# WRITTEN STATEMENT

# BY

# THE WELSH GOVERNMENT

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| **TITLE**  | **Update on Cwm Taf Morgannwg University Health Board**  |
| **DATE**  | **08 October 2019** |
| **BY** | **Vaughan Gething AM, Minister for Health and Social Services** |

In April, I published the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives joint report, following their review of maternity services at the former Cwm Taf University Health Board. One of my immediate actions was to place maternity services into special measures and the overall organisation into targeted intervention in light of wider and underlying quality and governance concerns that had emerged. A number of interventions were put in place immediately to help secure necessary improvements both within maternity services and the wider organisation.

I committed to providing regular updates on progress and will provide an oral statement this afternoon.

Members will be aware I established an Independent Maternity Services Oversight Panel to provide the necessary oversight of the improvements needed in maternity services. I have recently received their first [quarterly update report](https://llyw.cymru/adroddiad-chwarterol-y-panel-trosolwg-annibynnol-ar-famolaeth-hydref-2019) and I am now publishing this together with the [strategy](https://gov.wales/independent-maternity-services-oversight-panel-clinical-review-strategy) that they have agreed for undertaking the clinical reviews and look back exercise as set out in the Panel’s terms of reference.

Their report provides a comprehensive picture on the progress to date in maternity services at the health board, whilst outlining the Panel’s work to date and planned next steps. I welcome the collaborative approach the Panel has adopted in working with the health board and the way in which they in turn have responded to this. I’m encouraged to hear that a number of key posts have now been filled and the foundations for continued improvement within maternity services have largely been laid.

In developing their assurance framework to assess progress against all the recommendations, the Panel has initially focussed on reviewing the evidence to ensure the eleven immediate ‘make safe’ recommendations from the Royal Colleges’ review have been embedded in practice. While there is some encouraging progress reported against the overall recommendations, albeit initially slower than the Panel had hoped for, it is clear that a considerable amount of work is still required and the health board will need to remain focused on the challenges ahead.

It is reassuring that the Panel’s engagement work with women, families and staff continues to move at pace and I am pleased that the health board is now taking increasing ownership of this. I particularly welcome the series of co-production events that are being planned by the health board as it is vital that women, families and staff contribute to the design and delivery of sustainable and aspirational maternity services.

 A key responsibility of the Panel is to design and implement a programme of clinical case reviews. In doing this they have decided to adopt a very broad approach in determining which cases should be subject to a multidisciplinary review. They will review cases within the 2016-18 time period initially, which will include the 43 cases originally identified by the health board. However this extended scope and agreed criteria will mean that considerably more cases will be now be included. This approach is designed to maximise learning and opportunities for improvement as well as enable areas of good practice to be identified and shared. This will intentionally be an evolving process and, depending upon learning, further areas for review may be identified to ensure all areas for improvement are identified. I welcome this approach. Arrangements are being made to establish multi-disciplinary clinical review teams in partnership with the Royal Colleges so that this phase of the work can get underway as soon as possible. It is essential that this process is conducted thoroughly and robustly. All women and families included in the review will be given the opportunity to be involved if they so wish.

More generally considerable work is underway across the health board to ensure that robust governance arrangements are in place. David Jenkins, former Chair of Aneurin Bevan University Health Board, has continued to provide support and advice to the Chair and the Board. He has assured me that that the Board has fully accepted and embraced the need to drive forward meaningful improvement across the organisation in an open, transparent and inclusive way. The NHS Wales Delivery Unit continues to work with the health board to ensure that arrangements for the management of concerns and incidents are effective and driving learning in patient safety and experience. The Wales Audit Office and Healthcare Inspectorate Wales are concluding their joint governance review of the health board. This will be key in confirming what further improvements need to be made over the coming months.

There is clearly still a considerable way to go to address the fundamental issues and concerns which have come of light within the health board. I appreciate this has been a very difficult time for all staff concerned. However I am encouraged by the way in which they have accepted the need to make sustainable, organisational wide change which puts quality, safety and patient experience at the heart of all that they do.