MINUTES OF THE EXTRAORDINARY MEETING OF CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD MEETING HELD ON TUESDAY 30 APRIL 2019, IN YNYSMEURIG HOUSE, NAVIGATION PARK, ABERCYNON

PRESENT:

Mr P Griffiths *(on behalf of Prof M Longley)*	– Independent Member (Chair)
Ms A Williams	– Chief Executive
Mr K Montague	– Independent Member
Mr M Jehu	– Independent Member
Mr J Hehir	– Independent Member
Mrs J Sadgrove	– Independent Member
Mrs D Jouvenat	– Independent Member
Mrs N Milligan	– Independent Member
Mr G Isingrini	– Associate Member
Cllr P White	– Associate Member
Ms R Treharne	– Director of Planning & Performance/ Deputy Chief Executive
Mr G Dix	– Director of Nursing, Midwifery & Patient Care
Mr S Webster	– Director of Finance
Mr A Lawrie	– Director of Primary, Community & Mental Health Services
Mr S Webster	– Director of Finance & Procurement
Mr S Harrhy	– Board Director

IN ATTENDANCE:

Mr R Williams	– Director of Corporate Services & Governance / Board Secretary
Mr D Kitto	– Chief Officer, Cwm Taf Community Health Council
Mr J Beecher	– Cwm Taf Community Health Council
Ms C Moss	– Cwm Taf Community Health Council
Dr R Alcolado	– Deputy Medical Director
Mrs J Sumner	– Deputy Head of Communications
Ms G Roberts	– 'Interim' Board Secretary
Mrs W Penrhyn-Jones	– Corporate Governance / Committee Secretariat

Unconfirmed

HB/19/52 **RESOLUTION TO NOMINATE AN INDEPENDENT MEMBER TO CHAIR THE BOARD MEETING**

Due to the Health Board Chair and the Vice Chair not being present to oversee proceedings, Mrs A Williams asked Mr R Williams to explain the provisions within the Health Board's Standing Orders which provided for such circumstances. Members also **NOTED** the arrangements in place to support staff across Health Board sites, which resulted in a number of Executives not being present at the Board meeting.

Mr R Williams provided a summary of the provisions and explained that the Chair had taken the decision to attend the event arranged for the families affected by the findings of the Review, produced by the Royal College of Obstetricians & Gynaecologists (RCOG) and Royal College of Midwives (thereafter referenced in these minutes as the 'Review Report').

Board Members **NOTED** the UHB's Vice-Chair was also unable to attend the meeting due to pre-arranged annual leave. Mr R Williams stated that in such unusual circumstances, providing the meeting was quorate (which was confirmed to be the case with three or more Independent Members and Executive Directors present), it was possible to elect an alternative meeting chair from the Independent Members present. It was **PROPOSED** that Mr P Griffiths be nominated as Chair of the meeting; this was **SECONDED** by Mr M Jehu.

The Board **RESOLVED** to:

- **AGREE** the meeting be chaired by Mr P Griffiths.

HB/19/53 **WELCOME & INTRODUCTIONS**

Mr P Griffiths formally welcomed Community Health Council (CHC) representatives – Mr D Kitto, Mr J Beecher and Ms C Moss, members of the public and the representative from Welsh Government to the Extraordinary Meeting of Cwm Taf Morgannwg University Health Board.

Mr P Griffiths stated that the Board was meeting to formally receive the Review Report commissioned by the Welsh Government and that the meeting had be timed to coincide with its publication. Board Members **NOTED** the report would take some time to digest and would require the Board's fullest attention.

Unconfirmed

Those present were made aware that whilst the Board was meeting in public this was not a public meeting and as such it would not be possible for members of the public to ask questions during the meeting. However, Mrs A Williams offered that once the meeting concluded, she would make herself available to address any questions.

HB/19/54 APOLOGIES FOR ABSENCE

Apologies for absence were **received** from Prof M Longley, Mrs M Thomas, Mr J Palmer, Prof K Nnoaham, Cllr R Smith, Mr K Asaad, Mrs J Davies and Prof A Hopkins.

HB/19/55 DECLARATIONS OF INTEREST

There were none.

HB/19/56 MATERNITY SERVICES

Mr P Griffiths asked the Chief Executive to present the key findings of the Review Report.

Mrs A Williams began by explaining that Mr K Asaad, Medical Director and Prof A Hopkins, Board Director and Lead for Maternity Services, had tendered apologies for this 'Extraordinary' Board meeting as they were currently supporting staff at the maternity unit in Prince Charles Hospital sharing the Review Report findings. Mrs A Williams stated that this was in addition to offering additional senior clinical support for staff who were caring for women accessing services. Mrs A Williams also explained that following the Board meeting, Mr G Dix, Director of Nursing, Midwifery and Patient Care would also be providing support to staff alongside Mr J Palmer, Chief Operating Officer who was supporting staff at the Royal Glamorgan Hospital, which had a busy free-standing midwifery unit and ante-natal clinics in operation.

Board Members **NOTED** Dr R Alcolado, Deputy Medical Director was attending the Board on behalf of the Medical Director should the Board wish to address any clinical issues arising from the Review Report.

Mrs A Williams stated that the Review Report's findings illustrated that the Health Board had failed a number of women and their families and the Board needed to be determined to act upon the recommendations.

Board Members **NOTED** the Review Report built upon other reports received by the Board over the past six months relating to the under reporting of clinical incidents within maternity services, initially highlighted following a change in senior personnel within the specialty during 2018.

Unconfirmed

Mrs A Williams explained to Members that external and independent reviews were important in helping the organisation understand and learn from what had happened. Members were reminded that at its meeting in September 2018, the Board had supported proposals to carry out a four-stage review process which planned to align learning points to an improvement plan, as outlined in point 2.3 of the Board report.

Board Members **NOTED** that following an announcement by Vaughan Gething AM, Minister for Health & Social Services, it had been confirmed that the commissioning of the Review would be via the Welsh Government rather than the Health Board as originally planned. Mrs A Williams stated this was significant, as by not commissioning the review directly, the ability of the Health Board to clarify fully the report findings in full, prior to its publication had been limited. Mrs A Williams stated that the Health Board had received key messages from the report at the end of the previous week which built on the feedback received in January 2019 by members of the Board from the Review Team.

Mrs A Williams reminded Board Members that given the timing of Welsh Government arrangements, a decision had been taken to stand-down the planned external review due to be commissioned by the Health Board and to pause other internal review processes (other than the clinical case reviews) on the basis that the Welsh Government's Review took precedence. Board Members were aware that in the meantime, a Maternity Improvement Board was established to oversee the development and delivery of a Maternity Improvement Plan (MIP) and assistance was secured through the Welsh Government's Delivery Support Unit to help the multi-disciplinary team in processing elements of reviewing serious untoward incidents.

Mrs A Williams referenced an internal report commissioned from a secondee Consultant Midwife during August 2018. Board Members **NOTED** that the resultant report had not been formally taken through the Cwm Taf University Health Board's governance processes and consequently had not been formally received and discussed. Board Members **NOTED** this represented an internal system failure although the Consultant Midwife's report's recommendations had however been incorporated into the MIP. Mrs A Williams apologised to the Board for this oversight and recognised that the handling was not in keeping with usual Board governance processes.

Unconfirmed

Independent Members commented that they had been surprised at the contents of the Consultant Midwife report, which raised many similar issues to those raised by the Joint Royal Colleges report, but that they found the feedback from women, outlined in the patient experience / engagement report to be the most difficult read. Mrs A Williams explained that Board Members had received the report at for the first time and under embargo, at its 'closed' that took place the previous week and whilst the fact that the report had not previously been scrutinised, represented a clear governance process failure. However, the key findings and themes in the report, including recommendations had not been 'lost' as they had been carried forward into the Maternity Improvement Plan (MIP).

Board Members **NOTED** the Chair had requested the Board Secretary and two Independent Members undertake a detailed review of the circumstances behind this handling / governance failure.

Board Members **NOTED** the scope of the review would be confirmed within the next 10 days with the outcome being reported to the Board in due course. Mrs A Williams suggested that if any Board Member wished to submit comments on the proposed scope of the review they would have the opportunity to do so. It was proposed that Chair's Action be taken to finalise the review's scope ahead of it being submitted to the Board meeting on 30 May 2019. This was **AGREED.**

Independent Members suggested that it would be helpful if all the issues from the Consultant Midwife's report were mapped to the MIP. Mrs A Williams stated this had already been undertaken and would need to be further developed to align with the Joint College report's 70 recommendations and confirmed that this would be made available to Board Members (**Added to Action Log**).

Independent Members reiterated that the women and families within the maternity services and patients in the wider health board were the top priority for the board in ensuring safe and effective services. Members discussed the importance of ensuring open and transparent governance systems relating to service delivery and care. Members expressed disappointment that the internal Consultant Midwife's report had not been channelled through the Board's usual internal governance processes and welcomed the internal review commissioned by the Chair of the Board to better understand and learn from what has happened.

In relation to the issue of staff engagement, Mrs A Williams informed the Board that this had been a key issue in the Review Report, in that a significant number of staff had expressed that they did not feel engaged in the management and delivery of services.

Unconfirmed

The Chief Executive made reference to previous organisational development efforts to engage with staff, which clearly had not been sufficient and advised the Board that the actions to address this issue was critically important in order that staff felt supported in caring for women.

Mrs A Williams advised the Board that progress continued to be made with delivery of the Maternity Improvement Plan (MIP) and referenced pages 11-12 of the Board report where related progress on key themes was summarised. Members **NOTED** that MIP progress was currently being tracked through the weekly maternity assurance meetings and formally reviewed by the Maternity Improvement Board, which meets monthly with progress being reported to the Board's Quality, Safety & Risk Committee. Members **NOTED** that the MIP would be revised in light of the Review Report recommendations, given it was the vehicle for providing assurance to the Board that the necessary issues were being delivered at pace.

Independent Members referenced the ongoing challenges that the organisation was facing and sought clarity as to whether the issues would have an impact on matters such as recruitment. Mrs A Williams agreed that this could happen and reminded the board of the national shortage of midwives. Members **NOTED** that Welsh Government had increased Welsh midwifery training places by around 40% which would result in an additional quota of qualified staff in around 18 months' time. However, Mrs A Williams emphasised the importance of tackling the improvement actions and reported cultural issues in order for new recruits to be attracted to working in CTMUHB. Board Members **NOTED** that issues within maternity services could impact upon recruitment and retention of staff and that it was critical that the appropriate support was provided to maternity staff who were working hard to maintain a service at this challenging time. Mrs A Williams explained with the inevitable publicity that the Review Report would generate and the seriousness of the information within the report, this would create anxiety and grave concern within the community.

Board Members **NOTED** daily situation reports on midwifery staffing were being produced and processes had been established to escalate issues whereby neighbouring health boards worked together to review and manage available capacity. With regard to services at the Princess of Wales Hospital, Mrs A Williams said that the site had fewer midwifery vacancies than in the former Cwm Taf maternity units and that some of the midwives originally working at the Royal Glamorgan Hospital had chosen to transfer to Bridgend in recent months. Mrs A Williams stated that the Princess of Wales Hospital had also benefited from a re-instatement of neonatal cots.

Unconfirmed

Board Members **NOTED** the Review Report findings did not relate to services at the Princess of Wales Hospital, but that all the learning arising from the recommendations would be applied across the whole service.

Mrs A Williams informed the Board that following the publication of the Review Report, some women could decide to deliver their babies at other sites, but advocated that any such arrangements should be made through and with the support of their local midwife. Advice to staff and women had been prepared in order to support women who wished to make a different booking choice.

Mr S Harrhy raised the issue of staff engagement and its links to the MIP. Mrs A Williams responded by saying that there was a need to listen to both women as service users and staff in terms of helping shape services and that expert advice would also be sought in taking this forward. Board Members **NOTED** the intention to establish a consultative maternity liaison committee and that any lessons learned would be appropriately shared across the organisation. However, there was recognition that the Health Board needs to better engage with women.

Mrs A Williams said that staff had experienced significant change over the past five years and whilst there had been a degree of engagement work it was clear from the Review Report this had not delivered the desired outcomes. Mr S Harrhy suggested that continuous evaluation and good communication was key. Mrs A Williams concurred, adding that real-time feedback was needed.

Independent Members suggested that given the gravity of the issues raised within the published reports, it would be important to accept assistance as necessary. Mrs A Williams concurred saying that there was also a need to identify a high performing strategic partner organisation from which it could learn and make the necessary improvements.

The Director of Nursing, Midwifery and Patient Care stated that it would be important for the Board to see outcomes arising from the implementation of the MIP. Board Members **NOTED** that 'soft' information and data gained from performance report triangulation would need to be brought back to the Board when arrangements were agreed with the Maternity Oversight Improvement Panel (**Added to the Action Log**).

It was also recognised that whilst it was important that the Board operated in an open and transparent way, the role of the Community Health Council (CHC) as a proxy service user voice remained an important part of mechanisms required to restore confidence in Health Board Maternity services.

Unconfirmed

Although the Board Report (page 11) stated progress continued to be made with the delivery of the MIP which was being tracked through weekly maternity assurance meetings and formally via the Maternity Improvement Board. Members felt that despite those arrangements, the Board would still require comprehensive reports. Mrs A Williams concurred adding that as a result of the announcement that morning by Welsh Government (regarding the intention to put into place additional external support with regard to Maternity Services – Maternity Oversight Panel), it would be important to consider membership and reporting arrangements going forward. Mrs A Williams added that whilst this was a serious matter, the organisation was also responsible for a range of other services and therefore an appropriate balance would need to be struck in providing assurance to address the very serious issues raised and also to ensure the Health Board continues to deliver and report on other services provided by the Board.

Board Members **NOTED** the existing commitment to the further independent scrutiny of the 43 cases which had already been subject to internal review and there would also now be a 'look back' to cases as far back as 2010, the arrangements for which, would be directed by the Maternity Oversight Panel. Board Members **NOTED** that once validated, the final position would be shared with the Board and any additional learning mapped across to the MIP.

Whilst it was difficult to identify themes from the 43 cases, Mrs A Williams said that it appeared that there were significant delays in various interventions (such as changes in baby's heart rate tracings, induction of labour and neonatal resuscitation) in a number of cases; she offered on behalf of the Board, sincere apologies in this regard. In instances where there were possible or confirmed failings in care, Board Members **NOTED** service users had been referred for consideration of redress in line with NHS Wales' 'Putting Things Right' guidance.

Independent Members sought clarity as to whether maternity services were now safe. Mrs A Williams stated that the fundamental recommendations of the Review following the visit in January 2019 had been actioned soon after and therefore the Board could take some assurance in that regard. Mrs A Williams added that since that time, significant changes had been made in that obstetric services had now been consolidated at Prince Charles Hospital with a standalone midwife-led service at the Royal Glamorgan Hospital.

Unconfirmed

Board Members **NOTED** that this had enabled an increase in consultant labour ward cover at Prince Charles Hospital and therefore greater senior consultant support for 'high risk' cases and that following the discussions at the 'closed' Board Meeting the previous week, the senior team managing safety issues remained a key focus for the senior team and additional monitoring of daily acuity and staffing levels was also in place.

Mrs A Williams referenced page 16 of the Board report regarding maternity data sources which had been the subject of a previous report to the Board. Board Members **NOTED** that work thus far indicated a correlation between data sets with regard to outcomes but recognised that this would now require external validation in light of the College Review comments regarding clinically validated data.

The issue of support being provided to the Head of Midwifery to address the related issues was raised. Mrs A Williams stated that support arrangements had been put in place for the senior team overseeing maternity services, including support for the Head of Midwifery, with Jayne Phillips also providing support from Swansea Bay Health Board. Mrs A Williams added that in relation to professional behaviours and a non-blame safety culture, this needed to sit alongside the processes governing professional conduct and standards enabling investigation when necessary so that any issues could be appropriately managed. Mrs A Williams reiterated that if any professional conduct issues are identified relating to any individual members of staff, appropriate action under the appropriate Health Board policy would be enacted.

Mr J Beecher said that where there were peaks in demand, staff were working under pressure and this would inevitably impact upon behaviours and culture. Mrs A Williams stated that it would be necessary to acknowledge the pressure brought about by uncertainty and change, but that professional behaviours needed to be maintained to ensure patients were treated with compassion in an environment that enabled staff to work well together.

Mr S Harrhy raised the subject of the benchmarking of data and sought clarity around how this information would be relayed back to the Board including across Wales and the UK. Mrs A Williams stated that there would be cross-referencing of data to provide assurances around incident reporting and that changes had been made to the Maternity Information System in this regard and that there was a weekly review of incidents together with complaints and legal claims.

Unconfirmed

With regard to external reports, Mrs A Williams stated comparison of outcome data across the UK was currently interpreted via the clinical audit function, but that consideration was being given to reporting this through the Board's Quality Safety and Risk Committee.

With reference to the patient experience report, Mrs A Williams commented that this had made very difficult reading with heart-breaking stories of both care delivery and the experience of care. Mrs A Williams also highlighted the examples of positive patient experiences, but emphasised that no women should have experienced the care that they recounted, as articulated within the report. Mrs A Williams stated that page 18 of the Board report set out key themes and messages from the Review such as lack of staff engagement, lack of inter-professional working and the need for role clarity. With reference to the 70 recommendations made in the Review Report, Members **NOTED** that certain areas had already been captured within the MIP, but that this would need to be reviewed and updated to ensure all College Review recommendations had been captured, and then scrutinised via the Maternity Improvement Board and the Quality, Safety & Risk Committee, to ensure all aspects were captured and that progress was being made. Importantly, Mrs A Williams explained that the work and views of the Maternity Oversight Panel would also be key in informing this work for the future. Mrs A Williams anticipated being in a position to update the Board further on the Oversight Panel arrangements at its next meeting in public.

Following discussions at the Board meeting the previous week, Mrs A Williams proposed that the Board accept the Review Report recommendations in full. Members **NOTED** that the Board would then need to focus on scrutinising the delivery of actions which needed to be put in place in a timely fashion, taking into account expert advice and working with Welsh Government colleagues to strengthen both Maternity Services and Governance systems. However, Members recognised the challenges presented relating to culture and that this can often take longer to address and improve.

Independent Members recognised the reference to and importance of governance and assurance intentions, which needed to be applied to every aspect of the Health Board's business. Mrs A Williams concurred and recognised it was her duty, along with the Health Board's, to provide the best possible services to the population served by Cwm Taf Morgannwg Health Board.

Unconfirmed

Mr D Kitto informed the Board that the CHC had not yet had the opportunity to comment on the Review Report's findings as it had only received them today at the Board meeting, but that it would seek to do so as soon as possible. In referencing the South Wales Programme, Mr Kitto explained that the Programme's intention was to support and bolster fragile consultant led services such as maternity so as to prevent service failures. He also referenced the CHC's role in representing the views of the public on local health services saying that normally their officers would become involved in around 10% of formal complaints lodged with the UHB but in respect of maternity services their involvement had been much smaller. Members **NOTED** that this indicated a need to work more closely with the Health Board and to ensure patients were made aware of the availability of and assistance that the CHC could offer.

Board Members **NOTED** the CHC had that day established an advocacy service as a result of the publication of the Review Report. Members **NOTED** that the CHC had not been invited by the Welsh Government to attend the event arranged that day with patients.

Mrs A Williams stated that it would be normal practice for the UHB to have linked with the CHC to discuss the review findings ahead of the report being published. However, members **NOTED** that given that the Review had been commissioned by the Welsh Government, its related handling was a matter for them and not the Health Board. Mrs A Williams stated that the work of the CHC was greatly valued by the Health Board and that they would continue to work closely with the CHC to improve services across the catchment area, including Maternity services. Members **NOTED** the Health Board had established a helpline and email contact address list, to support any women and families affected by the issues in maternity services within the former Cwm Taf University Health Board and that staff were promoting and signposting any support mechanisms for women, including the CHC. Mrs A Williams added that the CHC were already a member of the Health Board's Maternity Services Liaison Committee, which would need to be refreshed and reconstituted with external support to strengthen engagement and involvement of service users.

With reference to the decision of the Minister to increase the organisation's overall escalation status, to 'targeted intervention' together with that of the former Cwm Taf maternity services, Mrs A Williams stated the potential for this had been discussed at the 'closed' Board meeting discussion the previous week. Mrs A Williams felt the increased levels of escalation to be entirely appropriate to bring about immediate and sustained improvement.

Unconfirmed

Whilst the 'special measures' escalation status applied only to the former Cwm Taf maternity service (rather than Cwm Taf Morgannwg) University Health Board, Board Members **NOTED** any lessons learned from the review would be applied to the whole organisation.

Board Members **NOTED** that Mr David Jenkins (the former Chair of Aneurin Bevan UHB) had agreed to provide support to the Chair of the Health Board and to review and observe the Board's scrutiny and governance arrangements. As part of this work, there would be close liaison with the Welsh Government, with a view to providing the assurances required by the Board, Welsh Government and the women using the clinical services.

Independent Members felt that there was a need to fully understand the Board's role in responding, in terms of actions to provide the necessary assurances. Mrs A Williams stated that it was not yet clear what this meant in practice but that she intended to seek confirmation of this from the Director General of the NHS in Wales. Members **NOTED** there would be an update report for the next Board meeting on 30 May 2019 regarding the support arrangements being put into place to deliver this challenging agenda.

Board Members **NOTED** the recommendations within the Board report had been drafted prior to the official publication of the review recommendations.

Board Members **NOTED** these would now need to be reviewed to include a full reconciliation of actions in terms of the Maternity Improvement Plan (MIP), the future role, function, membership and reporting arrangements of the Maternity Improvement Board including consideration of the views of the Maternity Oversight Panel, the engagement of external experts and strategic partners as well as the outcome of discussions with Welsh Government officials.

The Chair thanked Board Members and the CHC for their important contributions. Mr P Griffiths reaffirmed that there was clearly a real determination, to deal with the identified service failings, as the communities the Health Board served deserved nothing less.

Members **RESOLVED** to**:**

- **RECEIVE** and **ACCEPT** in full findings and recommendations of the Maternity Service Review Report (produced by the RCOG and Royal College of Midwives);

Unconfirmed

- **AGREE** the Maternity Service Review Report be subject to further consideration, with a view to an update regarding actions, delivery outcomes, timescales and oversight arrangements (including the future role and function of the Maternity Improvement Board and full involvement of the CHC) to the next Board meeting on 30 May 2019;
- **AGREE** the failings in usual governance and communication processes surrounding the receipt & consideration of the draft report prepared by the secondee Consultant Midwife be subject to an investigation involving the Board Secretary and two independent members the terms of reference for which would be approved by Chair's Action;
- **AGREE** that a formal public apology be offered to women and their families who had a poor experience or outcome of maternity care in Cwm Taf.

HB/19/35 **ANY OTHER BUSINESS**

Paediatric Services

Mrs A Williams referenced the planned changes to paediatric services which had arisen following the implementation of the South Wales Programme. This meant that there were currently plans in place to transfer inpatient paediatric services (currently based at the Royal Glamorgan Hospital to Prince Charles Hospital) during the summer months. Mrs A Williams explained that further and more detailed discussions were required with senior staff and those managing the delivery of these services, to understand if the planned timescales should remain, or if there should be a delay of some months.

Board Members **NOTED** that this proposal was not in any way a change to the decisions made across the Region in relation to the South Wales Programme, but a potential change to the implementation timings. Any further related updates, will be brought back to the next Board meeting.

Offer of Engagement

Mrs A Williams extended an offer to members of the public and County Borough Council representatives who were present at the meeting, to discuss any issues following the completion of the Board meeting. This was accepted.

There was no further business and the meeting was closed.

Unconfirmed

HB/19/36 **DATE OF NEXT MEETING**

The next scheduled meeting of the University Health Board would take place on Thursday 30 May 2019.

SIGNED:………………………………………………

Paul Griffiths, Independent Member (On Behalf of Marcus Longley, Chair)

DATE:…………………………………………………

Unconfirmed