# WRITTEN STATEMENT

# BY

# THE WELSH GOVERNMENT

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| **TITLE** | **Publication of the Report on the Independent Review of Maternity Services at the former Cwm Taf University Health Board** |
| **DATE** | **30 April 2019** |
| **BY** | **Vaughan Gething AM, Minister for Health and Social Services** |

I am today [publishing the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives report](https://gov.wales/review-maternity-services-former-cwm-taf-university-health-board) following their review of maternity services at the former Cwm Taf University Health Board. I will make an oral statement this afternoon but I am setting out my immediate response.

The report makes very difficult reading. I would like to start by apologising to the women and families affected by the poor standard of care described.

I commissioned this independent review in October 2018, following serious concerns that initially came to light as a consequence of the under reporting of serious incidents in maternity services. Concerns were escalated to the executive team in Cwm Taf by a new senior member of maternity staff.

I was clear this review should provide an account of what had happened and why, but most importantly what must happen to ensure that mothers can be assured of receiving high quality, safe care. The review included a three day site visit in January when reviewers spoke with families and staff. I updated Members on 23 January of the immediate quality and safety concerns that had been identified during this visit and the immediate actions taken. This informed the maternity improvement plan that had already been put in place so that there was no delay in making immediate improvements. The final report was received by Welsh Government officials on 16 April 2019.

The findings of this review are serious and concerning. There are a significant number of recommendations for improvement. Crucially, the review is supported by a report which focuses on what women and families had to say about their experiences of maternity care in Cwm Taf. While there was feedback that reflected individual good practice and praise for individual staff working in difficult circumstances, overwhelmingly those who contributed spoke about distressing experiences and poor care. I would like to extend my thanks to the families who took part in this process. I understand that this will have been very difficult for many of those involved. It is vitally important that the action taken as a result of this work is informed and guided by those women and families who feel their voices were not listened to at such an important time in their lives.

I have been deeply saddened by this report. I cannot begin to appreciate quite how distressing it will be for families who have been directly affected by these failures. I am also conscious of the concern that will be felt by families currently receiving care in these hospitals and at a time when such a significant life event should be a moment of joy. I expect the health board to take every step needed to reassure women that they and their babies will be well cared for. The findings will also I am sure be very difficult and upsetting for staff working within the service. The report acknowledges the extreme pressure that they have been working under.

There is no doubt that this report confirms the service has fallen well short of the expectation that I have for care provision anywhere in Wales. It highlights a number of concerns relating to staffing, clinical governance and effective clinical leadership. I am particularly concerned by findings highlighting a blame culture, and how this has impacted on staff having the confidence to report concerns. It is clear that these deep rooted cultural failings have resulted in a punitive environment that is not supportive of patient safety. These conclusions support the findings of an internal report, conducted in September 2018. Neither I nor my officials were aware of this report until earlier this month.

It is clear, and the report confirms this, that these findings also raise significant concerns and questions about the effectiveness of wider board leadership and governance.

The health board was placed into enhanced monitoring (level 2) of the escalation framework in January 2019, following advice from an exceptional meeting of the tripartite group comprising my officials, the Wales Audit Office and Healthcare Inspectorate Wales (HIW). This was due to a number of issues, including maternity services but also identifying other emerging areas of concern in respect of governance. I asked the tripartite group to review the organisation’s escalation status following the formal external review of maternity services. I requested their advice on the impact of the review on the escalation status of this individual service. At the same time, I sought advice in respect of any consequences for the overall escalation status of the organisation.

The advice I have received is definitive, recommending that maternity services be placed in special measures. I have accepted this advice. I would like to be very clear that this applies to the maternity services of the former Cwm Taf University Health Board. However, I do expect any learning to apply to the Bridgend locality maternity services which since 1 April are part of the new Cwm Taf Morgannwg University Health Board.

I take very seriously the broader concerns about governance highlighted within the report and raised through the discussions of the tripartite group. These include concerns in respect of quality governance, data accuracy, serious incident reporting and critically leadership and organisational governance. The tripartite group expressed a high level of concern in relation to the Board’s governance arrangements for quality. This includes matters highlighted through serious incident reporting and regulator visits.

I have therefore decided to increase the organisation’s overall escalation to targeted intervention. This will allow a period for review bodies to look at these wider issues and for the Board and its executive team, with external support and overview, to put in appropriate improvement measures.

I will keep the escalation status under review and will receive advice from the range of external interventions and scrutiny that I am putting in place. I will consider this alongside ongoing advice from my officials and the tripartite group where required. As an organisation of previous good reputation, with an approved plan and low escalation status, Cwm Taf Morgannwg University Health Board must step up to this external scrutiny and the action that I am putting in place. It is for the Board and its Executive Team to demonstrate to me why I should be assured and confident in the organisation’s ability to address these broader concerns. This includes questions in respect of leadership and governance across the organisation.

I require action to be taken to secure immediate and sustained improvement in the quality and safety of maternity services as well as in the overall effectiveness of Board leadership and governance. I also expect all Local Health Boards in Wales to reflect on the learning from this review and assure themselves that their services are safe.

I am therefore taking action in three main areas.

Firstly, I am putting in place an independent maternity oversight panel to:

* + seek robust assurance from the health board that the report recommendations are being implemented against agreed milestones;
  + agree a process and establish an independent multidisciplinary clinical review of the identified 43 cases and a look back exercise to 2010, as recommended by the review;
  + advise CTMUHB on actions needed for effective public and user engagement in improving maternity services and rebuilding trust and confidence; and
  + advise me on progress, including the need for and timing of any follow up review.

Mick Giannasi, the former chair of the Welsh Ambulance Service NHS Trust, appointed Commissioner for Anglesey Council and Chief Constable of Gwent Police has agreed to chair the panel. He will be supported by a lay panel member, Cath Broderick, who authored the women and families report of this review. She will continue to engage with those individuals and work together seeking ideas for improved service provision. They will be joined on the panel by senior midwifery and obstetric leads who will be confirmed shortly.

Secondly, I am putting in place arrangements to seek assurance and improve the effectiveness of Board leadership and governance in CTMUHB. I have asked David Jenkins, the former chair of Aneurin Bevan UHB to:

* support the Chair of the health board;
* provide feedback to the Board as appropriate; and
* advise me of any further actions that may be required to develop the Board to ensure it has robust and effective governance and assurance arrangements in place.

This will be further supported by a governance review which HIW has confirmed that it plans to undertake over the coming months. The HIW work will be aligned with any further review work undertaken by the Wales Audit Office.

The NHS Wales Delivery Unit will work with the health board to ensure there are effective arrangements in place for the reporting, management and review of patient safety incidents and concerns.

Finally, I am seeking immediate assurance across NHS Wales. The NHS Wales Chief Executive is this morning speaking to all health board Chairs and Chief Executives on my behalf. I expect all health boards to consider their own services in the context of the recommendations of the report and to provide assurance to me within two weeks. The Chief Nursing Officer and Chief Medical Officer will also work with heads of midwifery, clinical directors and user led maternity service liaison committees to ensure that the learning from this report informs the actions for Wales in the new 5 year vision for Maternity Services which will be published as soon as that has been achieved. HIW has also confirmed that it will be undertaking a review of all maternity services across Wales during 2019 / 20.

Pregnancy and childbirth should be a positive experience, a joyous celebration of new life. I know from my own experience how the support of medical and midwifery care can make such a significant positive difference to a family. Women who are expecting to use maternity services in Cwm Taf will be understandably concerned by the findings of this report and those who have experienced adverse outcomes rightly expect to see changes made. Similarly I want staff to know that they will be supported to make the improvements needed and within an environment where they can feel safe to report concerns and provide the very best care for women and babies. The actions that I am announcing today will help to drive these necessary changes and I will be keeping the impact under review to ensure that is the case.

I would like to thank the review team for the work they have undertaken and for the objective and constructive recommendations in their report. They have worked diligently to support the improvement of services and the focus now must be on implementing their findings.

At their core, this is about mothers and babies, about their experiences in pregnancy and during birth, and the level of safety that every family has the right to expect. I am determined to ensure that maternity care is a positive experience that women in Wales and their families can look back on and cherish.