Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 4.1** **30 May 2019**

University Health Board Report
MATERNITY SERVICES UPDATE

Executive Lead: Director of Nursing, Midwifery & Patient Care
Author: Chief Executive / Board Secretary
Contact Details for further information: Director of Nursing, Midwifery & Patient Services 01443 744800

Purpose of the Health Board Report
The purpose of this report is to provide the Board with an update on Maternity services, following the publication by Welsh Government on 30 April 2019, of the external review undertaken by the Royal College of Obstetricians and Gynaecologists (RCOG) & Royal College of Midwives (RCM). On the day of publication, the Board held an extraordinary public meeting at which an initial response to the report was made and a number of key actions agreed. This paper builds on that response and provides further updates on progress to date. Members will also note, that as a consequence of the recent publications of reports and their related serious findings, the Minister for Health & Social Services, has announced, that for Maternity Services, the Health Board has been escalated to 'Special Measures', the highest level of escalation. In addition the Health Board's escalation level of 'enhanced monitoring', has been increased to 'targeted intervention'. An update on actions taken since the last Board meeting and the known related implications of the special measures arrangements to date is summarised in this report.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within its approved 3 Year Integrated Medium Term Plan 2019-2022 and the related organisational objectives aligned with the 'Quadruple Aim' described within 'A Healthier Wales' (Welsh Government, June 2018) these objectives in summary are: • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future.

	• To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses on all of the above objectives.
Supporting evidence	Where necessary references are included in the body of the report.

Engagement – Who has been involved in this work?
This Report has been developed from a range of work undertaken across the Health Board, which has involved internal and external staff as appropriate.

Health Board Resolution to:							
APPROVE		**ENDORSE**	√	**DISCUSS**	√	**NOTE**	√
Recommendation	The Health Board is asked to: • **NOTE** and **DISCUSS** the updates contained in this report; • **AGREE** that the detailed Programme arrangements will be endorsed by the Board in July; • **AGREE** that the Chief Executive and Director of Nursing, Midwifery and Patient Care, will discuss the proposed Programme arrangements and likely resource requirements with Welsh Government officials to inform the infrastructure requirements; • **AGREE** that the Chair can take Chair's action to commit resources to the Programme in advance of the July meeting if required.						
Summarise the Impact of the Health Board Report							
Equality and diversity	There are no directly related Equality and Diversity implications as a result of this report.						
Legal implications	There is reference to legal processes e.g. Clinical Negligence and 'Putting Things Right' regulations.						
Population Health	The delivery of safe high quality maternity services across Cwm Taf Morgannwg UHB is essential to good public health.						
Quality, Safety & Patient Experience	There are significant quality, safety and risk implications referenced within the report and its related documents.						
Resources	There are no direct financial resource implications contained within the report although it is recognised that significant additional resources will be necessary in supporting the delivery of the required improvement actions. This will need to be subject of further discussion with Welsh Government officials.						
Risks and Assurance	There are significant risks and assurance issues outlined within the report and its supporting documents, that the Board will need to consider.						

Health and Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported in this summary and related annexes take into account many of the related quality themes.
Workforce	There are references to workforce and related factors contained within the report and its supporting documents.
Freedom of information status	Open

MATERNITY SERVICES UPDATE

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to provide the Board with an update on Maternity services, following the publication by Welsh Government on 30 April 2019, of the external review undertaken by the Royal College of Obstetricians and Gynaecologists (RCOG) & Royal College of Midwives (RCM).

On the day of publication, the Board held an extraordinary public meeting at which an initial response to the report was made and a number of key actions agreed. This paper builds on that response and provides further updates on progress to date.

Members will also note, that as a consequence of the recent publications of reports and their related serious findings, the Minister for Health & Social Services, has announced, that for Maternity Services, the Health Board has been escalated to 'Special Measures', the highest level of escalation. In addition the Health Board's escalation level of 'enhanced monitoring', has been increased to 'targeted intervention'.

An update on actions taken since the last Board meeting and the known related implications of the special measures arrangements to date is summarised in this report.

The Board is requested to **NOTE** and **DISCUSS** the contents of this report.

2. BACKGROUND / INTRODUCTION

2.1 Overview

Members of the Board will know that provision of Maternity Services has been a key feature of the Health Board's business, since the launch of the South Wales Programme engagement and consultation exercise. Members will also understand that the related decisions, made by this Board and other NHS Wales organisations' in 2016, where changes to the delivery of Paediatric, Obstetric & Neonatal Services were agreed on a Regional basis, would impact the greatest on the former Cwm Taf University Health Board.

As previously reported to the Board, following changes in the senior management team and clinical governance arrangements in the Cwm Taf maternity services early in 2018, concern was expressed internally that there was potential variation in the reporting arrangements and investigation of incidents. This meant that the Board could not be wholly assured that all serious incidents had been appropriately investigated and any learning fully addressed.

This concern was initially escalated in the early summer 2018 to the responsible Executive Directors; discussed with Welsh Government in August 2018; presented to the August 2018 Health Board development session; and reported to the Health Board Quality, Safety and Risk Committee 'In Committee' in September 2018.

The concerns were reported in outline at the Public Board meeting in September 2018, with a more detailed report presented to the Public Board meeting in November 2018 https://cwmtaf.wales/we-are-cwm-tafmorgannwg/board-papers/?drawer=Board Papers*2018-2019

In subsequent months, a number of actions were agreed by the Board to include:

- A 4 stage review process of our maternity services (including the direct commissioning of a peer review and an external review by the RCOG);
- The establishment of a Maternity Improvement Board (MIB), with an external chair, to provide oversight of the delivery of an improvement plan for maternity services;
- Regular progress reporting to the Board.

An update on these arrangements was reported to the extraordinary Board meeting in April 2019 https://cwmtaf.wales/we-are-cwm-tafmorgannwg/board-papers/?drawer=Board Papers*2019-2020*02 Board Meeting Papers 30 May 2019

The failings and challenges outlined in the Joint RCOG & RCM Report and the accompanying patient experience report have been the most difficult issues this Board has ever encountered. The impact on the women and families affected remains foremost in all considerations and will continue to do so as we move forward.

Some of the key issues identified were known to the Board including staffing challenges, more recently identified problems with incident reporting and pressure on the service (particularly relating to the planned service moves). A number of actions were already being taken with progress monitored via the MIB. However, the extent of the dysfunctionality in professional relationships and underlying cultural issues, as reflected in the feedback from women on their experiences of care, was not known or understood. It is this issue that has, quite rightly, invoked the greatest concern from the Board and from the community. The bravery and honesty of those people who have come forward with their stories is humbling. It is for them and all the women and families we serve in Cwm Taf Morgannwg that we must ensure that all possible actions are taken so that the experience of care in our maternity services is addressed.

2.2 Update since last Board meeting

The Board met at 9.30am on 30th April 2019 to correspond with the time of the publication of the Report. This enabled the Board to immediately, and in public:

- Consider and accept in full all the findings and recommendations of the review;
- Make a formal public apology to women and their families who have had a poor experience or outcome of maternity care in the former Cwm Taf UHB;
- Agree a number of key 'next-steps' pending confirmation of the independent panel oversight arrangements.

The agreed 'next steps' and a progress update is included in Table 1.

Table 1: Update on actions agreed at Board meeting on 30 April

Action	Update (24/05/19)	Next Steps
Review of the handling of the Consultant Midwife Report	The Chair has identified an external reviewer and had an initial scoping meeting with the individual.	The review has commenced. Ensure full internal cooperation with the review.
Reconciliation of all RCOG Actions with Maternity Improvement Plan (MIP)	Cross-referencing and updating of MIP complete	Continue to drive delivery of all actions. Identification and agreement with Board and WG the external capacity and capability to support delivery To agree success criteria and performance reporting with Independent Oversight Panel (IOP)
Review of role, function and reporting arrangements for Maternity Improvement Board (MIB)	MIB continues to meet to provide the oversight of the delivery of the MIP. It is currently chaired by the Director of Nursing with the existing membership.	Once the IOP functionality is determined, the internal MIB will be realigned with the broader organisational and oversight governance arrangements. It is anticipated that this will be confirmed before end June.

Action	Update (24/05/19)	Next Steps
Strengthen Maternity Services Liaison Committee (MSLC) and associated systems for engagement of women and families	Meeting with IOP member on 23/5/2019. Engagement Plan being developed by IOP lead Contact being made with all people currently engaged through RCOG process with a view to establishing ongoing wishes and needs. This may assist in identification of new members for the MSLC or a reference group (actual and/or virtual) to support future work of the MSLC.	Baseline assessment to be undertaken. Engagement plan to be agreed with IOP as soon as possible. Engagement Workstream to be established to feed into the MIB. 'Measures of Success' to be developed by IOP lead working with families. This will provide the basis upon which we can effectively measure progress. Urgent consideration of options for commissioning 'Friends and Families Test' real-time feedback
Identification of opportunities for further learning and strategic partnerships	Initial discussion with IOP lead on 23/5. This is encouraged and will be most effective when the infrastructure and engagement plan is in place.	Further discussions and agreement with IOP lead by end June
Confirmation of mechanism for various reviews and oversight arrangements	Meetings with IOP lead on 13/5 and 23/5 to discuss and arrangements and how reporting can be aligned.	First WG Targeted Intervention / Special Measures meeting 03/06/19 Anticipate final IOP arrangements to be complete by end June. Awaiting information on HIW/WAO reviews.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

3.1 Response to the RCOG Review Report

At the Board meeting on 30 April 2019, an initial response to the RCOG Review report was made. The seriousness of the findings was fully acknowledged; the key themes that have emerged were articulated; and the absolute commitment to take all possible actions to improve services and the experience of care for women and their families was strongly confirmed. It is fully acknowledged that there is a significant amount of work to be done to address all the issues raised and to restore confidence in the maternity service and in the Health Board more generally.

Looking back at the various reports the Board has received previously into specific issues within the maternity service, the approach to resolution has always been about delivering the specific actions to respond to the concern raised. What is clear from the RCOG Review is that whilst periodic improvements have been delivered, the underlying cultural and behavioural issues have remained.

The scale of the challenges in our maternity services, as clearly reflected in the patient feedback, means that this is a moment in time for the Board to adopt a totally different approach to sustainable improvement.

Whilst every recommendation and action must be addressed, delivering a high quality service that we can be proud of in the future requires a totally different approach.

The Maternity Improvement Plan itself at **Appendix 1** contains a large number of actions that respond to the recommendations of the RCOG Review and the findings/recommendations from the report produced by the secondee Consultant Midwife. It also reflects the findings of the Healthcare Inspectorate Wales (HIW) unannounced inspection in October 2018, any themes emerging from the 'Putting Things Right' process and themes arising from staff engagement sessions.

Sustained improvement, however, will only be achieved if, in addition to the delivery of the actions in the Maternity Improvement Plan, there is a properly resourced programme of authentic engagement with women and a robust organisational development programme for staff that will change culture once and for all.

3.2 Special Measures – Maternity Services

In his written statement on 30 April 2019, the Minister for Health and Social Services advised that in response to the serious and concerning findings of the RCOG Review, that the escalation status for maternity services in the former Cwm Taf University Health Board area would be placed in Special Measures.

In recognition of the seriousness of these concerns and other issues of quality governance (previously reported to the Board in line with the escalation letter received in January 2019), the Minister also confirmed a change of escalation status from Enhanced Monitoring to Targeted Intervention.

The detail was confirmed by the Director General in a letter to the Chief Executive on 3 May 2019 which is attached as **Appendix 2**. These revised escalation arrangements include the establishment of an independent Maternity Oversight Panel as well as further scrutiny and accountability mechanisms with Welsh Government Officials.

The precise nature of these arrangements is in the process of being finalised and the full detail will be reported to the Board in public once confirmed.

3.2.1 Independent Maternity Oversight Panel

Mick Giannasi has been appointed by the Minister as Chair of the Oversight Panel. Other members include Cath Broderick, Lay Advisor and a Consultant Obstetrician and a Senior Midwife.

The formal Terms of Reference for the Oversight Panel have not yet been finalised, but we understand they will align very closely with the commitments made in the Minister's statement. This will undoubtedly include:

- the provision of independent oversight of the Health Board's delivery of the Maternity Improvement Plan;
- oversight of the further independent clinical reviews and look-back exercise;
- advice on actions for effective engagement of women and their families in improving maternity services together with wider public and stakeholder engagement to build trust and confidence;
- other actions and advice as determined by Welsh Government.

Initial meetings have taken place with the Panel Chair and we are currently scoping our internal mechanisms to respond to the requirements of the panel as they are firmed up over the next few of weeks.

The Maternity Improvement Plan (MIP), which has formed the work-programme for the Maternity Improvement Board (MIB) to date, has been updated to reflect all the recommendations of the RCOG report. This will need to be 'signed-off' by the Oversight Panel and its delivery is likely to form an important part of the oversight arrangements going forward. Discussions will need to take place to confirm the evidence that will be required to enable the recommendations to be assessed as complete and to identify ongoing audit processes to provide assurance of continued delivery of new systems of working.

The Executive Team is working with Welsh Government and the Oversight Panel Chair to align, where possible, the reporting arrangements to the Board with the requirements for the Targeted Intervention / Special Measures processes.

By the time we reach the public Board meeting in July, it's expected that a report will be able to be presented, that outlines in full all the arrangements in place to deliver the MIP and its alignment with the relevant escalation arrangements.

3.2.2 Internal management and scrutiny arrangements

Working with the Chair of the Oversight Panel and with David Jenkins, in his capacity as providing expert governance advice to the Board, it is imperative that the internal management arrangements for the delivery of the improvements in Maternity Services are robust and proportionate to the scale of the challenge.

The Board fully recognises the seriousness of the failings identified and the need to ensure that whilst there is clear focus on delivering the necessary improvements to maternity services, the quality governance and wider organisational performance also continues to improve at the same time.

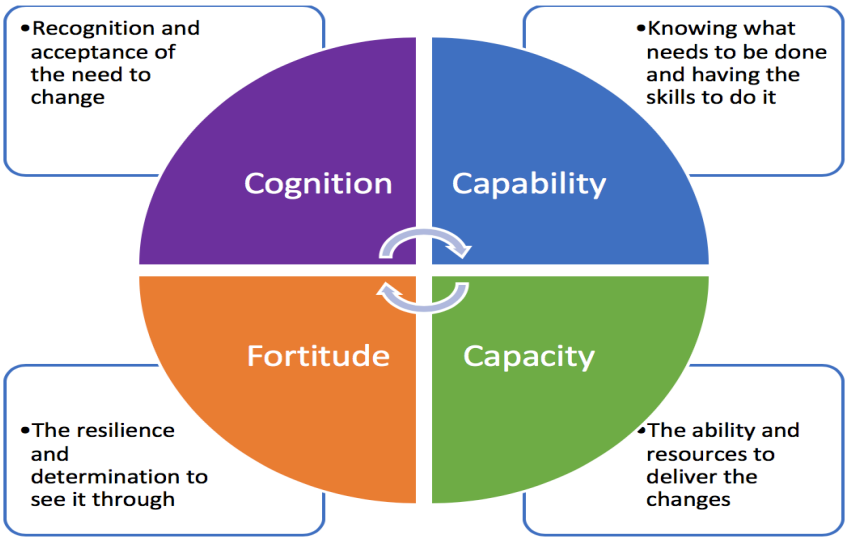
This means that there needs to be absolute clarity on the governance arrangements for the specific programme of work to deliver the MIP alongside an overall strengthening of systems of internal control. The forthcoming Healthcare Inspectorate Wales (HIW) and Wales Audit Office (WAO) governance reviews will be helpful in this respect but in the meantime, there will need to be a specific focus on the reporting arrangements to provide the right level of assurance.

3.3 Delivering the Maternity Improvement Plan (MIP)

To date, the delivery of the MIP has been undertaken by the Directorate management team alongside the day-to-day management of the service. The team should be highly commended for the work they have undertaken to date, however, whilst some additional capacity has been sourced to support them, it is totally inadequate to deliver sustainable improvements at pace.

Discussions with the IOP Chair have identified that the most effective approach to the intervention will be based on the organisations ability to demonstrate the key attributes identified in **Figure 1.**

Figure 1 Organisational approach to delivering improvements



In the context of the above, **cognition** is going to need to be authentically demonstrated throughout the whole organisation – from Board to front-line staff. Putting the women and their families at the centre of all actions and decision-making will ensure that there is a culture and system of continuous improvement that is sustained long after the work of the oversight panel is done.

Ensuring the organisation has the **capability** and **capacity** to deliver the necessary improvements will require the establishment of a properly resourced Programme which will need to be in place for at least the next 12-18 months to enable dedicated focus on delivering the necessary improvements.

The lead Director for Maternity Services is the Director of Nursing, Midwifery and Patient Care who will act as Senior Responsible Officer (SRO) for delivery of the improvements in maternity services.

The Programme arrangements will need to be carefully constructed so that they do not cut across the general management accountabilities of the Chief Operating Officer and Directorate Management Team who will have a key role in working with staff to deliver the necessary changes.

The Chief Executive is working with the Director General to identify a very senior, experienced, external Programme Director who will report directly to the SRO. There will need to be a dedicated Programme Team who will support the Programme Director and also ensure that the reporting mechanisms to the Maternity Improvement Board, Quality Safety and Risk Committee, Executive Board, Board, Welsh Government and the Independent Oversight Panel are fully aligned.

The Programme arrangements will need to align with the usual governance arrangements in the Health Board to ensure that internal decision-making, scrutiny and assurance is properly aligned. At the same time, the arrangements the Board puts in pace will need to satisfy the needs of the IOP.

Specific expertise will need to be commissioned to support the Programme arrangements – particularly in the delivery of innovative approaches to the engagement of women and staff. A bespoke Organisational Development programme to focus on leadership, team-working and behavioural change within the service will be critical to success.

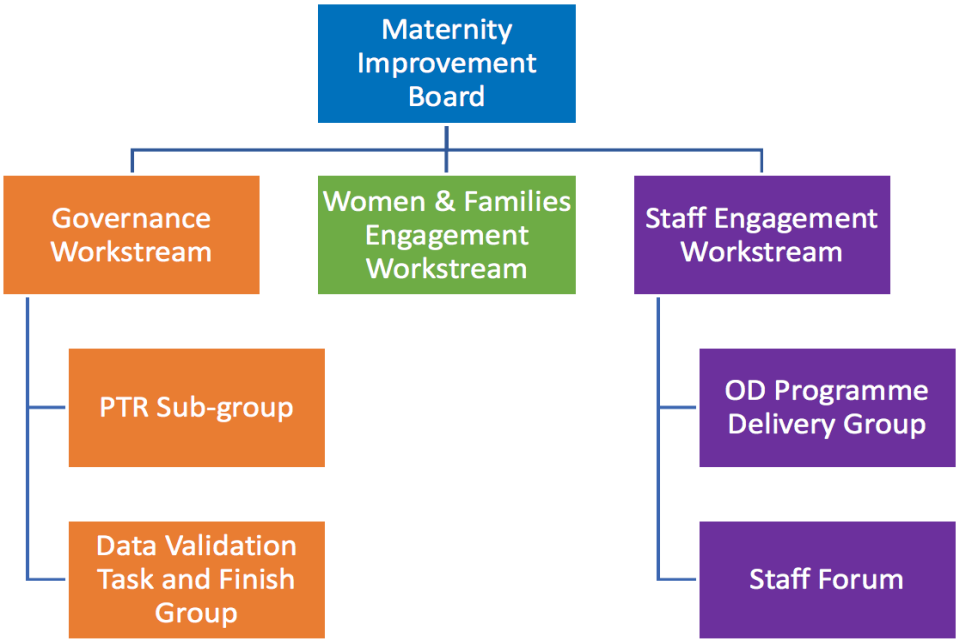
Whilst some of the improvement actions will be able to be delivered in a relatively short period of time, the cultural changes that will be necessary to ensure that the improvements are sustained will require considerable resilience and determination by key leaders in the organisation. The nature and extent of ongoing external scrutiny together with the need to continuously engage with women, staff and stakeholders alongside the delivery of the improvement programme is going to require considerable commitment and **fortitude** by those leading the programme. It will therefore be imperative that effective coaching support is procured as part of the overall organisational development programme.

The approach taken by University Hospitals of Morecambe Bay provides a very helpful framework for consideration. It is recommended that Board members read the Kirkup 'One Year On' report which outlines the progress made and the ambition we should have for the next 12 months.

https://www.uhmb.nhs.uk/files/7014/6409/6112/Agenda_Item_8i_MBI_One_Year_On_Report.pdf

Recognising that the membership will need to change to reflect the actions and methodologies to be agreed with the Independent Oversight Panel, the working assumption is that the Maternity Improvement Board will continue to be the vehicle for overseeing delivery of the improvement plan. The programme structure will need to reflect the distinct but integrated functions required to deliver whole-system change and a first draft of the sub-structures is outlined in **Figure 2**. This will be refined with input from key staff and stakeholders over the next few weeks. It should be noted that there is no suggested infrastructure to support the Women and Families Engagement Workstream as this needs to be co-produced with IOL Panel lead and the women who are willing to engage with the next steps of this process.

Figure 2 Working Draft - Proposed supporting work-streams



The Programme Director will need to be supported by a Programme Team that will include:

- a dedicated Patient Care and Safety Task and Finish Group to ensure timely and effective response to concerns / redress raised as part of the retrospective review processes and any concerns raised by women and their families through the contact line;
- a bespoke resource to support and encourage ongoing engagement and communications with women and their families;
- a rigorous infrastructure to ensure high quality, regular progress reporting to internal and external stakeholders

The Programme Team will also need to include a very senior midwife who will be responsible for providing clinical leadership and governance support to the delivery of the whole programme.

Consideration will also need to be given to the need for a dedicated staff engagement resource to include support for people to 'speak-up' in a safe space if they feel that their voices are not being heard through delivery of the improvement programme.

The Terms of Reference, membership and reporting arrangements for the Maternity Improvement Board are being urgently reviewed so that the internal scrutiny and assurance functions align with the oversight arrangements.

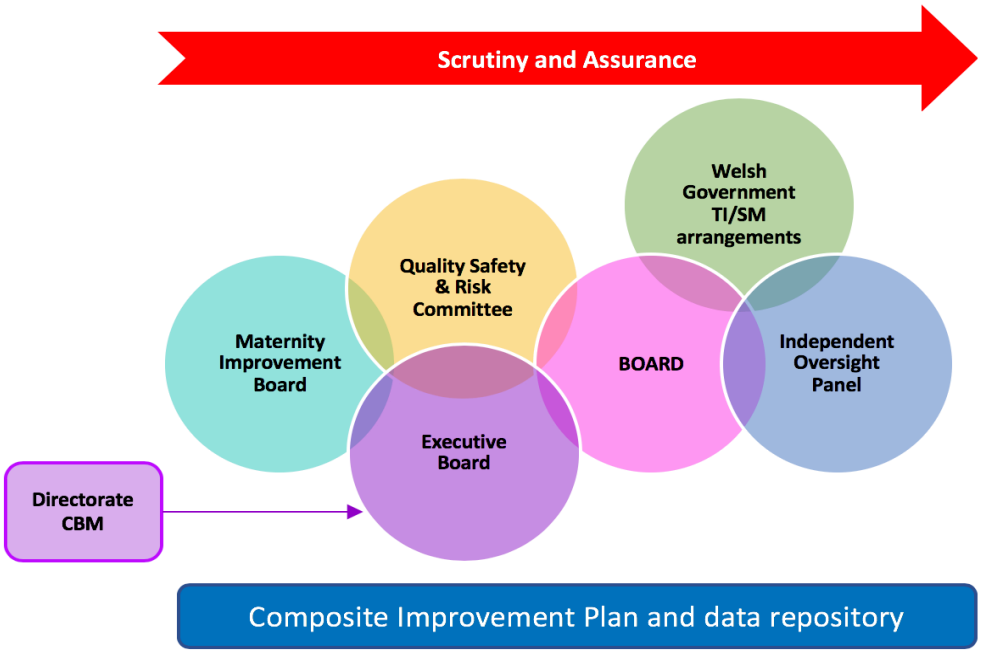
The full details of the programme management arrangements will need to be aligned with the Targeted Intervention / Special Measures processes as determined by Welsh Government, confirmed and then approved by the Board.

The Executive Team is keen to move quickly on these arrangements and by the time the full report is brought back to the Public Board in July, it is expected that significant progress should be made with establishing the necessary arrangements. In the meantime, progress will be maintained in the delivery of the actions within the existing Maternity Improvement Plan.

There will need to be a clear line of accountability between the programme arrangements and the Board with appropriate progress reporting to avoid duplication whilst at the same time facilitating effective decision-making, scrutiny and assurance.

Figure 3 depicts the escalating scrutiny and assurance mechanisms underpinned by a single Improvement Plan and data repository. The Programme Director will need to agree with each Group the reporting requirements which should be able to be drawn from a single data repository that will ensure consistency and avoid, as much as possible, unnecessary duplication.

Figure 3 Alignment of scrutiny and assurance mechanisms



In addition to meeting the external assurance requirements, it is imperative that this alignment is achieved with key delegated responsibilities to each of the various internal committees so that the Board can take assurance on delivery of the improvements.

Fully recognising the absolute priority for the Board in delivering the Maternity Improvement Plan, getting this infrastructure right will enable the Board to balance the needs of the maternity service with the other strategic and operational challenges over the next year.

3.4 Engagement with women and their families

The needs of women and their families must be central to everything that is done to address the failings in maternity services.

Experience to date has identified that there is a diversity of emerging concerns which is likely to need a number of different approaches to ensure people are engaged in the right way and get the answers they need. Whilst every case is very individual, they can be broadly grouped as follows:

- Women currently pregnant and concerned about their ongoing or future maternity care.
- Women who have had recent care in the maternity services in the former Cwm Taf area where their experience or outcome was poor. This includes those within the current review cohort and those going through the Putting Things Right (PTR) process.
- Women concerned about historical experiences of maternity care outside the current review period (some going back very many years)

Between 30th April and the time of writing this report, 39 women (or their families) have contacted the Health Board via the dedicated contact line or concerns in-box asking for advice or for their care to be reviewed.

Where the women is pregnant now, the advice and support has been directly picked up by the Head of Midwifery / Support Head of Midwifery according to individual need.

Where a retrospective review is being requested, the details are being taken, notes requested and we will now work with the IOP to establish an appropriate mechanism for these cases to be responded to.

Whilst all the work is being undertaken to finalise the governance and reporting arrangements and establish the Programme Team, there is an urgent need to ensure that the arrangements for ongoing support and engagement with women and their families is in place and meets their individual and collective needs.

As part of the RCOG & RCM Review process, the Health Board was asked to identify women and their families who had been directly engaged with the Health Board's maternity services in recent years through the incident, complaints or claims process.

These individuals were directly invited to be part of the RCOG & RCM engagement event in January and have subsequently also received invites to the feedback session facilitated by Welsh Government on the day of the release of the report (30 April 2019) and a meeting with the Minister on 13 May 2019.

The Health Board was appropriately asked to stand back from these events to enable women to engage directly with the process and retain their anonymity if they wished. Some women have been in ongoing contact with the Health Board through senior midwifery staff and/or the Putting Things Right Process but this has been separate to the arrangements linked to the RCOG & RCM Review process. A small number of families have also asked for direct conversations with the Chief Executive which has also been supported. However, we are now at the point whereby we need to ensure that the Health Board picks up the responsibility for ongoing engagement with families if that is what they would wish.

A conference call took place on 16 May 2019 with the Oversight Panel Chair, the Lay Advisor on engagement, Welsh Government Officials and the Health Board to discuss how this can be achieved to best support the needs of those people who have actively engaged with the process so far and ensure that there are ongoing options for others to engage at a future date if they so choose.

A further meeting took place on 23 May 2019. Cath Broderick, Lay member of the IOP, who facilitated the RCOG engagement process and has been present in the various Welsh Government meetings with families to date, led a discussion with key Health Board staff to establish the immediate priority actions. These include:

1. Establishing the precise cohort of individuals who wish to be actively engaged with the Health Board;
2. The nature of the engagement they would wish to have;
3. Establishing an Engagement workstream as part of the overall Programme arrangements;
4. Development of an outline engagement plan;
5. Working with families to identify key success measures against which progress can be monitored.

It is fully recognised that the Cwm Taf Morgannwg Community Health Council has a role in assisting in this process and will be invited to participate in further discussions as we move to finalise the plan.

The Engagement Plan and supporting measures will be an important component of the overall Maternity Improvement Plan and it is aimed to have the outline arrangements in place before the end of June.

3.5 Engagement with Staff

Whilst the RCOG & RCM Report reflected feedback from those who participated in the process, it is probably fair to say that the stark nature of the findings of the report, particularly the feedback from some of the women, has had a significant impact on many of our staff.

While they continue to personally and collectively reflect on the report findings, staff should be commended for the way in which they have acted professionally to carry on delivering care to women who are understandably anxious in light of all the public scrutiny of the service. Particular thanks are extended to those senior clinical staff who have worked tirelessly to respond to concerns and support colleagues during this difficult time.

Staff in the service are all being required to read the published reports, write a personal reflection and discuss this with their clinical supervisor or appraiser.

Poor multi-professional working and relationships; lack of staff engagement; and a culture where people did not feel able to speak up or have confidence that their concerns would be acted upon are stark and very serious findings from the review.

The Health Board has already developed and started delivering an Organisational Development plan to support the staff, but this needs to be extended and accelerated to ensure that the window of opportunity for cultural change is optimised.

Discussions are underway with Welsh Government to access expert advice in this respect, building on the experiences and success elsewhere in NHS Wales. Positive discussions have also commenced with Public Health Wales regarding the potential for support from the 1000 Lives Team to assist the Programme with Quality Improvement capacity and expertise.

A further update will be presented to the Board in July 2019.

3.6 Progress with retrospective case reviews

A detailed overview of progress with the retrospective case reviews was presented to the Board in April.

We understand that the IOP will shortly agree on a process to independently review the process and outcomes of the 43 case reviews. At the same time we will aim to seek their views on the arrangements now in operation for Root Cause Analysis reviews of incidents so that assurance can be given on the systems going forward.

In the meantime, we will continue to manage those cases that are being progressed under Redress or are subject of a claim as directed by the women and their families.

The IOP will also be considering the process that they will adopt for the 'look-back-exercise' to 2010 as identified by the Minister in his statement on 30th April.

The Health Board will work with the IOP to support the review processes as appropriate.

4. RECOMMENDATION

Work is already underway to make improvements in maternity care through the actions taken and being overseen by the Maternity Improvement Board. However, significant work remains to be done and success is dependent upon full engagement of women, their families and staff in delivering the necessary changes that will ensure that Cwm Taf Morgannwg has a maternity service that delivers best care for the population going forward.

The Board will need to draw on the skills and experience within the existing service as well as external expertise to help drive change and improvement in line with best practice and the needs of women. It will be essential for the Board to work closely with Welsh Government officials and others to strengthen systems of governance and scrutiny of the improvements to be made in response to this review. Alignment of internal governance systems with whatever additional oversight arrangements are determined by Welsh Government will be essential to deliver a comprehensive, transparent and accountable response to the very serious issues identified.

The Board has accepted in full, the Report's findings and formally offered an apology for the failings outlined in the report and is committed to delivering all the recommendations made.

The Board is asked to:

- **NOTE** and **DISCUSS** the updates contained in this report;
- **AGREE** that the detailed Programme arrangements will be endorsed by the Board in July;
- **AGREE** that the Chief Executive and Director of Nursing, Midwifery and Patient Care, will discuss the proposed Programme arrangements and likely resource requirements with Welsh Government officials to inform the infrastructure requirements;
- **AGREE** that the Chair can take Chair's action to commit resources to the Programme in advance of the July meeting if required.

Freedom of information status	Open