure complete and accurate information is given to families after any poor obstetric outcome. The Trust must give families the option of receiving the governance reports, which must also be explained to them. Written summaries of any debrief meetings must also be sent to both the family and the GP.

LOCAL ACTIONS FOR LEARNING: STAFF VOICES

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.62 The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service as illustrated by the results of the 2018 MatNeo culture survey.

LOCAL ACTIONS FOR LEARNING: SUPPORTING FAMILIES AFTER THIS REVIEW IS PUBLISHED

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.63 Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.

14.64 There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area.

Chapter 15

Immediate and Essential Actions to improve care and safety in maternity services (IEA) across England

15.1 We include these **Immediate and Essential Actions, (IEAs)** to improve safety in maternity services across England. These IEAs complement and expand upon the **Immediate and Essential Actions** issued in our first report. We note that NHS England and Improvement (NHSE&I) has supported the implementation of these actions in trusts across England since our first report was published.

15.2 These further **Immediate and Essential Actions** arise from findings from this large review into maternity services at Shrewsbury and Telford Hospitals NHS Trust. However, we are aware that similar problems may occur in other trusts across England and therefore these actions must be implemented widely in all maternity services.

15.3 This review is supporting and endorsing the latest Health and Social Care Committee Report "The Safety of Maternity Services in England"[243]. We agree with the select committee that the budget for maternity services be increased by £200-350million per annum with immediate effect. This funding increase should be kept under close review as more precise modelling is carried out on the obstetric workforce and as trusts continue to undertake regular safe staffing reviews of midwifery workforce levels.

15.4 We further agree that the Department of Health and Social care (DHSC) must work with the Royal College of Obstetricians and Gynaecologists, (RCOG) and Health Education England to consider how to deliver an adequate and sustainable level of obstetric training posts, to enable trusts to deliver safe obstetric staffing over the years to come. This work must also consider the anaesthetic and neonatal workforce and be advised by the Royal College of Anaesthetists (RCOA), Obstetric Anaesthetists' Association (OAA), Royal College of Paediatrics and Child Health (RCPCH) and British Association of Perinatal Medicine (BAPM). In this regard, the review team is also aware of and endorses the initiatives on workforce planning by the RCOA and the current national review of the obstetric anaesthesia workforce by the OAA in response to the first report.

15.5 We endorse the Health Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit. We also agree that NHS trusts must report this in public through their annual Financial and Quality Accounts.

15.6 We endorse the Health Select Committee recommendation that the Maternity Transformation Programme Board should establish what proportion of maternity budgets should be ring-fenced for training but it must be sufficient to cover not only the provision of training, but the provision of back-fill to ensure that staff are able to both provide and attend training.

15.7 We endorse the recommendation that a single set of maternity training targets agreed in all maternity services in England should be established by the Maternity Transformation Programme board, working in conjunction with and advised by the main Royal Colleges and the Care Quality Commission (CQC).

15.8 We endorse the recommendation that training targets should be enforced by NHSE&I's Maternity Transformation Programme, the Royal College of Midwives (RCM), the RCOG and the CQC through a regular collaborative inspection programme.

15.9 Along with staffing and training the Health Select Committee clearly articulated the need to learn from patient safety incidents. This issue has taken up a large part of both this second report and our first report and we endorse the committee's findings that families must be involved in the investigative process and that lessons must be learned and implemented in a timely way to prevent further tragedies.

243 Health and Social Care Committee. *The Safety of Maternity Services in England* (2021) https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm

15.10 We also note the committee recognised that maternity units appear to have been penalised for high caesarean section rates and recommended that there should be an end to the use of total caesarean section percentages as a metric for maternity services. We note the progress on this with the recent advice from NHS England and NHS Improvement to Trusts[244] to stop monitoring caesarean section rates. The recognition that Shrewsbury and Telford Hospital NHS Trust had a lower than average caesarean section rate (and was often praised for this) was identified in our first report. We noted that some mothers and babies had been harmed by this approach and we welcome the committee's findings and the progress on this.

15.11 This review also supports the NHS Maternity Digital Programme. We recognise this as a key enabler to improve quality and safety. The use of maternity digital notes will empower women by providing them with their own digital maternity care plan and record, discussed and agreed with them and their midwife. Enhancing and improving the digital programme will improve communication, and ultimately contribute to making maternity care safer.

15.12 The Parliamentary Health and Social Care Committee Report recommendations on staffing, training and learning from patient safety incidents echoes much of the work of our first and now this final report. We believe there is still so much more to do in order to make the maternity service in England the safest it can be. It is our intention that implementation of these further Immediate and Essential Actions will make a significant contribution to the delivery of safe maternity care.

15.13 Importantly: We state that DHSC and NHSE&I must now commission a working group independent of the Maternity Transformation Programme that has joint RCM and RCOG leadership to make plans to guide the Maternity Transformation Programme around implementation of these IEAs and the recommendations of other reports currently being prepared.

244 Letter dated 15th February 2022- Ref PAR 1393

1: WORKFORCE PLANNING AND SUSTAINABILITY

Essential action – financing a safe maternity workforce The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	• The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England. • Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements. • Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave. • The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.
Essential action – training We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.	• All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this. • All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.

1. WORKFORCE PLANNING AND SUSTAINABILITY (CONTINUED)	
	• All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce. • All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development. • All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7. • All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience. • The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.

2: SAFE STAFFING

Essential action

All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.

- When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.
- In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.
- All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.
- All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.
- The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction
- The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.
- All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.
- Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.

2: SAFE STAFFING (CONTINUED)	
	• All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication. • All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.

3: ESCALATION AND ACCOUNTABILITY	
Essential action Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	• All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals. • When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role. • Trusts should aim to increase resident consultant obstetrician presence where this is achievable. • There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit. • There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.

4: CLINICAL GOVERNANCE-LEADERSHIP

Essential action

Trust boards must have oversight of the quality and performance of their maternity services.

In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.

- Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.
- All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.
- Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.
- All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.
- All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.
- All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.
- All maternity services must ensure they have midwifery and obstetric co-leads for audits.

5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS

Essential action

Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.

- All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.
- Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.
- Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.
- Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.
- All trusts must ensure that complaints which meet SI threshold must be investigated as such.
- All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.
- Complaints themes and trends must be monitored by the maternity governance team.

6: LEARNING FROM MATERNAL DEATHS

Essential action

Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.

In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.

- NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.
- This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.
- Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.

7: MULTIDISCIPLINARY TRAINING

Essential action

Staff who work together must train together

Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.

Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training

- All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.
- Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.
- All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.
- There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.
- There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.
- Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.
- Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.

8: COMPLEX ANTENATAL CARE

Essential action

Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.

Trusts must provide services for women with multiple pregnancy in line with national guidance

Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy

- Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.
- Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.
- NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.
- When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.
- Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).

9: PRETERM BIRTH

Essential action

The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.

Trusts must implement NHS Saving Babies Lives Version 2 (2019)

- Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.
- Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.
- Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.
- There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.

10: LABOUR AND BIRTH

Essential action

Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.

Centralised CTG monitoring systems should be mandatory in obstetric units

- All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made
- Midwifery-led units must complete yearly operational risk assessments.
- Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.
- It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.
- Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.
- Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.

11: OBSTETRIC ANAESTHESIA

Essential action

In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.

Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.

Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.

- Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.
- Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.
- All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC
- Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.

Obstetric anaesthesia staffing guidance to include:

- The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.
- The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.
- The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.
- Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.

12: POSTNATAL CARE

Essential action

Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.

Postnatal wards must be adequately staffed at all times

- All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward.
- Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.
- Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.
- Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.

13. BEREAVEMENT CARE

Essential action

Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.

- Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.
- All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.
- All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.
- Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.

14: NEONATAL CARE

Essential action

There must be clear pathways of care for provision of neonatal care.

This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.

- Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.
- Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.
- Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.
- Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.
- Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.
- Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.

14: NEONATAL CARE (CONTINUED)	
	• Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm. • Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.

15: SUPPORTING FAMILIES	
Essential action Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	• There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate. • Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences. • Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.

Appendices

Appendix 1: Hearing the voices of staff

Staff voices engagement strategy

1.1 In engaging with and listening to current and former staff at the Trust, we intended to highlight where they saw and see scope for improvement, but also to report on good practice in maternity services over the years. Staff were offered the opportunity to share any information with us that they felt would support them in having their views and voices heard. The culture within the Trust and specifically maternity services and whether it has changed over time is an important factor in order to understand the potential cause of any systemic problems.

1.2 Prior to conducting the staff survey for this review we reviewed the results from annual NHS staff surveys at the Trust over the previous 10 years. Staff across NHS organisations are encouraged to complete this survey each year and data are used to improve staff experiences locally and throughout the NHS, ultimately benefitting patient care. We also reviewed the Trust results from the Maternity and Neonatal Health Safety Collaborative (MatNeo) Culture Survey in 2018, which was part of the national Maternity and Neonatal Improvement Programme.

1.3 The NHS annual staff survey has undergone several iterations over the years and the Trust has restructured its service centres/ clinical divisions on a number of occasions. It therefore proved difficult to attribute the available data specifically to staff who worked directly within maternity services. The MatNeo Survey[245], although identifying themes particular to the service, had limits in covering historical aspects of the culture at the Trust.

1.4 The review team worked directly with the Trust to ensure that past and present staff were offered the opportunity to contribute to this review. Reassurances were given with regards to anonymity and confidentiality and that responses would not be shared with the Trust. We developed a staff voices engagement strategy - known as 'Staff Voices', using a bespoke questionnaire survey followed by conversations with staff. The chair of the review also conveyed messaging regarding the Staff Voices strategy through local radio stations and via social media with the aim to reach out to as many former and current staff as possible.

1.5 Despite the assurances around confidentiality and not sharing findings with the Trust there is evidence from multiple conversations and contacts from staff themselves that they remained reluctant to participate. There appeared to be two main concerns from the staff who contacted the review who were uncertain about whether to participate or not - firstly they described being dissuaded from participating by their managers at the Trust. Secondly they expressed concerns about the ongoing police investigation at the Trust, Operation Lincoln, and whether the review team intended to pass information from staff to the police as a matter of routine. Whilst this was not the intention of the review team, the police have requested that we retain any relevant material and we may be required to disclose information to the police in due course.

1.6 In total only 109 staff came forward and participated in the review, some completed the survey only, some both completed the survey and spoke to us and some only spoke to us, declining to fill in the survey. We are sorry that so few staff members felt able to participate. In the last few weeks immediately prior to publication, 11 of the 109 staff who had come forward either fully or partially withdrew their cooperation or did not respond to multiple requests to use their content. This means that overall we have been able to use the staff voices of only 98 current or former staff at the Trust.

245 Provided to the review team by the Trust

The launch of Staff Voices

1.7 The staff voices survey was conducted from 12 May until 30 June 2021, with follow up conversations with staff occurring until January 2022.

1.8 Some staff employed by the Trust contacted the review team directly using the designated staff voices email address and asking for the link to the survey rather than accessing the link provided through the Trust. Many of these messages sought reassurance that the Trust would not know they had completed the survey. Some staff messaged the review chair directly, seeking assurance of confidentiality.

'...[I am] working for the trust and would like to take part in this survey but only if 100% confidential'. (Staff member, email to the review team)

'[working]...within SaTH [the Trust] as long as my name won't be mentioned and whatever I say is kept confidential I'm willing to take part in the survey'. (Staff member, email to the review team)

'Some staff were told be careful about how they answered this survey and were told to remember any comments made could be considered as part of the police investigation. This is the kind of passive aggressive approach of threat that NHS organisations use to deter staff from speaking up. It is so historically ingrained in the culture and possibly will have put staff off participating in the survey'. (Staff member, email to the review team)

1.9 These concerns were further confirmed during conversations held with current staff. One member of staff said: :

'…….and I know a lot of my colleagues didn't want to get involved because they were frightened, they were intimidated by the process'.

1.10 Another member of staff told the review team:

'I said, "Have you written out your questionnaire yet?" "No, we have been told not to"……...but people won't because they have to put their name against the allegations and that sort of thing, and these people they've, as I have said before, they've got their friends and they just will not speak up, they daren't, they daren't speak up, you know.'

'So I know multiple people that have not approached you to speak because of fear, because of how it was put in that briefing [from the Trust to staff] …….. there were people that had every intention of completing their survey and then after that, no way. I was like but this is your chance to speak. How can you make any changes? How can you do anything about it when we're given this opportunity but they're still working there? I think they were perhaps fearful of their jobs, I don't know'.

Another member of staff describing how fearful they felt about speaking up in the maternity service in early 2022 told the review:

'We used freedom to speak up and because of the reporting process they have to follow those concerns ended up going back to those we had concerns about...'

1.11 Overall, when taking into consideration the number of staff who are currently employed within the service and the number of former staff employed throughout the twenty years of the review's timeframe, we are disappointed that just 84 staff completed the survey. By comparison, in 2018, 192 (58%) staff who were working within the maternity and neonatal services at the Trust completed the MatNeo culture survey. Therefore we appreciate that our findings and conclusions are of limited value. However, having put considerable effort into hearing the voices of staff and having been told by the staff who participated how important it was to them to be heard, we believe this content is important despite the low number of participants.

Staff Conversations

1.12 Staff were asked within the questionnaire survey whether they agreed to a confidential face-to-face video interview with members of the review team and 76% of those completing the survey responded with 'yes'. Some staff contacted the review team via email requesting to speak with us, but did not want to complete the questionnaire survey.

1.13 The review team was also keen to speak with staff who held leadership positions within the Trust, maternity services and Clinical Commissioning Groups (CCG) to gain insight into the culture and changes over the years. The Trust and CCG contacted those staff who were of potential interest to the review to advise them of the request and to gain their consent for sharing their contact details. Other Trust and CCG staff were also able to contact us directly if they wished.

1.14 All interviews were conducted via a videoconferencing platform. Participants were advised they would receive a copy of the transcript of the conversation which they could annotate as they wished and that they could send additional information to the review team.

Staff Voices Results

1.15 In total, we received 84 staff survey questionnaires and conducted 60 staff interviews. Each staff member was allocated a confidential staff number. Of the survey respondents, 49% had been employed by the Trust for less than 10 years, 39% for between 10 and 20 years and 12% for more than 20 years. The majority of staff who engaged with the review were still employed by the Trust. The majority of staff were either employed or had been employed in clinical roles.

	Question	Yes	Sometimes	No	Total	Percentage 'Yes'
Professional and / or clinical concerns	Have you ever raised any professional or clinical concerns?	48	-	36	84	57.1%
	Have you ever been concerned about patient safety?	52	-	32	84	61.9%
Bullying	Have you personally witnessed or experienced bullying in the workplace at SaTH?	55	-	29	84	65.5%
Mandatory training	Do / did you have managerial support to attend mandatory training days?	55	20	9	84	65.5%
Teamwork	Did / do you think your multidisciplinary team works well together?	37	36	11	84	44.0%
Staffing Levels	Have you ever escalated concerns about staffing levels during your shift?	51	-	22	84	60.7%
Improvements	Did / do you feel there were / are any barriers to attempts to make improvements to the maternity service?	42	21	21	84	50.0%
Family and Friends Test	Would you recommend SaTH to family and friends for maternity care?	38	27	19	84	45.2%

Category	Question	Never	Rarely	Sometimes	Often	Always	Total
Culture	Whilst at SaTH did / do you enjoy coming to work?	2	16	34	27	5	84
	How often did / do you take part in multidisciplinary traning) (e.g. obstetricians, midwives, neonatologists, support staff training together)	15	16	30	12	11	84

1.16 Many staff who spoke to us appeared very committed to the Trust, spoke of pride in the service and demonstrated loyalty and support towards their colleagues. Staff members told us: *'…So I wanted to make clear that was what I'd seen. These people I've worked with have been trying really hard'*…Another member of staff said: *'I do actually enjoy it and the team that I work with are a fantastic team…'*

1.17 From the questionnaires and interviews we identified key themes that had an impact on staff working in the Trust over the years and can give (albeit limited due to the small numbers) some insight into the culture throughout the years.

Merger of two trusts to form one trust

1.18 Staff described the difficulties they felt they experienced caused by the merging of the two sites to form one Trust and subsequently the move of consultant maternity services to Telford in 2014. One staff member said:

'…I think it's really tough for the management board. I think there was a disconnect in previous Trust boards, I think it was really hard. We did have quite an aggressive management structure when it was all about reconfiguration. It clearly felt like a new Chief Exec had come, Department of Health driving through, reconfiguration and relocating to Telford. We felt pretty coerced into agreeing to relocate to Telford, which clearly is wrong, and now, there's talk about it was the wrong decision, the services are in the wrong place, but the majority of us thought that in the first place'.

1.19 Another staff member said:

'As far as I could tell, you know, the Trust had been stuck, basically, for about twenty years, unable to make any progress, the two local authorities, the two populations at daggers drawn, you know, resisting every single change. …..trying to find a way through that log jam and come out the other side of it with a set of proposals that would make services less unsustainable.'

1.20 Another staff member told the review:

'…..we hadn't merged yet, …. and one of the great things that made me take the job in Telford was because the management team were based in Telford, because it was just one hospital, and they were incredibly responsive. You would bump into the Chief Exec on the corridor, the Medical Director, you could raise a concern or make a suggestion,…. oh, I wonder if this could actually improve patient care or this would be a good thing for safety, and it was really easy to get things …..changed because there was that responsiveness. With the merger…..the management structure was almost entirely based at RSH. They don't come over, they're not based at Telford, so you get none of the corridor conversations, which shouldn't really be the way we communicate but actually is often the way communication happens, so we don't have that access.'

Trust leadership

1.21 In our first report we discussed the high turnover of Chief Executives (CEOs), executives, non executives and other leadership roles at the Trust. Such a high turnover will inevitably impact on the performance of an organisation. One staff member told the review team:

'…..I think that's part of the problem…. they haven't got a consistent leadership…..and it was a mess, you know, you can't describe it any other way, there'd been no leadership whatsoever'.

1.22 Another staff member said:

'One of the historical factors for the Trust is that there have been several management restructures, many different chief execs, and a real churn at the Trust board level as well…… I went through three management restructures, reappointed each time to a slightly different role…… Each of those management restructures sometimes took up to about eighteen months from the first letter of people being put at risk to people being

in place…… each time you lose good people, because there's only so many management restructures……. So, no sooner had you made a working relationship with an executive, than the next one was on their way. And also, with each of those structures came, obviously, slightly new ways of doing things, new policies, new training, some of the previous ways were not required, and there was a new focus'.

1.23 Another staff member said:

'….I guess that takes time, developing that trust in leadership does take time, and certainly one of the things that SaTH has not benefited from is longevity of leadership.'

1.24 Three other staff members told the review:

'So, there's been little in the way of corporate memory and additionally, the new incumbents would have to establish their relationships with the existing management structure'.

'We'd just had another Chief Executive who wanted to do yet another reorganisation and we were all supposed to apply for our posts and do maths tests and English and chemistry and I just thought, "I can't….."'.

'…it's really bizarre, we've had … we're on our third Medical Director since I've been in this role and we're on our third Director of Nursing. The current establishment, it seems to have much more traction and we seem to see much more evidence of things happening. The previous people that were in post, similarly, were saying all of the right things but it just wasn't translating it, the action wasn't happening. It was like there was a disconnect. The executives knew of the problem, they didn't understand the core cause of the problem'.

Culture

1.25 A priority when reaching out to staff at the Trust was to understand the culture within the maternity service and possibly the wider Trust. Through the survey, staff were asked 'Have you personally witnessed or experienced bullying in the workplace at the Trust? 65% of respondents replied with 'yes'. Of those 65%, 38% felt able to report it and of these, 33% felt it was adequately dealt with.

1.26 One staff member told the review team:

'Culture is a big thing because I feel there's a reluctance to change there.'

1.27 Another staff member told us:

'I feel that there are historical organisational/cultural issues that are very complex in how this situation has developed. I really believe that there are wider system errors that have let down women and their families but also staff. There are some really good people who care immensely about what they do but operating in a system that is in crisis management continually, can have significant impact on the ability to maintain passion and compassion.'

1.28 A further contributor stated: *'…. the fear of speaking out is all-pervasive in SaTH and it's a very difficult thing to get rid of if that has been the culture for not just ten years, but twenty years, thirty years, it's inbred within the culture at SaTH that if you speak out, something is going to happen to you……you'll be bullied or you'll be moved or you'll be … you know, something will happen, something will be … make it difficult for you.'*

1.29 One staff member described their own experience: *'X .was so strident that you tended not to argue with her, she was a bully, 100%'.*

1.30 Another contributor said: *'*

….when I joined. We just had the conversation about the need to change the culture, in terms of safety culture, that was very clear, and the organisation went with that process, including Listening into Action, which was another initiative that was brought in…… which is important, because I think staff hadn't felt previously that they'd got a voice to be heard. So, I think that Listening into Action was very important at that stage in terms of changing that culture within the organisation'.

1.31 Three different staff members told the review team:

'….previously, these groups have been split up in clinical areas but they go elsewhere and still behave in the same way. They are…big voices, they're dominating, they're intimidating…'

And: *'There are cliques there and, you know……. they are a little gang, and, yes, they will make your life hell…… I am speaking to colleagues now and they won't speak out… you couldn't speak to senior management, if you tried you got shot down'.*

And: *'And the safety huddles that we used to go to, I mean some of them were…. would speak to some of the managers like absolute … it was just you'd stand back and think, "This is bullying".'*

1.32 Other staff members described a 'clique' on the labour ward at the Trust with a culture of undermining and bullying. Some staff members described that this had negatively and seriously affected their mental health. Other staff members described that the behaviour experienced on the labour ward was so bad that they had difficulty finishing their shifts and cried secretly whilst in work. These staff declined for their direct quotes to be used, because they were fearful of being identified.

1.33 Many staff members told the review team of the fear of speaking out within maternity services. This included those who are currently working in maternity services at the Trust.

1.34 One staff member said: *'….it's very hard to speak up because despite what anybody will tell you, there are consequences to speaking up and the consequences are your life gets made very difficult or you get subtle … you can't really pinpoint it as bullying, it's like subtle, made to feel uncomfortable when you go to work, not sure how people are going to be with you, not being invited out onto nights out. Simple things like that, not being included in coffee mornings, and things like that….. it's very difficult to speak out, I've been there myself and I ended up going off ill with it'.*

1.35 A current staff member in maternity services at the Trust spoke to the review team in early 2022 but described themselves as fearful to do so. The staff member said *'I really had to think very carefully about approaching the staff voices….when we were told not to speak out, but I will do it and take the consequences because it is the right thing to do…I am clear that there is no support for those that speak up...'.*

1.36 Periodic rotation through the clinical areas within a maternity service is a system evident in most maternity services. Its aim is to ensure that staff remain competent to deliver care in the main clinical environments and gain wider experience, and it also enhances professional development. It is also believed to improve communication as there is an understanding and awareness of what happens in other clinical areas. Some staff commented on the process within maternity services at the Trust, with some saying that poor behaviours still remain at the Trust.

'…they would have almost three or four months of these rumours going around, "There's going to be a change list; there's going to be a change list", and then finally, when the change list came out, there was a lot of anxiety from quite a few midwives.'

'The communication of the change list over the years has been very poor and has caused a massive amount of stress for all of us because you just find out that you're on the change list and off you go.'

'There was a lot of cliques there, a lot of managers were cliquey, there was the change list that was used as a… you had the impression that if you were a pain you would get moved, you know and nobody wanted that and, you know, it still goes on today….. I think that the managers, I think they are aware of the clique and I think they have tried to separate them but they're so deeply ingrained into the system… the management's almost scared to get rid of them because they almost form the core of the delivery suite expertise.'

'…they just didn't want students at all, they were not happy to have students…'

Governance

1.37 We routinely questioned staff regarding the governance systems across the wider Trust. Two staff contributors said:

'……one of my concerns at the time was really that…, I don't think the Trust had a robust governance framework, to be honest.' '….and we ended up having to just work within our department, because when we asked within the Trust there just wasn't that resource... the Trust wasn't as advanced as that, they just didn't understand what we needed, so we ended up doing that'.

'certainly my experience is it's not about the people on the floor doing the work, it's the whole system behind it that isn't always as helpful as it could be and that affects those people that are trying their best …'

1.38 Another contributor told the review: *'……yes, it did feel as though we weren't perhaps hearing all that we should have been hearing…….. We struggled consistently to get information from SaTH in those meetings from 2009 -2012. Reviews of serious incidents seemed to take a long, long, long time to happen and there was an impression of evasiveness around how the learning from those reviews was shared. Reading the last Ockenden Report it was clear to me that whatever learning was taken from the incidents that are described wasn't actually shared and taken forward, so the same things were happening over and over and over again, and in the context of an organisation who may describe themselves as a learning organisation I never felt that it really was'.*

1.39 A number of other staff members told the review team of their experiences:

'It was a system wide failure to be able to escalate these priority pieces of work and to push it through, there didn't seem to be the guidance, there didn't seem to be the governance, there didn't seem to be the process of challenge…'

1.40 Another staff contributor said:

'This has just started recently, by recently I would say in the past four or five years, but before then we didn't have this system, you see. We didn't have clinical governance, it was just on the go, word of mouth, that if there was an issue you would get it discussed between you and the consultant, for example, or whoever was involved, but we didn't have this learning procedure or learning process as is currently being done.'

1.41 Another staff member said

'….things started to become visible when the CQC went in and we were given [an] inadequate rating……. but prior to that, it would be that things were kind of filtered down really by word. To be honest, there was a lack of process, a real lack of processes.'

Staff voices on statutory supervision of midwifery

1.42 Commenting on the ineffective nature of the process of statutory supervision of midwifery at the Trust one contributor said: *'My recommendation was that there was a supervisory investigation. At the time it was dismissed because it was such a tight, tight group of supervisors, it was impenetrable and if you're in, you're in, and X was in. So, they were not keen to conduct that….. If they decided that this particular practitioner did not need a supervisory investigation then it was up to them. So, if your face fits, then you were okay.'*

1.43 Other contributors told the review team that the same people were involved in supervision investigations as in internal maternity governance investigations and that statutory supervision was only a process of internally 'marking their own homework'.

Improvements in maternity governance from the perspective of staff

1.44 Some staff reported that in more recent years, the governance processes within maternity services at the Trust have improved.

'It has improved, there is no doubt that it has improved in comparison to the past, whether this is enough I don't know now. Obviously time will tell, but definitely there is now clinical governance, there are high-risk case discussions, meetings, and these issues that we've never had in the first ten, twelve years of my work here in this hospital.'

'…..there were lots and lots of changes that were really, really for the better, and the MDT really came together. I think also there was organisational developments as well, because the anaesthetist started doing some scenario-based training that we would all be invited to.'

'….there is a much better process now of incidences being shared. Certainly in the last five years, maybe even less than that……. Some line managers are very good at sharing all memos and other managers not so'.

1.45 Other staff cautioned that the improvements seen within maternity services at the Trust remain very fragile and that the Trust needs further observation, scrutiny and support as of spring 2022. A staff member said: *'Ladies are being cancelled, rebooked and cancelled due to staffing issues and I have considered leaving as I worry about the impact this is having…'. The staff member added: 'I have been really worried…it is important people are aware of the situation...'.*

Oversight of safety and performance within maternity services

1.46 A number of contributors reported to us that, for a long time, executives and board members viewed the maternity service as performing well and as a result did not apply a high level of scrutiny to the service. Equally external scrutiny did not raise sufficient concerns at board level. The following remarks illustrate this:

'….whilst they were confident and very strong individuals, very clear about their ability to manage their teams and manage the business, I didn't have any reason to question that they would come to me if they had concerns'.

Another contributor added: *'…at no stage did me, and this is my fault, but at no stage did I pick up that there was such a deep-seated problem in that service…'*

1.47 Other staff members told the review team:

'…….we got best performing and we got CNST Level 3, you know, so these are independent organisations coming in, looking at it. Therefore……. you should have some confidence in what these bodies are telling you…'

'……when scrutinised by quality and safety, when scrutinised by the Trust Board to give a reasonable account of their abilities to maintain their service. We did develop "deep dive" reviews at various stages and there was a sense that compared with some other areas of difficulty within the Trust, Maternity was not on the radar at that stage. That, of course, was triangulated with other perspectives, so views from the CQC, and you'll be aware that in the early phases, the CQC reports were positive ones. They were rated as good.'

'….it was published and it obviously came to our Board meeting, we discussed it in the Board. I think, I mean the overall message from that report was that…. they said safe and good quality services in a learning organisation.'

'It was presented to us, I think, by SaTH as being more positive than it actually was. It was a kind of oh well, the RCOG think we're okay.'

'They were one of the ones I trusted and, given all the external results we were getting that actually confirmed how good the service was they ran'.

'…..we were working within a Trust that had considerable financial challenges, some challenged services, and that was the focus of the Trust, really. So, maternity and women's and children's was referred to as the flagship of the organisation, and trying to get additional resources into the care group was really difficult.'

'….we'd achieved CNST level three gold standards, and that was … I don't know, not a badge of honour, but there was a lot of interest within the Trust that we should be awarded that….gave evidence with others at a parliamentary review into maternity care, and we were asked to go as one of those services that was considered to be providing good care, and we gave our evidence there. So, I think from that time, 2004 onwards there was this perception that we had a really good service, and we were regularly reviewed and visited.'

'As a maternity service, we were considered to be very good, which is why it's been a bit of a shock, all this happening. We were considered to be very good….'

Staffing

1.48 It appears from our survey and interviews, albeit with limited staff numbers engaging, that many staff had raised concerns about safe staffing levels over a protracted period of time. Within the survey 61% of respondents said that they escalated staffing concerns but just 33% of these received an adequate response. The following six vignettes highlight some of the concerns expressed about staffing:

'…it was really clear just how difficult it was to sustain a safe level of cover…'

'I don't remember them actually saying that they needed more funding for midwifery staff, but certainly they raised staffing as an issue repeatedly.'

'I asked for a Birthrate Plus review…… which - surprise, surprise - really showed everything that we'd felt…… deficit 30 whole time [posts]…. Were your co-coordinators supernumerary? Not always, usually because of the staffing levels.'

'…the midwives, they were obviously short-staffed….. The shift leader was constantly having a patient…. When you're working on the labour ward, you sometimes couldn't get hold of the shift leader because she was in looking after a woman….. Was not supernumerary and it was really difficult.'

'….but a lot of the shifts there were like by the grace of God that one could have been me… it was scary…. it was a system issue, as in this lady needs to go and we can't get her, she can't go, there aren't enough midwives, you know. They were the issues.'

'I feel like there isn't enough of everyone to kind of go round to make sure that everybody's getting the care that they need.'

In 2018, 46% of respondents to the MatNeo survey reported concerns about poor levels of staffing.

Patient Safety

1.49 Within the staff voices survey, 62% of respondents reported they had been concerned about patient safety, with many feeling their concerns were not adequately addressed.

'T*he patient safety issues I would say they were probably more when I worked on the wards, and that was mainly again just staffing. I spent a lot of time on the antenatal ward, and the amount of times, you know, you needed to get a lady to labour ward and "no staff, no staff, I can't take her, I can't take her" or "Yes, you can bring her, but you will have to come with her", you know, leaving just one other member of staff, you know, that, that, they were the main things really, was trying to get ladies to labour ward in a timely manner. I think they would be the biggest, biggest issues I had seen really.'*

'..Nobody went out at any time wanting to harm anybody, it's just we didn't have the training and we didn't have the staff and that's how it was, unfortunately, and we didn't know any different.'

'We're not giving them the right tools here, we're not supporting them, and we're not giving them the right staffing levels.'

Caesarean section

1.50 Staff commented on the low caesarean section rate at the Trust, which was discussed in our first report. There was disagreement from the staff who contributed to the review as to whether there was a reluctance to offer caesarean section when requested. One staff member said:

'There was always a perception that we were reluctant to offer maternal request caesarean section, which wasn't true but we had a policy to arrange appointments with senior clinicians in order to fully understand the request and provide advice.'

1.51 However, a number of other staff interviewed had differing recollections on the same topic, with examples from four staff shared below:

'….and they would definitely try to avoid a caesarean section…… they were always trying to, how can you put it, try for a normal birth all the time…… it was a couple of times, I pulled the emergency bell because I had a bradycardia going on. They came in and I was actually told off for pulling the emergency bell. I thought to myself, "What's going on here?" I absolutely did not understand it. It's like, you know, they would just let things run purely because they didn't want the doctors to come in, and sometimes you could see some of the shift leaders not wanting to call the registrar in or any of the doctors in …..'

'They were always very proud of their low caesarean rates…….I personally found all the failed/attempted instrumental deliveries very difficult to deal with. I had never seen so many injuries/HIE/resuscitations from this. Nothing to be proud of.'

'I was worried with this escalation thing especially with the patients who are going with the emergency caesarean section….. when we are worried about, for example, a CTG, and they will try and try and try at the end until the baby is really poorly…..because they told me they want to keep the caesarean section really low.'

'I couldn't believe that that was still, the culture was the same – it was almost we have to do everything to get a vaginal delivery and we've got to keep the section rate low, we've got to keep the epidural rate low…….. In 2014 it was the same guys that I'd seen in early 90s', very much the same culture.'

Midwifery led units

1.52 A number of staff discussed the safety of working in the Midwifery Led Units (MLUs) and the challenges they faced. Examples from three staff are shared below:

'….that to run five midwifery-led units out of our establishment, I questioned whether our model was fit for modern-day purpose…….. but Shropshire, you know, its accolade was, "We've got five midwifery-led units". … one of the consultants described it as, you know, the MLU as being the sacred cow, and that's how it felt, that it was okay to have five midwifery-led units if we were staffing the whole organisation in the way that it needed to be done, but we weren't, and it just felt as if you'd got two completely opposite ends of the care that was being given.'

'So, I was put in this really difficult situation of knowing what to do with this woman who's booked at the consultant unit and they could have transferred her earlier. I mean, by the time I went into the room, right, I mean this woman was delivering anyway, but it was… you could say it's a near-miss really, that it was a near miss.'

'The one thing I was really struggling with was whenever the consultant unit was short-staffed, they would take MLU staff, but they wouldn't close the MLUs at that time. So some MLUs were left with one midwife available and no on-call midwife and hope that a woman didn't come in in labour because there wouldn't be a second MLU midwife to back her up and that troubled me no end. It was not a safe situation and it was a disaster waiting to happen.'

Escalating concerns

1.53 Within the survey, when asked whether they had ever raised any professional or clinical concerns, 57% responded with 'yes'. Of these, 52% said there was a clear pathway to follow to escalate professional or clinical concerns. Examples from staff are shared below:

'The culture at SaTH is that if you have done something wrong, keep it in-house and we punish you for that, you know, whether that's you're investigated or whether that's you're moved on a change list or we make your life very difficult or you end up handing your notice in because you have been almost hounded in a way to the point where you have left because of your mental health, you become more and more reluctant to speak out and that's the danger, isn't it?'

'….has actually told us off for putting in Datix, or raising critical incidents about concerns we have, because this is, [they] would describe it as whistleblowing and it's wrong….. to have significant individuals in the organisation telling you that isn't what you should do is very harmful.'

'….So I went along and was basically, yes, told that everything was, I shouldn't be raising concerns and, you know, that I didn't understand the system and that everything was fine and, you know, again just not to raise concerns. I was in tears because I was basically a rotten person and I shouldn't be upsetting the apple cart and, you know, it was irresponsible to go raising these concerns. Afterwards I was completely shocked, I actually couldn't face going in for a few days.'

'It is difficult to know where to take concerns when you have escalated through relatively senior channels and there is no improvement. A clear pathway or process would, I believe, support staff in expressing these frustrations - everyone is under immense pressure and everything is a priority however there needs to be a means of acknowledging concerns and identifying how to implement an improvement strategy irrespective of if this needs to be over a long period of time.'

'So I think we've been proportionate when we've raised concerns but most of the time people say yes, we understand, that's a valid concern, but there's no practical solution to it.'

Multidisciplinary team (MDT) working and training

1.54 Some staff were keen to share with the review team that they had positive working relationships across the multidisciplinary teams, that the Trust was a good place to work and they were focussed on giving high standards of care. When asked within the survey whether they felt the MDT works well together 87% responded with 'yes' or 'sometimes'. 37% of respondents replied that they 'rarely' or 'never' took part in MDT training, 36% said 'sometimes' and 27% 'often' and 'always'.

1.55 Some staff described fractious relationships amongst the teams that may have presented as barriers to effective communication.

'…….but there were fallings out between the Band 7s and the consultants, I remember there being arguments, maybe clashes in personality….. some of the Band 7s…., maybe weren't as much good communicators.'

'…was so arrogant and rude, you'd be afraid to ring [X} with any concerns. [X] was intimidating….. was very derogatory about midwives,… the midwives found [X] very rude and arrogant and intimidating and would prefer not to deal with [X]...'

'We would find that the doctors would walk in and just come and look at what was going on because there wouldn't be that communication from the coordinator to the doctors. You just felt like there was very much an "us and them".'

'I think bullying was rife on the maternity unit and this is part of it, that these consultants, there were one or two or even three that would intimidate the midwives and junior doctors, and make sure that they are not approachable'.

'…this collaboration of training together, it really wasn't happening'.

Improvements

1.56 Within the survey, staff were asked whether they felt there were any barriers to attempts to make improvements to the maternity service. 50% of respondents replied 'yes' and a further 25% replied 'sometimes'.

'So we're going to put that into our protocols and policies and before it was just "mañana", we'll do it tomorrow. Tomorrow never comes. There's no urgency to address or change or do anything. They'll do that and if it works for them, we'll do it. No, we have to do it. We're answerable, we're accountable'.

'I think we have always wanted to improve the services because things never, you know, they must obviously change in order to improve, you just can't carry on the same way as you are. So, as far as I was concerned, yes, there was a thirst for improvement, for learning, you know, and how we can actually change things as well'.

'I wholeheartedly believe, and I know my colleagues believe senior management ….. have been a barrier for change'.

1.57 Other staff, however, reported that continuous improvements within maternity had been made over the years and the unit had engaged with national initiatives such as customised growth charts, the maternity early warning score and 'Saving Babies Lives'. A staff member told the review team:

'Since my appointment to consultant I have been involved in, instigated and led a number of improvement projects within the maternity department. All of the projects became multidisciplinary from an early stage.'

Impact of the review on staff

1.58 Staff reported being deeply affected by the ongoing review. Some staff explained that they would decline to meet with the review team for this very reason. One of the criticisms levied at the review team was there were misconceptions regarding the culture at the Trust.

'I feel that the culture in the unit now is different, I think there's a lot of people who have struggled, and personally my health's not been good as a result of this. ..there's been a lot of people who have really struggled from a mental health point of view, physical health point of view, because of this….. there's a resolve in the unit that we will improve and get better but there's also a sadness in the unit that we've ended up where we've ended up, and I think it is quite hard for the staff who've been there a long time.'

1.59 Other members of staff told the review team:

'…there's a number of colleagues who will never recover from this…'

'From the media perspective, it feels like people like me or my colleagues are portrayed as some sort of perpetrators, villains, but actually, I do feel we should all be on the same side here, but it doesn't feel like it.'

Response to the Independent Maternity Review

1.60 Staff who spoke to the review team were generally positive about the changes they had witnessed following the publication of our first report and the maternity services improvement programme:

'I think that the lessons from this inquiry are going to be transferable to the whole NHS'. The same staff member continued: *'….so the really great thing to come out of the external review has actually been the funding to expand … and I'm really grateful for that, really, really grateful'.*

1.61 Another staff member told the review team:

'No, I really hope that things change. I hope it changes for the…..good….. It's not all bad, and for the families, first and foremost really, because it's heart-breaking to see some things on Facebook where [The] Shropshire Star have put something up and if you read the comments from public members it's horrible to see people questioning whether they're going to be safe or not, when I know that there are so many staff there, I would quite happily let them look after me and have done.'

1.62 Further staff comments included their distress at not being listened to when they had tried to raise concerns at an earlier time *'… we were all just shell-shocked. Whenever a report comes in, you read it and there are bits you identify with and I couldn't even talk. I broke down ……I remember breaking down and they were proper angry sobs, it's not just, "I'm upset because families have gone through this, clinicians have gone through this", I am angry and I am hurt and I'm angry because nobody has listened and I don't believe the change has happened quick enough and I tried to explain that.'*

'I do feel very sorry about what's happened and I've reflected a lot on what I could have done differently…'

There were a number of positive comments about the first report from a range of staff including:

'I was impressed by the report identifying the need for nationwide improvements, learning from this experience. I think there's a story there that has been identified and it will be lovely to see that being implemented more effectively, more widely.'

'I mean maybe actually we didn't know necessarily the right questions to ask, so knowing some of the right questions to ask would have been helpful. For instance, I had no idea that they didn't have an adequate anaesthetic service, so that, if you haven't got adequate anaesthetic cover for your sections, obviously you're not going to do one if you can get away with it, or think you can get away with it, and that was something I had never thought of asking. So maybe it's about actually having a national sense of exactly what we should be checking on, as commissioners, so that we're not falsely reassured.'

'….it was shocking and very upsetting to see that those things hadn't come to light during the time that I thought that we were doing as good a job as we could at understanding what was going on in the services that we commissioned.'

Conclusions

1.63 This engagement strategy reached out to staff through liaising directly with the Trust and through social media platforms and local media reporting. We are extremely grateful to the staff who have been willing to share their experiences as we appreciate how difficult it has been to make that decision. Some expressed feelings of guilt at speaking with us and many were tearful as they recalled individual experiences and what they had observed in dealing with other colleagues and within their service over many years.

1.64 The members of staff who engaged with us really matter and their voices must be heard. They speak about the culture and raising concerns but not being heard. They speak about trying to do things to the best of their ability without the necessary frameworks in place that would enable them to learn from any errors made. What they say is supported by what we have seen throughout this review- that maternity services within the Trust had poor governance systems for a long time, which allowed it as an individual service to develop its own systems in isolation without effective internal and external surveillance.

1.65 We cannot underestimate the toll on staff of being under constant intense scrutiny. We met staff who were deeply affected by what had happened in their service. However, many of the staff who engaged with us stated that they were adamant to learn and do all they could to ensure their maternity services were safe for the families in Shropshire.

LOCAL ACTIONS FOR LEARNING: HEARING THE VOICES OF STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

1.66 The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service as illustrated by the results of the 2018 MatNeo culture survey and the recent feedback from current staff.

Appendix 2: Immediate and Essential Actions from our first report

Immediate and Essential Actions to improve care and safety in maternity services as outlined in our first report

1: ENHANCED SAFETY	
Essential Action Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	• Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. • External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. • LMS must be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them. • An LMS cannot function as one maternity service only. • The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda. • All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.

2: LISTENING TO WOMEN AND FAMILIES

Essential Action

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.
- CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.

3: STAFF TRAINING AND WORKING TOGETHER

Essential Action

Staff who work together must train together.

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

4: MANAGING COMPLEX PREGNANCY

Essential Action

There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead.
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.
- The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.
- This must also include regional integration of maternal mental health services..

5: RISK ASSESSMENT THROUGHOUT PREGNANCY

Essential Action

Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

6: MONITORING FETAL WELLBEING

Essential Action

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

- The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:
  - Improving the practice of monitoring fetal wellbeing
  - Consolidating existing knowledge of monitoring fetal wellbeing
  - Keeping abreast of developments in the field
  - Raising the profile of fetal wellbeing monitoring
  - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported
  - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on he review of cases of adverse outcome involving poor FHR interpretation and practice.
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

7: INFORMED CONSENT

Essential Action

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

- All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care
- Women must be enabled to participate equally in all decision making processes and to make informed choices about their care.
- Women's choices following a shared and informed decision making process must be respected.

Appendix 3: Glossary of terms

Definitions and medical and midwifery terms used throughout our report

Abruption	Is the early separation of a placenta (afterbirth) from the lining of the uterus before completion of the second stage of labour. It is one of the causes of bleeding during the second half of pregnancy.
Abscess	Collection of pus
Absent End-Diastolic Flow	Is a useful feature which indicates underlying fetal vascular stress if detected in mid or late pregnancy
Acidaemia	A condition of raised blood acidity
Acute respiratory distress syndrome (ARDS)	A life-threatening lung injury that allows fluid to leak into the lungs. Breathing becomes difficult and oxygen cannot get into the body
Advanced neonatal nurse practitioners (ANNP)	Introduced to undertake the Tier 1 duties on the neonatal rota, jointly shared with ST1 - 3s. The post holders practice at a senior practitioner level to provide autonomous clinical care
Anomalous Left Coronary Artery to Pulmonary Artery (ALCAPA)	A very rare form of congenital heart disease
Amniocentesis	A medical procedure to obtain a small amount of amniotic fluid that is used to further investigate suspected fetal chromosomal abnormalities
Amnio-infusion	Refers to the instillation of fluid into the amniotic cavity
Amniotic Fluid Embolism	A rare condition where the amniotic fluid – which surrounds and protects a baby inside the womb – can leak into the mother's blood vessels during labour, causing a blockage. This can lead to breathing problems, a drop in blood pressure and loss of consciousness. A small number of women survive amniotic fluid embolism with risks of long-term complications including neurological problems because of a lack of oxygen to the brain, however most women do not survive
Amniotomy	Artificial rupture of the membranes (ARM)
Anaemic	Lack of enough red blood cells to carry adequate oxygen to the body's tissues
Antepartum	The period of pregnancy that includes the 24th week of pregnancy until birth

Antihypertensive medication	Drugs used to control high blood pressure
Apgar score	This is an accepted method of assessing how a newborn baby has adapted to extrauterine life, immediately following birth
Augmentation of labour	Is the process of increasing the frequency, length and strength of uterine contractions after the onset of labour either by intravenous oxytocin infusion and/ or artificial rupture of membranes. It can be used to increase uterine contractions when they are reduced, particularly during prolonged labour and facilitate cervical dilatation and vaginal birth
Auscultation	A method of periodically listening to the fetal heart with a stethoscope
Arachnoid cyst	Benign cyst in the brain
BCH	Birmingham Children's Hospital
Birthing centre	A birth centre staffed by midwives, they may be "stand alone", (some distance from a consultant-led unit) or alongside, often in the same building/ on the same floor as a consultant-led unit.
Birthrate Plus® (BRP)	Is a method for assessing the needs of women for midwifery care throughout pregnancy, labour and the postnatal period in both hospital and community settings. From the data collated, the methodology calculates the number of midwives required to meet the defined standards and models of care whilst informing local workforce requirements, holiday and travel allowances etc
BLISS	A charity for babies born premature or sick
Born Before Arrival (BBA)	Refers to a birth which takes place before arrival to a maternity unit, or a homebirth before the arrival of a midwife
Bougie	A small wire over which a breathing tube can be passed in difficult airways
British Association of Perinatal Medicine (BAPM)	Is a professional association and registered charity. They aim to improve standards of perinatal care by supporting all those involved in perinatal care to optimise their skills and knowledge, deliver and share high quality safe and innovative practice, undertake research, and promote the needs of babies and their families
Cabergoline	A drug used to suppress lactation (milk production).
Caesarean hysterectomy	Hysterectomy (surgical removal of the womb) at the time of, or soon after, delivery by caesarean section

CAF	Common Assessment Framework is a tool designed to help practitioners working with children, young people and families to assess children and young people's additional needs and strengths for earlier, and more effective services, and develop a common understanding of those needs and how to work together to meet them
Cardiopulmonary	Relating to the heart and lungs
Cardiotocograph (CTG)	A technical means of recording the fetal heart rate and the uterine contractions during pregnancy and labour
Care Quality Commission (CQC)	An executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England
Category 1 caesarean section	Is when there is immediate threat to the life of the woman or fetus and delivery is recommended within 30 minutes
Category 2 caesarean section	Is when there is maternal or fetal compromise which is not immediately life-threatening and delivery is recommended within 75 minutes.
Catheter	Tube (usually to drain the bladder)
CBT	Cognitive Behavioural Therapy
CDH	Congenital diaphragmatic hernia, a serious congenital anomaly where some of the bowel lies within the chest and causes breathing difficulties
CEMACH	Confidential Enquiry into Maternal and Child Health
Cerebral Palsy	Is caused by a problem within the brain that develops before, during or soon after birth. Cerebral Palsy affects movement and coordination
Clinical Commissioning Groups (CCG)	Were established as part of the Health and Social Care Act in 2012, and consist of groups of general practices (GPs) which come together in each area to commission the best services for their patients and population
Clinical Negligence Scheme for Trusts (CNST)	An insurance scheme administered by NHS Resolution (NHSR) in which individual NHS organisations pay an annual premium to mitigate against the cost of clinical negligence claims. Trusts which achieve standards set by the scheme receive a reduction in premiums
Chorioamnionitis	A serious condition in pregnant women in which the membranes that surround the fetus and the amniotic fluid are infected by bacteria. It can also cause serious complications in the newborn baby. This includes infection (such as pneumonia or meningitis), brain damage, or death

Coagulopathy	Coagulopathy is often broadly defined as any derangement of haemostasis resulting in either excessive bleeding or clotting, although most typically it is defined as impaired clot formation
Colloid fluid	Non-crystal fluid used as a temporary substitute for blood
Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI)	Was created to improve the understanding of the causes of death in late fetal life (from 20 weeks post-conception) to infancy (one year after birth). CESDI created a standardised grading system to categorise mortality reviews and identify cases of suboptimal care
Consultant-led Unit (CU)	Refers to a maternity unit which has the support of obstetricians and midwives to facilitate high-risk care during the antenatal, intrapartum or postnatal period. Consultant-led units also require the support of the wider multi-disciplinary team including (but not limited to) anaesthetists, theatres and a neonatal team
Consultant obstetric unit	A place to give birth staffed by obstetricians, midwives and anaesthetists. They have a neonatal unit staffed by neonatologists and nurses
Continuous Positive Airway Pressure (CPAP)	It is a type of non-invasive ventilation (NIV) or breathing support
Cooling	Therapeutic hypothermia is an effective way to treat newborn babies who have experienced a lack of oxygen and/or blood flow to the brain and other organs before or during labour and delivery. Reducing a baby's body temperature to 33.5oC to protect the brain
Cord prolapse	Happens when the umbilical cord slips down in front of the baby after the waters have broken. The cord can then come through the open cervix (entrance of the womb)
Counselling	Professional guidance and discussion to support complex choices with families that ensures sharing of evidenced-based information to enable informed decision and personalised care
CPR	Cardio pulmonary resuscitation (chest compressions and breaths)
Critical care unit	Intensive care or high dependency care unit
CRP	C-reactive protein. A marker of infection or inflammation
Crystalloid	A solution of water and salts for intravenous administration
Culture	Organisational culture represents the shared ways of thinking, feeling, and behaving in healthcare organisations

Diaphragmatic Hernia	Diaphragmatic hernia is a birth defect where there is a hole in the diaphragm
DATIX	An incident reporting form
Dichorionic, diamniotic (DCDA) twins	Each has their own separate placenta with its own separate inner membrane (amnion) and outer membrane (chorion)
Direct Maternal Deaths	Are defined as those related to obstetric complications during pregnancy, labour or puerperium (six weeks) or resulting from any treatment received.
Deflexed occipito-posterior position	Poor position of the fetal head
Diuretics	Drugs used to increase urine production
Doppler assessment	Assessment of the blood flow in various fetal blood vessels, commonly the umbilical vessels or the middle cerebral artery (MCA)
Dual instruments	There are two main instruments used in operative deliveries – the ventouse and the forceps. In general, the first instrument used is the most likely to succeed. Dual instrumentation describes both types of instruments being used to perform an operative vaginal delivery
Duty of candour	Legislation to ensure that providers are open and transparent with people who use services. It sets out some specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
Each Baby Counts	A national quality improvement programme set by Royal College of Obstetricians and Gynaecologists (RCOG) to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. This improvement programme is now closed
Eclamptic fit	A fit occurring as a consequence of severe pre-eclampsia
E. Coli	A bacterium that can cause infection
EMDR	Eye Movement Desensitisation and Reprocessing
Empyema	Pus in a body cavity
Endometritis	Infection within the uterus (womb)
Escalate	To become more important or serious, or to make something or someone do this.
Executive Director	A member of a board of directors who also has managerial responsibilities
Extended perinatal death	A stillbirth or neonatal death

External Cephalic Version (ECV)	Is a process by which a breech baby can sometimes be turned from buttocks or foot first to head first. It is a manual procedure that is recommended by national guidelines for breech presentation of a pregnancy with a single baby, in order to enable vaginal delivery
Extradural haematoma	A sub-periosteal haematoma located on the inside of the skull, between the inner table of the skull and parietal layer of the dura mater (which is the periosteum)
Extubation	Removal of an artificial breathing tube from a baby's airway
EUA	Examination under anaesthetic
Faecal incontinence	Lack of bowel control
Fetal blood sampling (FBS)	Is a procedure to take a small amount of blood from an unborn baby (fetus) during pregnancy. FBS should be advised in the presence of a pathological fetal heart rate (FHR) trace unless there is clear evidence of acute compromise (i.e. immediate delivery is thought necessary)
Fetal bradycardia	Fetal heart rate of less than 120 beats per minute
Fetomaternal haemorrhage	The entry of fetal blood into the maternal circulation before or during delivery
Fibroids	A benign tumour of muscular and fibrous tissue which develops in the wall of the uterus
Footling breech	Is when one or both of the baby's feet are born first
Forceps	An instrument shaped like a pair of large spoons which are applied to the baby's head in order to guide the baby out of the birth canal
Fresh eyes assessment	Refers to a "buddy system" of CTG review to improve interpretation and documentation
Funisitis	Inflammation of the connective tissue of the umbilical cord that occurs with chorioamnionitis
Furosemide	A drug that promotes removal of fluid from the body by production of urine, a diuretic
GAP	The Growth Assessment Protocol: a national programme to improve patient safety in maternity care
Gastroschisis	A defect of the abdominal wall where intestines are found outside of the baby's body, exiting through a hole alongside the umbilicus (belly button)
General Medical Council (GMC)	A statutory body with the purpose to protect, promote and maintain the health and safety of the public by working to protect patient safety and support medical education and practice across the UK. The GMC works with doctors, employers, educators, patients and other key stakeholders in the UK's healthcare systems

Governance	The way that organisations are managed at the highest level, and the systems for doing this. Clinical governance can be defined as a framework through which the National Health Service (NHS) organisations and their staff are accountable for continuously improving the quality of patient care. NHS staff need to ensure that the appropriate systems and processes are in place to monitor clinical practice and safeguard high quality of care
GROW Chart	Customised antenatal charts for plotting fundal height and estimated fetal weight
Growth retardation	Growth significantly less than expected
Grunting/grunty	An abnormal noise made by a newborn baby with breathing issues
Guedel airway	A device placed in the mouth to keep the airway open
Haematoma	Blood clot (not in a blood vessel)
Haematologist	A doctor specialising in disorders of the blood
Haematuria	Blood in the urine
Haemodynamic	Relating to the flow of blood
Haemoperitoneum	Blood in the abdominal cavity
Hb	Haemoglobin level i.e. assessment of anaemia
HDU	High Dependency Unit
Healthcare Commission (HCC)	The Commission for Healthcare Audit and Inspection, also known as the Healthcare Commission was created in 2004. It was responsible for assessing standards of care provided by the NHS. Its responsibilities were taken over by the Care Quality Commission in 2009
Headbox oxygen	An oxygen hood or head box is used for babies who can breathe on their own but still need extra oxygen. A hood is a plastic dome or box with warm, moist oxygen inside. The hood is placed over the baby's head
HELLP	Haemolysis (of red blood cells): Elevated Liver (enzymes): Low Platelets. HELLP is a syndrome that occurs with serious pre-eclampsia, and indicates severely deteriorating organ function
High frequency oscillatory ventilation (HFOV)	An advanced form of respiratory support
Hypoxic ischemic encephalopathy (HIE)	Refers to the damage caused in a baby's brain when the baby does not receive enough oxygen and / or blood flow around the time of birth, or during pregnancy. Graded into HIE grades 1-3 depending on severity
High Risk Case Review (HRCR)	An internal process used in Shrewsbury and Telford Hospitals NHS Trust over the period of this review created to investigate incidents which were said to not meet the threshold for being a Serious Incident

The Healthcare Safety Investigation Branch (HSIB)	They investigate incidents that meet the Each Baby Counts criteria and their defined criteria for maternal deaths *www.hsib.org.uk/maternity/what-we-investigate/*
Higher Specialist Trainee (HST)	Middle grade, or Tier 2 doctor, registrar
'Hub and Spoke' Model	Refers to a specific type of service model design consisting of a main base supported by additional bases or branches. In maternity services, the hub is the consultant-led unit and the spokes are midwiferyled units or community bases
Human factors	Refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety
Humerus	The long bone in the arm
Hydronephrosis	Swelling of the system that collects urine from the kidney, usually because of obstruction lower down the renal tract
Hypercalcaemic	High calcium levels in the blood
Hyperinsulinism	Excessive secretion of insulin, leading to low blood sugar
Hypertension	High blood pressure
Hypotension	Low blood pressure
Hypotensive	Abnormally low blood pressure
Hypothermic cooling	Involves cooling the baby down to a temperature below homeostasis to allow the brain to recover from a hypoxic-ischemic injury
Hypovolaemia	Low blood volume, usually secondary to blood loss
Hypoxia/Hypoxic	Is a state in which oxygen is not available in sufficient amounts at the tissue level to maintain adequate homeostasis; this can result from inadequate oxygen delivery to the tissues either due to low blood supply or low oxygen content in the blood (hypoxemia)
Indirect Maternal Deaths	Are those associated with a disorder, the effect of which is exacerbated by pregnancy
Indices of Deprivation	Are datasets used to classify levels of deprivation within small areas. Deprivation rates are measured by the assessment of various factors including income, employment rates, education, housing and crime
Inflammatory markers	Substances that can be measured in blood tests that, when elevated, indicate that there is inflammation occurring within the body
Infused	Given intravenous fluid (not blood)
Inotropes	Intravenous medication to treat very low blood pressure

International Normalised Ratio (INR)	A blood test/ calculation which assesses the time taken for blood to clot
Intermittent auscultation (IA)	The technique of listening to and counting the fetal heart rate (FHR) for short periods during active labour
Instrumental delivery	An assisted birth (also known as an instrumental delivery) is when forceps or a ventouse suction cup are used to help deliver the baby
Intrapartum	During labour
Intrauterine death (IUD)	Also called stillbirth: An unborn baby dies inside the womb before birth. This is described as 'late' when it happens in a woman who is 24 weeks pregnant or more, and is estimated to occur in 1% of all pregnancies
Intraventricular Haemorrhage (IVH)	Bleeding inside or around the ventricles within the brain
ITU	Intensive therapy (care) unit
Intubation	Placing a breathing tube in a baby's airway to assist ventilation
Intraventricular haemorrhage (IVH)	Bleeding into the fluid cavities within the brain, usually in preterm babies
Ketonuria	Occurs when high levels of ketone bodies which occur when cells are broken down for energy are present in the urine
KIDS-NTS	Children's and Neonatal Transport team for the West Midlands
Labour ward coordinator	Senior midwives who coordinate the clinical workload and activity on the labour ward
Laparotomy	Surgical opening of the abdomen
Laryngeal mask	A device placed in the airway instead of intubation
Liquor	The water surrounding the baby in the womb
Left ventricular failure	When the left side of the heart is unable to pump blood to the body effectively such that it is insufficient for the body's needs
Level 3 neonatal unit	Neonatal units are graded 1-3, 3 being equipped to care for the most pre-term and unwell infants requiring the highest levels of investigation and treatment
LMNS	Local Maternity and Neonatal System
LNU	Local Neonatal Unit (formerly known as level 2 neonatal unit)
Local Authority	Refers to an organisation within local government which is responsible for public services and facilities.

Local Maternity System (LMS)	The Local Maternity Systems are the mechanism through which it is expected that a Sustainability and Transformation Partnership (STP) will collaboratively transform maternity services with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes for women and their families. The LMS's are overseen by the Maternity Transformation Board
Local Supervising Authority Midwifery Officer (LSAMO)	A senior officer who was responsible for upholding the standards of statutory midwifery supervision at a regional level. Statutory supervision was abolished in 2017
Local Supervisory Authority (LSA)	This organisation was responsible for the function of statutory supervision of midwives. The LSA was accountable to the Nursing and Midwifery Council (NMC) which set rules and standards for midwifery. This authority was disbanded when Supervision of Midwifery was abolished
Loculated empyema	Pockets of pus that have collected inside a body cavity
LSCS	Lower segment caesarean section
Lower specialist trainee (LST)	Tier 1 doctor or Senior House Officer
Macrosomic	A newborn baby that is much larger than expected
Magnesium infusion	Drip used to decrease the risk of an eclamptic fit
Malpositioned baby	Usually the fetal head engages in the occipito-anterior position (more often left occipito-anterior (LOA) rather than right) and then undergoes a short rotation to be directly occipito-anterior in the mid-cavity. Malpositions are abnormal positions of the vertex of the fetal head relative to the maternal pelvis
Maternal death	Defined as the death of a woman while pregnant or within 42 days of termination of pregnancy
Maternity Dashboard	Is a tool which can be used within clinical governance to benchmark activity, and to monitor quality and performance indicators such as birth complications and mode of delivery
Maternity and Neonatal Collaboration	The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England
Maternity Transformation Programme	The purpose of the Maternity Workforce Transformation Strategy is to support NHS maternity services to deliver more personalised and safer care and improve outcomes for women by ensuring that there is the capacity in the workforce nationally

Maternity Voices Partnerships (MVP)	A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care
Mat Neo collaborative	The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. A national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths
MDT	Multi-disciplinary Team
Meconium	Baby's bowel contents in the liquor (water) which sometimes suggests fetal distress (thick meconium is more likely to suggest this)
MEWS or MEOWS	An early warning score or guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs. The MEOWS is a Modified Early Obstetric Warning System
Midwife-led units (MLU)	Are another name for birth centres that are run by midwives and have a home-like environment. They are most suitable for women without complications and can be next to a hospital maternity unit ('alongside') or situated in the community ('freestanding')
Midwifery Continuity of Carer (MCoC)	Midwifery continuity of care is a model of care, which aims to limit the number of different healthcare professionals a woman sees throughout her pregnancy. Its aim is that the pregnant woman will receive intrapartum care from a midwife she has met previously during her current pregnancy, thereby providing greater continuity
Mifepristone	A drug used to prepare the uterus (womb) for early contractions usually induced by another drug given approximately 36 hours later
Monochorionic twins	Twins sharing the same blood supply from the placenta. This can lead to unequal sharing of the blood supply which can lead to the death of one or both twins
Moulding	The bones of the fetal head can move closer together or overlap to help the head fit through the pelvis.
MRI scan	Magnetic Resonance Imaging –detailed scan, often of the brain
Multiparous	A woman who has given birth once or more

Multidisciplinary team	Is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended care. In maternity this tends to be midwives, obstetricians, anaesthetists and neonatologists
Myelomeningocele	A form of spina bifida where the spinal cord is exposed at birth. This is when a sac of fluid comes through an opening in the baby's back. Part of the spinal cord/ nerves can be in the sac and are damaged
Neonatal Data Analysis Unit (NDAU)	Analyses neonatal data nationally
National Reporting and Learning System (NRLS)	Is a central database of patient safety incident reports
Neonate	Refers to an infant in the first 28 days after birth
Neonatal death	An infant who dies in the first 28 days of life • Early neonatal death - a live born baby who died before 7 completed days after birth • Late neonatal death - a live born baby who died after 7 completed days but before 28 completed days after birth
Neonatal Networks	A network of neonatal units working together to provide neonatal care to a geographical area. Also knows as 'managed clinical networks' or 'operational delivery networks'
NHS England and NHS Improvement (NHSE&I)	The body that leads the NHS in England
NHS Litigation Authority (NHSLA)	The NHS Litigation Authority (NHSLA), now known as NHS Resolution (NHSR), manages negligence and other claims against the NHS in England on behalf of its member organisations. Its aim is to help resolve disputes fairly; share learning about risks and standards in the NHS and help to improve safety for patients and staff
NHS Resolution	A body of the Department of Health and Social Care. It provides expertise to the NHS on resolving concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care
National Institute for Health and Care Excellence (NICE)	Provides national guidance and advice to improve health and social care
NICHE	An independent consultancy service available to all healthcare providers (including mental health, acute, specialist, ambulance, primary and community), social care partners, commissioners, local authorities and regulatory organisations
NICU	Neonatal intensive care unit
NLS	Newborn Life Support Course (national training course)

NMR	Neonatal mortality rate (deaths within 28 days of life)
National Neonatal Audit Project (NNAP)	National audit of neonatal outcomes
NNU	Neonatal unit
Non-Executive Director (NED)	A board member without responsibilities for daily management or operations of the organisation
NQM	Newly qualified midwife of less than one year since becoming a professional registrant.
Nulliparous	Describes a mother who has not given birth before
Nursing and Midwifery Council (NMC)	The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
Occipito posterior position	Common malpresentation in labour, which can be associated with a prolonged labour
Oedema	Accumulation of fluid in bodily tissues
Office of National Statistics (ONS)	Is responsible for collating and publishing statistics relating to health, economy, population and society at local, regional and national levels
Open Book	The cases identified by the Open Book arose from the Shrewsbury and Telford Hospital NHS Trust (supported by NHSI) undergoing its own investigation of cases of stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3) and maternal deaths. These were then reported to the review team
Operative delivery	Refers to a delivery in which the operator uses forceps, a vacuum, or other devices to extract the fetus from the vagina, with or without the assistance of maternal pushing
Operative vaginal delivery	Vaginal birth assisted with forceps or ventouse
Organisational structure	The way in which a large company or organisation is organised, for example, the types of relationships that exist between managers and employees
Oscillator	A form of high frequency ventilatory support that keeps the lungs open with a constant positive end-expiratory pressure
Oxygen saturation	Concentration of oxygen carried in the blood
Oxytocin	A hormone commonly used in obstetric practice to increase uterine activity
Paediatric	Branch of medicine that is dealing with infants, children and adolescents
Parliamentary and Health Service Ombudsman (PHSO)	An organisation which works with individuals and groups in an organisation to explore and assist them in determining options to help resolve conflicts, problematic issues or concerns, and to bring systemic concerns to the attention of the organisation for resolution

PCT	Primary Care Trust
Perinatal	The period of time that includes the entirety of pregnancy up until and including the first complete year following birth
Perinatal death	A stillbirth or early neonatal death
Perineal tear	A tear occurring during childbirth. 1st and 2nd degree tears are common, and not serious. A 3rd degree tear involves the anal sphincters as well as skin, vagina and muscle. A 4th degree tear extends into the rectum
Perineal follow-up clinic	A clinic to follow-up women who have experienced 3rd and 4th degree tears
Perinatal loss	Loss of a baby during pregnancy or soon after birth. Includes stillbirths and neonatal deaths
Peritoneum	The membrane which lines part of the abdominal cavity and covers the organs that lie within it
Placental	Reference to the 'afterbirth'
Placental abruption	When the placenta separates from the uterine wall either before or during labour
Placenta accreta	Abnormally deep attachment of the placenta into the muscle of the uterus (womb)
Perinatal mortality rate (PMR)	Stillbirths and deaths within 7 days of life
Post-partum haemorrhage (PPH)	Significant bleed after giving birth
Post-partum	After the birth
Pre-eclampsia (PET)	A condition that affects some pregnant women, usually during the second half of pregnancy (from 20 weeks) or soon after their baby is delivered. Early signs of pre-eclampsia include having high blood pressure (hypertension) and protein in the urine (proteinuria). The condition can be very serious for mother and baby
Pre-labour preterm rupture of membranes (P-PROM)	Is the rupture of membranes prior to the onset of labour, in a patient who is at less than 37 weeks of gestation
PRH	Princess Royal Hospital- Telford- current location of neonatal service
Primary Care Trust (PCT)	Were part of the National Health Service in England from 2001 to 2013. PCTs were responsible for commissioning primary, community and secondary health services from providers. Primary care trusts were abolished on 31 March 2013 as part of the Health and Social Care Act 2012, with their work taken over by Clinical Commissioning Groups (CCGs)
Primiparous or Primigravid	A woman who is pregnant for the first time

Professional Midwifery Advocates (PMAs)	Support midwives to ensure that women and babies receive good quality, safe care
Prophylactic	Intended to prevent something occurring by being given early – for example a medication
Prostaglandin	A synthetic hormone that is used in obstetrics to encourage uterine contractions and cervical ripening (Shortening and dilatation)
Proteinuria	Protein detected in a urine sample
Pulmonary	Relating to the lungs
Pulmonary oedema	An excess of watery fluid in the lungs
Pyelonephritis	Severe kidney infection
Pyrexia	High temperature
Qualified in Speciality (QIS)	Postgraduate specialist training for neonatal nurses
Royal College of Midwives (RCM)	A professional organisation and trade union committed to serving midwifery and its workforce
Royal College of Obstetricians & Gynaecologists (RCOG)	Professional body of obstetricians to improve healthcare for women everywhere, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women's healthcare worldwide
RCPCH	Royal College of Paediatrics and Child Health
Respiratory Distress Syndrome (RDS)	Breathing difficulty, usually in preterm babies due to immature lungs
Retained products	Pieces of placenta and/or membrane left in the uterus (womb) after delivery of the placenta (afterbirth)
Retropubic haematoma	Blood clot formed behind the pubic bone
Rectovaginal fistula	An abnormal channel that has developed between the rectum and vagina usually as a consequence of childbirth
Rectus sheath haematoma	Blood clot caused by bleeding from the rectus abdominus muscle (i.e. abdominal wall muscle)
Risk Management Strategy	The systematic identification, assessment and evaluation of risk. Used properly in healthcare, it can not only be a process to report incidents, but also minimise the harm that clinical or resourcing errors can cause to patients and staff
Root Cause Analysis (RCA)	Is the process of examining what happened in order to establish, how and fundamentally why an adverse event occurred. It should result in preventative measures to minimise future risk of reoccurrence.
RSH	Royal Shrewsbury Hospital – former location of neonatal service
SANDS	Stillbirth and neonatal death support charity

SaTH	Shrewsbury and Telford Hospital or NHS Trust or the Trust
Situation, Background, Assessment and Recommendation (SBAR)	An easy to use, structured form of communication that enables information to be transferred accurately between individuals
SBR	Serum bilirubin – to determine the level of jaundice in a baby
Serious Incidents (SI)	Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in unexpected or avoidable death, serious harm or injury. Serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Previously known as Serious Untoward Incidents (SUI)
Sepsis	Severe infection
Septicaemia	Blood poisoning
Shock	Fall in blood perfusing organs, usually recognised because of a fall in blood pressure and a rise in heart rate. Shock has a number of possible causes, blood loss being the most common in maternity patients
Shoulder dystocia	Shoulder dystocia is when a baby's head has been born but one of the shoulders becomes stuck behind the mother's pubic bone, delaying the birth of the baby's body
Situational awareness	Can be defined simply as 'knowing what is going on around us', or – more technically – as 'the perception of the elements in the environment within a volume of time and space, the comprehension of their meaning and the projection of their status in the near future'
Spina Bifida	A condition that affects the spine and is usually apparent at birth. It is a type of neural tube defect (NTD)
Squamous epithelial cells in the pulmonary vessels	Cells from the baby found in the lung vessels of the mother
SSCBCN	Staffordshire, Shropshire and Black Country Neonatal Network
SSCBCODN	Staffordshire, Shropshire and Black Country Operational Delivery Network
Stillbirth	A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks. An antenatal stillbirth occurs at or prior to the onset of labour. An intrapartum stillbirth occurs after the onset of labour

Subarachnoid haemorrhage	Bleeding in the space between the brain and the skull
Surfactant	A medicine given directly into the lungs of premature babies
Symphysis fundal height	A measurement from the Symphysis Pubis to the top of the fundus (womb) that monitors fetal growth
'T' incision	When the cut made on the uterus is both horizontal and vertical. The subsequent scar is weak, and therefore there is a greater risk of uterine rupture in a future pregnancy
Tachycardia	Fast heart rate
Talipes	A condition affecting one or both feet that is caused by a shortened Achilles tendon or as a result of fetal lie within the womb. Usually self-resolving with exercise or physiotherapy, but in some cases requires further intervention
Tethered Conus	Neurological condition where the end of the spinal cord is fixed by tissue attachments at the bottom of the spinal canal rather than moving freely
Therapeutic lactation suppression	Use of drugs to suppress milk production
Thermoregulate	Whereby the body maintains its core temperature
Third or fourth degree perineal tear	A perineal tear which involves damage to the fourchette, perineal skin, vaginal mucosa, muscles, and anal sphincter
Thrombosis	Blood clot in a blood vessel, usually in a vein
TOBY registry	A national register of babies that received cooling for HIE
Tocophobia	Is a pathological fear of pregnancy and can lead to avoidance of childbirth
Transfused	Given a blood transfusion
Transport team	A specialist service for safely transferring babies between care providers
Trial of instrumental birth	A term used when a difficult instrumental birth is anticipated, usually performed in an operating theatre with quick and easy recourse to caesarean section
Twin to twin transfusion syndrome (TTTS)	Is a rare condition that occurs during a twin pregnancy when blood moves from one twin (the 'donor twin') to the other (the 'recipient twin') while in the womb
UHNM	University Hospitals of North Midlands (Royal Stoke University Hospital)
Ureter	Tube down which urine passes from the kidney to the bladder
Ureteric obstruction	Blockage of the ureter

Urologist	A doctor specialising in disorders of the urinary tract
Uterine artery	Main artery (but not only artery) supplying blood to the uterus (womb)
Uterine rupture	When the uterine wall bursts, this usually occurs during labour, but can occur during pregnancy. Uterine rupture generally occurs when the uterus has a previous scar. Some types of scar, increase the risk of rupture in future pregnancies
Urinary PCR	Protein/creatinine ratio in the urine to measure the level of protein more accurately than a dipstick assessment
Ventouse delivery	A suction cap is applied to the baby's head in order to deliver the baby through the birth canal
WMNODN	West Midlands Neonatal Operational Delivery Network

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Hearing the voices of staff

Provided to the review team by the Trust

Appendix 5: Terms of reference (TOR)

Original terms of reference as of May 2018

An independent review of the quality of investigations and implementation of their recommendations relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospitals (the Trust).

The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry (subject to receiving consent from the families).

Background

This review follows a number of serious clinical incidents, beginning with a new born baby who sadly died in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. In subsequent years from 2009 until 2014 a number of further investigations and reviews (internal and external) were also undertaken to confirm whether:

- Appropriate investigations were conducted and
- The assurance processes relating to investigations in the maternity service were adequate.

In response to these previous reviews a comprehensive maternity service improvement action plan was put in place by the Trust. The progress of the implementation of the recommendations from these previous reviews has been monitored on a continual basis by the Trust Board. The action plan was devised with input from the parents of the baby who died in 2009. The parents have received ongoing communication in regard to the progress and implementation of actions identified within the plan.

Scope and purpose of this latest independent review

The independent review will be undertaken by a multidisciplinary **REVIEW TEAM** of independent external reviewers who will submit their findings to an **INDEPENDENT REVIEW PANEL**.

The **REVIEW TEAM** will comprise:

- Two midwives
- Two obstetricians
- Two neonatologists

The multidisciplinary **REVIEW TEAM** will undertake to:

- Review only those cases for which consent is granted to access the records pertaining to the case;
- Review the quality of the investigations and subsequent reports into the identified cohort of incidents;
- Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;
- Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;
- Consider how the parents, patients and families of patients were engaged with during these investigations;
- Reserve the right to undertake a second-stage review of primary cases should the considerations

above justify such action following agreement with the Executive Medical Director NHS Improvement and

- Present their findings of the review of each case to the REVIEW PANEL for challenge and quality assurance monitoring.

The **INDEPENDENT REVIEW PANEL** will undertake to:

Receive and quality assure the **REVIEW TEAM's** findings in each case reviewed;

- Under the leadership of the chair, develop the report of the findings of the review and
- Actively engage and communicate with families relevant to the specified cases, where they have expressed a preference for such engagement, in particular around the review's findings and recommendations.

In addition the **INDEPENDENT REVIEW TEAM** will assess the extent to which the Trust had appropriate arrangements in place for the oversight and governance of the incidents and the reporting mechanisms to the Trust Board.

The review process will comprise:

- A review of all the investigations in the cohort including but not limited to root cause analysis (RCAs), preliminary fact finding reviews, supervisory investigations and associated action plans from each incident investigation. All will be reviewed in relation to the then contemporaneous Trust policy and National Guidance;
- A review of the relevant / associated improvement plan and pace of improvement against the timelines identified in the plan and
- Contact with parents or relatives to establish their understanding of their involvement in previous investigations.

The **REVIEW TEAM** and **REVIEW PANEL** will be provided with direction in relation to the conduct of the review to ensure that there is consistency in the approach to reviewing each case. The **REVIEW TEAM** and **REVIEW PANEL** will give due consideration to the application of relevant policies and procedures that were in place both nationally and locally at the time of the incident, as well as during the subsequent investigation process.

If the **REVIEW TEAM** or **REVIEW PANEL** identifies any material concerns that need further immediate investigation or review, the NHS Improvement Executive Medical Director must be notified immediately.

The **REVIEW PANEL** will provide a report and recommendations of any actions required to Dr Kathy McLean, Executive Medical Director, NHS Improvement.

The Review Panel

The **REVIEW PANEL** will be chaired by an independent chair, appointed by NHS Improvement and supported by a panel of experienced clinicians and stakeholders with expertise in maternity services or governance and assurance processes.

The **REVIEW PANEL** will comprise:

- An NHS Improvement-appointed independent chair
- An NHS Improvement-appointed Director of Midwifery from outside the region
- A Senior Quality Manger from NHS Improvement
- An external independent midwife
- An external consultant obstetrician
- An external consultant paediatrician/ neonatologist
- NHS England midwifery representative from outside the region.

Key Principles

The review will be expected to:

- Engage widely, openly and transparently with all relevant parties participating in the review process;
- Be respectful when dealing with individuals who have been impacted by the incidents being investigated;
- Adopt an evidence-based approach;
- Acknowledge the importance of inter-professional cooperation in achieving good outcomes for women and children;
- Consider links to the time relevant national policy and best practice in relation to midwifery and investigation management and
- Consider the implementation challenges of proposals including the workforce.

Timeframe

The final review report and proposals should ideally be available within one month of the review being completed.

Directions to the REVIEW TEAM and REVIEW PANEL in relation to the conduct of the review:

1. Did the Trust have in place at the time of each incident mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?
2. Were incidents and investigations reported and conducted in line with the time relevant national and Trust policies?
3. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?
4. Were families involved in the investigation in an appropriate and sympathetic way?

Appendix 6: Revised terms of Reference (TOR)

Revised Terms of Reference - November 2019

1. This document sets out the revised Terms of Reference for the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, which was commissioned in 2017 by the Secretary of State for Health. These updated Terms of Reference reflect changes to the scope of the review.
2. The original Terms of Reference set out an 'independent review of the quality of investigations and implementation of their recommendations, relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospital (the Trust). The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry.' Terms of Reference, May 2017.
3. Following the original launch of the review, more families have come forward with concerns about the care they received at the Trust. NHS Improvement commissioned an Open Book review of Trust records which also identified additional cases for review. These two factors have led to an extension to the scope of the original independent review as outlined in the original Terms of Reference.

Background

4. The Independent Review was established following a number of serious clinical incidents, beginning with the death of a new born baby in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. From 2009 to 2014 a number of further investigations and reviews (internal and external) were undertaken to confirm whether:

   a. appropriate investigations were conducted; and

   b. the assurance processes relating to investigations in the maternity service were adequate.

Governance

5. The review was commissioned by the Secretary of State for Health.
6. The NHS Senior Responsible Officer for the review is the National Medical Director of NHS Improvement and NHS England who will periodically update the Department of Health and Social Care on progress.
7. The review will continue to be led by independent Chair, Donna Ockenden and the final report will be presented to the Department of Health and Social Care.
8. The Chair will be supported by the Review Team, a multidisciplinary clinical team of independent external reviewers.

Revised scope

9. The review will now include all cases which have been identified since the original review was established. Cases where families have contacted various bodies with concerns regarding their own experiences since the commencement of the original review will also have oversight from the clinical review team undertaking the Secretary of State commissioned review. This is in addition to cases identified in the 'Open Book' review. Any reports from previously commissioned reviews will also be submitted to the Chair of the review to ensure consistency and record any recommendations and lessons learnt for sharing more widely. The processes applied to the Trust case review and the associated governance process will also be review

Review approach

10. The multidisciplinary Review Team will:

a. Review the quality of the investigations and subsequent reports into the identified cohort of incidents;

b. Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;

c. Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;

d. Consider how the parents, patients and families of patients were engaged with during these investigations;

e. Reserve the right to undertake a second-stage review of primary cases should the considerations above justify such action following agreement with the National Medical Director of NHS Improvement and NHS England; and

f. The review team will present cases internally, and on an as required basis seek further external advice

11. If the Review Team identifies any material concerns that need further immediate investigation or review, the National Medical Director of NHS Improvement and NHS England must be notified immediately.

12. All relevant case notes and other information will be passed by the Trust to the Chair and the Review Team and will be treated confidentially by them. Every effort will be made to contact families to let them know whether their case forms part of the review and to ask how they wish to be engaged, if at all. In the interests of conducting a comprehensive review and maximising the clinical learning, it is necessary for the Chair and Review Team to consider all cases within the scope of the review but no patient or family member will be identified by name in the final published report unless they have consented to this.

13. Directions to the Review Team:

a. Did the Trust have in place, at the time of each incident, mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?

b. Were incidents and investigations reported and conducted in line with national and Trust policies, that were relevant at the time?

c. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?

d. Were families involved in the investigation in an appropriate and sympathetic way?

Appendix 7: Review team members

Ms Donna Ockenden – Director, Donna Ockenden Limited, Chair of the review.

Donna Ockenden was assisted and supported by the following team members (In alphabetical order from their first name):

Obstetricians

Mr Alexander Taylor – from June 2020

Dr Anthony Falconer – from November 2018 until September 2020

Dr Antoinette Johnson – from March 2021

Dr Austin Ugwumadu – from July 2020

Dr Bode Williams – from April 2021

Dr Bronwyn Middleton – from November 2020

Dr Clare Tower – from March 2021

Professor Dharmintra Pasupathy – from October 2019

Dr Elisabeth Peregrine – from February 2021

Dr Heather Brown – from November 2018 until June 2020

Dr Joanne Page – from November 2020

Dr Jonathan Frappell – from December 2019 until March 2021

Dr Louise M Page – from November 2018 until October 2020

Dr Karin Leslie – from August 2020 until March 2021

Dr Marwan Salloum – from August 2020

Dr Matthew Cauldwell – from January 2021

Dr Michael Magro – from March 2021

Dr Nikki Jackson – from October 2020

Dr Paula Galea – from September 2020

Dr Penny Law – from November 2018 until June 2021

Dr Rachel Marshall-Roberts – from September 2020 until November 2021

Mr Richard Howard – from November 2018

Dr Sandra Newbold – from January 2020

Dr Umber Agarwal – from April 2021

Midwives

Amanda Mansfield – from November 2018 until June 2020 and from March 2021

Amanda Davey – from May 2017

Angela Frankland – from May 2021

Angie West – from May 2017

Bronwen Grigg – from January 2021

Caroline Clarke – from May 2017

Carolyn Romer – from November 2018 until August 2021

Ceri Staples – from September 2020

Charlotte James – from July 2019 until January 2022

Helen Harling – from December 2020 until May 2021

Helen Smith – from March 2020

Jacqueline Oliver – from May 2019

Jane Patten – from May 2017

Jessica Scoble – from September 2019 until September 2020

John Bell – from July 2019

Julie Jones – from November 2018

Dr Kate Nash – from April 2020

Kerry Madgwick – from January 2021

Kerry Thompson – from June 2020

Konstantina Stavrakelli – from September 2020

Lauren Graham – from September 2020

Merida Sculthorpe – from November 2020

Natalie Adams – from September 2020

Nicola Rose-Stone – from November 2019 until November 2020

Teresa Manders – from October 2019

Tina Spiers – from October 2020

Neonatologists

Dr Alison Jobling – from April 2020 until October 2021

Dr Chris Day – from March 2021

Dr Charlotte Groves – from November 2018 until June 2020

Dr Eilean Crosbie – from March 2021

Dr Huw Jones – from November 2018 until March 2021

Dr Lawrence Miall – from March 2021

Dr Michelle Parr – from March 2021

Dr Michael Hall – from March 2019

Professor Minesh Khashu – from June 2021

Dr Ngozi Edi-Osagie – from March 2021

Dr Paul Crawshaw – from February 2019

Dr Ranganna Ranganath – from April 2021 until October 2021

Dr Ryan Watkins – from December 2018 until March 2021

Dr Sarah Davidson – from July 2021

Dr Sunita Seal – from April 2021

Dr Tosin Otunla – from February 2020

Dr Vimal Vasu – from February 2019 until September 2020

Paediatricians

Dr David Gibson – from August 2021

Professor Ian Maconochie – from November 2018 until June 2021

Dr Julian Sandell – from March 2019 until April 2021

Obstetric Physician

Dr Anita Banerjee – from November 2018

Anaesthetist

Dr Andrew Combeer – from February 2021

Dr Elizabeth Combeer – from February 2021

Dr Renate Wendler – from November 2018

Neurologist

Dr Sean J Slaght – from December 2019

Cardiologist

Dr Richard Jones – from May 2020

Intensivist

Dr Phil Young – from July 2020 until March 2021

Dr Frank Schroeder – from May 2021 until December 2021

Family Support and Psychology Provision for Families

Maternity Review Psychology Service, hosted by Midlands Partnership NHS Foundation Trust

Dr Katie Bohane – Lead for Psychology Service from January 2021

Dr Katie Woodward – Clinical Psychologist from April 2021

Eloise Lea – Clinical Psychologist from April 2021

Emma Campbell – Assistant Psychologist from October 2021

Dr Kirsty Langley – Clinical Psychologist from July 2021

Dr Rachel Lucas – Trust Recovery Lead and Director of Psychological Services from June 2020

Dr Ursula Bacon – Clinical Psychologist from September 2021

Dr Victoria Caines – Clinical Psychologist from November 2021

SANDS – Stillbirth and neonatal death charity

Dr Clea Harmer – Chief Executive of Sands from January 2021

Jen Coates – Director of Bereavement Support and Volunteering from June 2020

Maria Huant – Bereavement Support Services Manager from June 2020

Bereavement Training International

Paula Abramson - Bereavement Training International and lead for the Listening Ear Service from June 2020

CBUK – Child Bereavement UK

Ann Chalmers – CEO, Child Bereavement UK from June 2020

Karen Smith – PA to the Chief Executive & Executive Manager from June 2020

Sarah Harris – Director of Bereavement Support and Education from November 2021

Administrative support provided by:

Aimee Humphrey - Administration for the Maternity Review from May 2021

Barbara Watkinson – Administration for the Maternity Review from April 2019 until July 2020

Charlotte Lidster – Administration for the Maternity Review from January 2020 until December 2020

Michelle Wright – First Rate PA, Administration for the Maternity Review from April 2018

Monika Niziol – Administration Assistant to Donna Ockenden the Chair of the Maternity Review from July 2020

Rebecca Jones – Administration Assistant for the Maternity Review from October 2020 until December 2021

Sara Kempton-Hayes – Administration for the Maternity Review from February 2019 until July 2020

Zoe Bolt – Administration for the Maternity Review until September 2018

HR and Employment Law specialist:

Dianne Lambdin, Director Sussex HR Hub Ltd

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Hilary Julian – Maximus Accountancy Services Limited

IT support

VENOM IT – IT services provider

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OCKENDEN REPORT - FINAL

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality, Safety & Outcomes Committee 7th June 2022 Agenda item: 2.7

Patient Quality, Safety and Outcomes Report

Executive Summary

- Cancer performance has declined with challenges in managing the backlog hampered by increasing cancer referrals. Cancer harm reviews have commenced to consider impact of breaches. Cancer has been added to the 'status at a glance' and RAG rated Red.
- There has been a reduction in the number inpatients diagnosed with Covid up to April 2022, with minimal outbreaks now being observed in hospitals and care home settings.
- An improvement in the Clostridium difficile rate has been observed although occurrence remains above target, mirrored across Wales.
- The Health Board has declared compliance with one Patient Safety Notice - safe prescribing of steroids. An update of compliance with PSN008: nasogastric tubes is included within the report.
- Options to implement a Child & Adolescent Mental Health (CAMHS) crisis hub are being considered, with a brief update provided. This will improve the experience of children in crisis.
- Work is underway to support improved communication when transferring patients between ABUHB hospital sites. Inter-site transfers has been added to the 'status at a glance' report and RAG rated Amber.
- The Health Board has received a draft report following a review of venous thromboembolism prevention undertaken by Welsh Risk Pool. A summary regarding the current Health Board position and an action plan is in-development.
- There is a concern regarding 'Never Events' resulting in an increase in the RAG rating from Amber to Red and a separate report is provided.

Quality & Patient Safety Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	
Executive Sponsor: Clinical Executives	
Authors: Alexandra Scott, Assistant Director of Quality and Patient Safety Tracey Partridge-Wilson, Assistant Director of Nursing – Quality, Safety and Patient Experience Karen Hatch, Assistant Director of Therapies and Health Science Rhiannon Jones, Executive Director of Nursing	
Date of the Report: 23 May 2022	
Supplementary Papers Attached: Nil	

Purpose of the Report

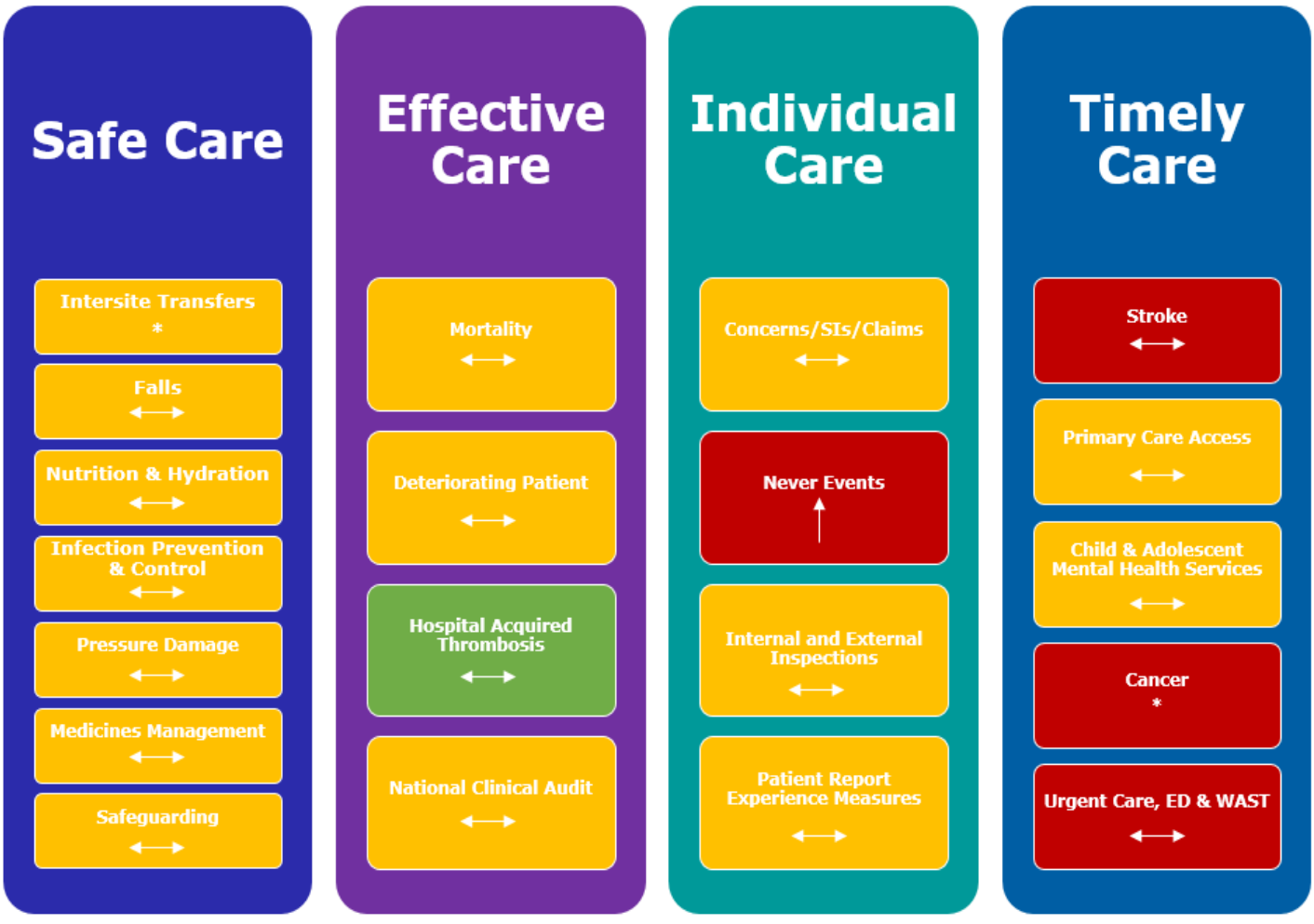
The quality and patient safety report is produced around the themes of the Health and Care Standards (HCS) and aims to provide assurance in relation to priority areas that are deemed to be higher risk in terms of the experience, quality and safety agenda across Aneurin Bevan University Health Board.

Background and Context

The report is generated using key performance indicators, information from incident reporting, concerns and complaints and includes escalation from any of the quality & safety-associated groups which report to the Quality, Patient Safety Operational Group (QPSOG) and directly to the Patient Quality, Safety and Outcomes Committee (PQSOC).

The following is an 'at a glance' Red, Amber, Green (RAG) rated summary of key metrics that are regularly monitored, some of which (and notably the 'red' rated areas) are included within this report, providing an overview of the Health Board position for March and April 2022. The position against the previous reporting period includes an arrow as to whether the position is static, has increased or decreased or indeed it is a new area.

KEY:	↑ Increase	↓ Decrease	↔ Static	* New



Assessment

There remain two areas of specific concern in terms of red RAG rating, namely stroke and urgent care with a static position. An additional area has increased to red (Never Events) and this has been included as a separate report for the PQSOC. Cancer has been added a RAG-rated red due to increasing referrals, backlog and performance. Inter-site hospital transfers has also been added as an area under the 'safe care' category, rated amber.

Under patient experience (individual care) the 'Civica' all Wales platform for collection and collation of patient experience has been procured, which is positive progress and will enable systematic reporting of patient experience.

The following are aligned to Health & Care Standards and the ABUHB IMTP priorities

Safe Care IMTP Priority: 1 2 3 4 5

Patient Safety Solutions (Standard 2.1 Managing Risk and Promoting Health and Safety)

The Health Board has declared compliance with the following Patient Safety Alerts and Notices Since April 2022:

PSN057 Emergency Steroid Therapy Cards: Supporting Early Recognition and Management of Adrenal Crisis in Adults and Children

Analysis of incident data submitted to the National Reporting and Learning System (NRLS) identified four patient deaths, four patient admissions leading to critical care and another 320 incidents associated with steroid replacement therapy. The Health Local work to ensure compliance with this Notice is ongoing, to include: -

- The dissemination of the Welsh health Circular WHC 2001/008 to support the provision of a steroid card and to advise patients to seek medical attention during illness.
- An NHS Wales emergency steroid card has been developed for all applicable patients.
- Wales have commissioned emergency hydrocortisone therapy kits to support swift and standardised approach to emergency hydrocortisone therapy.

PSA008 Nasogastric Tube misplacement: continuing risk of death and severe harm

Use of misplaced nasogastric (NG) and orogastric tubes1 was first recognised as a patient safety issue by the National Patient Safety Agency (NPSA) in 2005 and three further alerts were issued between 2011 and 2013.

Misinterpretation of x-rays by medical staff who did not appear to have received the competency-based training required by the 2011 NPSA alert is the most common error type. Other error types involve nursing staff and pH tests, unapproved tube placement methods and communication errors resulting in tubes not being checked.

PSA008 was issued in 2017 to support the safer insertion and management of NG tube placement, however the majority of Health Boards in Wales have not declared compliance as there is no standardised CE marked product to test pH – the method for confirming correct placement of an NG tube. Furthermore, the alert requires nursing and allied health professionals to meet specified training requirements but lacked clarity around medical training requirements. Insertion and confirmation of placement by interpretation of images is not included in the current list of core skills for trainee doctors. The GMC publication, Practical Skills and procedures does include nasogastric tube placements but only as a skill safe to practice under simulation. Issues have been raised around the training with HEIW and the GMC.

An All-Wales approach is now under development to support a national programme of e-learning and competency assessment for medical trainees, so competency travels with the trainees as they move between health organisations in Wales. The ESR record would be accepted as confirmation of competence to be repeated every three years. Each Health Board will be required to train and assess all medical staff who transfer into Wales from England and overseas.

In addition, an All-Wales CE marked pH strip has been identified for use by the Surgical Materials testing Laboratory (SMTL). ABUHB is currently transitioning to this product and will be delivering a brief educational programme to ensure full compliance and awareness of the new product.

To review compliance of PSA008 in relation to the documentation of placement for NG tubes an audit is planned of all inpatients with an NG tube over 1 week in June 2022.

Inter-site Transfer (Standard 2.1 Managing Risk and Promoting Health and Safety)
AMBER

A number of incidents relating to patient transfers between hospital sites resulting in patient safety incidents, poor patient experience or inefficiencies in care have been reported. Incidents include transfers of patients with inadequate information, clinically inappropriate transfers, failure to consider discharge home from GUH and into-the-night transfers have occurred which is poor from an experiential perspective.

In response, the Divisional Nurse for Primary Care & Community has taken a lead role in reviewing all transfer incidents reported on Datix, conducting analysis and theming, with the production of a monthly report shared with all Divisions. The report identifies:

1. Inappropriate transfers from acute to Community Hospitals.
2. Inappropriate transfers from Community to Acute Hospitals.
3. Inappropriate discharges from Acute or Community Hospitals to patient's home (who require ongoing community support and interventions by District Nurses or Community Response Teams).

16 incidents were reported in April 2022, an increase on previous months. 9 of the incidents related to discharges home, with GUH being the most common discharging site. Themes included:

1. No referral to a Diabetic Specialist Nurse or District Nurse.
2. Lack of family engagement/support.
3. Lack of communication with community services who would be responsible for ongoing care needs.

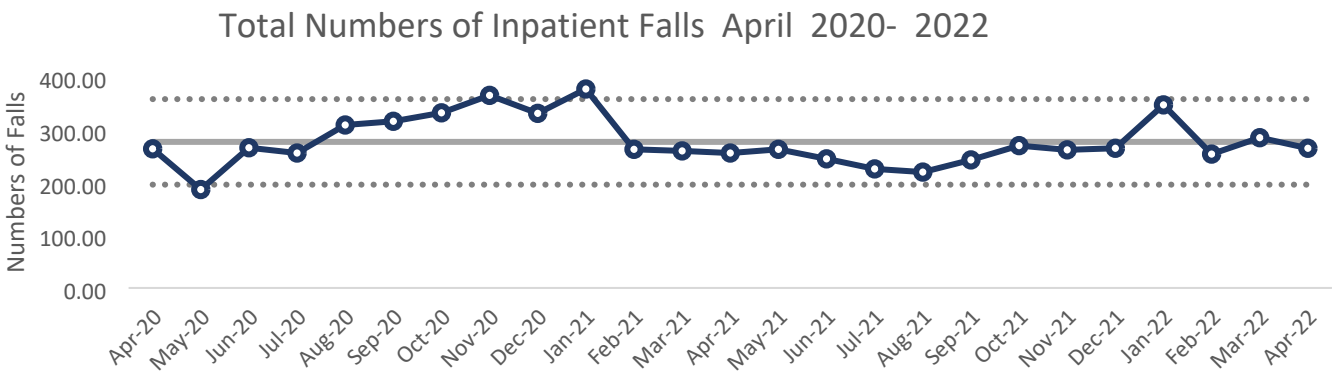
A meeting with Divisional Nurses has been established to review all incidents and develop improvement plans where there is harm associated with a transfer. This follows the Health Board incident reporting and management process.

Safe Care (Standard 2.3 – Falls Prevention) **RED**

The information provides an ABUHB overview of the status for falls as of April 2022, which is subject to continuous monitoring and review through multiple quality and governance forums to include the 'Falls and Bone Health Committee' and the associated 'Hospital Falls and Bone Health Group'. The data period of 24 months is used to support the establishment of control charts which identify shifts and trends associated with the numbers of reported falls incidents. The process for monitoring and analysing inpatient falls incidents continues with data being made available on a weekly and subsequently monthly basis.

Chart 1 below demonstrates the total numbers of inpatients falls across ABUHB for the rolling 2-year period to April 2022. As of February 2021, a pronounced shift has been evident up to December 2021 in which the numbers of reported falls incidents have been consistently below the mean average value of 276. January 2022 saw a change in trajectory with an increase in numbers to marginally below the upper control limit of 356. A review of the area specific data identifies both Medicine and Urgent Care as those which have contributed more significantly to the given peak. Both have seen a subsequent reduction in numbers of falls incidents reported with Medicine seeing a decrease of 30% and Urgent care 27% in April 2022 as compared to the respective figures in January 2022. Since this month, the numbers of incidents have returned to values that are more closely aligned to the October to December and February to May period of 2021.

Chart 1: Total Number of Falls April 2020-22



In the previous report (February 2022) from a site-specific perspective both GUH and NHH had demonstrated upwards trajectory in the numbers of falls incident aligned to the overall picture for total numbers of falls at that time. As of April 2022, GUH has seen a decrease in the numbers of falls incidents, although the numbers remain higher than that for the period since opening to December 2021. March and April 2022 have seen values of 49 as compared to the mean average of 39.65.

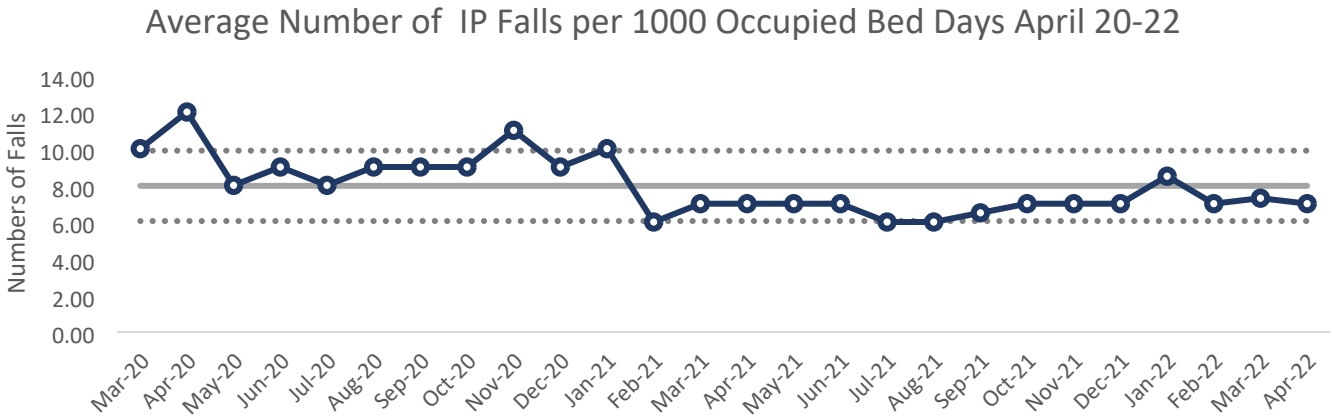
NHH has likewise seen a decrease, returning to values below the mean average of 40. With numbers of 37 and 39 respectively for March and April 2022 as compared to 59 in January 2022.

Although YYF as a site has continued to demonstrate a reduction in falls to below the mean average value, February and March 2022 saw the numbers of incidents on Bedwas ward increase above what may be considered normal variation. This promoted discussions to support the understanding of any changes which have influenced the upwards trajectory and the implementation of any necessary initiatives. As of April 2022, the numbers of reported incidents have decreased by 55% as compared to March 2022.

There have been no significant variations in shifts or trends for the Community Hospitals.

Chart 2 below places the total numbers of falls in the context of average numbers per 1000 Occupied Bed Days (OBD's), April 2020-22. Following a sustained period in which the numbers of falls have been on or aligned to the lower control limit with minimal variation January 2022 saw an increase to marginally above the mean average value of 8. However, February to April 2022 has seen a return to values of an average of 7 which is more akin to that of most of 2021.It is important to note that the January 2022 figure is not statistically significant.

Chart 2: Average Number of Falls per 1000 OBD's January 2020-22



An in-depth analysis to ward level data continues to provide information to support the advent of more focussed falls reviews to inform change initiatives and sustained improvement in falls management.

This work has been further informed by the outcomes of the March 2022 internal audit on inpatient falls in which overall reasonable assurance was provided. The assurance

objectives looked to take account of the implementation of the revised policy, its application and staff adherence, the completion of the MFRA and the governance associated with the oversight and monitoring of performance.

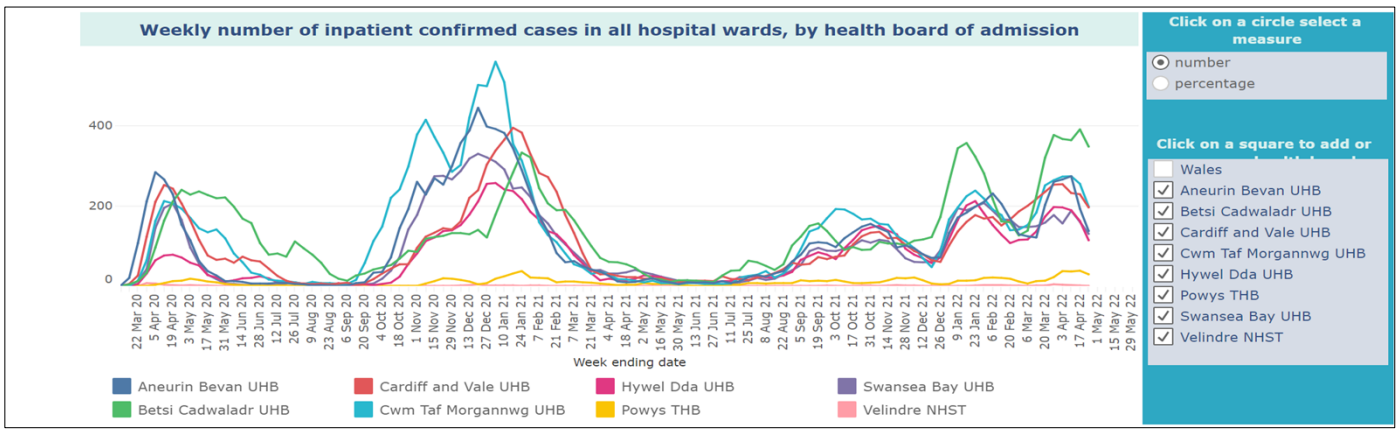
- From the report it is recognised that a degree of challenge remains in relation to the completion of the MFRA. It is anticipated that ABUHB will adopt this in its electronic format as part of the Welsh Nursing Care Records during the summer of 2022 which will support improved compliance rates. Climate allowing this will be supplemented by reviews, audits and visits to the wards to inform the establishment of key metrics as an output of the implementation of the electronic document.
- It is acknowledged that training is a key component in supporting ABUHB's approach to minimising falls. Aligned to the current work of ABUHB the organisation has representation at an all-Wales level and are proactively engaged in discussions and actions on the development of a foundation level falls learning platform linked to ESR to support the learning of all staff who have a role in falls management. It is intended that this will translate into a national product and provide consistency of approach across Wales. This is being managed under the auspices of the 'National Falls Taskforce'.
- From the perspective of the revision of the Policy and oversight and monitoring of performance substantive assurance was provided.

IP&C (Standard 2.4 – Infection Prevention and Control) AMBER

Covid -19

During March and April 2022, a decline has been experienced in the number of positive inpatients up to the 24th April (Fig 1). At this point, Aneurin Bevan University Health Board demonstrated an admission rate of 9% for positive Covid-19 patients, which is slightly below the Welsh average of 11%.

Fig 1. Confirmed inpatient Covid compared with Welsh HBs



In March, the Patient Placement protocol was amended in line with National guidance resulting in patients being cared for on a ward suitable to their clinical presentation rather than transferring through Covid pathways. The number of patients requiring

critical and high-level respiratory care continues to be significantly lower than in previous surges, with a maximum of 2 patients at any time.

Within this period, the Health Board has also adopted the Welsh Government Testing Strategy which advocates that asymptomatic patients no longer require routine testing during their hospital admission. Patients are now required to be tested on admission, for elective admission, discharge planning or if they become symptomatic.

Staff testing has reduced from daily pre-shift to twice weekly. Social distancing in non-Covid areas has also reduced to one metre.

To support patients and their families, another significant change is the relaxation of visiting restrictions across the Health Board. It remains 'visiting by appointment', but the hours have increased to 8am until 8pm. Visitors are required to take a Lateral Flow Device (LFD) test and can only visit if negative. This change is being monitored through the Reducing Nosocomial Transmission Group (RNTG) and, so far, does not appear to have caused any concern. At the time of writing the report revised Guidance has been received in the Health Board making further changes to Covid management. The letter was received from Welsh Government on the afternoon of the 20th May 2022. The implications are being worked through.

Covid-19 Outbreaks

Fig. 2 - Hospital Outbreaks

The number of outbreaks has reduced significantly, undoubtedly impacted by the changes to testing.

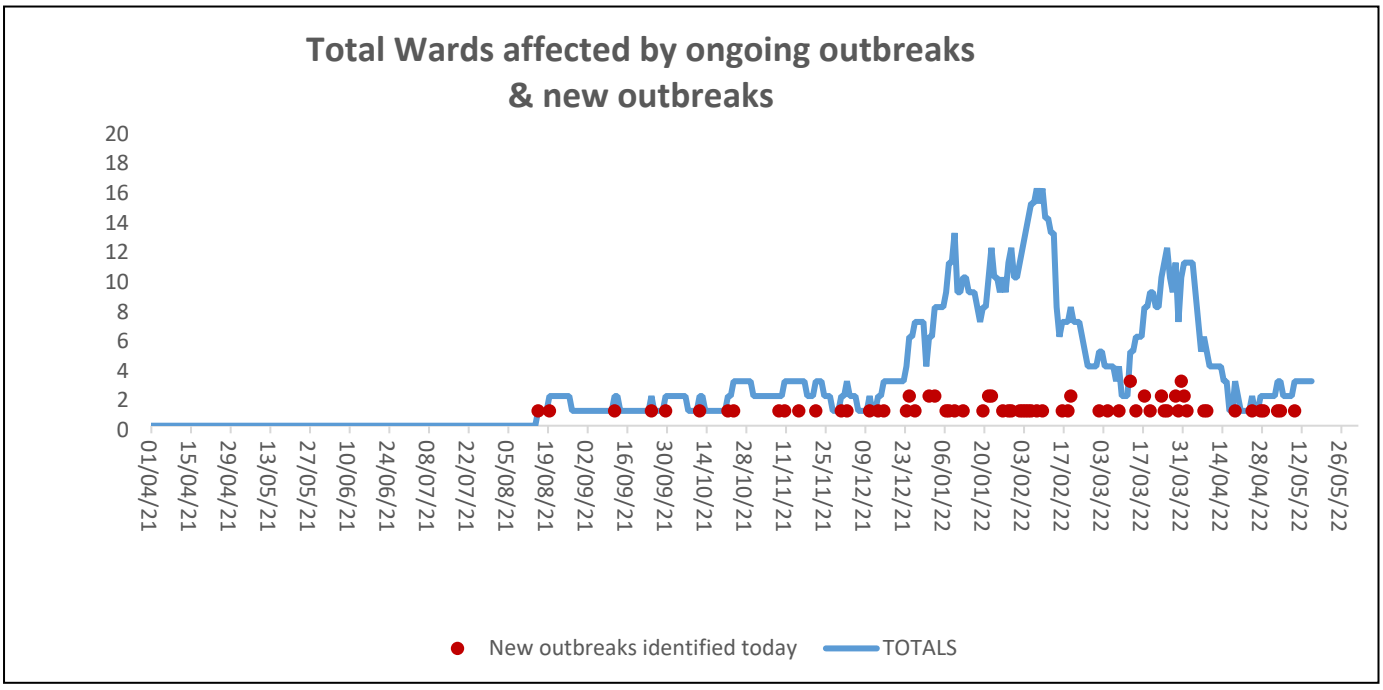
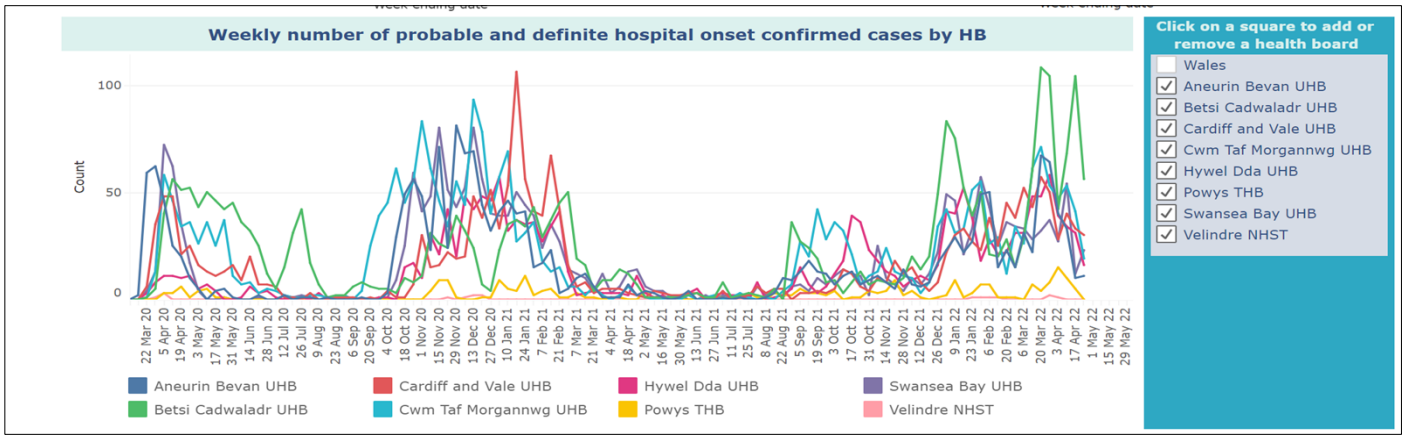


Fig. 3 demonstrates ABUHB probable and definite hospital onset of Covid-19. The rate of probable and definite hospital onset within ABUHB is 2% compared to all Wales rate of 10% and ABUHB has the lowest rate in Wales.

Fig. 3 – All Wales Hospital Onset



There are some specific challenges in the eLGHs and Community Hospitals associated with aged estate, limited cubicles, shared facilities and ventilation all of which are likely to be contributing to onward transmission. Since the change in testing, it has become more difficult to ascertain a hypothesis and root cause for an outbreak occurring.

Care Homes

Care Home prevalence has improved considerably over the past two months (where a resident or a member of staff has tested positive). The care home position impacts on patient flow from secondary to primary care as transfers and admission are restricted when a care home is in outbreak mode. In collaboration with Public Health Wales, the Infection Prevention and Control Team has developed a Patient Discharge passport to support a risk assessed approach for safe discharge to reduce hospital length of stay, which has been updated to reflect the new testing requirements. During March up to 31 homes were in outbreak, this reduced to 23 during April.

Covid-19 Mortality

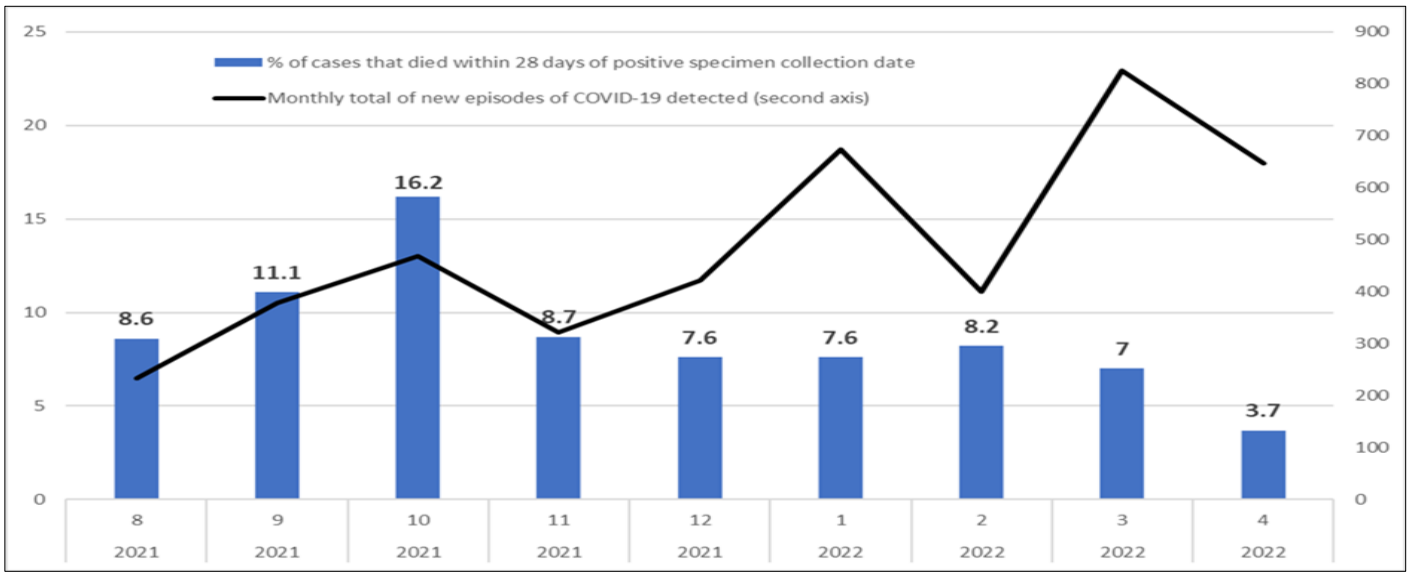
Deaths in patients with COVID-19 are an important measure of patient outcome and intervention success. Over the pandemic period we have seen improvements in patient management and treatments for COVID-19 disease, so would expect deaths to fall over time. Likewise, the development of effective vaccines and their high uptake, would also lead to reductions in deaths. This is demonstrated in the table below where ABUHB have the lowest death rate across Wales for wave 4.

Fig 4. All Wales comparison for Covid-19 Morality

	Wave 1		Wave 2		Wave 3		Wave 4		Total	
	Deaths n (%)	Cases n	Deaths n (%)	Cases n	Deaths n (%)	Cases n	Deaths n (%)	Cases n	Deaths n (%)	Cases n
Wales	**622 (34%)**	**1856**	**1428 (27%)**	**5236**	**245 (17%)**	**1476**	**113 (13%)**	**886**	**2408 (25%)**	**9,454**
Aneurin Bevan UHB	97 (40%)	244	255 (29%)	879	35 (18%)	192	6 (7%)	91	393 (28%)	1406
Betsi Cadwaladr UHB	199 (32%)	630	179 (25%)	705	41 (15%)	281	38 (14%)	264	457 (24%)	1880
Cardiff and Vale UHB	95 (31%)	303	210 (27%)	777	29 (18%)	166	12 (13%)	93	346 (26%)	1339
Cwm Taf Morgannwg UHB	115 (33%)	354	317 (28%)	1115	59 (18%)	327	16 (11%)	141	507 (26%)	1937
Hywel Dda UHB	25 (29%)	87	207 (39%)	694	50 (19%)	270	19 (13%)	148	301 (25%)	1199
Swansea Bay UHB	86 (40%)	214	243 (25%)	985	28 (16%)	180	21 (15%)	136	378 (25%)	1515

All patients are reviewed 28 days post COVID-19 positive result and from March to April 2022 there have been 31 inpatient deaths associated with indeterminate, probable, or definite healthcare associated Covid infection.

Fig. 5 Health Board Mortality data



Patients with nosocomial COVID-19 are likely to have other serious comorbidities warranting a stay in hospital of more than a week, which may mean they would have died irrespective of their COVID-19 infection. Likewise, patients with longer hospital stays are likely to be older and therefore more likely to die of other causes. The Covid Investigation Team are in the process of being appointed and will assess the level of harm associated with patients' outcomes following a positive result associated with hospital onset. A further 23 patients with community onset of Covid-19 have died within 28 days of testing positive.

National Guidance

During March, a Welsh Government Reset Forum was held to promote the UK Infection Prevention and Control guidance first issued in November 2021; revised in January and April 2022. Within the guidance, it was recommended Health Boards make provision to create local respiratory and non-respiratory pathways. There was also a steer to move to a business-as-usual arrangement. RNTG has reviewed this recommendation and supported the following:-

- Testing - reduce inpatient to day 1 and when symptomatic
- Reduce staff testing to twice weekly for patient facing roles
- Patient Pathways - a transition to Covid and non-Covid pathways (as opposed to respiratory and non-respiratory)
- Gradually relax visiting restrictions

These recommendations were based on the following: -

- Sustained reduction of number of Covid-19 inpatients
- Falling rate of hospital acquired infection
- Community prevalence
- Mortality rate

Other Respiratory Infections

The number of inpatients presenting with Influenza and Respiratory Syncytial Virus (RSV) has remained low.

Nationally, influenza began to increase from April however ABUHB detected sporadic cases in early March. Sentinel surveillance indicators signify activity has not exceeded thresholds for seasonal circulation.

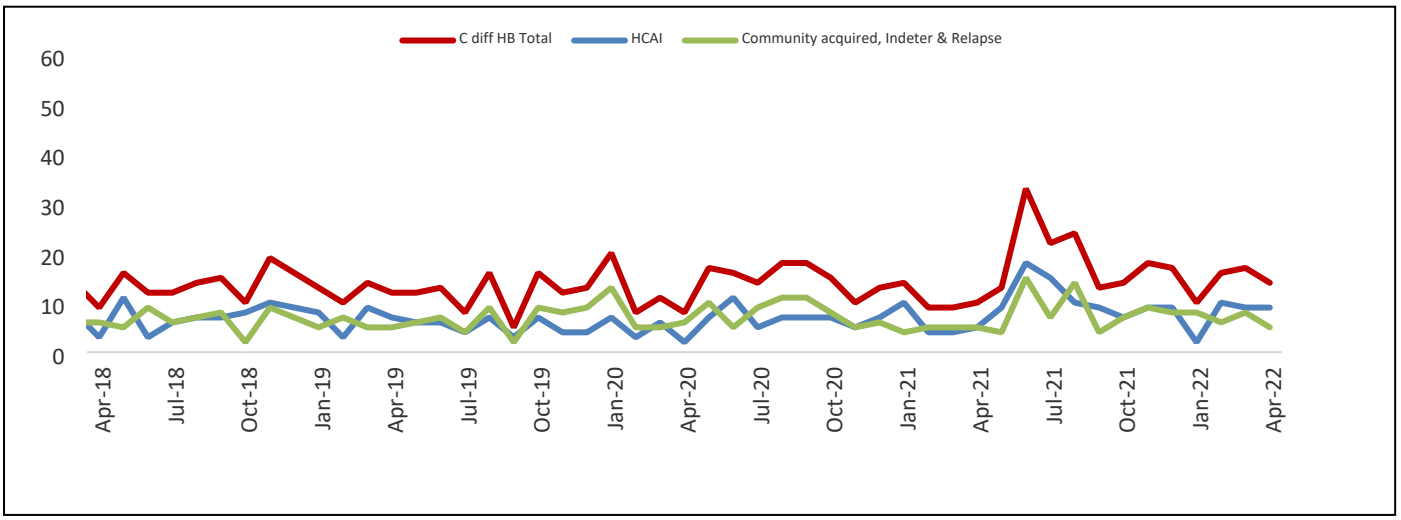
Welsh Government Reduction Expectation Goals

The Welsh Health Circular outlining the reduction expectations has been issued with an extension date to March 2023.

C *difficile*

There have been 205 cases of C *difficile* reported from April 2021 - March 2022. This is 40% more than the equivalent period 2020/21 equating to a rate of 34.27 per 100,000 population. There were 18 reportable cases for March 2022 and 14 cases in April as per graph below. C *difficile* continues to be above trajectory and remains a concern albeit an improvement is being seen and is a picture seen nationally.

Fig. 7 - C difficile Prevalence



There were 9 associated with hospital acquired in March and April. Below is a breakdown of compliance with key elements of the C *difficile* care bundle for healthcare associated cases discussed at root cause analysis meetings in March and April.

The HB has not received any laboratory Genotyping indicating cross infection has likely occurred locally.

Antimicrobial Resistance

Of the 18 C *difficile* cases in March, 11% patients had not received antibiotics, 13 received no suboptimal antibiotics, however there were 17% cases of potentially

suboptimal antibiotics, all of which have been fed back as part of the root cause analysis process:

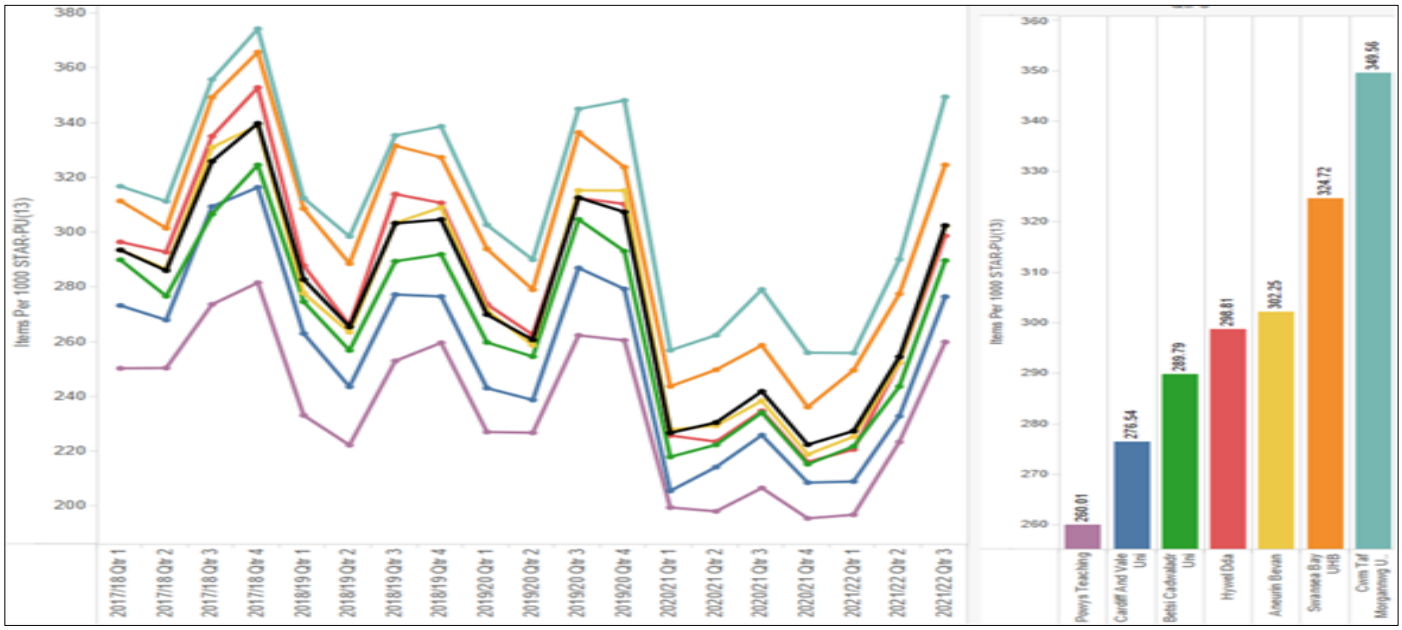
- Co-amoxiclav for unknown indication (GUH)
- Ceftriaxone for cholecystitis (GUH)
- Co-amoxiclav (GP locum)

Feedback is awaited for 5 of the 14 cases in April. Of the remaining 9, 33% had not received antibiotics, and 6 had not received suboptimal antibiotics in ABUHB.

2022-23 Welsh Government improvement goals for antibiotic usage remain the same:

- A minimum 25% reduction in antimicrobial usage in the community from the 2013/14 baseline.
- In secondary care, increase to or maintain the proportion of antibiotic usage within the WHO 'Access' category (narrow spectrum antibiotics that carry a lower risk of resistance and other adverse effects) to ≥55% of total antibiotic consumption
- implementation of 'Start Smart Then Focus' (SSTF), the principles of best practice for antimicrobial stewardship, via roll out of the Antibiotic Review Kit (ARK) methodology

Fig. 9 - Total antibacterial items per 1,000 STAR-Pus
(Specific Therapeutic group Age-sex Related Prescribing Unit)



Primary care data are only available to the end of Q3 21-22, however there was a significant increase in antibiotic volume in Q3, back to pre-pandemic levels. The current position against baseline has yet to be determined by Public Health Wales, however it is likely that we are now above target. It is hoped to recruit to the vacant primary care Antimicrobial Pharmacist post soon, therefore outlying practices will be a key priority for them.

Secondary care data is only available to the end of Q2 21-22, however all ABUHB sites were above the 55% target, with the ABUHB average over 60%. More recent local data

demonstrate broad-spectrum antibiotic use in secondary care remains stable, with a slight increase in co-trimoxazole over the last quarter.

Further roll out of the Antibiotic Review Kit (ARK) methodology is planned, which includes a hard stop of all antibiotics at 72 hours, forcing review and, if required, re-prescription of antibiotics. YYF and NHH are live, but there have been isolated incidences where an antibiotic course had been stopped unintentionally. There have been no adverse outcomes for the affected patients.

Staphylococcus aureus bacteraemia

134 cases of Staph aureus bacteraemia have been reported from April 2021 - March 2022. This is 15% fewer than the equivalent period 2020/'21 equating to a provisional rate of 22.40 per 100,000 population. Within the month of March, 10 cases were reported and 9 cases in April.

Over the two-month reporting period, 4 cases were associated with hospital admissions, there have been no clusters identified. The themes of infection are varied.

Gram Negative bacteraemia

There have been 344 cases of E coli reported from Apr 2202 to March 2022, equating to a rate of 57.51 per 100,000 population. There have been 30 cases in March and 27 cases in April. Bench marking from the previous year (2019/'20), shows a significant reduction in the overall rate of Gram-Negative Bacteraemia, which is a comparable year due to the pandemic.

Patients presenting septic on admission continues to be the highest contributing factor to the case rate. There have been no clusters identified and no links with the management of urinary catheter both in hospital and community settings. There is a correlation to respiratory infections secondary to Covid-19.

Pseudomonas

There have been 2 reportable cases of pseudomonas in March and no cases in April equating to a rate of 5.30 per 100,000 per population. There have been 31 cases of Pseudomonas reported from April 2021 to March 2022. This is 29% more than the equivalent period 2020/21.

Klebsiella

93 cases of Klebsiella reported from April 2021 to March 2022. This is 20% fewer than the equivalent period 2020/'21, a provisional rate of 15.55 per 100,000 population. There were 7 cases in March of which 5 were assessed as Community Acquired. Of the 11 cases reported in April, 7 were associated with the community. No clusters have been identified and no cases associated with urinary catheters.

All Wales comparisons

With the exception of C *difficile*, ABUHB has the lowest rates for all other measures across Wales, as can be seen in the following table.

Higher than same period of previous FY | Lower than same period of previous FY | Same as same period of previous FY

	C. difficile		MRSA bacteraemia		MSSA bacteraemia		S. aureus bacteraemia		E. coli bacteraemia		Klebsiella sp bacteraemia		P. aeruginosa bacteraemia		Gram negative bacteraemia	
	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate
Aneurin Bevan UHB	205	34.27	4	0.67	130	21.73	134	22.40	344	57.51	93	15.55	31	5.18	468	78.24
Betsi Cadwaladr UHB	215	30.57	10	1.42	169	24.03	179	25.45	436	61.99	138	19.62	37	5.26	611	86.87
Cardiff and Vale UHB	156	30.92	11	2.18	131	25.97	142	28.15	311	61.65	120	23.79	35	6.94	466	92.37
Cwm Taf Morgannwg UHB	155	34.46	2	0.44	118	26.23	120	26.68	390	86.70	81	18.01	29	6.45	500	111.15
Hywel Dda UHB	152	39.00	16	4.11	105	26.94	120	30.79	356	91.35	87	22.32	31	7.95	474	121.63
Powys THB	11	8.27	0	0.00	0	0.00	0	0.00	3	2.26	0	0.00	0	0.00	3	2.26
Swansea Bay UHB	196	50.13	10	2.56	129	33.00	139	35.55	288	73.67	94	24.04	24	6.14	406	103.85
Velindre NHST	5		0	0.00	3		3		5		4		1		10	
Wales	1,095	34.55	53	1.67	785	24.77	837	26.41	2,133	67.30	617	19.47	188	5.93	2,938	92.69

Decontamination

Improvement is noted across several areas in terms of decontamination namely:-

- Urology Outpatient Department in RGH - a water scavenger filtration machine commissioned for use to filter water prior to water disinfectors for decontamination. This is in readiness to recommence use of reusable cystoscopes as opposed to the single use.

- The Royal Gwent Hospital (RGH) proposed Business Case has been finalised for the four theatre endoscopy suite, with approval from Welsh Government awaited.

- Training in the use of 4 new decontamination Trophon units in Family and Therapies continues to be undertaken enabling staff to be appropriately trained. This will allow for validated decontamination process in line with national standards.

- The Endoscopy unit in Ysbyty Ystrad Fawr (YYF) have purchased 3 drying cabinets of which 1 has been commissioned for use as part of the replacement programme, due to existing age of equipment.

- Endoscopy in YYF continue to strive toward Joint Advisory Group (JAG) accreditation. Frequent meetings have occurred with relevant task and finish groups.

- Commissioning of the Grange Hospital (GUH) HSDU has taken place which has resulted in a state of the art decontamination facility at GUH and the Nevill Hall Hospital (NHH) HSDU being decommissioned, agreed.

Water Safety

In line with National Guidance ongoing water testing across the Health Board has identified raised counts of Legionella and Pseudomonas within the Family & Therapies areas. Following review, it is evident the taps are not being flushed for the allotted time, which has been shared with the Division for action. Works & Estates have installed filters onto the taps, disinfected the water tanks and revisited the cleaning protocol of clinical handwashing sinks to minimise risk to patients. These incidents have not resulted in onward transmission of infection to patients. The Water Safety Group is closely monitoring the situation.

Nutrition and Hydration (Standard 2.5 – Nutrition and Hydration) **AMBER**

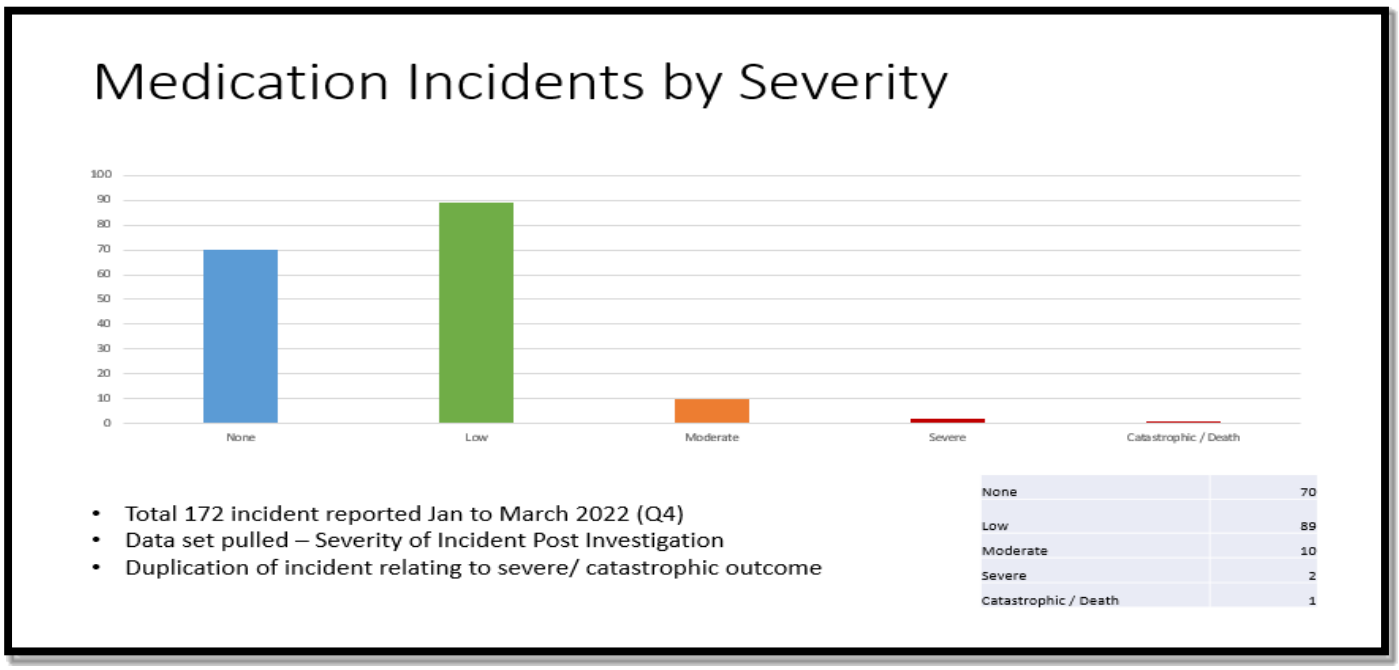
A task and finish group has been convened in response to a number of concerns relating to completion of fluid balance charts that have emerged thorough Serious incident investigation and Medical Examiner reviews.

The work will support the roll out of a standardised approach through Careflow. This work is jointly led by nursing and Dietetics and will be reported to the multi-disciplinary Nutrition and Hydration Group.

Several developments are underway to improve nutrition and hydration for inpatients with cognitive impairment. This work includes the delivery of training to increase awareness amongst staff of the benefits of snacks and finger foods to optimise nutrition. The Nutrition and Hydration Group are now auditing this aspect of care, as well as undertaking training for staff and the Red Robin Volunteers.

Medicines Safety (Standard 2.6 Medicines Management) **AMBER**

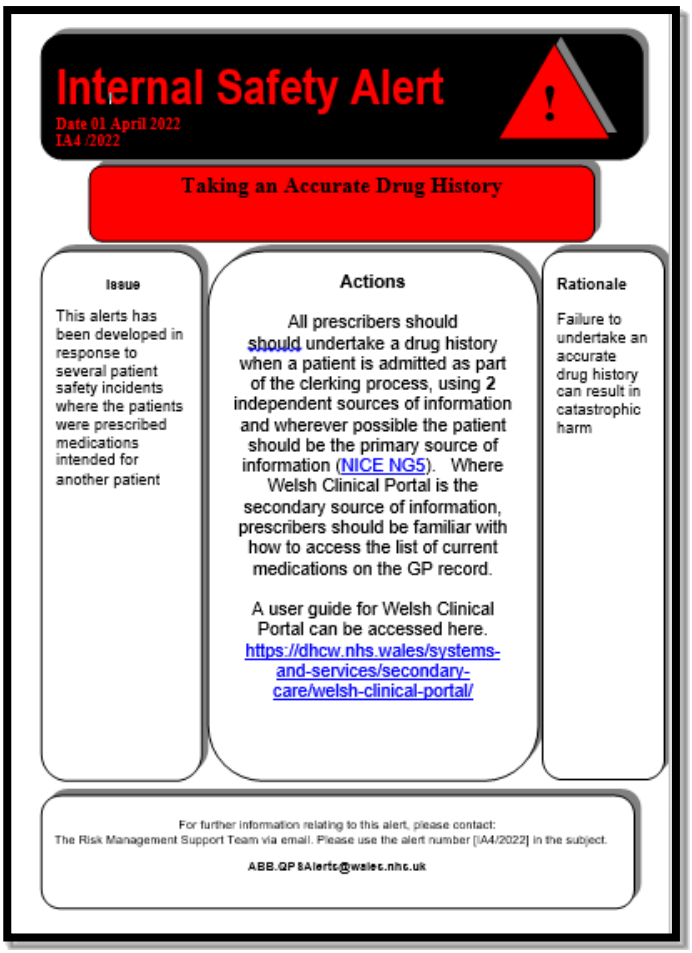
A review of quarter four of the 2021/22 Datix reporting identified 172 patient safety incidents associated with medication safety, the vast majority of which resulted in either no and minor harm. Ten incidents were associated with moderate harm, two severe harm and 1 incident had catastrophic outcomes.



The catastrophic incident was associated with medicines reconciliation and patient identification. An internal alert has been circulated to all staff to remind them of the importance of using two independent sources of information when taking a drug history and wherever possible the patient should be the primary source of information. In addition a Health Board wide audit of patient identification is planned for June 2022 to

inform improvement work, noting Patient Identification appears to be a theme in a number of Patient Safety Incidents following a thematic analysis.

Medication incidents by site show that the top five sites account for 75% of reported incidents with GUH the area with the highest number of incidents reported, although the majority resulted in no or low harm. The most commonly recorded incident is associated with administration errors followed by prescribing errors, with the majority recorded as no or minor harm. The pharmacy department undertake review of pharmacy interventions to extrapolate themes relating to these incidents for improvement. In response to one emergent theme relating to the prescribing of Vancomycin, a thematic review is being undertaken of historic vancomycin incidents. The outcomes of this review will be included within a future report.



Internal Safety Alert

Date 01 April 2022
IA4 /2022

Taking an Accurate Drug History

Issue

This alerts has been developed in response to several patient safety incidents where the patients were prescribed medications intended for another patient

Actions

All prescribers should should undertake a drug history when a patient is admitted as part of the clerking process, using 2 independent sources of information and wherever possible the patient should be the primary source of information (NICE NG5). Where Welsh Clinical Portal is the secondary source of information, prescribers should be familiar with how to access the list of current medications on the GP record.

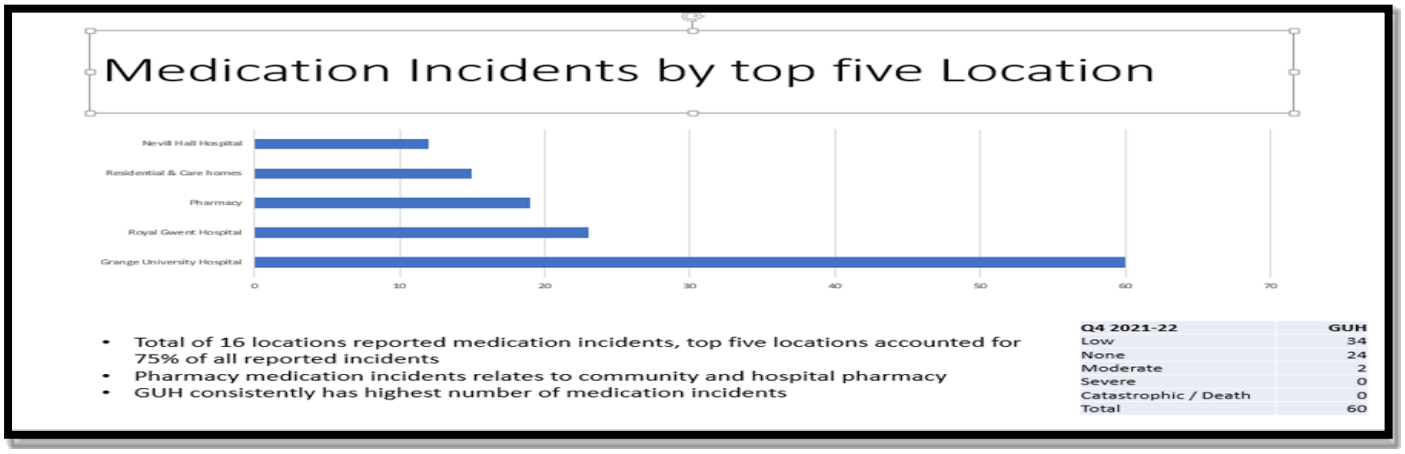
A user guide for Welsh Clinical Portal can be accessed here. https://dhcw.nhs.wales/systems-and-services/secondary-care/welsh-clinical-portal/

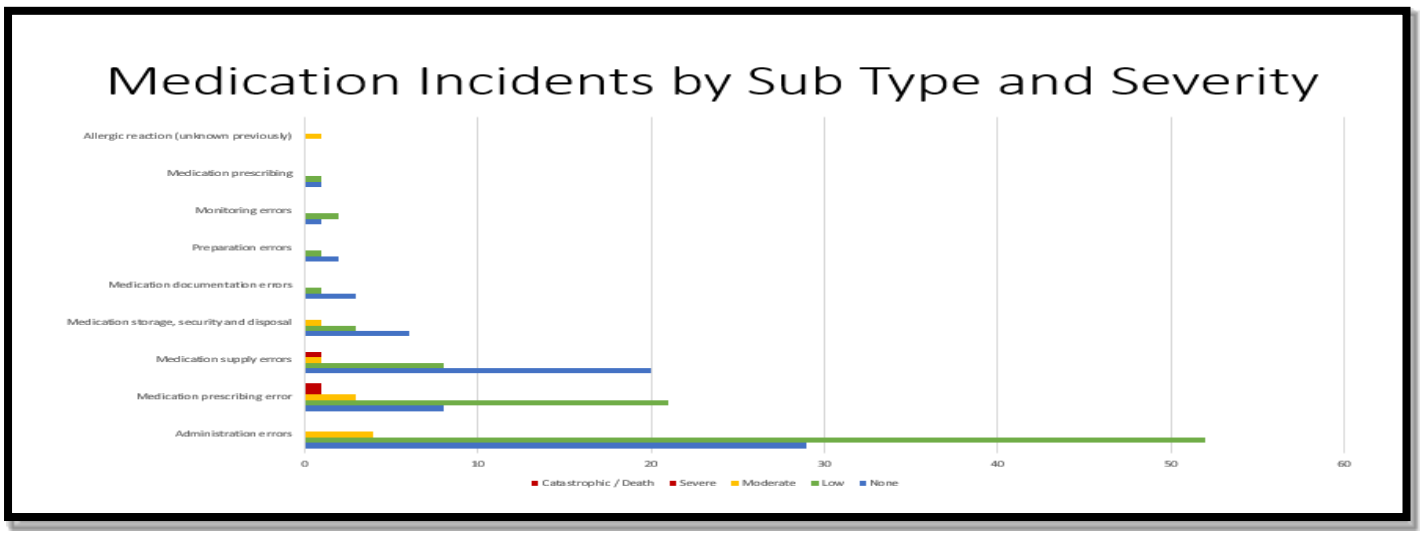
Rationale

Failure to undertake an accurate drug history can result in catastrophic harm

For further information relating to this alert, please contact:
The Risk Management Support Team via email. Please use the alert number [IA4/2022] in the subject.

ABB.GPSAlerts@wales.nhs.uk





Effective Care IMTP Priority: 1 2 3 4 5

Thrombosis (Standard 3.1 Safe and Clinically Effective Care) **GREEN**

In April, Welsh risk Pool (WRP) wrote to all Health Boards following their commissioned review of venous thromboembolism. The teams in ABUHB are considering the letter and report and will provide comments by the deadline. The WRP have offered to attend Health Boards to discuss the report and the Committee are asked to consider this request for the August meeting. The letter is included in the 'for information' section of the agenda.

During 2021, 58 cases relating to venous thromboembolism (VTE) were submitted to the Welsh Risk Pool (WRP) by Welsh health organisations for either approval of a Learning From Events Report (LFER) or reimbursement. The WRP reimbursed health bodies £1.7million for VTE related cases during 2021. 44 of the 58 cases were at the LFER stage and so reimbursement values are not included in the £1.7million; the true figure is likely to exceed £10m. ABUHB submitted three cases to WRP during this time, which equates to a rate of 0.5 per 100,000 population compared with 1.8 per 100,000 population across Wales.

In response WRP commissioned a patient record review across all health boards in Wales with the Terms of Reference developed in conjunction with the All-Wales Hospital Acquired Thrombosis (HAT) Committee, to assess application of the All-Wales Thromboprophylaxis Policy standards.

The review established that:

- There was under recording of VTE risk assessment across Wales
- Completion of the VTE section of the adult inpatient medication administration record when thromboprophylaxis was prescribed was excellent.
- Completion of the VTE section of the adult inpatient medication administration record when thromboprophylaxis was not prescribed was unsatisfactory.
- Most Health Boards had a VTE risk assessment within their clerking proformas but compliance with completion was poor.
- There is no mandatory training relating to VTE within Wales
- All Health Boards' demonstrated compliance of over 90% in the administration of prescribed thromboprophylaxis within 24 hours of admission or as dictated on the drug chart.

The draft report makes 5 recommendations:

1) **All Health Boards within Wales adopt the All Wales Thromboprophylaxis policy**

The ABUHB policy for Thromboprophylaxis for all Hospital Inpatients incorporates the All-Wales Thromboprophylaxis Policy and aims to improve awareness of thromboprophylaxis and patient safety in the hospital setting.

2) **All clinical staff undertake All Wales training, both in relation to the recognition of patients presenting with symptoms of a VTE and in the prevention of hospital acquired thrombosis**

At present ad hoc training is delivered across the organisation but this will be superseded by the All Wales training package delivered through ESR which is currently under development. A business case will be developed to support additional resource to support face to face training to address findings from Hospital Acquired Thrombosis (HAT) reviews and patient safety incidents relating to VTE and broader use of anticoagulant

3) **All patient receive a documented VTE risk assessment using a Department of Health Risk Assessment Tool (or similar) on admission, as part of the initial clerking of patients.**

A compliant VTE risk assessment is incorporated into the general medical and surgical clerking proforma although completion rates are poor. A gap analysis will be undertaken to identify areas where standardised VTE risk assessments are not part of clerking documentation. Work will be undertaken with the Divisions to support improved completion of the risk assessment.

4) **An All Wales checklist for the investigation of HAT is developed in order to maintain a uniform investigation approach across NHS Wales**

All potential hospital acquired thrombosis are subject to review by experienced clinicians working in the field to establish if they were preventable and to support the identification of modifiable risks. Preventable HAT occurrence have reduced significantly since 2020. ABUHB will amend the review process as required when an All-Wales review tool becomes available.

5) **VTE risk assessment compliance data and HAT data is shared at appropriate health body governance meetings**

Work is underway across ABUHB to standardise the Quality and Patient Safety agenda. VTE will form part of the agenda with consideration given to producing data to support scrutiny, assurance and to inform improvements.

An action plan will be developed to support the delivery of the requisite improvements and will be submitted to WRP in July 2022, with presentation to the August PQSOC.

CHILDREN & ADOLESCENT MENTAL HEALTH SERVICES (Standard 3.1 Safe and Clinically Effective Care) **AMBER**

Pressures on Children and Adolescent Mental Health Services (CAMHS) across Wales has been sustained, with Tier 4 (highly specialist / inpatient care) demand often exceeding capacity and resulting in children and young people being assessed and cared for in less than appropriate settings, including Emergency Department and adult mental health wards. A review of CAMHS capacity and the delivery of the services across Wales is being undertaken by Welsh Government and is receiving ministerial attention.

ABUHB is developing a CAMHS Crisis Hub to support the rapid assessment and, where appropriate, the discharge of children and young people home with proportionate support. A location on St Cadoc's site has been identified to accommodate the new service. The implementation of the service will facilitate swift specialist assessment. Funding options are currently being explored. The development of short term inpatient care facilities in Windmill Farm will provide an alternative to admission to adult mental health services for some patients. More detail will be provided to the Committee when the case is more developed.

Mental Capacity Act and Liberty Protection Safeguards Consultation and Engagement (Standard 3.1 Safe and Clinically Effective Care)

ABUHB has been proactively engaging with professionals, service user groups, paid carers and families in relation to the forthcoming implementation of Liberty Protection Safeguards (LPS), and the revised Mental Capacity Act (MCA) Code of Practice.

ABUHB, working with its Local Authority partners, has arranged and hosted a series of virtual conferences to support participation in the long-awaited consultation on a new MCA code of practice and regulations for LPS implementation, as well as providing substantial regional briefings for staff and stakeholders.

In addition to a programme of regional briefings ABUHB has recorded 2 podcasts in relation to LPS implementation and developed several Mental Capacity Act training films and are also developing an animated training film for health and social care staff that explains how the MCA and LPS work together.

There was an official launch of the consultation on the regulations and Code of Practice for the revised Mental Capacity Act and Liberty Protection Safeguards on the 17th May 2022.

Dignified Care IMTP Priority: 1 2 3 4 5

Dementia Hospital Action Plan (Standard 4.1 Dignified Care)

The ABUHB In-Patient Dementia Hospital Steering Group is now well established and includes representation from all specialities and divisions within the Health Board. The principles of person-centred dementia care are embedded within the agenda and the priority actions, including nutrition and hydration, continence care, involvement of relatives and meaningful activities have been agreed by the Group. These priority actions have been informed by patient, relative and staff feedback. This group will support the All-Wales Dementia Pathways of Standards Dementia care specifically workstream 4. This includes the "All Wales Hospital Friendly Charter Premier" launched on 6th April. The Grange University Hospital (GUH) has already established a 'GUH Dementia Subgroup'. There are now 2 informal carers represented on the In-Patient Hospital Group.

On the 17th May, supporting Dementia Awareness Week, a Dementia Webinar was held with members of the public to outline both the National Dementia Standards and the Hospital Charter. The Webinar was attended by members of the public, staff and partners across the geographical area. A fundamental aim of the Webinar was to encourage people living with dementia and carers to work with the Regional Dementia Board as 'Experts by Experience'. A number of people have pledged to work with the Health Board to shape and influence the dementia work programme and improve the lived experience for people with dementia.

Meaningful Activities

During the pandemic, patients reported increased boredom as a result of limited visiting and a lack of meaningful activities. Funding was obtained to purchase a suite of meaningful activities that would benefit all patients in hospital, particularly those with cognitive impairment and sensory loss.

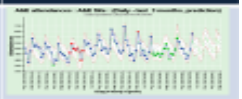
There are now resources in place to support person-centred ward-based activity. Staff can access online resources such as large print crossword puzzles, reminiscence activity, and Boredom Busters via the Ffrind I Mi web pages. Training around the purpose and therapeutic value of meaningful activity has been developed internally. This training promotes the theory and how to use the resources in practice.

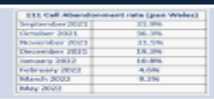
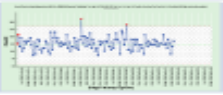
Meaningful activity baskets contain a variety of resources, including empathy dolls, hugs, and electronic cats and dogs. In April 2022, the first phase of issuing 40 baskets began. This progress will be measured and evaluated in order to identify patient and staff satisfaction. Staff are encouraged to report positive outcomes from these activities, particularly for patients who exhibit challenging behaviours.

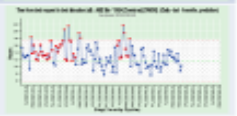
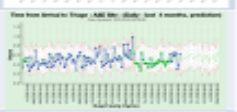
Timely Care IMTP Priority: 1 2 3 4 5

Urgent Care (Standard 5.1 – Timely Access) **RED**

Urgent and Emergency Care remains one of the top organisational risks for ABUHB, an issue mirrored nationally and is receiving significant Ministerial attention. Key metrics have been identified, with oversight through the Urgent Care Transformation Board, and weekly analysis via the System Leadership and Response meetings. The following tables illustrate the data collected, analysed and reviewed for drive improvement.

Key Metric	Target	Feb22	Mar22	Apr22	Signal	Signal explanation/ Comment	Chart/Graph
ED Attendances (all sites/daily avg)	↓	472	517	477		Increasing trend since Jan.	
UPCC Consultation / Treatment (monthly totals)	↑	6,192	7,283	8,674		Increase in consultations / treatments Daily average no. of contacts in Apr: 279.	
Redirections from GUH (Count of both in and out-of-hours)	↓	131	139	151		151 redirections from GUH in April	
Redirections from MIU (Count of both in and out-of-hours)	↓	388	453	473		473 redirections from MIU in April	
Think 111 calls (Count of both in and out-of-hours)	↑	372	362	556		Improvement in the number of call during Feb.	

Key Metric	Target	Feb 22	Mar 22	Apr 22	Signal	Signal explanation/ Comment	Chart/Graph
111 calls abandoned	↓	19.3%	10.8%	4.6%		Significant reduction in abandonment rates	
Ambulance Handovers >1 hour	↓	43.2%	40.1%	44.2%		Overall increasing trend. 43.2% of handovers >1 hour in Jan 22.	
<12 hours %	↑ 100%	89.5%	91.7%	91.7%		Following projection and seasonal trend.	
<4 hour %	↑ 100%	67%	67.2%	68.5%			
Waits in ED over 16 hours	↓ 0	463 events	472	447			

Key Metric	Target	Feb 22	Mar 22	Apr 22	Signal	Signal explanation/Comment	Chart/Graph
Time to be seen by first clinician never above 2 hours	↓ 95%	5 events	13 events	6 events		Average of 1.5 hours in Feb.	
Time for bed available from request - 8 hours	↓ 95%	14 hours	12.7 hours	11.5 hours		Decreasing trend since Feb 22.	
No more than 70 Ambulance hours lost in a day (daily average)	↓ 95%	113.2 hours	84 hours				
ED Triage Time	↓ 0.25 hours	0.48 hours	0.55 hours	0.45 hours			
Occupied Beds monthly av	↓	1505	1498	1519		Out of range since 26th April.	

The Minor Injury Units (MIU) continue to see a high number of patients. The Redirection Policy is used robustly to ensure patients are being cared for in the most appropriate environment to manage their clinical condition and risk. The Emergency Nurse Practitioners (ENP) scope of practice has been reviewed and expanded; e.g, to support manipulations. Monthly performance data illustrates a month on month increase in redirections from both MIUs and GUH in quarter 4 on 2021/2022, suggesting that some patients continue to attend the wrong sites for their condition.

Sick, self-presenting patients attending MIUs in the enhanced Local General Hospitals (eLGHs) was a high clinical concern when the GUH first opened. However, focussed work regarding these concerns, especially in relation to establishments has been undertaken, and additional training has been offered following practitioner concerns. For example, there was an increase in the volume of pregnant women attending MIUs. As a result, ENPs on all four MIU sites have accessed midwifery input; these sessions have been well received and well evaluated, especially in relation to confidence-building amongst staff.

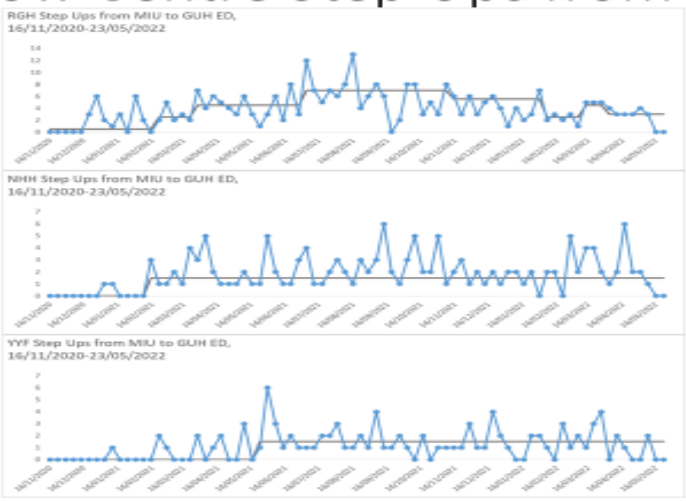
Communications with the public have been regularly updated to ensure that key messages, especially in relation to where to attend for what condition or ailment. It is evident that communications in this area will be consistently required.

Action Cards, clearly identifying the roles and responsibilities and steps to take if a sick patient attends a MIU have been developed and embedded. These identify access channels to the Emergency Physician in Charge (EPIC – the most senior ED doctor on duty).

Additionally, when the GUH opened, there were a number of Serious Incidents (SIs) raised in relation to sick, self-presenting patients. However, the last SI raised in relation to this was in March 2022, and there has also been a reduction in the number of associated Datix reports being generated.

Therefore, the key messages being provided to sick self-presenters (patients of most concern) appear to be having a positive impact and there is more confidence in the workforce in how to manage these patients if they do present.

Flow Centre Step Ups from MIU to GUH ED

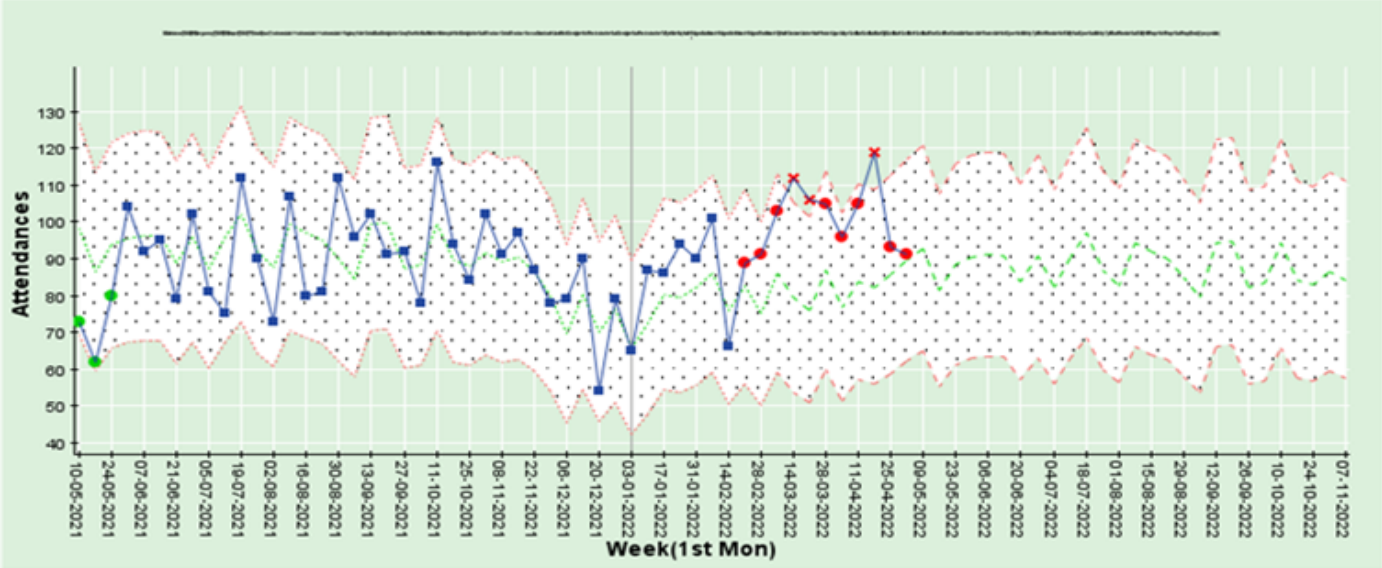


RGH step ups to GUH increased from GUH opening until it peaked with 14 in a week in summer 2021. It has been gradually decreasing since then, and currently stands around 4 patients per week.

NHH step ups to GUH are quite variable between 1 and 6 per week, but currently stand at around 2 per week.

YYF step ups to GUH are not as variable as NHH, and are around 2 patients per week.

There have been reports of out-of-area patients attending MIUs and initial data shows that the number of patients attending MIUs (RGH, NHH and YYF) from outside of ABUHB has increased in recent weeks. This volume has been above the expected levels continuously since 21 February 2022 and has exceeded the upper expected range three times since this date in the weeks commencing 14 March, 21 March and 18 April 2022.



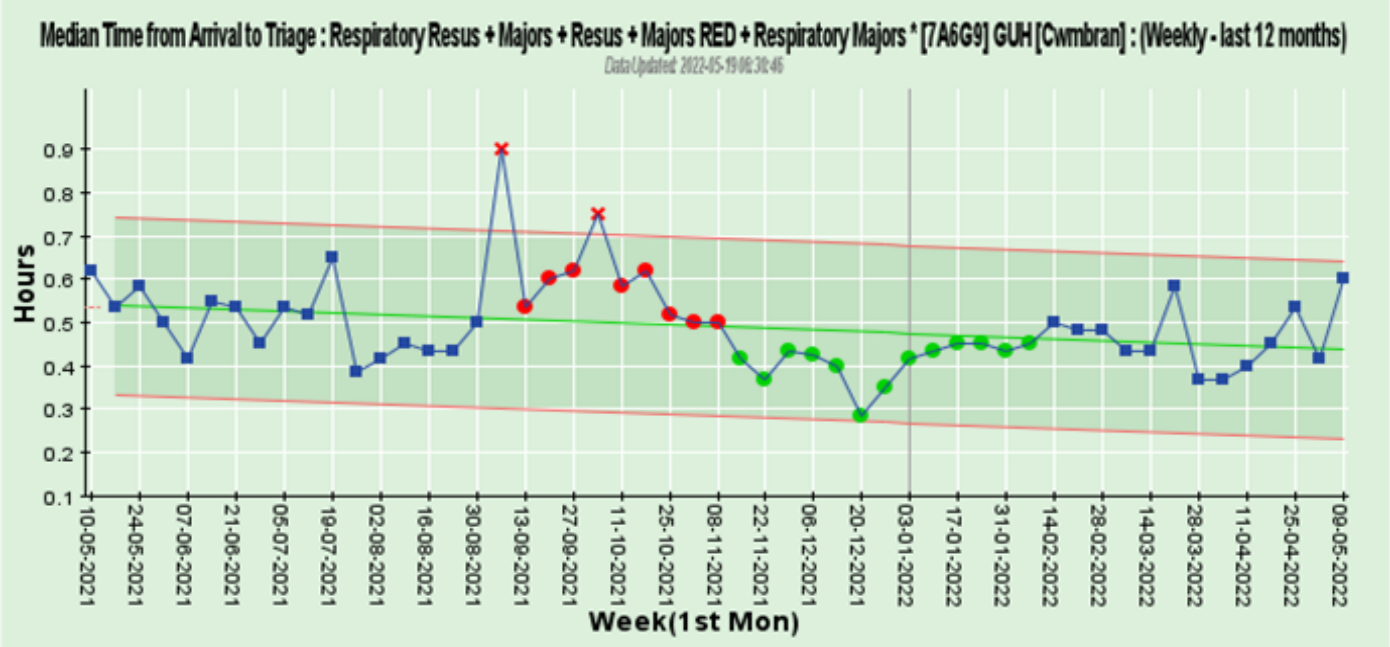
Patients from the areas below being the highest attenders:

Registered General Medical Practice	Value
South Powys	689
South Merthyr Tydfil	268
South Cynon	213
South Taf Ely	164
North Taf Ely	148

In order to inform further work, an additional scoping exercise is being undertaken.

The number of attendances to the GUH ED is also seeing an increasing trend. In order to be able to identify the level of risk within the department, a clear focus has been placed on triage. Triage is a 'sorting' of patients and allocates categories to patients dependent on their presenting complaint and acuity. This then influences a time frame for the patients to be seen by clinician. Knowing the triage category of patients helps to manage the risk for individuals and the department.

The national target for triage is 15 minutes from arrival in the department. A triage working group led by the Nurse Consultant continues to review triage performance and effectiveness. The triage work has been further supported by our Practice Educator team within the ED, supporting and building confidence in our workforce. The graph below shows the trend in reduced time to triage.



Ambulance Handover times have an overall increasing trend (43.2% of handovers >1hr). A review of criteria, which enable patients to be moved from ambulances to sit within the department has been undertaken. In addition, a Standard Operating Process (SOP) for ED has been developed to ensure the department meets the fundamental needs of the patients.

The SOP clearly references the actions that are required to be taken and by whom when there are off-loading delays for patients and if handover cannot be taken from ambulance crews. The SOP also reinforces that patient investigations and treatment should be commenced, pressure care provided as well as toileting and nutrition and hydration offered. This ensures timely and dignified care for patients.

Patients waiting in ED >16hrs is decreasing, however, numbers remain high at 447 and the average time from bed request to bed allocation remains high at an average of 11.5hrs. Quality metrics are regularly monitored by the Senior Management Team (SMT), the Divisional Management Team (DMT) and escalated accordingly. Patient falls, medication incidents and violence and aggression incidents are reducing. There has been an increase in grade 1 pressure ulcers reported, which is being further analysed and will result in an improvement plan.

To support the 'Right Place First Time' process, there has been an increased focus on the streaming of patients, to improve patient experience by bringing efficiencies into the system. There is Consultant input at the Flow Centre, who advise on options for admission; 45-50% of patients are deemed appropriate for eLGHs (data which has been consistent since the GUH opened).

To manage patient flow more efficiently, ABUHB are developing a Same Day Emergency Care (SDEC) Unit at the GUH and plan to pilot an appointment-based ambulatory care model in the Acute Medical Unit (AMU) at the RGH. The SDEC unit at GUH is planned to open in August 2022. This will mean patients who meet the criteria can be seen in SDEC rather than being accommodated in ED, AMU or Surgical Assessment Unit (SAU).

There are significant benefits associated with treating people through SDEC services, these include:

Patient experience:

- The ability for patients to be assessed, diagnosed and commence their treatment on the same day, improving patient experience and reducing hospital admissions.
- This has a knock-on effect on the quality of care provided in AMUs, as only patients in need of specialist Acute Medicine care will remain at the GUH.
- Avoiding unplanned and longer than necessary stays in hospitals, resulting in lower risk of infections and patient de-conditioning.
- Providing direct access for some specialties which may avoid the need for patients to return to the hospital for an outpatient appointment.
- The potential reduction in the number of Clinicians patients will see.
- Patients who have already been seen by a GP will not need to be seen by the ED team; they will be seen by the right clinician first time.

Benefits to Staff:

- *Team engagement:*
  There is a considerable amount of positive energy linked to the implementation of SDEC.
- *Recruitment benefits:*
  Recruiting to SDEC will likely be a more attractive proposition than the existing care model.
- *Wellbeing:*
  Seeing the patient journey from start to finish has been noted as a staff wellbeing benefit.
- *Team working:*
  Promoting integrated working especially between Medicine and Surgery even at the planning stages, will become a bigger benefit once integration occurs.

From a nursing perspective, recruitment remains ongoing for all areas, following positive additional financial investment agreed by the Executive Team. The Practice Educator team have increased their establishment to enable provision of a strong preceptorship model for new starters. The student nurse Streamlining recruitment process is very successful for GUH, 10wte have been recruited for ED and 3 WTE for AMU. Recruitment is also ongoing for SDEC.

The Medical workforce is more challenged across all grades. The Consultant roster has not been fully recruited to and there is also constant backfilling of the middle grade tier, which remains a national issue. SHO grades are also under pressure, but these are proving easier to fill at a Locum grade. There are no long-term sickness or absence issues currently.

The Health Board is currently revising the Urgent Care Transformation Programme to align to the recently published national 6 Goals for Urgent and Emergency Care. Further detail will be provided at the extraordinary Board meeting mid-June 2022.

Stroke (Standard 5.1 – Timely Access) **RED**

As an unscheduled, urgent care pathway, the Health Board's stroke pathways are directly impacted by the continued urgent care system wide pressure that is being seen nationally, regionally and locally; this is especially evident with regard to the access related stroke quality metrics.

The Health Board benefits from having a modern, purpose designed Hyper Acute Stroke Unit (HASU) at the Grange University Hospital (GUH) which provides urgent intervention at the most acute stage of the stroke. Since opening the GUH, and in the context of the continued urgent care system pressures, the Health Board has been unable to fully protect this HASU capacity to maintain access and timely flow. Similarly when a patient with a stroke is ready to move on from the HASU, to the sub-acute rehabilitation facilities (currently at the Royal Gwent, Nevill Hall and Ystrad Mynach hospitals), the transfer can be delayed due to lack of capacity at those sites, again directly related to system wide pressures in all parts of the urgent care pathway (including community social care that supports discharge for patients with increased dependency). Flow through the pathway is effectively stalled as a result of the pressurised and congested system, which has been further restricted by repeated COVID-19 outbreaks that can cause ward closures and delayed discharges to closed settings.

The Health Board monitors a number of key quality metrics for urgent intervention in stroke that determines whether a patient was able to have a CT scan within 1 hour and be admitted to the HASU within 4 hours of arriving at the hospital. Whilst stroke patients will receive necessary care interventions in the Emergency Department, and often pre-hospital by the paramedics, a timely scan and HASU care are critical for optimal outcomes.

Over the past 6 months, the proportion of patients with a suspected stroke who have a CT within 1 hour of arriving at the Emergency Department has been in region of 50% (52.9% in March 2022) which reflects a similar performance across Wales. This can be partly explained by the very congested Emergency Departments that lead to logistic and processing delays.

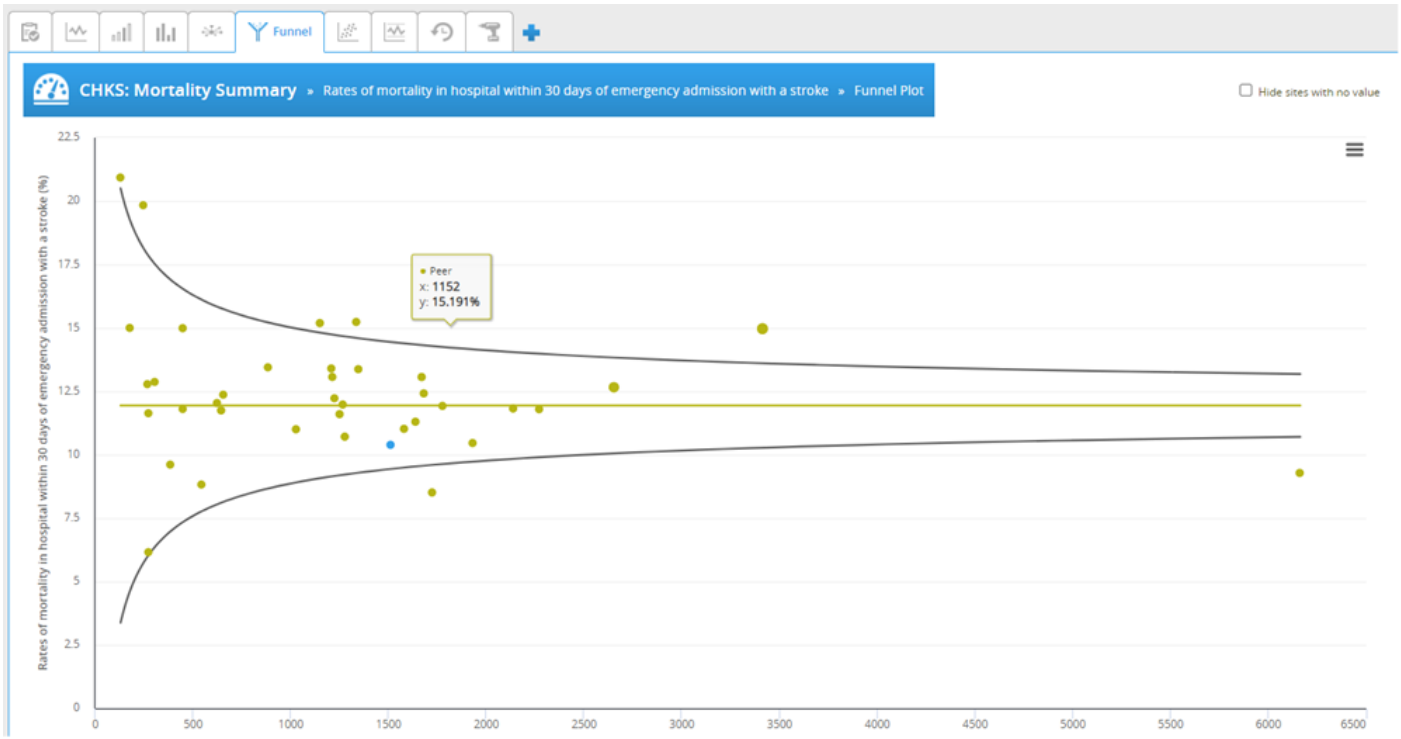
The proportion of patients with a confirmed stroke directly admitted within 4 hours has remained stubbornly low over the past 6 months (14.5% in March 2022) which also reflects a similar performance across Wales (14.7%).

In March 2022, the Health Board recovered its previously good and best in Wales performance for the percentage of patients assessed by a stroke consultant within 24 hours at 94.3% in March 2022 (84.3% all Wales).

The proportion of applicable patients assessed by at least one therapist within 24 hrs of clock start improved with 44.3% in March 2022, up from 29.3% in January 2022, though still low in comparison to previous best performance over 75%. The impact of the urgent care system pressures has resulted in decisions being taken to use the HASU therapy assessment room as additional bed capacity; whilst this assessment facility is unavailable then it is not possible to undertake the required level of therapy assessment for stroke patients during the critical acute phase.

Thrombolysis rates (proportion of stroke patients given thrombolysis) was 10% in March 2022. The thrombolysis audit is ongoing to identify any opportunities to improve thrombolysis performance. An earlier review of the data identified that patients have not arrived at the Grange University Hospital in a timely basis and, in some cases, there have been delays in referral to the HASU and stroke team. It is important to note that 100% of all clinically eligible stroke patients are given thrombolysis.

Notwithstanding concerns about timely access to stroke care, the reported mortality summary (comparison with top peers in the UK from Jan 2020 to March 2022) as shown in the funnel plot below, indicates that the Health Board is not an outlier for rates of mortality in hospital within 30 days of emergency admission with a stroke.



Whilst the urgent care system pressures are a major contributing factor to the access performance with the stroke care, there are also workforce factors (medical, nursing and AHPs) that must be considered. In recent years, the service has struggled to recruit into Stroke Consultant vacancies. However, it has been agreed for the service to develop a joint post to cover Acute Medicine and Stroke with the view to attracting a wider interest from applicants and will support both the Stroke service and the Medical Assessment unit.

The service has now successfully recruited into the Acute Medicine and Stroke post and is hopeful that the new consultant will commence post in August 2022.

An external review of therapy services across the stroke pathway has been undertaken to map the existing therapy workforce across the Health Board against clinically recommended levels in each setting. The report highlighted that gaps in specialist stroke therapy cover varied between professions and between sites, which is further complicated by those staff having to travel between sites. The review will form part of the stroke recovery plan and the focus will be to ensure that there is equitable therapy

provision and determination of the best use of limited resources and the requirement for future stroke therapy provision.

As part of the stroke recovery plan and ongoing improvement work the Stroke Directorate has engaged with an external provider called "Getting it Right First Time" (GIRFT) for a specialty review. The specialty review will involve a local data pack being produced detailing ABUHB's stroke performance data, followed by a series of meetings with members of the Stroke MDT including Senior Operational Managers and Divisional Leads. The review will examine a wide range of factors, from length of stay, access to the HASU and rehabilitation sites, patient mortality, sharing of best practice, and areas for improvement and individual service costs through to overall budgets.

The GIRFT first meeting happened at the end of January 2022 and included representatives from all of the Stroke Multidisciplinary Team and the peer review will be conducted in May 2022. The findings / recommendations of the review will be feed into and be taken forward as part of the stroke recovery plan, with a planning task & finish group being established and progress monitored through the Stroke Delivery Board with reporting to the Executive Team.

In summary, a range of action being taken forward to address performance issues with stroke quality metrics as part of the recovery plan:

- Utilising public communication opportunities to promote the importance of seeking immediate help at the signs of stroke (F.A.S.T.) by working in partnership with the CHC and the Stroke Association;
- Continued work with Emergency Department to ensure timely identification of stroke patients and expedite CT scans and transfer to the HASU;
- Work with the Director of Operations to put in place protection of the critical stroke pathway capacity as part of the Health Board's escalation procedures;
- Address workforce sustainability (medical, nursing and AHPs), aligned to a review of the entire stroke pathway, considering rehabilitation capacity and configuration, innovative roles, and most prudent use of limited resources;
- Support the GIRFT review process and establish a task & finish structure to respond to any recommendations as part of the recovery plan, with oversight by the Stroke Delivery Board.

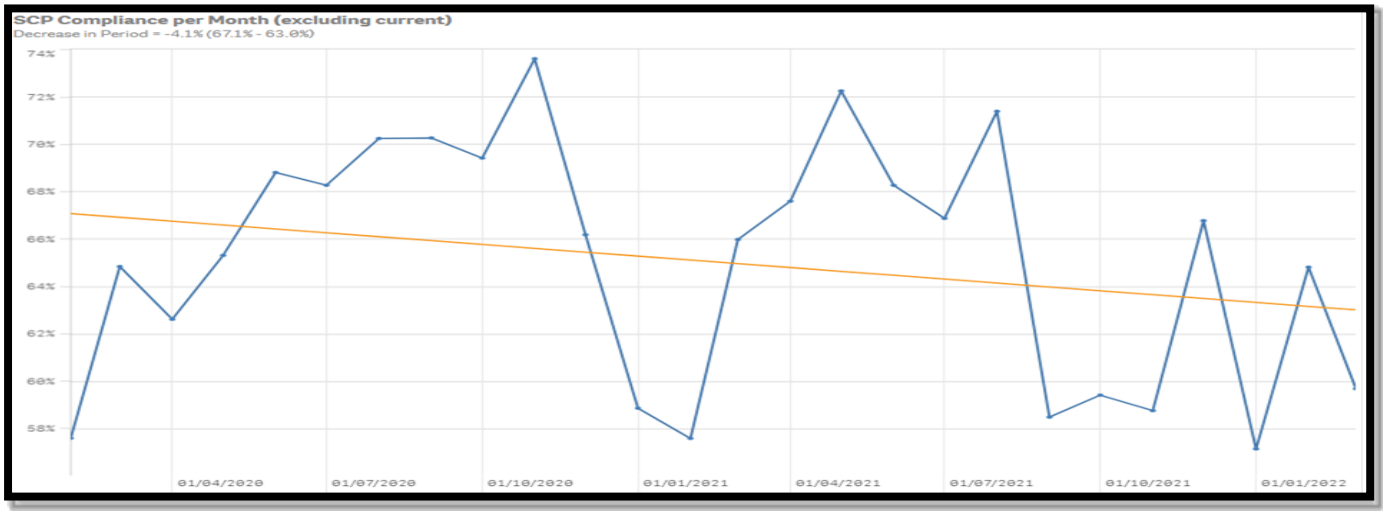
Cancer (Standard 5.1 – Timely Access) **RED**

The implementation of the Single Cancer Pathway in 2020 continues to ensure that patients are receiving equitable access to services. Following a year of supressed demand, March 2021 saw a rapid increase in referrals, with referral rates exceeding previous rates. Most specialties, observed higher numbers of referrals during 2021 than previously. Managing this level of demand whilst continuing to manage the risk associated with Covid has been a challenge and has required creative approaches to ensure patients receive diagnostic tests in a timely manner.

Health Organisations across Wales are subject to a 62 day target with a pass threshold of 75%. In recent months compliance has varied between 50-60% with a further decrease in April 2022. Low compliance is significantly impacted by skin cancer

performance. A 14% increase in suspected cancer referrals was observed in 2021/2022 compared to 2019/20. Furthermore, the first 3 months of 2022 have seen a further 12.4% increase. High referral rates are an encouraging sign of resumption of pre covid screening and primary care access, however the increase in demand is contributing to the poor compliance for the 62 day target.

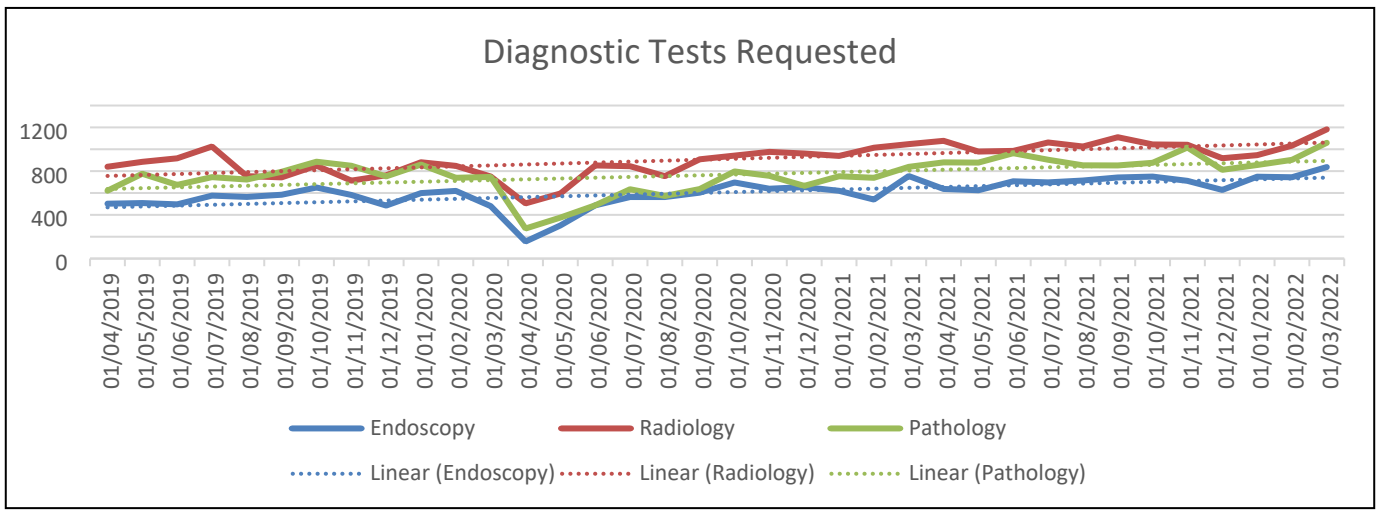
Single Cancer Pathway 62 day compliance



The demand, coupled with increased use of 'straight to test' services within pathways has resulted in high demand within diagnostic services leading to increased waiting times. Most notable for pathology and endoscopy.

The recovery of pathology waiting times a high priority. The movement of laboratory from the Royal Gwent site to a more suitable off site location is in progress. Ongoing plans are in place to try and reduce the level of unwarranted Urgent Suspected Cancer demand coming through. The turnaround time for pathology samples is having a notable impact on performance and is likely contributing to the reduced numbers of reported skin treatments.

Endoscopy demand, mirrors the high referral rates within colorectal services. There is active engagement with the Gastroenterology service to improve administrative workstreams currently delaying the scheduling times for endoscopy requests. The following graph illustrates the increased requests across endoscopy, radiology and pathology.



Cancer harm reviews commenced from February 2022 in response to direction from Welsh Government. The purpose of the reviews are to establish if the patients waiting for over 146 days for treatment have come to harm as a result of their prolonged wait and to capture information to specific delays within the pathway process.

Cancer Services will develop a case report for each patient outlining the pathway timelines, reasons for the breach to include where possible staging progression and change in performance status. Changes to treatment modality resulting from the length of wait will also be identified where possible.

A harm review panel will assess against a harm/no harm outcome, and whether the harm can be deemed avoidable or unavoidable against a set criteria with consideration of Redress in cases of avoidable harm. Where harm is identified and the length of waiting time has wait been avoidable, cases will be managed in line with Putting Things Right regulations.

Two Cancer review meetings have been undertaken since February 2022 and 32 cases reviewed. A more detailed report will be provided for a future meeting outlining outcomes.

Individual Care IMTP Priority: 1 2 3 4 5

End of Life (Standard 6.2 Peoples Rights)

In March 2022 Health Boards in Wales received correspondence from Welsh Government reminding them of their responsibility to undertake two yearly Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) audits reviewing a minimum of 50 cases in each audit. In 2021 ABUHB undertook a retrospective audit of DNACPR forms completed during the first and second Waves of Covid. 124 forms completed between March and June 2020 (wave 1) and 95 form completed between October 20 and January 21 (wave 2) were reviewed and an addition 30 cases review prospectively. The results demonstrate good documentation of the reasons for the DNACPR decision with 98% compliance in the first wave and 91% in the second wave. 94% of forms recorded the patients mental capacity status and 84% in the forms completed during the second wave. There was poor completion of the existence of a Lasting Power of Attorney or an Advanced Decision Document in both waves.

An audit of CPR is currently underway and will be reported to the June ABUHB Mortality Review Group. A Treatment Escalation Plan audit is currently planned and will be undertaken by August. Both results will be shared with the All Wales Advance and Future Care Planning Strategy Group.

Following the recommendations of the Internal MCA Audit, an educational film has been created to guide staff through the completion and review of a DNACPR. This will be available by June for all staff, via the MCA and Resuscitation ABUHB Intranet page. Additionally, an educational film explaining what should be considered when undertaking a mental capacity assessment will also be available. These educational

films were discussed at the All Wales Service User Feedback Safety & Learning Network Group on 18th May and the films have been shared with Patient Experience Leads across Wales. Further discussion will now take place at the National Listening and Learning Committee to determine how resources like this can be more readily shared to benefit staff across Wales.

In addition two training session have been delivered at the ABUHB Grand Round to support awareness of mental Capacity assessment and DNACPR.

A series of training sessions for Anticipatory Loss and Dementia were delivered in collaboration with Cruse during March and April 2022, (6 sessions provided with a total of 49 staff attending). A learning module for Anticipatory loss and dementia is being developed which will complement the existing 10 Dementia modules available to the NHS workforce via ESR.

Patient Experience Feedback (Standard 6.3 Listening and Learning from feedback)

Patient Reported Experience Measures (PREMS)

A number of Patient Reported Experience Measure Surveys (PREMS) have been undertaken across the Health Board. However, there is no structured approach to collecting, actioning or reporting this data and collection relies on a physical presence of staff to both ask the survey questions and manually analyse the results. A business case has been produced to support the adoption of the Once for Wales Patient Feedback System, Civica, which will allow real time feedback from patients across all divisions of the Health Board. The software will allow patients to feedback and reports to be generated instantly. It will enable the Health Board to have a planned and structured approach and response to this valuable feedback. Funding has finally been sourced and the Civica system will now be procured.

PREMS at St Woolos and the Royal Gwent Hospital

Three visits were made to Holly Ward during February and March 2022, in order to collect PREMS from the patients. A total of 14 patients provided feedback during the visits. An additional 3 questions were added specifically in relation to Holly Ward.

Holly Ward is being used as a Test of Change for the Step Closer to Home Pathway.

14 patients provided feedback, none of whom were Welsh speakers. 90% of patient reported they were always treated with dignity and respect and felt well cared for whilst 10% reported 'usually'. Although most patients reported that they were communicated with and were provided with information, a number of patients had difficulty hearing what was being said due to hearing impairment. 9 patients said they were always involved in decisions around their care, others reported 'sometimes' with 2 patients saying 'never'. All patients said they 'generally' felt listened to.

There were some reports of negative staff attitude, boredom, observations that staff talk very quickly making it difficult for people with hearing loss to comprehend, and the need for more comfortable chairs. To aid patient orientation at St Woolos, Dementia

Friendly clocks have been purchased for the wards. Also a supply of meaningful activities have also been distributed. At the end of the visit, feedback was immediately provided to staff and senior nurses and a written report sent to the ward with an expectation for improvement. The PREM data has been included in the evaluation report for Holly Ward due to be presented to Executive Team in June.

PREMS at County Hospital

Members of the Person Centred Care Team visited Rowan and Oak wards at County Hospital on 20th April in order to speak to patients and collect PREMS. A total of 17 patients provided feedback. An additional 4 questions were added to gain information regarding meaningful activities and bladder and bowel care.

17 patients across two wards provided feedback, none of whom were Welsh Speakers. 16 patients reported that they are always or usually treated with dignity and respect and felt well cared for. The 1 person who said sometimes attributed this to a long wait to use the bathroom. 15 patients said that things were explained to them, with the remaining two patients saying sometimes. Responses in regards to whether patients felt that staff listened to them were generally positive, although 3 patients who responded 'sometimes' attributed this to some staff listening and others not. There were some negative comments in regards to continence care, relating to delays in assistance to loss of dignity when needing to use the toilet. County Hospital are now working with the Continence Service to achieve 'excellence' in continence care.

At the end of the visit, feedback was immediately provided to staff and senior nurses and a written report sent to the wards.

Patient Liaison Service /Officers (PLO's)

The Patient Liaison Service for GUH are now located on the 2nd Floor at GUH. The team are taking calls from relatives and average around 35 –40 per day. This relieves pressure on the ED where the Patient Liaison Officers (PLO's) were previously based. The RGH PLO's have commenced in service this week. NHH service is due to commence at the end of May following final recruitment processes being completed and training provided. A Task and Finish Group has been initiated to look at telephone answering across the Health Board to scope a proposal as to how this can be resolved and improved in the longer term.

Digital Stories

3 digital patient stories have been produced during the last quarter. These have been used at listening and learning events and shown at internal meetings/committees. These stories are already proving to be invaluable in both culture and service change and have seen a review of current dementia action priorities. Two carers are now represented on the In-Patient Hospital Dementia Group.

The digital stories include:

1) **Gemma's Story** - this story focusses on the experience of a person with significant physical disabilities in a general hospital and highlights the importance of reasonable adjustments.

2) **Pat's Story** - this story focusses on a patient with dementia. Her daughter is member of staff who explains the difficulties she had in trying to navigate a complex healthcare system whilst working in it, highlighting how much harder it would be for informal carers.

3) **Alan's Story** - this story focusses on the care of a person living with dementia in a general hospital at the height of the pandemic and the difficulties his wife experienced with communication

Complaints/Concerns and Serious Incidents (Standard 6.3 Listening and Learning from Feedback) **AMBER**

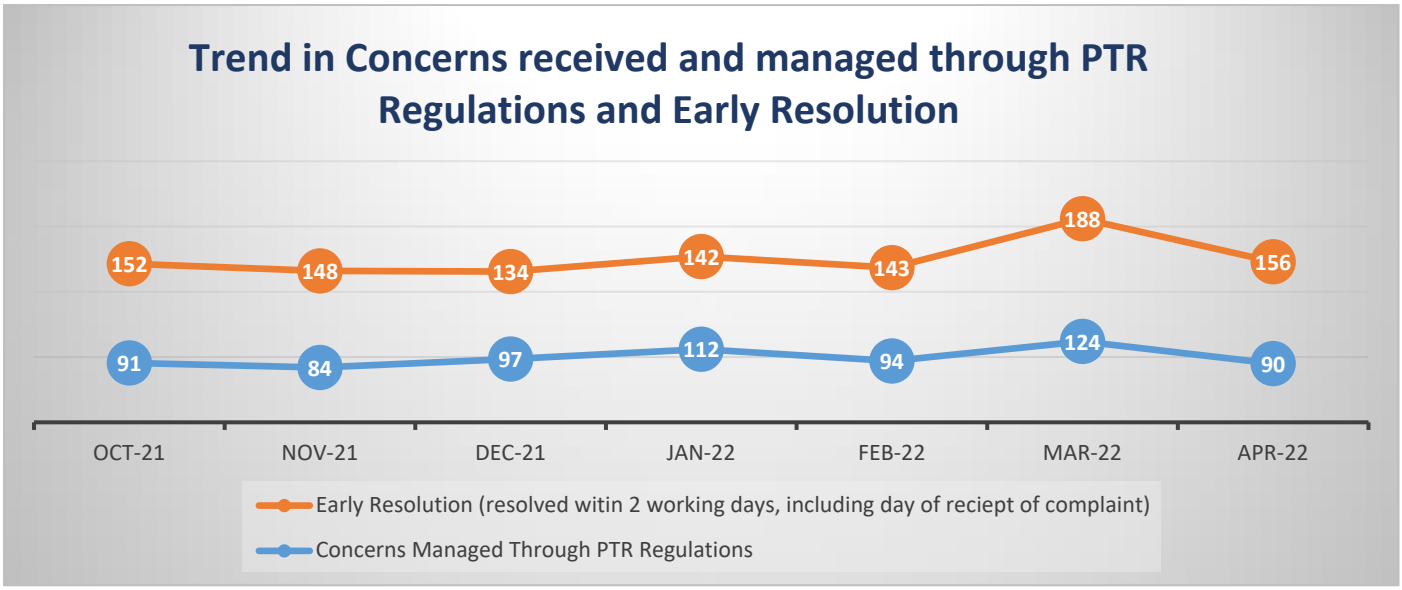
The 'Once for Wales' RLDatix Feedback Module is still being implemented throughout the Health Board, with actions and lessons learned shared at the monthly 'ABUHB Once for Wales Concerns Management Project Group.'

The number of formal and early resolution concerns received during this reporting period was 558, a 13.5% increase over the previous reporting period. The numbers received each month are shown in the table below.

	March 2022		April 2022	
	Complaints received	**% Performance closed within target**	**Complaints received**	**% Performance closed within target**
Early Resolution complaints received	124	58%	90	59%
Received and managed through PTR Regulations	188	47%	156	52%
Total	**312**		**246**	

Formal complaints performance has fallen to 47% and 52% retrospectively, from 75% and 83% during January and February, respectively. To improve compliance, a multifaceted approach is being implemented, which includes recruiting experienced retired colleagues to assist with complaint management.

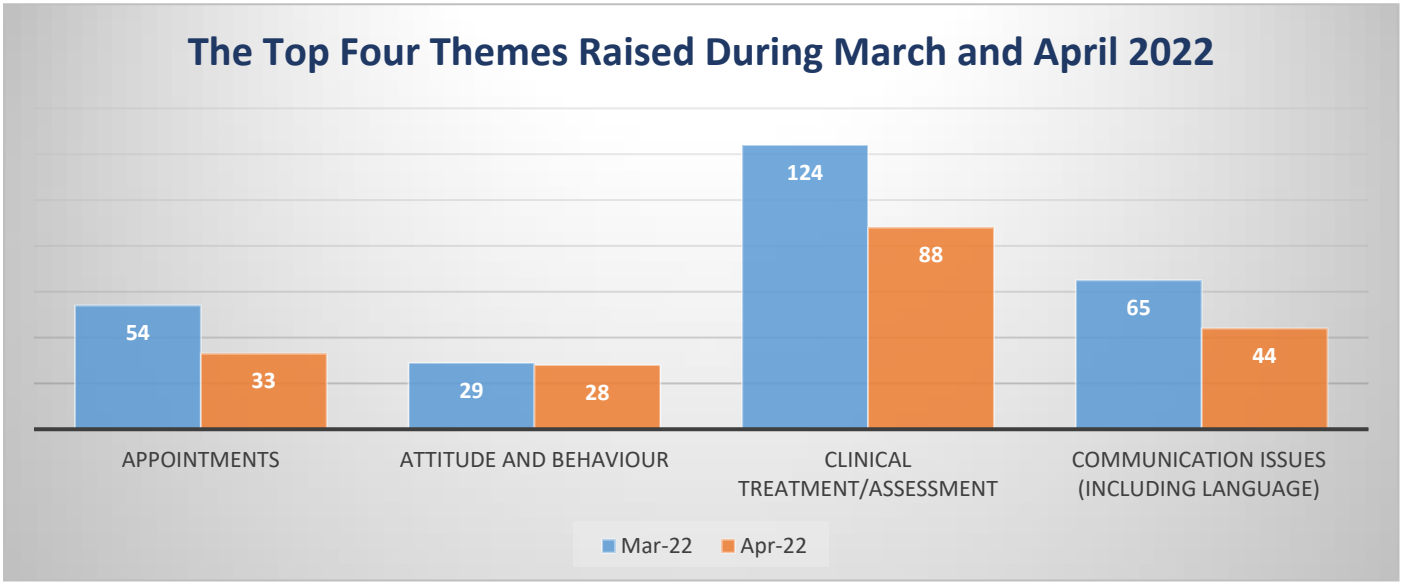
A review is being conducted to streamline Corporate PTR processes. As a result, CEO final responses are now electronically signed off, which improves governance and timeliness.



The top 4 themes remain consistent as follows:

1. Clinical treatment/assessment
2. Communication issues
3. Appointments
4. Attitudes and behaviour

These equate to approximately 80% of the total concerns raised, as illustrated in the graph below.



From the beginning of May 2022, the Corporate PTR team are managing phone concerns received by the Customer Management Centre. This is expected to provide a better experience for the complainant, especially if the issue is one that can be managed corporately through 'early resolution.' Concerns about communication, for example, difficulty getting through to the ward and receiving updates from clinical staff, could fit these criteria. This was recently tested, with very positive feedback from complainants, reinforcing the importance of making early contact, ensuring complainants are listened to, and importantly they feel 'heard.'

Staff attitudes and behaviours are being monitored and addressed as needed. If staff are specifically mentioned in a concern, a one-on-one discussion takes place, ensuring reflection and shared learning as required.

Public Services Ombudsman for Wales (PSOW) Update

At the end of April 2022, there were a total of 39 open PSOW cases at various stages within the process.

The Health Board is also notified of cases which remain anonymous to the Health Board, and which the PSOW has decided not to take forward. For this 2 month period, the Health Board was notified of 4 such cases.

8 Final Reports were received, with of 6 Upheld and 2 Not Upheld.

Within these Final Reports, the Ombudsman upheld the following failures.

- To involve families on the discharge process
- To consider the recurrence of Hodgkin's Lymphoma
- To keep robust records

Concerns were also raised around clinical care, nursing and assessment failings, communication and complaint handling failings.

Health Board teams continue to meet quarterly with the Head of the Complaints Standards from the Ombudsman's Office. This provides opportunity to discuss specific cases, review data and strengthens relationships. A new PSOW has been appointed and an induction meeting with the CEO is planned.

Patient Safety Incidents (Standard 6.3 Listening and Learning from Feedback)

During this reporting period there were 74 Serious Patient Safety Incidents (SI's) recorded which would have been reportable under the previous reporting Framework, compared to 51 recorded during the same reporting period in 2021. Of the 74, 8 met criteria for reporting, 5 of which were Never Events. The following table provides a breakdown activity during March and April.

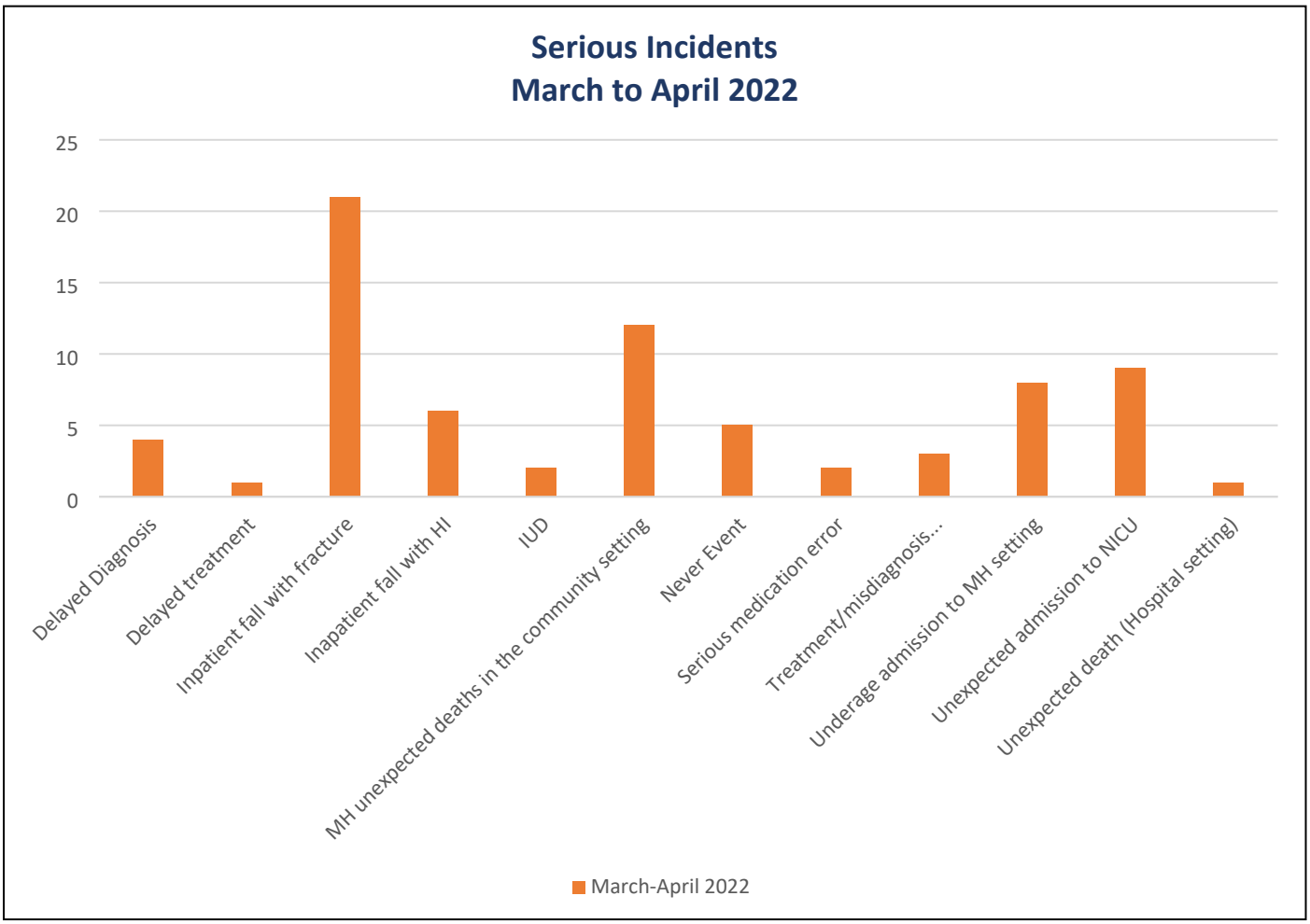
2022	All PSIs	Reported to the Delivery Unit	Early Warning Notification	Never Events	Red 1	Red 2
March	35	6	2	4	9	26
April	39	2	4	1	2	37
Total	**74**	**8**	**6**	**5**	**11**	**63**

To contextualise, organisationally approximately 500-600 incidents are reported weekly via RLDatix. These range from:

- No harm
- Low harm
- Moderate harm
- Severe harm
- Catastrophic/death

During the reporting period 3,767 patient/service user incidents were reported, with serious incidents equating to approximately 2% of the overall total.

As illustrated on the following graph, of the 74 serious incidents noted, approximately a third are inpatient falls with fractures or where the patient has suffered a head injury. There is a vast amount of work ongoing across the organisation relating to falls, as evidenced in Safe Care section of this report and regularly reported to PQSOC.



The following table illustrates the number of open Red 1 Serious Incidents across Divisions. Three weekly meetings continue to review progress, and address and escalate if unnecessary delays are encountered.

Recently a meeting took place with the Delivery Unit to review the number of open incidents. It was a helpful data cleansing opportunity, as there were discrepancies that have since been rectified.

Number of Open Serious Incidents		
Division	**March 2022**	**April 2022**
Scheduled Care	9	5
Unscheduled Care	14	14
Mental Health & Learning Disabilities	1	1
Therapies	2 (1 PRUDiC)	3 (1 PRUDiC)
Community	1	1
Primary Care	2	2
Complex Care	1	1
Total	**30**	**27**

Never Events

5 Never Events were reported during March and April, this was a marked increase on January and February where none were reported. They included 1 wrong route medication and 4 wrong site surgeries. Never Events have been RAG rated red for this reporting period.

A theme identified in the preliminary investigations of the four 'wrong site surgery' has been a lack of positive patient identification. An Internal Safety Alert was widely circulated across the Health Board during April, reinforcing the necessity for patients to have an ID band in-situ, along with positive identification. This is fundamental to ensure patient safety, particularly in the following circumstances,

- Blood transfusion
- Medication administration
- Radiology
- Interventional procedure
- Transfer or discharge of patients using Hospital transport/WAST

Never Events are managed corporately and receive Executive sign off. A thematic review was prepared following an increase in the number of Never Event incidents within the Health Board between February and May 2022. The purpose of the thematic review was to collectively scrutinise incidents which had occurred to identify key themes, wider learning and any actions arising from these.

The scope of the thematic review was considered, and a decision made to review all incidents categorised as Corporate Red 1 Serious Incidents. This extended to incidents which were categorised as Never Events as per the NHS Wales Never Event Guidance 2018-19. The thematic review analysed incidents which had undergone a full and comprehensive investigation and had been closed between April 2021 and April 2022. The thematic review was undertaken through the lens of the Yorkshire Contributory Factors Framework, which is a tool embedded in human factors and systems thinking which understands Healthcare organisations as complex systems. By addressing such

themes through a series of 'systems', it is proposed that learning can be richer and more meaningful, enabling the organisation to make improvements which can impact positively on patient care and clinical practice.

The thematic review identified that task factors were the single biggest contributor to clinical incidents, and that the tasks performed by clinical teams are often complex and yet completed within busy environments under pressure. Specifically in respect of the 10 Never Event incidents reviewed, it identified that LOCSSIPS, NATSSIPS and WHO Safety Checklists, when used effectively and robustly, have the capacity to dramatically improve the safety of procedural care. This means, incorrect patients or laterality of procedures are not miscommunicated or mistaken.

In addition, the thematic review captured the importance of effective Deteriorating Patient procedures to support escalation, appropriate communication and effective documentation among clinical teams, which mitigates against ongoing deterioration and ensures timely rescue of patients and supportive management.

Thematic reviews will become more commonplace within ABUHB and further guidance from Welsh Government will support this process in forthcoming months. Future work could concentrate on looking specifically at incidents by category over a longer time period to capture more themes and use these in learning. Current literature on thematic analysis in qualitative research, identifies coding as the best methodology to extract themes more clearly. There is scope to explore whether RLDatix may have capacity within its software to support this in future.

Regular meetings with WAST quality, patient safety colleagues continue. Discussions are underway to improve the process relating to Appendix B submissions to ABUHB and the proportionate investigation of ambulance delays. These are submitted by WAST following an incident raised by their staff.

External Inspections (Standard 6.3 – listening and learning from feedback)
AMBER

A separate paper is provided for the Health Inspectorate Wales (HIW) Review of ED and Assessment Units, GUH.

HIW conducted a visit to Northview Dental Practice on the 4 May 2022 which resulted in concerns about the environment of care and potential patient safety risks. An Immediate Assurance letter was issued for which the Practice provided a response but HIW are not satisfied. The Practice must resubmit by 27th May. ABUHB IPAC Team have been asked to visit the practice. The matter has been flagged with the Director of Primary Care, Community and Mental Health for oversight.

Glossary

Health and Care Standards

Safe Care - The principle of safe care is to ensure that the population are protected from harm and supported to protect themselves from known harm. The health, safety and welfare of people are a priority. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers. Although the provision of care has some associated element of risk of harm to service users, safe care identifies, prevents or minimises unnecessary or potential harm. Therefore people will be kept safe and protected from avoidable harm through appropriate care, treatment and support.

Effective Care - The principle of effective care is that people receive the right care and support as locally as possible and are enabled to contribute to making that care successful. If people receive the right care and support they will be empowered to improve or manage their own health and wellbeing. Interventions to improve people's health must be based on best practice, derived from good quality research. Data relating to care delivery should be maintained in structured, accurate and accessible records. The ability to manage data and information and to communicate effectively will contribute to the delivery of safe and effective care.

Dignified Care - The principle of dignified care is that the population are treated with dignity and respect and treat others the same. Fundamental human rights to dignity, privacy and informed choice must be protected at all times, and the care provided must take account of the individual's needs, abilities and wishes.

Timely Care - The principle of timely care is that people have timely access to services based on clinical need and are actively involved in decisions about their care. Not receiving timely care can have a huge impact on individuals' experience of health services and their ability to achieve the best health outcomes. To ensure the best possible outcome people's conditions should be diagnosed promptly and treated according to clinical need.

Individual Care - The principle of individual care is that people are treated as individuals, reflecting their own needs and responsibilities. All those who provide care have a responsibility to ensure that whatever care they are providing includes attention to basic human rights. Where people are unable to ensure these rights for themselves, when they are unable to express their needs and wishes as a result of a sensory impairment, a mental health problem, learning disability, communication difficulty or any other reason, access to independent advocacy services must be provided. Every person has unique needs and wishes. Individual needs and wishes vary with factors such as age, gender culture, religion and personal circumstances, and individual needs change over time, respecting people as individuals is an integral part of all care.

Patient Safety Solutions - through analysis of reports of patient safety incidents, Ombudsman and Coroners reports and safety information from other national and international sources, the Welsh Government issues advice and/or guidance for the NHS in Wales that can help to ensure the safety of patients. These are issued as Patient Safety Notices (PSN) or Patient Safety Alerts (PSA).

Intersite Transfer - Transfer of patients between ABUHB inpatient sites as part of their treatment pathway.

Covid-19 - Coronavirus is an infectious disease caused by the SARS-CoV-2 virus. Most people infected with the virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Some people will become seriously ill and require medical attention.

Clostridium difficile (C. *difficile*) - a type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. When someone has C *difficile* infection, it can spread to other people very easily if the bacteria gets onto objects and surfaces.

Gram-negative infections - include those caused by Klebsiella, Pseudomonas aeruginosa, and E. Coli. Gram-negative bacteria are enclosed in a protective capsule. This capsule helps prevent white blood cells (which fight infection) from ingesting the bacteria. Under the capsule, gram-negative bacteria have an outer membrane that protects them against certain antibiotics, such as penicillin. When disrupted, this membrane releases toxic substances called endotoxins.

E coli - one of the most isolated bacteria in the bloodstream (responsible for approximately 20% of all clinically significant isolates) and is the Gram-negative organism most frequently isolated in adult patients with bacteraemia. The most common underlying cause of bacteraemia is of the genital/urinary tract.

Pseudomonas - infections caused by a kind of bacteria called Pseudomonas that's commonly found in soil, water, and plants. The type that typically causes infections in people is called Pseudomonas aeruginosa. The most severe infections occur in hospitals. Pseudomonas can easily grow in humidifiers and types of medical equipment i.e. catheters. If health care workers don't wash their hands well, they can also transfer the bacteria from an infected patient to patient.

Klebsiella - a type of Gram-negative bacteria. Klebsiella bacteria are normally found in the human intestines and in human stool. When these bacteria get into other areas of the body, they can cause infection. The bacteria are mostly spread through person-to-person contact. Less commonly, they are spread by contamination in the environment. As with other healthcare-associated infections, the bacteria can be spread in a health care setting via the contaminated hands of health care workers.

Influenza - a highly contagious viral infection of the respiratory passages causing fever, severe aching, and catarrh, and often occurring in epidemics.

Respiratory syncytial (sin-SISH-uhl) virus, or RSV - a common respiratory virus that usually causes mild, cold-like symptoms.

Staphylococcus aureus bacteria (staph) - lives on the skin and in the nose of many people. It usually only causes a problem such as MSSA bacteraemia if it gets inside the body. Staph infections can be either methicillin-resistant staphlococcus (MRSA) or methicillin-susceptible staph (MSSA). MSSA infections are usually treatable with

antibiotics. However, MRSA infections are resistant to antibiotics. Many staph infections are mild, but they can also be serious and life-threatening.

Careflow - a digital clinical platform that support the recording of observation and fluid balance for inpatients.

Vancomycin - an intravenous antibiotic. Safe prescribing requires ongoing monitoring of vancomycin levels in the blood to prevent kidney damage and auditory damage.

Venous thromboembolism (VTE) - blood clots that develop within blood vessels.

Hospital Acquired Thrombosis (HAT) - thrombosis that occur in hospital and within 90 days following a hospital admission.

Thromboprophylaxis - medical treatment to prevent development of thrombosis.

Preventable Hospital Acquired Thrombosis - thrombosis that occur in hospital and within 90 days following a hospital admission where the necessary risk assessment and prescribing of thromboprophylaxis is not undertaken.

Single Cancer Pathway - a Welsh Government target to support diagnosis cancer and starting treatment within 62 days.

Do Not Attempt Cardio Pulmonary Resuscitate (DNACPR) - when an individual has a cardiac arrest of dies suddenly there will be guidance on what action should or shouldn't be taken by a health care professional including not performing CPR on the person.

Patient Reported Experience Measure (PREM) - a quantifiable measure of patient satisfaction and experience in health services.

Once for Wales - a term used to describe a project or service improvement undertaken in all health organisations in Wales**.**

Public Service Ombudsman for Wales (PSoW) - an independent body that has legal powers to look into complaints about public services and independent care providers in Wales

Serious incident – national reportable patient safety incidents.

Never Events - a patient safety incident that is deemed entirely preventable.

LOCSSIPS – locally derived safety standards which apply to invasive procedures with the goal of improving patient safety.

NATSSIPS – national safety standards for invasive procedures to reduce the number of safety incidents related to invasive procedures where a never event could otherwise occur.

WHO – World Health Organisation

Recommendations

The Patient Quality, Safety and Outcomes Committee is asked to:

- **Note** the Health Board position against a range of key quality and safety metrics.
- **Discuss** performance, themes and actions for assurance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report reviews high level data in order to highlight clinical risks in the system. The quality improvement initiatives in this report are being undertaken to improve patient safety and therefore reduce the risk of harm to our Patients. Improved patient safety also reduced the risk of litigation. Issues are part of Divisional risk registers where they are seen as a particular risk for the Division and a number of areas are also included within the Covid and Corporate Risk Registers.
Financial Assessment, including Value for Money	Some issues highlighted within the report will require additional resources to support further improvement. These will be subject to individual business cases which will contain the full financial assessment. In many cases, improving the quality will reduce harm to patients and/or waste, but this will also be highlighted in the business cases.
Quality, Safety and Patient Experience Assessment	The report is focussed on improving quality and safety and therefore the overall patient experience.
Equality and Diversity Impact Assessment (including child impact assessment)	N/A
Health and Care Standards	Health and Care Standards form the quality framework for healthcare services in Wales. The issues focussed on in the report are therefore all within the Health and Care Standards themes, particularly safe care, effective care and dignified care.
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP and the quality improvements highlighted here are within the Plan.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being*

	Objectives and should also indicate to which Objective(s) this area of activity is linked.
	Long Term – Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Involvement –Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	See above section where a glossary is provided separately.
Public Interest	Report has been written for the public domain.

Committee:	Patient Quality, Safety & Outcomes Committee
Date:	7th June 2022
Agenda Item:	**2.8**
Document Title:	**Operation Jasmine and the Coroner's Inquests: further reflection and learning**

Aneurin Bevan University Health Board

Patient Quality, Safety and Outcomes Committee

Operation Jasmine and the Coroner's Inquests: further reflection and learning

Summary

Further to the Board Development session held on the 27th April 2022 whereupon members were appraised of further Health Board actions and learning following the Coroners Inquests associated with cases involved in Operation Jasmine, it was agreed an overview of the improvement plan and progress would be presented to the Patient Quality, Safety and Outcomes Committee.

This paper provides an update on progress for assurance.

Purpose: **Patient Quality, Safety and Outcomes Committee is asked to:**	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	

Author: Rhiannon Jones – Executive Director of Nursing

Report Received consideration and supported by:

Executive Team	X	**Sub-Committee**	

Date of the Report: 25 May 2022

Supplementary Papers Attached:

- The Operation Jasmine Improvement Plan (ABUHB)

Background

Operation Jasmine was a historic inquiry by Gwent Police into allegations of neglect at a number of nursing homes in South East Wales from 2005 to 2013. It began as a result of a cluster of deaths in Gwent care homes linked to pressure wounds. It was the subject of an independent review by Margaret Flynn who published her report, *In Search of Accountability: a review of the neglect of older people living in care homes investigated as Operation Jasmine*, in May 2015.

In January 2021, inquests commenced into the deaths of seven people whose cases were considered as part of Operation Jasmine. The Coroner explored the care at the care home (Brithdir Care Home) as well as the role of the state agencies in their oversight and regulation of the care home. This included the Care Standards Inspectorate Wales (now Care Inspectorate Wales (CIW)), the then Caerphilly Local Health Board and Caerphilly County Borough Council (CCBC).

The Coroner concluded the deaths of five of the people were contributed to by neglect. He found state agencies were too focused on processes and opportunities were missed to take action earlier.

These were incredibly important inquests, particularly for the families of the deceased who had waited so long for these matters to be explored in public.

Much has changed since these tragic events both through legislation and in our ways of working. However, we must never become complacent and must continue to reflect, learn and improve. This is particularly important as we respond to the continued impact and pressures on the health and social care sector arising from the Covid-19.

In December 2021, CIW, CCBC, Aneurin Bevan University Health Board and Social Care Wales worked in partnership to facilitate an online reflection and learning event on Operation Jasmine. As well as the multi-agency learning, the Health Board has considered further actions to ensure on-going improvements as a direct result of the inquests.

Assessment

An improvement plan has been developed following a local learning event involving all Divisions, in the Summer 2021. The recommendations were shared with the Board in April 2022, with approval and agreement for oversight via the Patient Quality, Safety and Outcomes Committee.

The improvement plan includes 9 recommendations for action and the attached plan (Appendix 1) provides a high level overview of actions. Positively, all actions have been progressed, with one completed in full.

Conclusion

Good progress has been made against the improvement plan.

A further update will be provided in February 2023.

Recommendations

The Patient Quality, Safety and Outcomes Committee is asked to:

- **NOTE** the progress against the ABUHB Improvement Plan for assurance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The improvement plan demonstrates organisational commitment to on-going learning and consequently reduces risk
Financial Assessment, including Value for Money	No financial risk identified, with the exception of the money required to fund procurement of the national Civica system.
Quality, Safety and Patient Experience Assessment	This report highlights key learning to improve the safety and quality of care provided & commissioned..
Equality and Diversity Impact Assessment (including child impact assessment)	Not applicable for the purpose of this summary report
Health and Care Standards	This report provides information around standards 1.1, 2.1, 3.1,3.2, 3.3, 3.5, 4.1, 4.2, 6.1, 6.3 and 7.1
Link to Integrated Medium Term Plan/Corporate Objectives	Aligned to all IMTP Priorities through the life course.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –**Improving the quality and safety of the services will help meet the long term needs of the population and the organisation
	Integration – The quality and patient safety improvements described work across directorates and divisions
	Involvement –Improvement initiatives are developed using feedback from staff.
	Collaboration – The quality and patient safety described work across directorates, Divisions and Health Board.
	Prevention – Improving patient safety will prevent patient harm within our services and improve public confidence.
Glossary of Terms	
Public Interest	Written in the public interest

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

OPERATION JASMINE / CORONER INQUESTS

Actions for Improvement

Corporate Nursing Aneurin Bevan

ACTION	RESPONSIBLE	PRIORITY	STATUS	START	END	NOTES
Action #1:						
"Lets not forget" – a schedule of awareness raising sessions	Linda Alexander Linda Jones		started	12/2021	12/2022	• Programme over the next 12 months. • Featured in CNT newsletter December 2021. • Awareness sessions via a 'Digital Story' will be completed by end of May 2022, plan in place to ensure awareness sessions, utilising the Digital Story, are embedded within all nursing programmes to include the N&M Academy.
Action #2:						
A standardised Quality Assurance Framework for commissioned work	Michelle Forkings Veronique Hughes Helen Morgan		started		06/2022	• Draft Framework will be completed by mid-June 2022.
Action #3:						
A review of the Margaret Flynn Action Plan to assess progress	Tracey Partridge-Wilson Amy Bucknall		started		06/2022	• Draft assessment plan developed.

Update – May 2022

Action #4:						
A review for the process of professional reflection	Linda Jones Lyn Middleton		Complete		01/2022	• Reflection template launched at Senior Leadership meeting in December 2021. • Featured in Corporate Nursing Newsletter. • REFLECT is promoted as the tool of choice for the N&M leadership Academy. • Clear evidence noted of being utilised in clinical practise. • Tool also shared cross–professionally.
Action #5:						
A strengthening of the patient and family voice with meaningful patient experience gathering	Tanya Strange		started		09/2022	• Numerous CHC buddying programmes in place since September 2020. • Dementia webinar being held for people living with, or caring for people with dementia in May. Objective is to secure an 'Expert by Experience' reference group. • 4 ABUHB members of staff have undertaken Community Engagement training which will enable community engagement across the boroughs and for dedicated groups such as carers. • Civica business case finalised with monies secured to procure the system.

Update – May 2022

Action #6:						
Education programmes – sessions on accountability, record keeping standards, raising concerns, reflective practice.	Linda Alexander Linda Jones		started	12/2021	12/2022	Programme over the next 12 months: • Current educational opportunities reviewed, and assurance sought in regards inclusion of sessions on accountability, record keeping, raising concerns and reflective practice. • NMC videos now utilised within JOE and preceptorship programmes which includes – short, snappy reinforcements. • Sessions incorporated into the OSN's well-being, educational and support cafés. • Reflective practice covered within the template.
Action #7:						

Update – May 2022

Review of DECI/HACI processes across all areas	Linda Alexander Linda Jones		started		12/2021	• HACi reviewed by EDoN –to be rolled out across all areas. • Task and Finish group established to progress roll out across Health Board. • Necessary amendments being made to audit. • IT capabilities being explored to improve compliance and tracking of metrics. • SOP under development • Workshop held to establish a framework for audit.

Action #8:						
Consider safety tools (10 steps for safety) to heighten awareness and positioning of QPS	Tracey Partridge-Wilson		started		02/2022	• Quality management system - Meeting with clinical execs 24th May 2022.
Action #9:						
Consider an approach of inter-Divisional reviews	Deb Jackson Penny Gordon		Not started		12/2021	[Potential to feed into #8 and #1] • There is good work already ongoing in relation to mortality reviews and patient transfers, which promotes inter-divisional reviews, need to learn from this. • Need to progress a meeting with the QPS leads; Karen Hatch, Alex Scott and Tracey Partridge-Wilson to discuss the concept more widely and identify areas where this approach could be used.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient, Quality, Safety and Outcomes Committee Tuesday, 7th June 2022 Agenda Item: 2.9

Aneurin Bevan University Health Board
PQSO Committee - Strategic Risk Report

Executive Summary

This report provides an overview of the profile of the current risks reporting to the Patient, Quality, Safety and Outcomes Committee (PQSOC). Whilst this report articulates the strategic risk profiles for the organisation, operational context is important to note as the Health Board continues to experience the challenges of the pandemic; restart and recovery of previously paused operational services; ongoing uncertainties related to Variants of Concern (VoC) alongside continued staffing pressures due to sickness and isolation requirements.

This report includes update on progress related to the organisational approach to risk management and continued development and embedding of the risk management strategy 2021.

The PQSO Committee is asked to note this report for assurance.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor:	Rani Mallison, Director of Corporate Governance
Report Author:	Danielle O'Leary, Head of Corporate Services, Risk and Assurance

Report Received consideration and supported by :

Executive Team	**N/A**	**Committee of the Board [Patient, Quality, Safety and Outcomes Committee]**	**As outlined.**

Date of the Report: 23rd May 2022

Supplementary Papers Attached:
Appendix 1 – Assessment of 8 Risk Profiles

Purpose of the Report

This report is provided for assurance purposes and seeks to provide a summary of the current key risks to the Health Board in respect of Quality and Patient Safety.

Background and Context

In conjunction with the revised Board Assurance Framework (BAF) and the revised Risk Management Approach, the Health Board is able to review and assess its strategic risks against achievement of objectives as set out in the IMTP 2022/23.

This report provides the Patient Quality, Safety and Outcomes Committee with an opportunity to review the organisational strategic risks which receive oversight from PQSO Committee.

The Health Board utilises the All-Wales Risk Matrix to assess the potential impact and likelihood of occurrence of all predicted risks to form an overall risk score. Risks may then be tolerated, treated, transferred or terminated in line with the Health Board Risk Management Strategy.

Assessment & Overview of Current Status

The revised risk management approach remains in the embedding phase throughout the organisation and thematic alignment can be evidenced through the Divisional risk reporting and strategic risk reporting. Continued engagement throughout the organisation has taken place and continues to progress to strengthen the utilisation of the Health Board's internal electronic risk management system (DATIX). The risk management system will form one of the key sources of business intelligence in respect of identification and escalation of operational risk, in conjunction with Executive level horizon scanning led risk identification.

This business intelligence and Executive level horizon scanning will be used to inform Board and Committee agendas and thereby, drive the business of the Health Board. This will ensure that an outward facing, strategic and risk focus is adopted. This will also be reflected in Board and Committee work plans and the Board Assurance Framework.

Further development work alongside Divisions is being undertaken to ensure risks are being captured on the system appropriately and consistently in terms of scoring, risk assessment and descriptors. One of the mechanisms for undertaking this development work will be the Risk Managers Community of Practice which last met in May 2022 and received a dedicated session on risk appetite. A session to re-set the Health Board risk appetite statement and associated descriptors is due to be held with the Board on 22nd June 2022.

Executive Team continues to support the embedding of the revised risk management approach and strategy provides an overarching position in relation to each risk area. In parallel to horizon scanning, strategic risk identification; the Health Board's risk management approach and infrastructure, is continually improving.

Further work to understand how we provide the Board with assurance on our commissioned services in relation to Continued Health Care (CHC), Looked After Children (LAC) and other Specialist Services for Mental Health is being undertaken. The Health Board recognises the need to take our internal strategic and operational risk management processes into consideration when we seek assurance on the services we commission and provided on our behalf. An update on this development will be provided in the next Committee strategic risk report.

Assessment

The risks reported to the Committee have been reviewed by risk owners and service leads in relation to risk scoring, descriptions, action plans and updates.

The Committee is asked to note the de-escalation and subsequent removal of the following risks since the last reporting period:

CRR030 Safeguarding – this risk has been de-escalated to be managed at a local level and is no longer deemed an organisational risk.

CRR026 Impact of COVID on in-patient beds – the risk environment in relation to this risk has changed, patients requiring hospital admission due to COVID has reduced, therefore this risk has de-escalated and is no longer relevant.

In relation to risk **CRR028** Access to crisis care beds for children and young people; significant developments in relation to the Health Board management of this risk continues. Plans are in place to develop a dedicated space for children and young people in crisis and although the last reporting period does not report any positive impact on the risk, it is anticipated that an improved position will be reported to the Board through the Strategic Risk Report at the July 2022 meeting.

A further de-escalation in relation to risk **CRR027** Effectiveness of COVID-19 vaccine, due to the high vaccination uptake rates for the Health Board area alongside robust weekly monitoring arrangements of epidemiological data has provided enough assurance to de-escalate from 5x5=25 to a 4x5=20.

A high-level table of risks is included within the body of this report however, the detailed risk updates are included at ***Appendix 1***.

Current Status

There are currently 21 risks comprising the Corporate Risk Register, of those 8 receive oversight from the Patient, Quality, Safety and Outcomes Committee. The following table provides a breakdown of the 8 risks by their severity:

High	5
Moderate	3
Low	0

There are also 4 risks being effectively managed within its target score and within the agreed risk appetite level (outlined in the table below). Therefore, the Committee is asked to note the current score, target score, an assessment as to whether the risk is managed within its agreed risk appetite, and trend since the last reporting period:

Risk ref and Descriptor	Current Score	Target Score (informed by Appetite level)	Risk Appetite Level	Managed to Agreed Level Y/N?	Risk Treatment	Date and Trend Since Last Reporting Period	Assurance/ Oversight Committee	Risk Owner
CRR019 Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand. **(re-framed Dec 2021)**	20	15	**Low** level of risk appetite in relation to patient safety risks. **Moderate** levels of risk with regard to innovation around mitigations to prevent demand and better manage the demand.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Board, May 2022)** 	**PQSO**	**Director of Operations**
CRR013 Failure to prevent and control hospital and community acquired infections to include COVID-19	10	10	**Zero or low** due to patient safety and quality of service.	**Yes**	**Treat** the potential impacts of the risk by using internal controls.	**(Board May 2022)** 	**PQSO**	**Director of Nursing**
CRR023 Potential risk to population health in relation to avoidable harm due to priority being given to management of the COVID pandemic.	20	20	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to different ways of working to address backlog. This would include the use of technologies and innovations.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Board, May 2022)** 	**PQSO**	**Director of Operations**

CRR010 Inpatients may fall and cause injury to themselves	15	10	**Zero or low** in the interests of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Board May 2022)** 	**PQSO**	**Director of Therapies and Health Science**
CRR027 Effectiveness of COVID vaccination and booster programme compromised leading to a Variant of Concern	20	20	**Moderate** risk appetite level will need to be applied to this risk profile, given the unpredictability of the potential of variants of concern. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control.	**Yes**	**Treat** the potential impact of the risk with mitigations. **Tolerate** the unpredictable element of the VoC and other mutations.	**(Board, May 2022)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR028 Continued inappropriate admissions of Children and Young People to adult mental health in-patient beds.	20	10	**Low** risk appetite level in relation to patient safety and experience. **Moderate** level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Board May 2022)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**
CRR001 High levels of seasonal influenza	8	8	**Low** level of risk appetite in relation to patient experience. **Moderate** levels of risk appetite can be applied to pursue innovative models and technologies to encourage uptake.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Board May 2022)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR003 Mental Health services will fail to meet the anticipated increased demand of the Health Board population, for Mental Health	12	8	**Low** risk appetite level in the interests of patient safety. **Moderate** risk appetite levels will need to be taken to explore further innovations and appropriately reconfigure services and implement new arrangements.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Board May 2022)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**

support, in light of the COVID 19 pandemic.								

A detailed assessment of each risk profile outlined above is available at **Appendix 1**.

We will be actively working to review risk targets to ensure realistic and as far as possible; set within the context of the Board's appetite for risk.

Recommendation & Conclusion

The Committee is requested to note the content of this report for assurance purposes, recognising that there will be further iterative development work to embed the revised risk management approach with QPSOG and Divisions.

The Committee is asked to acknowledge the de-escalating position and subsequent removal from the Corporate Risk Register of:

- CRR030 – Safeguarding.
- CRR026 [1]– Impact on in-patient arrangements and service capacity due to increased pandemic levels.
- CRR027 – Effectiveness of COVID-19 vaccinations.

The Committee is also requested to note the 4 risks being effectively managed within agreed risk appetite and target risk score levels and the detail within ***Appendix 1.*** The Committee is encouraged to review the risk profiles in conjunction with other, interlinked risk profiles to ensure consistent understanding of context.

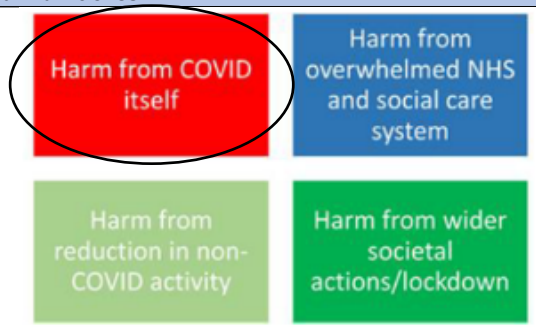
Supporting Assessment & Additional Information

Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment (including value for money)	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.
Quality, Safety & Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality & Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health & Care Standards	This report contributes to the good governance elements of the H & CS.

[1] Re-framed risk profile as of March 2022

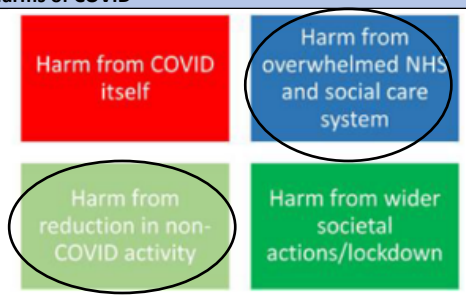
Linked to Integrated Medium Terms Plan & Corporate Objectives	The objectives will be referenced to the IMTP
The Wellbeing of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of Terms	None
Public Interest	Report to be published

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
• Less serious illness that require hospital care • Providing high quality care and support for older adults		***CRR013 – (Jul-18)*** ***Threat Cause: Failure to effectively manage community and hospital transmission of Health Care Acquired Infections (HCAIs) to include COVID 19.*** ***Threat Event: Widespread hospital and community harm, with potential increase in demand and acuity.*** **TREAT**					
High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence	**Risk Appetite**	Zero/Low Appetite				
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Patient, Quality, Safety and Outcomes Committee	• Robust internal policies • Multiple SOPs	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		3	5	2	5	2	5
Reducing nosocomial transmission group (RNTG) which is clinically led, reports to Executive Team weekly. COVID hospital transmission implementation plan is in place, recently updated to include the Hierarchy of Controls and with frequent auditing and monitoring. Organisational thermometer updated to reflect community prevalence Ongoing monitoring of the Clostridium Difficile rapid implementation plan via RNTG	Ongoing	**15**		**10**		**10**	
Trend		**Executive Owner: Director of Nursing**					

Mapping Against 4 Harms of COVID		**Update**
		**May 2022 COVID-19** There continues to be an ongoing community prevalence of COVID-19, which has impacted on patients presenting to hospitals with COVID-19 and onward hospital transmission. Currently there are 5 wards in outbreak across the ELGH and community hospitals which is a significant reduction. Each outbreak has undergone a thorough root cause analysis, essential to understand the transmission of COVID-19 and focus on improvement. Each outbreak has been reported to Welsh Government, index cases have been identified on five-day inpatient testing. In addition to the outbreak RCA mortality reviews are undertaken for patients who have died within 28 days of a probable and definite hospital acquired Covid-19 acquisition. The Health Board (HB) has an established Covid pathways supported by single room hospitals. This assists in reducing the risk of COVID-19 transmission and is in-line with the recommendations contained in the hierarchy of control risk assessment. The HB currently implements admission and inpatient five-day testing to identify asymptomatic carriers. It also supports the testing for other winter respiratory infections such as RSV and Influenza. This will change in April in line with National Guidance and revised National Alert Level There have been several care/residential homes reporting outbreaks of Covid-19 across the ABUHB footprint. IPT have continued to provide support and advice. The HB has a robust visiting policy which is regularly reviewed and updated in-line with Welsh Government “visiting with a purpose” guidance. LFD testing for all visitors continues to reduce the risk of COVID-19 transmission, with a revised visiting policy in train. All standard operating procedures and policies relating to COVID-19 are discussed and ratified at the reducing nosocomial transmission group (RNTG). The isolation period of exposed patients and for outbreak management from 10 to 7 days was recently agreed, recognising a whole system approach to risk is essential. Staff risk assessments have been developed and are regularly updated in line with WG guidelines, to support safe return to work when exposed to a positive case and have been identified by trace and protect or recent international travel. **Clostridium Difficile** Clostridium Difficile within ABUHB continues to exceed the Welsh Government reduction expectation target which mirrors all Wales trajectory. Recent months have seen a slightly improved picture. Last year an implementation plan was developed incorporating all key principles required for the reduction and management of Clostridium Difficile reflecting national guidelines. This continues to form a key agenda item with RNTG with a particular focus on antimicrobial stewardship, fundamental infection prevention principles and hospital cleaning.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
• **Getting it right for children and young adults** • **Supporting adults in Gwent to live healthy and age well** • **Provide high quality care and support for older adults** • **Staying healthy** • **Care closer to home** • **Less serious illness which require hospital care**		***CRR023 – (May 2020)*** ***Threat Cause: Priority being given to management of the COVID pandemic*** ***Threat Event: Risk to population health in relation to non - COVID harm*** **TREAT**					
High Level Themes	• Population health • Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Finance	**Risk Appetite**		Zero or low level of risk in terms of protecting patient safety and the quality of services however, innovative means of tackling backlogs of waiting lists and working SMARTER in the future needs to be considered and in this case, a higher risk appetite will be applied.			
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Patient, Quality, Safety and Outcomes Committee	• Departmental repurposing and redesign to accommodate non-COVID activity has occurred. New ways of working adopted e.g. virtual reviews. Nosocomial Group operating, providing advice and support. • Adapt and sustain progress being monitored through Exec Team meetings via Director of Operations. • Plan in place for for green recovery (treatments) RGH – all specialities excluding orthopaedics • Orthopaedic operating at OSU and NHH (P2) • Outpatient Steering Group • Robust escalation reporting and escalation arrangements within primary and community services division.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	4	5	4	5
Early recovery plan agreed focusing on Cancer, 52 weeks, Follow Up waits, Diagnostic and Therapies waiting times, and Eyes Care. Formal recovery plan for 2022/23 being developed as part of the Annual Plan. Focus on new ways of working will be fundamental to the approach. Risk stratification and validation of lists is ongoing and focus is on Urgent and Cancer work.	Mar-22	**20**		**20**		**20**	

Weekly tracking of recovery plus tracking of new ways of working in place, the priorities outlined above mirror those in F&T with similar work progressing operationally around risk stratification, validation, daily scrutiny of cancer pathways, WLI OPD sessions for clinically urgent patients, maximising PAC and theatres and on a transformational level, redesigning of services.	Mar-22			
Trend		**Executive Owner: Director of Operations and Director of Primary Care, Community and Mental Health**		
Mapping Against 4 Harms of COVID		**Update**		



May 2022

Overarching recovery session relaunch planned for June with all clinical services. Overarching programme of work established with key themes:

- Outpatients
- Elective Capacity/ Theatre Utilisation
- Diagnostics efficiency and optimisation
- Universal patient information, support, and active waiting
- Pathways – MSK/ Ophthalmology/ Diabetes

Prioritisation for use of capacity continues as follows:

- Cancer, suspected cancer, and urgent, for new outpatients (R1 for ophthalmology) for all surgical and non-surgical specialities including therapies
- Suspected cancer, urgent and routine for diagnostics (due to the number of cancer cases that arise from routine tests)
- New urgent and routine outpatients over 52 weeks
- Patients waiting for a new outpatient appointment over 104 weeks to be reviewed
- 100% delayed Follow-up outpatients
- Adhering to the surgical prioritisation during the coronavirus pandemic (Version 2 – June 2020 – P1a, 1b, 2, 3 and 4), as well as the separate guidance in terms of obstetrics and gynaecology (RCOG) and ophthalmology (RCOphth):

Speciality Demand and capacity plans are being reviewed with each Division to agree the priorities for planned care recovery during 22/23 onwards.

Speciality Outpatient Transformation Plans have been completed, which are aligned to the Welsh Government Planned Care Programme goals. With particular focus on Cancer delivery.

The formation of the central hub continues to develop. Their initial role was to undertake the contact of long waiting outpatients to establish if appointments were still required and P4 treatment patients for a number of high volume

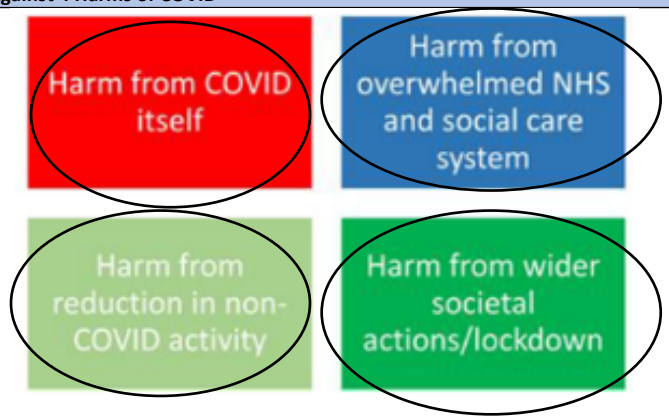
	specialities. The next stage is to provide a focal point for patients queries (quarter 2) and in quarter 3 to expand to treatments. **Outpatients** One stop treatment unit capital scheme completed and business case written and funding agreed by WG out of OP transformation fund .. This will assist in reducing waiting times for patients, and waiting list numbers and potential harm to patients. Plans in place to de-escalate COVID social distancing in all OP settings in line with current guidance and impact on increasing activity within clinic areas is currently being worked through. **Treatments** Review updated guidance in terms of social distancing and any impact on treatment capacity. There has been an increase in overall elective sessions to 89.6%. An elective pathway has been introduced which supersedes the green pathway. The successful implementation of paediatric surgery at RGH. **Primary and Community Services** • A Restart & Recovery Programme has been developed in primary care, including prioritising the areas of greatest concern / backlog from a primary care perspective. A Restart & Recovery Working Group has been established to oversee the work and now meets fortnightly. This Programme has since widened to include key priorities over winter, where we know that staff time will need to be prioritised but also where continued backlog / suspension of services is likely to have a significant impact if not addressed. The programme plan for this is attached. A mechanism for monitoring and reporting activity in primary care has been developed since the beginning of the pandemic and ABUHB is the only HB in Wales with this level of intelligence. This has now been supplemented with a more detailed assessment of one week's activity in primary care, which is currently being analysed in preparation for being presented to the Executive Team. This information is being used to assess the variation in practice activity / operational models during the pandemic and now. A summary of this data is now included in our weekly performance report and monthly performance briefing – latest versions of both attached for assurance. This shows that activity in primary care has steadily been increasing with more and more F2F contacts being performed.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22	Risk Description, Appetite and Decision
Priority 1 – Every child has the best start in life **Priority 2- Getting it right for children and young adults**	***CRR028 – (June-2021)*** ***Threat Event: - Continued inappropriate admissions of children aged under 18 to acute adult mental health wards. Particularly where admissions are of under 16 year olds, are for longer than 72 hours and/or are not compulsory detentions under the Mental Health Act.*** ***Threat Cause: Inability to access appropriate acute/crisis beds for this age group in the region*** **TREAT**

High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Staff Well Being	**Risk Appetite**	The risk appetite in this area is low however, a moderate level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.

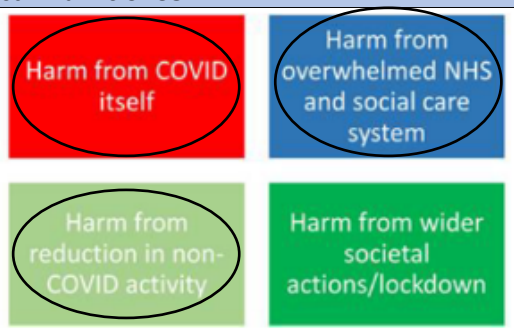
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**		
Patient Quality, Safety and Outcomes Committee	• Policy in place for the use of adult MH beds for up to 72 hours. • Designated bed in Extra Care Area • C&YP aged under 16 are nursed 1:1 and are prevented from mixing with other patients on the ward. • If YP is detained under the Mental Health Act, the safeguards inherent with this legislation apply.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***	**Current** ***Risk level after initial controls/mitigations have been implemented.***	**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***

Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	4	5	2	5
CAMHS is working with partners to develop Crisis support for C&YP which will include crisis beds.	Ongoing	**20**		**20**		**10**	

Trend		Executive Owner: Director of Operations
Mapping Against 4 Harms of COVID		**Update**
		May 2022 It should be acknowledged that this risk is part of a broader National risk in relation to children who present to acute services in crisis. The Health Board continues to work with Welsh Government on a National level to develop plans to mitigate this risk. Although it is acknowledged that this is an issue for the Health Board as it has already been realised, it remains a continuing risk not only to the Health Board but across Wales and as a result CAMHS has over the last few years created and extended their liaison response and crisis outreach response which is evidenced to have reduced self-harm and suicide and diverted children, young people from hospital with a reduction in bed use in spite of the increase in crisis presentation. CAMHS is also looking at further enhancements building on weekend cover, particularly boosting the out of hours cover and ongoing work with key stakeholders: a) At a meeting with Gwent Local Authority Heads of Children's Service on Monday 06 September 2021, we agreed to develop a guide document in relation to the support of Children's Crisis Admission (these are children classed as a delayed discharge from hospital on social grounds). b) As part of the agreement, CAMHS and the 5 Gwent Local Authority Heads of Children's Service agreed to a shared responsibility for keeping the child/young person safe in hospital (previously this had been the sole responsibility of ABUHB/CAMHS). c) CAMHS and the 5 Gwent Local Authority Heads of Children's Service also agreed to explore a medium to long term plan of providing psychosocial support to children and young people in the community as an alternative to hospital admission. d) CAMHS received an investment of £500k non-recurring in 2021 towards management of crisis admissions that will be utilised in partnership with ABUHB colleagues and Gwent Local Authority Heads of Children's Service, to meet crisis bed requirements. e) The convening of a pathway group between ED and CAMH's to ensure there is an agreed protocol and escalation should these patients present Further developments are underway currently working with Works Estates to establish a CAMHS Crisis Rapid Assessment Centre and Intervention at the St Woolos site. The site will aim to provide: • A safe space for young people struggling with emotional distress to be able to access skilled support on an ad hoc basis, as opposed to attending ED • The Centre will aim to reduce hospital admissions and emergency presentations by providing practical, therapeutic interventions. • Young people who have been assessed by CAMHS emergency liaison team and who are awaiting discharge can attend the centre to wait safely and securely for transport. CAMHS are presently in the early stages of developing a plan with help from Hannah Capel, Capital Projects/Planning and Justin Jones from Works and Estates. A schedule of accommodation has been drafted, identifying the number of rooms, functions, access and specification required to ensure the accommodation is fit for purpose. As the site has been unused for a significant amount of time, it will require a full renovation that is likely to be completed in two phases, 2022/23 onwards. A PPD has been drafted and awaiting further details re costings and proposals for the project Ie tendering works and contractors.

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="3">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2">• Getting it right for children and young adults
• Supporting adults in Gwent to live healthy and age well
• Provide high quality care and support for older adults
• Staying healthy
• Care closer to home
• Less serious illness that require hospital care
• Dying well</td><td colspan="3">CRR019 – (Jan 2022) Re-framed
Threat Cause: Failure to meet the needs of the population who require high levels of emergency supportive care.
Threat Event: Significant delayed transfers of care, domiciliary and care home constraints and inability to release ambulances promptly to respond to unmanaged community demand
TREAT TOLERATE</td></tr>
<tr><td>High Level Themes</td><td>• Patient Outcomes and Experience
• Population Health
• Quality and Safety
• Reputational
• Public confidence
• Financial</td><td>Risk Appetite</td><td colspan="2">Low level of risk appetite in relation to patient safety risks. However, moderate levels of risk with regard to innovation and changing models of care and roles to prevent demand and better to demand. Therefore the Health Board will seek to Treat and Tolerate this risk within agreed and specified tolerance/capacity levels.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Patient, Quality, Safety and Outcomes Committee</td><td>• Health Board Emergency Pressures Escalation Policy (revised Nov 2021)
• Health Board surge plans.
• Health Board SLA with WAST
• System Leadership and Response – whole system planning – meets weekly.
• Cross-site meetings to discuss system and flow pressures meets x4 daily.
• Emergency Care Improvement Board – meets monthly
• Urgent Care Transformation Board
• Hospital Management Board meets weekly</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	4	5	3	5
Short Term:		**20**		**20**		**15**	
• Public messaging including social media to ask the public to consider other options before attending the Emergency Department. These messages have been shared through partner organisations, the Health Board website and social media channels.	Ongoing Ongoing						
• Respiratory Ambulatory Care Unit go live - phase one consultant to identify suitable patients, phase two Flow Navigator	Ongoing						
• Discharge improvement Board – Nurse Led Discharge SOP to be ratified/ Criteria Led Discharge.	Ongoing / Awaiting ratification						
• GP/HCP - one single point of access for GP to arrange admission and book transport.	Ongoing						
• Continued GP aligned to the Flow Centre triaging patients on the ambulance stack, redirecting patients to appropriate pathways and services following a request for an emergency response by contacting 999	Ongoing						
• Home First service extend focus to First Floor at the GUH to ensure that those people who are able to be re-directed or are able to use Direct conveyance to community beds	Ongoing						
• Care home conveyance - Highest reasons for calls/conveyance is falls/injury from fall – response will be co-ordinated							
• High Risk Adult Cohort (Venn diagram) – pilot project, multiagency group building on existing compassionate communities framework to ensure that those individuals who have been in hospital in the last year have health review and plan in place							
• Table top exercises have commenced between MIU/UPCC/111 to ensure the 111 Algorithm is directing patients to the right places, this work has suggested there is further improving to the numbers of patients directed towards UPCC , size of opportunity currently being quantify.							
• Implementation of Trauma day unit in GUH site. However remains problematic due to staffing deficits	Ongoing						
Medium Term (3-12 months)							
• Development of the SDEC bid on the GUH site	Summer 2022						
• Integrated Front Door proposal at Nevill Hall	Ongoing						

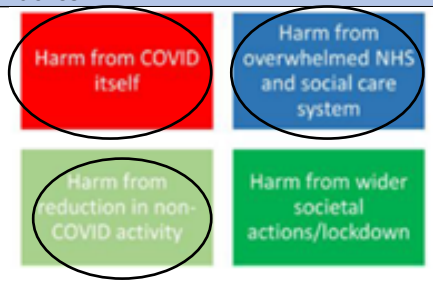
Trend since last reporting period		Executive Owner: Director of Operations
Mapping Against 4 Harms of COVID		**Update**
		May 2022 The Health Board continues to work alongside the Delivery Unit to maximise discharges, this includes engagement with Senior Nurses, discharge co-ordinators and relatives/family members. Continued population engagement on accessing most appropriate services, at the right place, at the right time and teams at the GUH are continuing to have sensitive conversations with family members regarding discharges. A number of Health Board initiatives are underway and regular reviews are undertaken to understand benefits and extract learning. SDEC care currently being delivered in Respiratory and Gastroenterology with the potential to increase patients being treated there if pts can be streamed from Flow Centre. Build has commenced for dedicated SDEC in GUH site that will incorporate surgery and acute medicine in Summer of 2022. The Clinical Operating Model for SDEC at GUH is being refined, workforce recruitment and on-boarding plans developed. Orders for the equipping of the facility have been progressed to capitalise on the funding that has been allocated by WG; to be committed this Financial Year. SDEC Manager appointed awaiting start date. SDEC running ahead of schedule. It is important to note that this risk profile should be reviewed and considered in conjunction with ***CRR002 (Workforce)*** and cross reference to ***CRR013 (IPAC)***

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="3">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2">Providing high quality care and support for older adults
Less serious illness that require hospital care</td><td colspan="3">CRR010 –
Threat Cause: Patients will fall whilst they are in our services
Threat Event: Patients will be harmed or injured.

TREAT</td></tr>
<tr><td>High Level Themes</td><td>Patient Outcomes and Experience
Quality and Safety
Reputational
Public confidence</td><td>Risk Appetite</td><td colspan="2">Risk appetite in this area is zero or low in the interests of patient safety.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Patient, Quality, Safety and Outcomes Committee</td><td>Comprehensive corporate inpatient falls prevention action plan agreed. Policy for the management of and reduction of Inpatient Falls is in place.
Multidisciplinary training and support to drive improvement
Reports on inpatient falls provided to Executive Team and Quality, Patient Safety and Outcomes Committee.
Improvement metrics agreed and overall numbers of inpatient falls is within trajectory for improvement.
An ongoing data analysis allows for the identification of shifts and trends associated with falls and activity outside of normal variation.
ABUHB engagement in the ‘All Wales Inpatient Falls Network’ in support of the development of a more consistent, standardised approach to falls management across Wales. ABHUH are also actively engaged in the’ 4 Nations Falls Collective’.
The ‘Falls and Bone Health Committee’ looks to align its work to the National Audits and associated recommendations.</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	Due Date	Likelihood	Consequence	Likelihood	Consequence	Likelihood	Consequence
		4	5	3	5	2	5
• Promoting (through training) the multidisciplinary requirements of the policy including completion of required risk assessments & care plans. ABUHB are actively engaged in the development of a generic level 1-2 falls training platform which will be promoted as a national production on completion and delivered via ESR. • To also include the promotion of the newly developed falls specific medication review tool and falls associated Head Injuries pathway. Further awareness sessions are being delivered. • Learning from serious incidents with audit of agreed actions and expected outcomes. • Evaluation of the falls components of the 'Once for Wales 'incident reporting system to ensure the opportunity to maximise the value of the data sets included. Further work is being undertaken to evaluate and confirm the accuracy of the systems outputs to inform the falls data sets.	Ongoing	**20**		**15**		**10**	

Trend		Executive Owner: Director of Therapies and Health Science
		

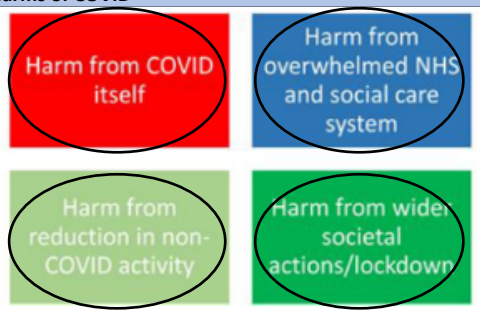
Mapping Against 4 Harms of COVID	Update
	**May 2022** The 'Falls Policy for Hospital Adult Inpatients' was formally launched in July 2021 supported by an extensive awareness raising campaign. Staff training has been aligned to the requirements of the revised Policy. Work continues across ABUHB sites to further promote the MDT approach and requirements. The Falls and Bone Health Committee monitor the progress and impact of this work. A collaborative review of the governance structures in support of the management of falls has been undertaken by the Falls and Bone Health Steering group. This group will be retitled the 'Falls and Bone Health Committee' with the establishment of two new subgroups to undertake work associated with inpatient falls and those in the community setting outside of the hospital environment. The Falls and Bone Health Committee will report directly to the Patient Quality, Safety and Outcomes Committee. The revised governance structure will come into effect from February 2022. The first meetings of the subgroups took place in March 2022 with a focus on defining the 'Terms of Reference' and determining the agreed membership. Both groups are developing programmes of work to further inform the corporate action plan. Whilst the 'Hospital Group' will focus on the inpatient setting the ''Community Group will look at the prevention and transition aspects of the persons pathway. Both groups will be cohesive in coordinating the elements of their programmes activities where commonality exists between both. Representatives from both groups would contribute to the work through a task and finish setting.

	A group is being established to review the learning processes and actions adopted for those inpatient falls associated serious incidents and injury, including the mechanisms for the monitoring/auditing of associated action plans. The group has identified that further work is required to ensure that learning is being implemented, monitored and audited in a consistent and coordinated way across the Health Board. The development of an incident reporting framework is being considered but would look to take account of those beyond that of falls incidents. From a falls perspective this would be coordinated via the 'Hospital Group' and feed to the Falls and Bone Health Committee for oversight. Work continues in light of ongoing system pressures and falls in the Emergency Department, with an Audit/ Pathway working group established to consider opportunities to improve safety in this specific environment. An evaluation of DATIX data is being undertaken to look at the themes that contribute to the numbers of incidents which will be used to inform next steps and subsequent improvement initiatives in this environment. A representative for ABUHB is working with other HBs in Wales to develop a level 1-2 falls foundation training platform which will be delivered via ESR and available to all staff. This is intended to support a guided introduction to falls prevention and management through an interactive learning approach. This will help to inform the development of an ABUHB falls training framework which will take account of the requirements of the hospital and community setting The Health Board continues to participate in the 'All-Wales inpatient falls Network, including engagement in the 4 Nations Falls Collaborative; this provides opportunity for shared learning and benchmarking. National audit outcomes will be presented to the respective Falls and Bone Health Groups and Committee to ensure any recommendations are considered within the context of the programmes of work. Inpatient falls management has been subject to an internal audit for which reasonable assurance has been given. The outcome was subject to several recommendation for which a management response has ben provided. The activities which for the response will be coordinated via the 'Hospital Group' with progress updates provided to the Falls and Bone Health Committee. In the advent of the newly established structure for falls management the inaugural meeting of the 'Hospital Falls Group' has seen the establishment of the draft 'Terms of Reference' in which both substantive and deputy nominations will be agreed to ensure continuity in representation for the meetings. The group took the opportunity to review the corporate action plan to inform its future programmes of work. On implementing AB Pulse as the new intranet site an opportunity has been provided to commence the development of a standalone page for 'Falls and Bone Health Management'. Although in its infancy it terms of content the page in future will be used to promote a network approach as a platform for sharing of good practice, learning and communication etc. aligned to work at a national level. Work is underway to evaluate the utilisation of the focussed review held within the 'Once for Wales's incident reporting system as an investigation tool to inform falls incident investigation going forwards. Cross referencing of content with the existing document is being undertaken to ensure the necessary level of detail is available.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
• **Getting it right for children and young adults** • **Supporting adults in Gwent to live healthy and age well** • **Provide high quality care and support for older adults** • **Staying healthy** • **Care closer to home** • **Less serious illness which require hospital care**		***CRR003 (March 2017)*** ***Threat Cause: Continued and sustained Health Board response to the COVID Pandemic*** ***Threat Event: Mental Health services will fail to meet the anticipated increased demand of the Health Board population*** **TREAT**					
High Level Themes	• Partnership • Research, Innovation Improvement Value • Quality and Patient Safety • Patient Outcomes and Experience	**Risk Appetite**		Risk appetite in this area is low in the interests of patient safety. However, further managed risk will need to be taken to explore further innovations and appropriately reconfigure services and implement new arrangements in the interests of service users.			
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Patient Quality, Safety and Outcomes Committee	• 1. Key transformation programme in place to address: a) A whole system model to meet mental health need with a key focus on developing/strengthening open access foundation tier and mental health support within Primary Care; to enable prevention and early intervention. b) Redesigning crisis services and acute care. c) Redesigning services for people with complex needs. • 2. A programme is in place monitoring bed availability and flow through the system, overseen by the Deputy Divisional Nurse. • 3. Systems and processes are in place to monitor demand. • 4. Engagement with local academia to continue to monitor the impact of COVID on the wellbeing of the general population. • 5. Securing additional resources both within year, and recurrent.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	4	3	4	2	4

• Development of new models to meet the mental health needs of the population across all Tiers e.g. Foundation Tier, Primary Care Mental Health, Secondary Care Specialist Mental Health Services	May 2022	**16**	**12**	**8**

Trend		**Executive Owner: Director of Primary, Community and Mental Health Services**

Mapping Against 4 Harms of COVID	**Update**
	**May 2022** No funding for sustainably funding PWP service currently identified although existing service will continue to be funded through NCNs. However, bids have been produced for additional funding from WG to fund a range of service improvements including reducing waiting times across IAS, PCMHSS and psychology. SBAR to Executive Team seeking support for proposed bids is attached. and paper presented to Exec Team outlining current progress and seeking guidance on increased capital and revenue costs of proposed development in advance of the OBC being presented to the Board in July 2022. Further action being taken to explain drivers for increased capital cost and to look at further opportunities to reduce revenue costs. SBAR attached. Gateway Assurance Planning meeting held on SISU with assurance process due to be completed by second week in June. A gateway assurance report will be received and the Division will be expected to develop an action plan in response. Risks associated with MAS clinic follow up waiting list in Caerphilly currently being investigated due to concerns about patients being lost to follow up during Covid period. Initial checks in other boroughs suggest issue contained within one borough. Review being undertaken of patient notes and full investigation of extent of the problem and remedial action plan being developed. Executive Team made aware of the issue and current actions. **External Assurance:** In relation to any external sources of assurance and any metrics to indicate whether we have been successful in mitigating any risks; • SBAR reported to Executive Team on 26 May 2022 regarding bids to be submitted to WG to support recovery and service improvement • SBAR submitted to Executive Team in May in regard to progress in developing the OBC for the new SISU and increased capital and revenue costs. SBAR -WG Blds 22-23 final.docx... SISU SBAR version Final.docx

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="3">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2">• Getting it right for children and young adults
• Supporting adults in Gwent to live healthy and age well
• Provide high quality care and support for older adults
• Staying healthy
• Less serious illness which require hospital care</td><td colspan="3">CRR001 (Mar-2016)
Threat Cause: Poor uptake of flu vaccination among Health Board staff, primary school-age children, and patients aged 65 and over and people under the age of 65, staff in care homes
Threat Event: Risk of co-infection with flu and COVID-19 leading to avoidable illness, hospitalisations and deaths.
TOLERATE TREAT</td></tr>
<tr><td>High Level Themes</td><td>• Partnership
• Patient Outcomes and Experience
• Quality and Safety
• Reputational
• Public confidence</td><td>Risk Appetite</td><td colspan="2">Low level of risk appetite in relation to patient experience. However, moderate levels of risk can be taken to pursue innovative models and technologies to encourage update through communication and engagement. Mass vaccination clinics.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Patient Quality, Safety and Outcomes Committee</td><td>• Seasonal flu action plans implemented in primary care (including care home staff), schools and for Health Board staff.
• Community Flu Group meets fortnightly.
• Staff flu group meets fortnightly.
• Campaign to increase staff uptake launched mid-September involving Flu champions, Divisional Flu Leads, clinical leaders, team managers and team leaders
• Flu uptake monitored weekly and Health Board staff uptake newsletter, produced and disseminated weekly.
• Staff flu vaccine uptake rate as of 31st March 2022 was 58.16% As at 15th March the flu vaccination uptake among those 65 years and older and in clinical risk groups aged 6 months to 64 years was the highest in Wales at 79.9% and 53.6% respectively compared to All Wales average of 77.9% and 48.2%.</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	Uptake among 2 and 3 year olds was 50.4% which is higher than All Wales average of 47.6%.						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*		**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
			4	4	2	4	2	4
• An internal audit of the ABUHB Flu vaccine programme was undertaken in March 2022. It provided substantial assurance on two assurance objectives and reasonable assurance on the remaining three objectives. • This audit report identified matters requiring management attention such as reviewing the TORs of the Staff Flu Working Group, more availability of communication materials, and more availability of flu clinics for staff. • The Health Board will be holding annual Staff Flu Vaccine planning event for 2022-23 in May 2022 and the audit recommendations will be considered in the next year planning. • Staff flu immunisation programme 2022-23 will be presented at the Exec Team meeting in August/September 2022. • NCNs will be reviewing this year's flu season to identify effective approaches to maximise uptake through cluster based delivery models in 2022/23. This will focus on 2 and 3 year olds, at risk clinical groups and care home staff. The NCN plans will also be informed by the results of this year's internal audit report. • The PCCS Division will be undertaking a stocktake of vaccine ordering across GP practices and community pharmacy to assess the level of vaccine supply for next year's flu season. There is currently uncertainty from WG about whether the 55 to 64 year old and secondary school aged cohorts will be recommended by the CMO. This may result in delays in ordering and is a current risk within the system as it will result in late delivery dates during next year's flu season. • There are ongoing discussions with LMC in regards to the logistics of the flu and COVID-19 booster campaign which is likely to be a blended approach between primary care and the MVCs during the Autumn 2022 campaign. • During the Spring and Summer 2022 there will be early planning for an on-site delivery model for vaccination of care home staff through liaison between Responsible Individuals, Care Home Managers and Community Pharmacies. • During next year's flu campaign GP practices will be asked to use the personalised letter piloted last flu season to maximise uptake among 2 and 3 year olds • NCNs will be asked to consider alternative delivery models to increase uptake in 2 and 3 year olds which may include working with pre-school		Aug-2022	**16**		**8**		**8**	

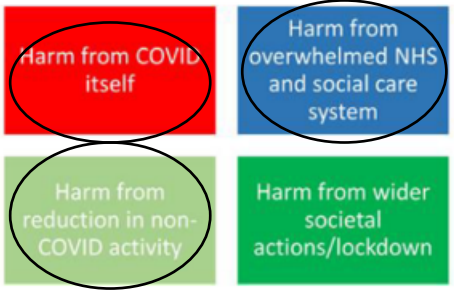
providers or an MVC type model to reduce barriers to access for parents.

- NCNs will also be asked to consider a more collegiate approach between GP practices and Community Pharmacies to reach those in at risk clinical groups who have not previously taken up the offer for flu vaccination.

Trend

Executive Owner: Director of Public Health and Strategic Partnerships

Mapping Against 4 Harms of COVID



Update

March 2022 update

Surveillance

The GP consultation rate for influenza in Wales during week 11 (week ending 20/03/2022) reported through the GP Sentinel Surveillance of Infections Scheme was 2.3 consultations per 100,000 practice population, and remains below the Moving Epidemic Method (MEM) threshold for baseline activity (11.0 consultations per 100,000). The rate increased compared to week 10 (0.8 consultations per 100,000). In terms of virological surveillance during week 11, one surveillance sample from a patient with influenza-like illness were submitted by a sentinel GP for testing as at 23/03/2022, the sample was negative for all routinely tested respiratory pathogens. During week 11, 28 of the 1,789 hospital and non-sentinel GP patients tested for respiratory infections by Public Health Wales Microbiology tested positive for influenza. A number of other causes of acute respiratory infection were identified. In the UK and Europe as of week 10, influenza consultations increased in Scotland and England, and remained stable in Northern Ireland, remaining below baseline levels in all countries. The WHO and the European Centre for Disease Prevention and Control (ECDC) report that as at week 10, influenza activity continues to be reported throughout the WHO European Region.

Vaccine uptake in primary care

Summary by Health Board and Local Authority (15mar2022)

		Children 2 to 3 years			Clinical risk 6m to 64y			65y and older		
		Denominator	Immunised	Uptake (%)	Denominator	Immunised	Uptake (%)	Denominator	Immunised	Uptake (%)
Aneurin Bevan UHB	Blaenau Gwent	1,526	834	54.7%	11,487	6,026	52.5%	14,462	11,057	76.5%
	Caerphilly	3,829	1,895	49.5%	27,220	13,879	51.0%	37,393	29,273	78.3%
	Monmouthshire	1,752	1,191	68.0%	13,118	8,293	63.2%	25,893	22,154	85.6%
	Newport	3,901	1,811	46.4%	22,049	11,535	52.3%	27,338	21,560	78.9%
	Torfaen	2,046	847	41.4%	14,761	7,744	52.5%	20,021	15,977	79.8%
	AB Total	13,054	6,578	50.4%	88,635	47,477	53.6%	125,107	100,021	79.9%
Wales	Wales	64,785	30,839	47.6%	443,895	213,782	48.2%	690,189	537,721	77.9%

Monmouthshire had the highest uptake across all LAs in wales for all four groups creating an opportunity to learn from and share what worked well through ABUHB NCN networks.
Health Visitors have been actively promoting flu immunisation for those aged 2 and 3 years since January but this has not translated into a significant increase in uptake.

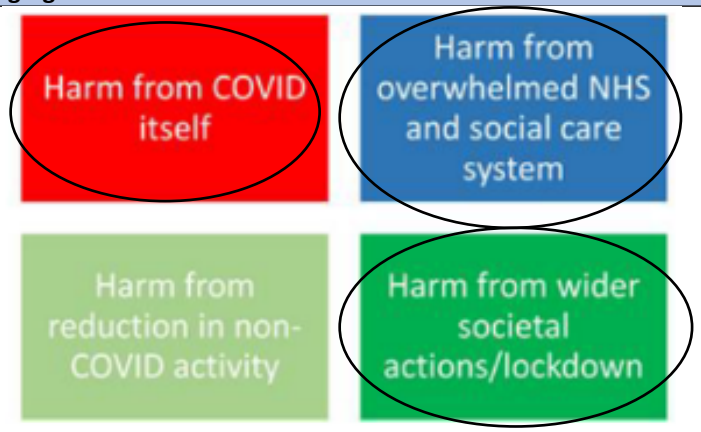
	Vaccine uptake in school age children Final uptake figures are now available. All the school sessions including mop up sessions were completed by the end of January 2022 and numbers submitted. Local figures show the School Health Service have given 50,722 vaccinations across all the schools with 66% uptake in Primary Schools and 57% in Secondary Schools. Evaluation on this year's programme in being undertaken and a staff and school survey received a good response in gathering feedback in order to improve delivery and uptake next year. **Vaccine uptake in Health Board staff** Uptake for ABUHB staff with direct patient contact was 57.4% (as at 15/02/2022) which is in line with the Wales average. A staff flu immunisation programme recovery programme started on 25/01/22 with a 'it is not too late' message to staff yet to have their flu vaccination followed by a range of measures to promote the vaccination and make it easy for staff to access it. Clinics will cease at the end of March. As at 22/02/22 the 7 day rolling rate of transmission of COVID-19 in the ABUHB area increase to 460.3/100,000 (Wales 416.1 / 100,000) with 8.7% of tests being positive. If rates of COVID-19 remain high and influenza starts to circulate in Wales, as expected by the CMO, there will be an increasing risk of patients being seriously unwell with COVID-19 and influenza at the same time. Public messaging about personal behaviours to reduce risk of infection with COVID-19 – hands, face, space, ventilation – will also reduce the risk of infection with influenza. **Welsh Health Circular (WHC) 2021 019 on The National Influenza Vaccination Programme** 04-08-2021_Welsh Government - ...

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="3">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2">Priority 2- Getting it right for children and young adults
Priority 3 – Adult in Gwent live healthy and age well
Priority 4 – Older adults are supported to live well and independently</td><td colspan="3">CRR027 (June - 2021)
Threat Cause: Effectiveness of COVID-19 vaccination and booster programme compromised
Threat Effect: - New Variants emerge

TREAT TOLERATE</td></tr>
<tr><td>High Level Themes</td><td>• Patient Outcomes and Experience
• Quality and Safety
• Reputational
• Public confidence
• Staff Well Being</td><td>Risk Appetite</td><td colspan="2">Given the unpredictability of the potential of variants of concern, a flexible, moderate risk appetite level will need to be applied to this risk profile. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control. Therefore an element of this risk will need to be tolerated.</td></tr>
<tr><th>Committee Assurance</th><th>Internal Controls – Policies/Procedures</th><th colspan="3">Risk Score</th></tr>
<tr><td>Patient Quality, Safety and Outcomes Committee</td><td>• Continuation of data, surveillance, and monitoring activities to inform any deterioration from 'Covid Stable' to 'Covid Urgent' (as per WG national policy), as could be triggered by emergence of a new variant, and initiate standing up of IMT arrangements as necessary e.g.:
▪ Local IMTs controlling clusters and outbreaks and keeping cases as low as possible (standing up / frequency of local IMT arrangements are determined by local need – however, data and surveillance information outlining the epidemiological situation continues to be shared on a routine basis and escalated as necessary).</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	▪ Gwent IMT – *a handover and governance certificate has been produced to transfer Gwent IMT's key responsibilities (including ongoing surveillance, analysis and impacts of Covid-19) to the Gwent, Test, Trace Protect Leadership Group and the Gwent Local Resilience Forum Human Infectious Diseases Group* • Keeping abreast of guidance from WG. • Continuing public messaging on adherence to restrictions. • Vaccination Programme Board monitoring roll-out of programme weekly. Transitioning of the Gwent Test, Trace, Protect Service – with a focus on vulnerable settings including Health and Social Care - into a Health Board and Single Host LA model (Caerphilly County Borough Council) during Q1 2022/23 until at least 31st March 2023. The Health Board component of the Service will be led by a Consultant in Public Health and consist of: ▪ Regional Cell Delivery Team (programme and project management expertise, business support and administration) ▪ Public Health and Protection Team (specialist public health expertise, clinical expertise, and contact tracing teams) ▪ Data & Surveillance Team (epidemiology and data analysis expertise)			

Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		5	5	4	5	4	5
When standing, Gwent IMT leads on multi agency response to manage community response. Sit reps (SBAR) to WG are submitted on a routine basis when required *(stood down as of February 2022)* or on an exceptional basis. Gwent IMT involves representatives from 5 x Local Authority Directors of Public Protection, ABUHB Director of Public Health, & Public Health Wales Health Protection. Gwent IMT & Gwent, TTPS delivery and management of National VAMC guidance, regional testing plans etc. Gwent IMT has handed over to GTTPS Leadership and Gwent LRF HIDG as described above under controls. The Wales Outbreak Control Plan and the Gwent Covid-19 Prevention and Response Plan describe the operational 'response model' moving forward and the IMT will be reinstated if necessary in accordance with those arrangements. It is noted that there is a commission from Welsh Government to Public Health Wales to review the Wales Outbreak Control Plan and that the Gwent LRF Human Infectious Diseases Group is to review the Gwent Covid-19 Prevention and Response Plan The Gwent Test Trace Protect Service Leadership Group is the key partnership body established to lead and guide the TTP service established in the face of the Covid-19 pandemic and will continue in this role as the service transitions to an Integrated Health Protection Service. Transitioning of GTTPS to facilitate ongoing Covid-19 response where required, inclusive of Data & Surveillance capabilities to inform the need for any escalation of the Health Board response.	Monitored weekly at present	**25**		**20**		**20**	

Trend since last reporting period		Executive Owner: Director of Public Health and Strategic Partnerships
Mapping Against 4 Harms of COVID		**Update**
		May 2022: The Omicron variant spread rapidly around the world in December 2021 with control measures having little effect on slowing spread down due to it being much more transmissible than previous variants. The easily transmissible sub-variant of Omicron, called BA.2, now appears to be causing most cases. Recent easing of restrictions and waning immunity from the vaccines could be factors behind the rise too. Experience to date shows that the Omicron variant has resulted in a much lower rates of serious illness than previous waves, due to high levels of vaccine induced population immunity (realised risk) and the variant itself causing less serious illness (inherent risk). However, there has been an increase in hospitalisations in recent week particularly in older age groups. It is hoped that future variants of COVID-19 will also have a lower inherent risk of serious illness and that vaccines will be equally effective (realised risk), but that is by no means certain. The risk of a future variant being both highly transmissible and having a higher inherent risk of serious illness than Omicron remains a very real risk. On 4th March 2022 Welsh Government published their transition plan 'Together for a Safer Future: long-term COVID-19 transition from pandemic to endemic' which recognises that vaccination and treatments are our best future defence. Together for a Safer Future sets out two future planning scenarios – Covid Stable and Covid Urgent. Covid Urgent is premised on a new variant that has a high level of vaccine escape or other advantages that puts large numbers of people at risk of severe illness (similar to the Alpha wave in Dec 2020). If this scenario were to arise in the future it would require all of us to work together to reintroduce protective measures. The ABUHB COVID-19 mass vaccination programme has given over 374,337 booster vaccinations. The programme continues to provide first, second and third doses of the COVID-19 vaccination in line with JCVI guidance and WG policy for all relevant age groups. Last month Welsh Government announced the Spring booster programme for over 75s, care home residents and immunosuppressed. The Spring booster has recently commenced through the MVC model for over 75s and immunosuppressed with mobile vaccination crews vaccinating care home residents (starting on 21/03/22). Welsh Government have also confirmed that Wales will be providing a universal vaccination offer to 5-11 year olds which started on the 10/02/2022 and is also being delivered through the MVCs.

Highlight Report			
Group Name:	**Maternity & Neonatal Services Assurance Group:** Executive Lead - Rhiannon Jones		
Date Completed:	19 May 2022	**Date of last meeting**	4th May 2022
Completed By:	Jayne Beasley – Head of Midwifery		
Distribution List:	Executive Team QPSOC		
Summary:	A constructive and varied meeting covering key metrics, improvement agenda and compliance against Health and Care Standards. Key issues and risk: Midwifery staffing		

Summary

Maternity Dashboard

ABUHB Births for 2021 totalled 5353.

The surge experienced in October/November last year, although challenging, was managed within the maternity environment. Projected birth data continues to be monitored with the next peak expected in November.

ABUHB Caesarean Section for 2021 was 33.2% (elective 17.6% and emergency 15.6%) which is an increase on the previous year (29%).

There were 25 stillbirths in 2021 which is an increase on the previous year and equates to a rate of 4.6 per thousand births and compares to the Welsh national average.

To note: 1 Never Event for maternity (no harm). Investigation ongoing.

Other metrics (Reviewing 2021/2022 data)

Birthing

Instrumental Deliveries for 2021 = 8% (lower than national average)
Induction of Labour for 2021 = 22% (lower than the national average)

Neonatal

Admission to Neonatal Intensive Care Unit (NICU) for babies over 36 weeks at 3% - falls within the national indicator.

There were 5 cases of Hypoxic Ischaemic Encephalopathy (HEI) in 2021. There have been 10 cases so far this year. Incidents are being robustly monitored to identify any common themes.

The Division have been requested to strengthen the neonatal indicators for reporting to the Assurance Group going forwards.

Clinical Incidents 2021

There were 26 post-partum haemorrhage – PPH) (over 2.5 litres) 4.8 per thousand, 31 shoulder dystocia (1 fractured clavicle), 26 third degree tears and 42 failed instrumental deliveries.

Training Compliance

Overall Maternity Training: 61% (a 5% reduction from 2021).

Quality Improvement

Actions on Improving Breast Feeding Rates

Comprehensive work ongoing, supported by a Lead Midwife and team.

- Golden drops initiative
- Information on Healthier Together platform - Funding for volunteer project focusing on women who do not have English as their first language
- Social media platforms to share information
- 62.8% breast feeding month for last month and an average of 82% of women having skin to skin contact after birth
- Breast feeding support groups and antenatal education (virtual and face to face)

BABI Group

Funding has been received to take forward a volunteering project to support how to relay information to women who do not speak English as their first language. It is anticipated that this work will have an impact on service user engagement and will improve inclusivity.

Health and Care Standards – metrics

- Vaccination offer: pertussis 93.3% flu 90.6%
- Vaccine administered 80.0% 86.6%
- COVID vaccine offered 84%
- Surgical Site Infection (SSI audit) - 2.7% rate in 2021 a reduction of 0.3% and best in Wales
- 60 formal complaints in 2021 which is an increase of 14 on the previous year

External Reviews – CHC & HIW

The previous HIW report, recommendations, actions and compliance are currently being reviewed.

CHC engagement report on maternity services during covid on line survey presented (48 responses). Evidence has been provided to CHC for assurance that recommendations have been taken forward. The results mirrored the outcomes of the much larger national survey.

Ockenden Report (NHS England) – There is work ongoing at a national level which is being taken forward by the Heads of Midwifery through the Chief Nursing Officer's office and the new Maternity & Neonatal Improvement Board. A self-assessment is being conducted to determine the ABUHB position.
Re: Ockenden - a seven point briefing, originally developed by Hywel Dda, has been reviewed and updated for information.

Medical Staffing

Report not provided at the meeting.

Midwifery Staffing - Current

There are significant challenges with midwifery staffing. At the end of May there will be 19 WTE Band 6 and 1.8 WTE Band 7 vacancies. There has been a constant advert for midwives live this year but there has been little success in recruiting other than through streamlining. There is high maternity leave and high sickness.

- 6 WTE HCSW have been appointed
- 12.4 WTE maternity leave, this should reduce over the summer with staff returning
- 21 applications from the band 5 streamlining (plus 2 potentially from escalation) – start date September/October
- Advert also out for community midwives
- Advert out for RGN plus RGN bank shifts advertised
- Bank only contract has recruited two applicants
- Two ward assistants posts appointed
- Roster creator poster recruited which will release clinical hours
- Specialist rates have helped to fill banks shifts and continue until August

The Division have produced an SBAR for Executive Team outlining options to mainstream safety and staff wellbeing.

Risks
Top risk is midwifery staffing. In terms of the Risk Register the Division have been asked to review with pace.
AOB
Terms of Reference to be reviewed.
Future Agenda
• Review of services against the Ockenden Report, HIW and CTM • Feedback on the All Wales Covid Survey results • Review of HIE and Neonatal Indicators

Reporting Committee	**Quality Patient Safety Committee**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**30 March 2022**

Summary of key matters considered by the Committee and any related decisions made

Presentation/Patient Experience
Members received an informative and sensitive presentation from Locality Nurse Director for Cwm Taf Morgannwg University Health Board (CTMUHB) in relation to the findings and determinations of an inquest held into the death of a patient at Ty Llidiard in 2018.

The presentation explained the focus of the inquest and provided a detailed explanation of the narrative findings. The coroner issued a Regulation 28 Report to Prevent Further Deaths and this centres on the absence of a single patient record. A briefing was received from the Health Board on 2nd February.

Development Day Feedback
Feedback from the WHSSC QPSC Development Day which took place on February 10th, 2022 was received and members approved the amended Terms of Reference for QPSC for consideration and approval for onward recommendation to the Joint Committee.

Commissioning Team and Network Updates
Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below:

1.0 Welsh Renal Clinical Network
The Committee received the report. The Chair noted the WHSSC Integrated Governance Committee (IGC) had received a detailed update briefing from Stuart Davies, Executive Lead for the Network at their meeting on 30 March 2022. The Chair noted a number of reports were to be considered by the Committee in relation to the home dialysis service and peer review of Renal Units as discussed at IGC. The Chair further noted IGC had asked a number of questions about the nature of Vital Data and developments in data systems and that as a result the Network and Commissioning Team reports would be enhanced with that information in future.

2.0 Cancer & Blood

The Committee received a further update regarding the burns services at SBUHB that is currently in escalation level 3 because of the closure of the Morriston Hospital Burns ITU due to staffing constraints. The Swansea Bay University Health Board (SBUHB) Burns Service had re-opened on Monday 14 February 2022 with an interim service model delivered with the support of general anaesthetics and general ICU consultant. WHSSC would monitor the action plan with input and advice from the South West & Wales Burns Network (SW&WBN) with regard to maintaining burns standards of care through the process of transition to the new long-term service model,

Positron Emission Tomography Imaging Centre (PETIC) was still a cause for concern and **t**he WHSSC escalation process would be used to discuss the options and put in place an action plan for strengthening the NHS service element of PETIC. This would be of key importance given the planned capital investment by WG into PETIC and therefore WHSSC's long-term commitment to commissioning services from University Hospital of Wales run by Cardiff University,

Thoracic surgery had been reduced from risk level 15 to risk level 9 because of the reduction in waiting list times due to joint working between SBUHB and Cardiff & Value University Health Board (CVUHB).

Members queried waiting times for plastic surgery patients at SBUHB. Members were assured that a management plan for patients on the waiting list was in place and that SBUHB was managing patients in line with Royal College of Surgeon guidelines. SBUHB was planning to outsource some patients for treatment and reconfigure services between Morriston and Singleton Hospitals. A recovery plan from SBUHB had been requested.

It was noted that a Service Innovation Day for sarcoma had taken place and that the Neuro Endocrine Tumour (NET) service in CVUHB had recently been inspected for ENET accreditation. Whilst they had not received formal notification the feedback on the day was very positive.

3.0 Cardiac

An update was received on the action plan in place in response to the GIRFT report undertaken at SBUHB and the Committee received assurance that SBUHB was making good progress on its delivery. The Committee also noted that the Royal College of Surgeons review was taking place in April.

Bariatric surgery had restarted at SBUHB and a conversation was underway to ascertain if a second provider was required.

4.0 Mental Health & Vulnerable Groups

Members received the Mental Health & Vulnerable Groups Commissioning Team update and noted;

The CAMHS unit at Ty Llidiard remain at escalation Level 4. Health Inspectorate Wales (HIW) undertook an inspection on the unit in November 2021 and published its report on 4th March. In addition, the National Collaborative Commissioning Unit (NCCU) undertook their Annual Review of the unit. This was due to be published at the time of the meeting. Discussions remain ongoing with the Health Board through the escalation process and both reports will be considered through that process and fed back to the next committee meeting.

The Committee was updated regarding the notice of termination of the contract given by Oxford Health NHS Foundation Trust for Cotswold House their Specialist Eating Disorder Service. WHSSC is in the process of reviewing the specialised eating disorder services aligned to the development of the Specialised Services Strategy for Mental Health. In the meantime, NCCU had been scoping alternative providers and had identified a five-bedded unit which is potentially available from August 2022.

Dr Hiliary Cass published an interim report on Gender Identity Service for Children on 10 March 2022 WHSSC have subsequently met with Dr Cass and will be working with NHS England to consider the clinical model going forward.

5.0 Neurosciences

Members received the Neurosciences Commissioning Team update and noted;

The main risk remained around neurosurgical waiting lists which were reducing but theatre capacity had still not returned to pre COVID-19 levels. The WHSSC Team were working with CVUHB to discuss the recovery action plan and assurance had been given that they were prioritising patients in line with Royal College of Surgeons guidance. Outsourcing was also being considered

6.0 Women & Children

Members received the Women & Children Team update.

The committee was informed that there was an increased risk on Paediatric Intensive Care directly as a result of staffing issues. They were also assured that there were a number of control in place and ongoing monitoring at Quarterly Commissioner Assurance Meeting with the provider.

The committee heard that there was an ongoing risk in Paediatric Surgery with extensive waits for some children. The WHSSC team had asked for a recovery trajectory and plan and there is continuous monitoring with the Clinical Board at CVUHB and through SLA meetings.

Neonatal transport

Members noted that a Delivery Assurance Group was now in place chaired by the Director of Planning at WHSSC and that this was providing additional commissioner assurance. Additionally, members were updated on the progress being made to implement an operational delivery network. A task and finish group was in place chaired by the Executive Nurse Director of SBUHB.

Other Reports Received
Members received reports on the following:

- **Services in Escalation Summary**

WHSSC currently has seven services in escalation. PETIC is a new service in escalation since the last meeting and no services have been de-escalated since the last report.

- **Draft QPSC Annual Report 2021-2022**

Members approved the draft QPSC Annual Report 2021-2022 for forward distribution to the Joint Committee.

- **CRAF Risk Assurance Framework**
- **CQC/HIW Summary Update**
- **Incidents and Complaints Report**

Items for information
Members received a number of documents for information only which members needed to be aware of:

- National Reporting and Learning System Letter from Welsh Government;
- Chair's Report and Escalation Summary to Joint Committee 12 October 2021;
- Q&PS Forward Work Plan;
- Q&PS Circulation List.

Key risks and issues/matters of concern and any mitigating actions
The items highlighted above.

Summary of services in Escalation (Appendix 1 attached)

Matters requiring Committee level consideration and/or approval
The Terms of Reference and the Annual Report will be submitted to the Joint Committee for final approval.

Matters referred to other Committees
None identified

Confirmed minutes for the meeting are available upon request

Date of next scheduled meeting:	7 June 2022 at 13.00hrs

1.0 SERVICES IN ESCALATION

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 21.03.2022	Movement from last month
November 2017	North Wales Adolescent Service (NWAS)	BCUHB	2	• Medical workforce and shortages operational capacity • Lack of access to other Health Board provision including Paediatrics and Adult Mental Health. Number of Out-of- Area admissions	• QAIS report outlined key areas for development including the recommendation to consider the location of NWAS due to lack of access on site to other health board provision – This is being considered in the Mental Health Specialised Services Strategy. • Participation in weekly bed management panel meeting. • Medical workforce issues improved with further appointments made and the issue of GMC registration resolved for 1 clinician.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 21.03.2022	Movement from last month
March 2018 Sept 2020 Aug 2021	Ty Llidiard	CTMUHB	4	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11 September	• Escalation meetings held monthly, however March 22 meeting stood down for the report on a visit from NCCU into the unit to be published to inform ongoing discussions. • Service spec discussions progressed with work ongoing to consider the requirements of the unit. • Awaiting publication and implementation of Medical Emergency Response SOP by CTM. • Coroner's inquest concluded. Implementation of outcomes of inquest to be incorporated into escalation plan alongside the outcomes of HIW and NCCU visits.	⟺

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 21.03.2022	Movement from last month
September 2020	FACTS	CTMUHB	3	• Workforce issue	• 10 CQV meetings have now been held and the service will remain at level 3 until all key actions are met. • Substantive Consultant Psychiatrist post is planned to go to advert in early May. • Clinical Lead to be advertised once CAMHS Consultant posts have been appointed. • The FACTS service specification is being finalized subject to input from CAMHS colleagues.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 21.03.2022	Movement from last month
July 2021	Cardiac Surgery	SBUHB	3	• Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review	• Six weekly meetings in place to receive and monitor against the improvement plan. • Service de-escalated on delivery of the immediate actions as outlined in the GIRFT recommendations, including moving to consultant only operating and only mitral valve specialists operating on mitral valve repairs. • Further work is required between SBUHB, C&VUHB and WHSSC to improve the aorto-vascular pathways and develop the preferred options. In the meantime due to the complexity, the	

					pathway will remain unchanged	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 21.03.2022	Movement from last month
July 2021	Cardiac Surgery	C&VUHB	2	• Lack of assurance regarding processes and patient flow which impact on patient experience	• C&VUHB have an agreed programme of improvement work to address the recommendations set out in the GIRFT report. • Bi- monthly meetings agreed for monitoring purposes. • C&VUHB have shared a plan setting out the intentions for improvements across the key process metrics outlined in the GIRFT report. However, the WHSS Team have again asked for a SMART action plan to enable appropriate monitoring of the actions within appropriate and realistic timeframes.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 21.03.2022	Movement from last month
November 2021	Burns	SBUHB	3	• The burns service at SBUHB is currently unable to provide major burns level care due to staffing issues in burns ITU.	• The burns ICU is restored to full capacity (3 beds) with support from general ICU and anaesthetics consultants (stage 1 of the plan). • Mutual assistance is available via the South West and Wales Burns Network and wider UK burns escalation arrangements, should it be required. • The three-stage plan has been agreed following advice and support from the Burns Network and a peer visit to Swansea. • The escalation meetings will be led by WHSSC with support	

					and advice from the Burns Network to ensure standards are maintained through the transition process.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 21.03.2022	Movement from last month
February 2022	PETIC	Cardiff University	3	Concern over management capacity within the service to ensure a safe, high quality timely service is maintained for patients. These concerns include: • Recent suspension of production of PSMA due a critical quality control issue identified during MHRA inspection. Service slow to address impact on service for patients. • Failure to undertake a timely recruitment exercise leading to isotope production failures.	• The quality control issue has been addressed and isotope production restarted on 25 February after a three week suspension. • Analysis of the impact of the delays on patients indicates that while it caused patient anxiety and stress, it is unlikely there will be harm to patients' clinical outcomes. • Current waiting times are within the target turnaround time of 10 days. • The first escalation meeting is scheduled for Friday 25 March.	New N/A

				• Failure to produce a business case of sufficient quality in a timely manner for replacement of the scanner.		

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

Patient Quality, Safety & Outcomes Committee

7th June 2022

Agenda Item: 3.2

An overview of 'Enhanced Care': linking provision, cost & outcome

Document Title:	**An overview of 'Enhanced Care': linking provision, cost & outcome**		
Date of Document:	**28 April 2022**		
Authors:	**Greg Bowen – Assistant Director of Finance** **Linda Alexander – Deputy Director of Nursing**		
Executive Sponsors:	**Rob Holcombe – Interim Director of Finance** **Rhiannon Jones – Director of Nursing**		
Purpose:	Approve change		Comment: A paper, for information, based on a request from an IM at the February 2022 Board meeting
	Approve funding		
	For information	x	

Purpose:

This paper provides an overview on the increase in the hours and cost of 'enhanced care' both pre and during the pandemic and attempts to link this increase to patient outcomes, specifically fall events. Patient Falls have been identified as the most readily recorded quality metric in assessing outcomes for patients requiring Enhanced Care and is the highest reason for requesting enhanced care.

Introduction:

Enhanced Care is a closer level of patient supervision used when staff have risk-assessed a patient and deemed enhanced observation, care and intervention is required to maintain safety, dignity and reduced distress whilst utilising a person-centred approach. Examples include people who are wander-some and at high risk of injurious falls, people with significant cognitive impairment whom are unable to understand their limitations, or those with unstable clinical conditions not meeting the threshold for critical care but require intensive clinical interventions.

There are various levels of enhanced observation, depending on a person's individual needs. This is assessed by a Registered Nurse supported by those involved in the delivery of care.

Since the first wave of the Covid-19 pandemic, the Health Board has seen a significant increase in the requirement for providing such care, which has continued throughout 2021/22 and this report provides context.

Situation

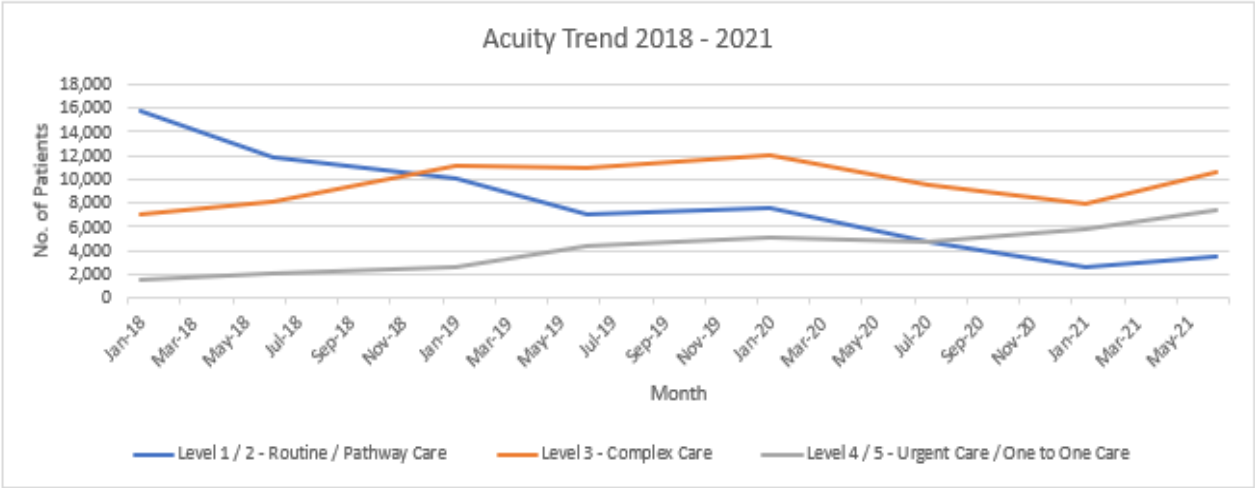
<u>Acuity Trend</u>

Acuity is determined by using the evidence based Welsh Levels of Care Tool. It consists of five levels of Acuity, as below:

- **L1 – Routine:** The patient has a clearly identified problem, with minimal other complicating factors.
- **L2 – Care Pathway:** The patient has a clearly defined problem but there may be a small number of additional complicating factors.
- **L3 – Complex Care:** The patient may have several identified problems, some of which interact, making it more difficult to predict the outcome.
- **L4 – Urgent and Unstable:** The patient is in a highly unstable and unpredictable condition, either related to their primary problem or an exacerbation of other related factors.
- **L5 – One to One Care:** The patient requires 1 to 1 care continuous nursing supervision.

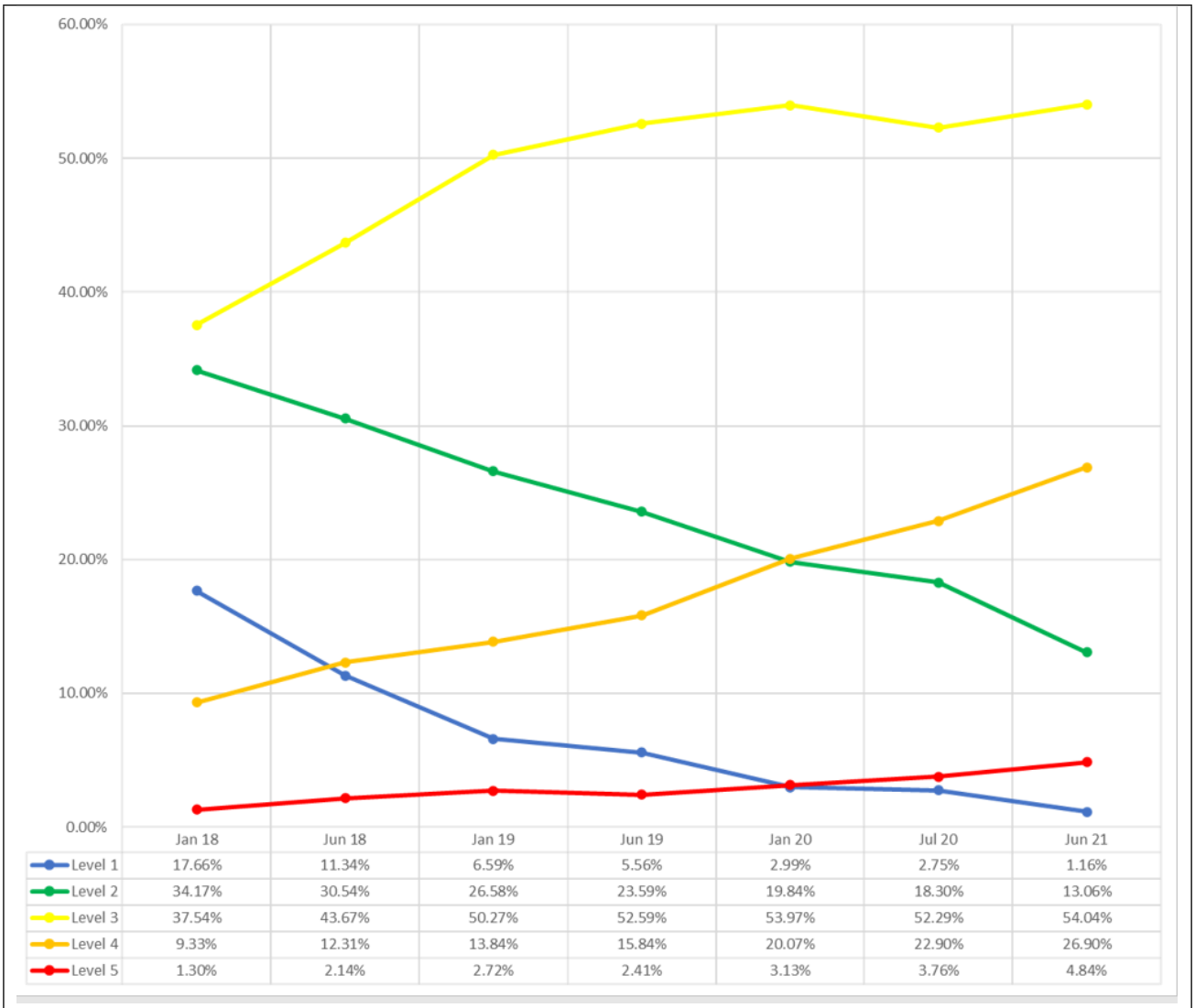
The requirement for Enhanced Care typically starts at L3, whereupon the numbers of nursing staff agreed per shift (the funded establishment) are insufficient to effectively manage the patient caseload based on acuity.

The below table shows a 3-year Acuity trend in the number of patients assessed to be in each of the five categories (L1/2 and L4/5 combined), based on the bi-annual audits of patient acuity. The Health Board has a statutory obligation to undertake acuity audits as part of the Nurse Staffing Levels Wales Act.



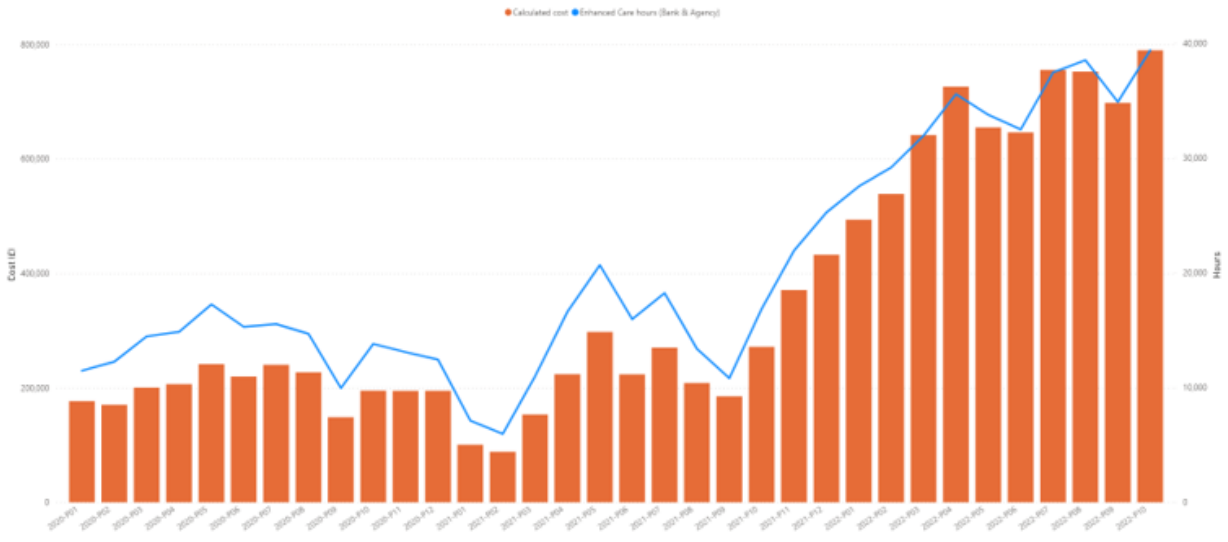
The above 3-year period shows there is a significant shift in patient acuity which has resulted in patients requiring a higher level of care. This is particularly so with both Level 4 and Level 5 care.

The Acuity trend demonstrated in the above graph is not specific to ABUHB. A recent benchmarking exercise has reported a similar trend across Wales. The following graph illustrates the All-Wales position taken from Patient Acuity Audits across 6 Health Boards from January 2018 to June 2021 and shows the decline in the number of patients assessed as Level 1,2 and an increase in Level 3,4,5 with Level 4 the most stark.



	Jan 18	Jun 18	Jan 19	Jun 19	Jan 20	Jul 20	Jun 21
Level 1	17.66%	11.34%	6.59%	5.56%	2.99%	2.75%	1.16%
Level 2	34.17%	30.54%	26.58%	23.59%	19.84%	18.30%	13.06%
Level 3	37.54%	43.67%	50.27%	52.59%	53.97%	52.29%	54.04%
Level 4	9.33%	12.31%	13.84%	15.84%	20.07%	22.90%	26.90%
Level 5	1.30%	2.14%	2.72%	2.41%	3.13%	3.76%	4.84%

The ABUHB financial impact of the change in trends of Nursing Hours and Acuity can be seen below.



Pre-pandemic, and as per the above graphs, demand for enhanced care was lower than current with an additional cost in the region of £200k per month. With the rise in patient acuity there has been a step change through 2021/22, where operational pressures have been greater, with peak monthly costs attributed to this type of care between £600k and £800k per month.

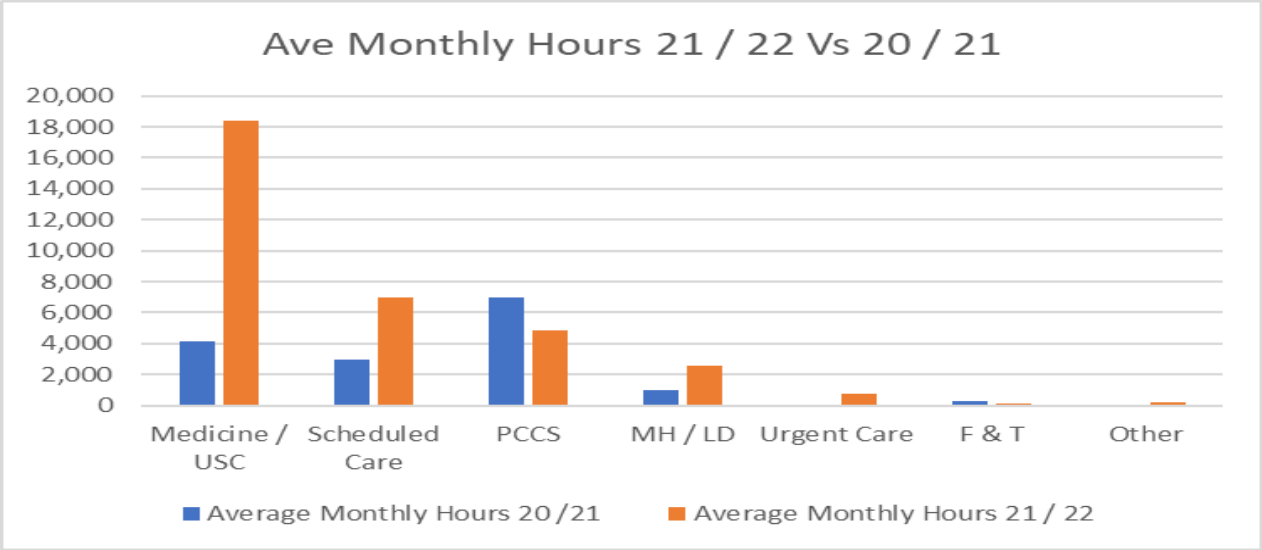
Other considerations

The opening of the Grange University Hospital, earlier than anticipated in November 2020 in response to the Covid-19 pandemic, has also had an impact on nurse staffing levels. With 355 additional single occupancy rooms which, by design, has shown to require additional staff.

The Senior Nursing Teams have also articulated the impact of restricted visiting in terms of an increased requirement for additional staff for some patients. Previously family members would be called upon to sit with patients, in some circumstances. It is unquantifiable but there is no doubt that some enhanced care hours have been necessary due to continued restriction on visiting.

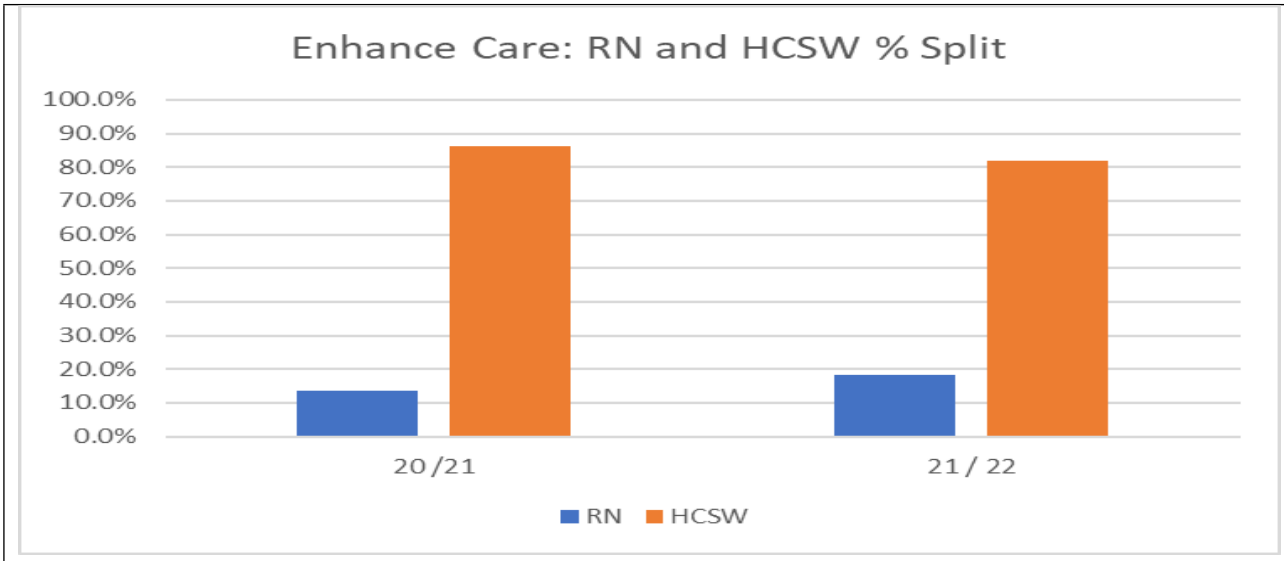
2021/22 Overview

The average Enhanced Care hours required per month in 2021/22 was 34,000 vs 15,000 in 2020/21, an increase of 126.7%; the costs of which are usually met by Bank & Agency staff, which is additional to baseline rosters.



The greatest use, and increases, are seen in the Medicine Division, although figures are slightly affected by the YYF ward transfers with effect from April 2021 (an average of 3,313 hours per month), which impacts on the Primary Care & Community Services comparison.

As illustrated in the graph below, enhanced care is generally provided by Health Care Support Workers (HCSWs) although there are instances where Registered Nurse (RN) resource is required for certain types of specialist care, for example patients with spinal injuries and laryngectomy.



Outcomes

The level of falls has been identified as the most readily recorded quality metric in assessing outcomes for patients requiring Enhanced Care. Below is an analysis of Enhanced Care hours by ward:

HCW top use Enhanced Care hours 2021/22 to Month 10		
2933	YYF ICC GENERAL REHABILITAION WARD 2.1 OAKDALE	11,529
2931	YYF ICC FRAILTY WARD 3.2 PENALLTA	11,036
2932	YYF ICC STROKE REHABILITATION WARD 2.2 BARGOED	10,562
4508	CTY OAK WARD	10,412
1026	RGH D4W ON B6 COTE	9,618
4985	RGH MED D4E (EFU) NURSING (G.UH)	8,938
4960	MED 3/1 COTE NHH (G.UH)	8,818
2555	YYF RISCA WARD 3/1 SUB ACUTE	8,809
1021	RGH MED C4E NURSING	8,807
4961	NHH STROKE WD 3/4 (G.UH)	8,593
4991	RGH MED C6W NURSING (G.UH)	8,524
		116,116
% of Total HCW Enhanced Care hours		42%

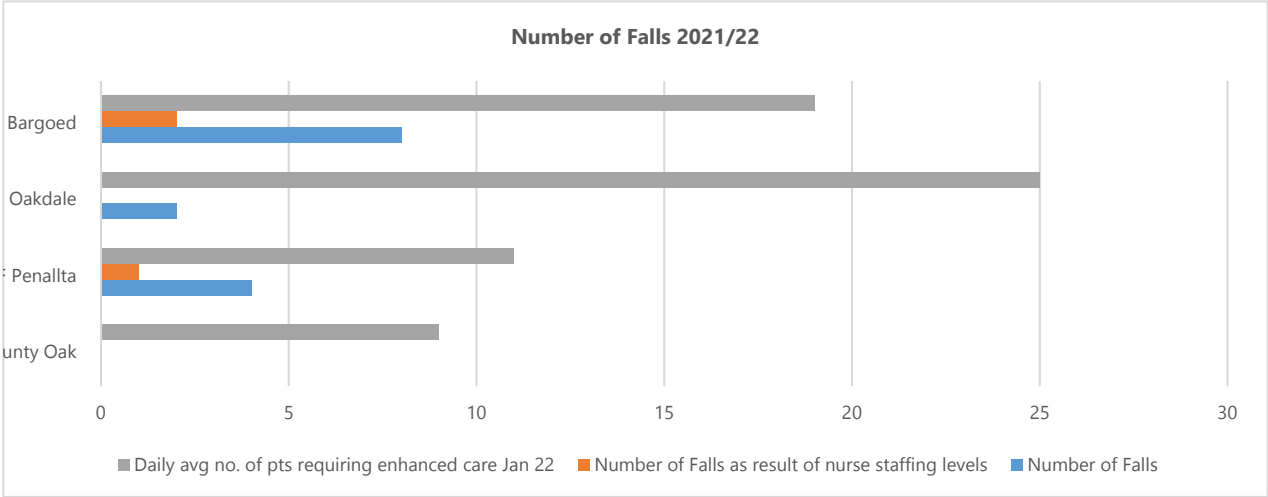
For the top four wards which have used Enhanced Care hours in the current year, an analysis has been undertaken on the level of falls for the same period:

Number of Falls 2021 / 22 - January YTD

Site	Ward	Number of Falls	Total Falls Recorded for Patients Requiring Enhanced Care	Daily Average No. of Patients Requiring Enhanced Care
County	Oak	0	0	9
YYF	Penallta	4	1	11
	Oakdale	2	0	25
	Bargoed	8	2	19

All four wards are within the specialty of Care of the Elderly (COTE). In total, on the four wards, fourteen falls have occurred over the same 10-month period. Of these falls, 11 (78.6%) were associated with patients who were independent, self-caring and with no requirement for Enhanced Care.

No falls have occurred on Oak Ward at all, with Oakdale not seeing any falls for patients requiring Enhanced Care.

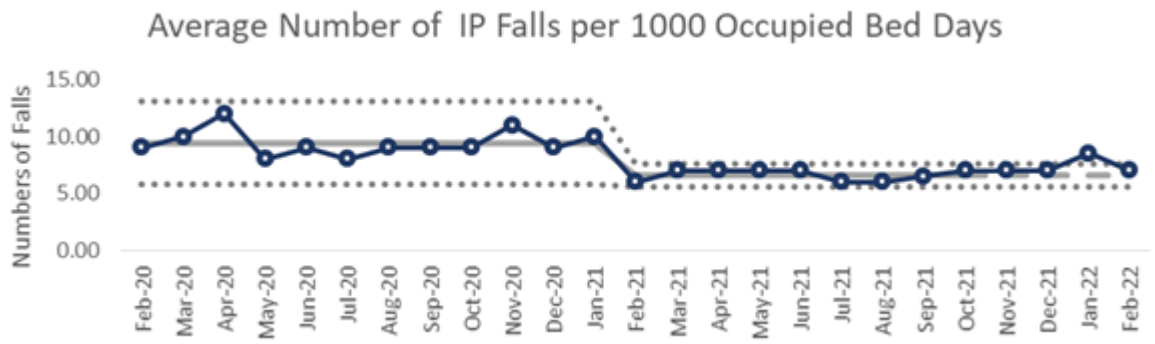


Note:

Number of Falls = Total Falls Recorded on the Ward
Total Falls Recorded for Patients Requiring Enhanced Care = Total Falls Recorded on the Ward for Patients Requiring Enhanced Care

Trend in falls over time

The following graph demonstrates despite the increase in patient acuity, there has been statistically a reduction in patient falls, as reported at the Patient Quality, Safety and Outcomes Committee, despite the significant increase in Level 4 and Level 5 patients requiring 'Enhanced Care' during the pandemic.



Summary & Conclusions:

Enhanced Care is a risk-based assessment process which is essential to maintain patient safety and dignity and is supported by a robust framework within Aneurin Bevan University Health Board. Patient Acuity has seen a marked increase over the past three years, a picture mirrored nationally, and is evidenced within the statutory Acuity Audits completed as part of the Nurse Staffing Levels (Wales) Act.

The upward trend in Acuity has resulted in a significant increase to the levels of Enhanced Care required, beyond funded nursing establishments, and has increased demand for Bank and Agency staff as well as the consequent increase in nurse staffing expenditure.

Patient Falls are the single-most identifiable metric for assessing impact of enhanced care and is the highest reason for the request for enhanced care particularly across Medicine and Unscheduled Care Division and Care of the Elderly Directorates. The increased hours associated with Enhanced Care requirements on the top four wards by usage indicates a significant benefit, which is evident in the exceptionally low number of falls recorded on these wards for patients assessed as needing this level of care.

Facilities - Care After Death
Final Internal Audit Report

May 2022

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Contents

Review reference:	AB-2122-24
Report status:	Final
Fieldwork commencement:	1st February 2022
Fieldwork completion:	10th March 2022
Draft report issued:	15th March 2022
Debrief meeting:	25th March 2022
Management response received:	29th March & 4th May 2022
Final report issued:	5th May 2022
Auditors:	Simon Cookson, Acting Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit John Cundy, Principal Auditor
Executive sign-off:	Leanne Watkins, Director of Operations – Interim
Distribution:	Gareth Hughes, Divisional Director – Facilities Steve Bonser, Head of Transformational Change Lorraine Jenkins, Care after Death Manager
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To provide assurance on the care after death service within the Facilities division, which commenced operations during January 2021.

Overview

Care after death (CaD) is a new service that came into operation during the pandemic. We found considerable effort has been undertaken to establish the service, which is supported by documented processes.

We have seen positive actions taken by the CaD Team, including the establishment of a bereavement service. However, we identified further work to be undertaken with the supporting IT software, for the day-to-day operations of the service. A more automated process would reduce duplication of effort, minimise errors and provide real time tracking and management information.

Overall, we have provided reasonable assurance on this area.

Further detail highlighting process refinements have also been noted within Appendix A.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N / A - first report on new service

Assurance summary[1]

Assurance objectives		Assurance
1	Standard operating procedures	Reasonable
2	Business continuity plan	Substantial

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Care after death management database	1	Design	Medium

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 The Facilities – Care after Death (CaD) review was completed in line with the 2021/22 Internal Audit Plan. The review provides Aneurin Bevan University Health Board (the 'Health Board') with assurance that the policies and procedures for the CaD service are adhered to.

1.2 The key risks considered in this review are:

- lack of dignity and respect for patients and their relatives; and
- processes for the care after death of a patient are inadequate and / or do not adhere to legal requirements

1.3 We did not test the following as part of this audit:

- mortuary services, as these are the responsibility of the Pathology directorate;
- deaths within the community;
- the transport of deceased patients;
- the physical facilities used for the storage of deceased patients; or
- the maintenance of the deceased patient storage areas, as this remains the responsibility of the Pathology directorate.

1.4 A proposal to set up a CaD service was presented to the Health Board's Executive Team during October 2020. The aim was to improve governance, encourage more efficient use of resources and to standardise practice across the Health Board, including collaboration between teams.

1.5 The service aims to provide a seamless, coordinated, standardised and consistent approach to the care of deceased patients and their families. Additionally, it facilitated a clear pathway and support for the introduction of the medical examiner role, which will become a statutory requirement in April 2022.

1.6 The CaD service commenced development during October 2020 and became operational during January 2021. It currently sits within the Facilities Division.

2. Detailed Audit Findings

Audit objective 1: There are defined processes for the storage of deceased patients, which incorporate relevant legal requirements and are adhered to by staff.

2.1 There is no Human Tissue Authority[2] (HTA) requirement for non-mortuary service, deceased patient storage areas to be licenced, where this is not for a scheduled purpose[3].

2.2 When the CaD service was initially launched, a range of standard operating procedures (SOPs) were developed setting out the key processes for staff to adhere to. These closely align to other relevant service areas within the Health Board that operate under a HTA licence e.g. the mortuary. However, there are no licence requirements for the CaD service to adhere to and we found the SOPs clearly set out the key steps required by the CaD Team. However, we found that some improvements should be considered for the management / format of the SOPs. This has been raised as **matter arising one.**

2.3 We tested the process for the issue of the Medical Certificate of Cause of Death (MCCD). This is completed by the respective consultant of the patient and co-ordinated by the CaD Team. The statutory timeframe for registering a death is within five working days[4]. We tested a sample of five patients and found all MCCDs were completed within the required timeframe. We also reviewed the cremation forms (where required) and confirmed that the Cremation 4 forms were completed by the relevant consultant in a timely manner.

2.4 The CaD service has developed a training programme, which utilises the expertise of the Mortuary Technicians within Pathology. However, we identified that the training record does not detail if all staff have completed all relevant training. All staff should complete the training and be signed off as competent by the training deliverer before they are allowed to work unsupervised. This has been raised as **matter arising two.**

2.5 Whilst the CaD service is not required to undertake automatic storage capacity monitoring, the current process is manually operated. A capacity spreadsheet is completed, Monday to Friday at 10:00 am. Whilst this provides a regular check over capacity and volume, it does not provide a real time update and is reliant on manual inputting. We have not raised this as a recommendation, as all current requirements are being successfully met.

2.6 Furthermore, the software used for managing fridges, freezers and contents does not link to other Health Board applications, e.g. PAS. Therefore, there is an increased risk of manual input errors and a duplication of effort. In addition, there is no audit trail information retained by the software nor does it provide up-to-

[2] The HTA regulates establishments in England, Wales and Northern Ireland that conduct licensed activities under the Human Tissue Act 2004 (HT Act).
[3] For the storage of patients for a scheduled purpose, such as research, determining the cause of death, clinical audit etc. a licence is required.
[4] Except where an inquest or coroner's post mortem is required.

date management / dashboard information, setting out real time changes in capacity. This software should be considered for replacement. This has been included within **matter arising three.** However, we recognise that the software is currently used as a repository with other compensating controls (e.g. capacity spreadsheet) in operation.

2.7 We observed that site security, including access control and CCTV, is being improved. We have not reviewed this within our audit scope but noted that this is considered as part of decision making within the CaD Team.

Conclusion:

2.8 Although the new CAD service has produced positive results, there is room for further enhancement and strengthening of the existing controls. We have provided **reasonable assurance** over this objective.

Audit objective 2: There are appropriate business continuity arrangements in place

2.9 The overall capacity for patient storage across the health board is fixed, with the early opening of the Grange University Hospital (GUH) adding a significant increase to that capacity. Alongside this, there is an appropriate business continuity plan (BCP) and scenario planned processes for managing continuity events that reach trigger points.

2.10 There is also a scenario outlining actions to undertake in the event of staff shortages. Although this was appropriate and reasonably documented, some of its contingencies could be improved with more detailed responses. We also note that there are only two scenarios planned for. We have raised this as **matter arising four.**

2.11 As this is a new service, there has been no test of the BCP. However, the CaD Team should liaise with the Health Board's Emergency Planning Team and arrange scenario testing of the BCP, when appropriate to do so.

Conclusion:

2.12 Overall, the CaD BCP provision is sufficient to meet the service needs at this time. It makes use of the Health Boards emergency planning templates, methodologies and includes appropriate actions and trigger points.

We have provided **substantial assurance** over this objective.

Appendix A: Management Action Plan

Matter arising 1: SOP Documentation (Design)	Impact
We found detailed standard operating procedures documented, which describe the basic processes required. The majority of the documents were developed shortly after the Care after Death service was established. Although they set out the processes required, the management of the documents could be improved further, for example, key dates when the documents have been agreed / reviewed, responsible owner and further enhancements to the supporting details contained therein.	Potential risk of: • Inconsistent application of processes • Lack of clear instruction of procedures / processes

Recommendations	Priority
1.1 The Care after Death (CaD) Team should ensure that standard operating procedures: • are documented on an agreed template, with version number, issue date, review date and document owner; • incorporates links to other SOPs, documents, standards or relevant websites; and • detail the full procedure, including all required paperwork / data entry into supporting records.	Low

Management response	Target Date	Responsible Officer
1.1 The CaD Team accept this recommendation in full.	30.09.2022	Care after Death Manager

Matter arising 2: Training (Design)	Impact
The Care after Death (CaD) Team has developed a training programme, to ensure all staff receive the same level of training and support. The training is delivered by the Mortuary Technicians within Pathology. However, there is no record maintained of who has received training and when, with details of any refresher training required. Whilst the training supports the documented processes, a record will become important in the future, as the team continues to evolve.	Potential risk of: • Insufficient training may impact on operational efficiency.

Recommendations	Priority
2.1 The Care after Death (CaD) Team should ensure a staff training register is maintained, which details the training completed by team members and the date for refresher training to be undertaken.	Low

Management response	Target Date	Responsible Officer
2.1 The CaD Team accept this recommendation in full.	30.09.2022	Care after Death Manager

Matter arising 3: Management Software (Design)	Impact
The software utilised for the management of the patients, transport, location, volume etc. operates in isolation (i.e. not linked to other Health Board software) and does not provide any significant management / performance information. Furthermore, as it is operated as a registry of patients, it does not provide active / real-time information and requires manual inputting, which is often a duplication of existing information. This may lead to inaccurate capacity / demand figures. Finally, there is no audit trail of amendments, updates or entries by individual users. As the software was an ad-hoc commission it may be overlooked for IT support. However, the software is used as a repository and thus, it is largely operated as a record of notes / actions completed. This mitigates the severity of the impact of any software failure.	Potential risk of: • Inaccurate management information. • Software failure. • Data loss. • Non-compliant with IT standards.

Recommendations	Priority
3.1 The Care after Death Team should determine if the software delivers sufficient benefits in excess of the potential risks. If not, then alternative software / system should be procured, to include some / all of the following features: • remotely accessible across all sites, at all times; • update immediately following any change inputted; • link to key software within the Health Board, to minimise manual data entry; • produce management information / a dashboard and other relevant information (e.g. patient location); • raise warnings where breaches to the SOPs are imminent, e.g. capacity, temperature (if recommendation three is adopted) warnings; • a full audit trail including access information and data changes; • support profile levels to facilitate access control; and • be fully compliant with the Health Board and DHCW shared service software requirements.	Medium

	Management response	Target Date	Responsible Officer
3.1	It is acknowledged that the current system does present the Health Board with a risk due to the issues as identified within the audit. The issue of the current & inherited database being unfit for purpose is acknowledged; the Estates & Facilities Division will now engage with suppliers to identify a suitable replacement software system. A three-month window to identify supplier, design a system and implement is believed to be a significant challenge. It is expected that this work may take up to a six-month period.	30.09.2022	Care after Death Manager

Matter arising 4: Business Continuity Planning (Design)	Impact
We confirmed business continuity planning documents had been completed, which were consistent with the Health Board's templates. However, whilst two scenarios were included, there are other aspects that could help in a continuity event, for example, clarifying the role of the General Office and identifying which fridges / freezers could be converted or utilised. Furthermore, the Care after Death (CaD) Team should consider alternative business continuity events / scenarios that may impact them and run regular testing to identify potential points of failure.	Potential risk of: • The continuity plans fail to provide the necessary continuity when required.

Recommendations	Priority
4.1 The Care after Death Team should: • develop call cascade lists to identify staff contact details in advance; • identify additional scenarios that may arise and detail action plans to overcome them; • test a range of continuity events regularly (at least once a year); and • identify fridge / freezer capacity plans that could be utilised in across different sites, in the event of unavailability.	Low

Management response	Target Date	Responsible Officer
4.1 The CaD Team accept this recommendation in full.	30.09.2022	Care after Death Manager

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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