Independent Report into the handling of the Secondee Consultant Midwife Report into Maternity Services, Cwm Taf University Health Board

December 2019

Author: Steve Combe Independent Governance Adviser

1. METHODOLOGY

A systematic review of formal documentation has been undertaken. This includes Board/Quality, Safety and Risk Committee papers and reports related to Maternity Services in the then Cwm Taf University Health Board. Discussions have also been held with senior members of staff to help understand the Health Boards processes and the actions of individuals. Individual comments have not been included in this report.

2. INTRODUCTION

Cwm Taf Morgannwg University Health Board was established on 1st April 2019. At its meeting in April 2019, the Cwm Taf Morgannwg University Health Board was informed by the Chief Executive, that there had been a failure in the previous Board's (Cwm Taf University Health Board) usual governance and communication processes, in relation to the handling of the internal Secondee Consultant Midwife Report.

The Board in noting the chronology of related matters provided to the Board, **RESOLVED** to **ENDORSE** a recommendation from the Chair, that an urgent internal review is undertaken of the handling of the Secondee Consultant Midwife Report into Maternity Services and that the focus of the review will be on learning and taking forward any recommendations, in order to strengthen its governance and assurance arrangements and mitigate any potential for a recurrence.

Subsequently it was agreed that the review should be undertaken by an independent person.

This report is written as a result of the Board resolution. The terms of reference for the review are attached at **Appendix 1.**

It is important to stress that this report is not intended to be an investigatory report into all the issues related to the reporting on maternity services in general. Its focus is on the potential to improve governance arrangements in the light of the "failure in governance" identified. The focus of this review is on learning.

3. CONTEXT

The agenda facing health boards in Wales is large. In addition, there were a number of issues particular to Cwm Taf University Health Board at the time. These included:

- Absorbing the Bridgend population and health services to create Cwm Taf Morgannwg University Health Board on 1st April 2019.
- A relatively new cadre of Non Officer (Independent) Members.
- A degree of "churn" in the executive team due to departures and sickness, including the Board Secretary. This meant management capacity was "stretched".

At the same time there were a number of issues relating to maternity services, The impact of this large agenda should not be under estimated.

4. BACKGROUND

Before considering the issues surrounding the handling of the report by the Secondee Consultant Midwife it is important to consider the background leading up to the commissioning of the report.

At the Extraordinary Health Board meeting on 30th April 2019 the Interim Director of Nursing, Midwifery and Patient Services (IDofN), in her report on Maternity Services, stated that there were concerns about maternity services which were " initially escalated in the spring of 2018 by the Head of Midwifery (HofM) and subsequently 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".

In reviewing Board/Committee papers and reports, including the Secondee Consultant Midwife report it is clear that there was growing evidence about concerns in maternity services for some time. Some of the key points are set out below.

- **November 2016**: request for Pulse Survey based on information generated following a Royal College of Midwives walkabout. At this time, additional support was being provided via Local Supervising Authority Midwifery Officer walkabouts, the Director of Nursing providing Listening Clinics, provision of 'Share to Care' surgeries, and meetings with the Head of Midwifery, staff and staff side scheduled for 4 times a year on each site set for 2017.

- **December 2016:** Supervisor of Midwives Report identifying a range of issues, themes and trends related to policy and practice.

- **March 2017**: the results of the Pulse Survey in midwifery measuring staff' wellbeing indicating a blame culture and bullying were taking place (January 2017).

- **February 2018**: Following an unannounced visit by the Community Health Council to the maternity unit Prince Charles Hospital, acknowledgment and escalation of concerns related to governance occurred, specifying the number of still births.

- **February 2018**: Acknowledgment and escalation of concerns related to the levels of midwifery staffing and the impact upon quality of care.

- **March 2018**: Findings of the Human Tissue Authority following an inspection of mortuaries during March 2018, identified failings in relation to the management of stillbirths and neonatal deaths, along with foetal remains

- **April 2018**: Data related to serious incident reporting generated by the patient care and safety team, cross referenced with directorate data, identified discrepancies, including failure to escalate and report internally as well as to

Welsh Government and failure to investigate robustly, instigate remedial actions and generate learning. Concern in relation to these areas was further compounded by opportunistic contact from women requesting follow up or more information about pregnancy loss and other experiences, which prior to contact were not being actively pursued by the directorate, with limited oversight from the patient care and safety team.

- **April 2018**: newly appointed Head of Midwifery (HoM) highlights concerns and escalated to the executive team. This included concerns on the under reporting of Serious Untoward Incidents (SUIs).

- **April 2018**: Initial Internal review commences, and reports in August 2018.

- **April/May 2018:** - Following concerns relating to a number of unreported incidents including serious incidents (SI's) and a lack of robust investigations, it was agreed that a series of deep dives into maternal and neonatal events would be undertaken. This was to help provide assurance that incidents were appropriately investigated under the previous governance processes.

- **May 2018:** A provisional report covering 2016 from MBRRACE (Mothers and Babies: Reducing the Risk Through Audits and Confidential Enquiries across the UK, Oxford University) was received for comment. On examination, it became apparent there had been a lack of reporting of the numbers of stillbirths and neonatal deaths as well as the quality and completeness of information that had been submitted and subsequently included in the draft report.

- **June 2018**: The first of two deep dives based on a review of 34 obstetric notes related to pregnant women and 34 medical notes related to babies, during March – September 2017. This sample was chosen because there had already been 34 datix reports generated regarding the women which provided a basis to review, as well as provide the opportunity to review reporting related to neonates. Additionally, in the same period changes to senior midwifery staffing and possibly the local midwifery supervisory model, suggested this period may have been particularly prone to reporting issues. The review identified a range of process and practice issues, including underreporting, 9 unreported serious incidents, inadequate investigation and/or premature closure of incident reports.

- **August 2018:** Deep Dive 2 was initiated by the Senior Management Team to undertake a review of the stillbirths and neonatal deaths that occurred between 2016 – 2017. All 18 cases that were reviewed highlighted learning outcomes and reflected the same themes as of Deep Dive 1 and 3. From Deep Dive 2, a further 2 unreported SI's were identified. These included 5 late foetal losses and 3 stillbirths.

- **August 2018:** Initial internal review commissioned in April 2108 completed and sent to senior managers including CEO.

- **August 2018**: Agreed by the Chief Executive (CEO), Interim Chief Operating Officer (ICOO), Medical Director (MD) and IDofN that a robust internal review should be undertaken as a 'fresh pair of eyes' approach to the draft report was required. From the 21st August 2018, this was tasked to the newly appointed Secondee Consultant Midwife to be completed within a four-week period. (The Secondee Consultant Midwife was informed in writing by a senior member of staff that she had been commissioned by the CEO to undertake the review. There is no direct evidence that the CEO did actually commission the review).

- **17th September 2018:** – Deep Dive 3 consisted of 15 cases, 13 of which were identified through Deep Dives 1 & 2 which required further review and 2 new cases. Following on from a multi-disciplinary review of the 15 cases, 5 required an root cause analysis (RCA) due to practice concerns and an additional 2 unreported SI's were identified. This brought the total to 7 unreported SI's across all three Deep Dives.

- **25th September 2018:** - Secondee Consultant Midwife sends report in "draft format" to IDofN indicating report being finalised and that it "is not a pleasant read, but it is reflective and factual."

- **1st October 2018: –** Secondee Consultant Midwife report sent to MD, COO and IDofN via e-mail saying report "is not a pleasant read."

- **11th October 2018: -** Exchange of e mails between IDofN and Secondee Consultant Midwife. IDofN asks who commissioned report and advised it was CEO. IDofN replies indicating she has made arrangements for responses to be collated and asks the Secondee Consultant Midwife to "hold on to it (the report) for now and that they (the collators of the comments) will find a suitable time to meet with you…so that we can get a final signed off version of your report."

- **15th October 2018** – Secondee Consultant Midwife "draft" report circulated for comment, including to the CEO.

During this period there was also a change in executive responsibility for maternity services. The Director of Nursing retired in August 2018 but the replacement Interim Director of Nursing did not take up post in the organisation until mid September 2018. This was after the report had been commissioned.

There are a number of occasions when the Board/Quality, Safety and Risk Committee and Board (including Board development sessions) considered Maternity Services and there are some references to an internal review and it is not clear from the papers/minutes what this referred to. No clear reference could be found to the existence of the Secondee Consultant Midwife report and the reports do not highlight the significance of the issues in Maternity Services, which have subsequently come to light.

5. SECONDEE CONSULTANT MIDWIFE REPORT

As indicated above the report was issued by the author in 1st October 2018 via an e mail to a group including the MD, COO and IDofN saying the "completed internal review" report was attached and that the report "is not a pleasant read."

The report was overseen and reviewed by a professional person who acted as an external friend to the report author (Secondee Consultant Midwife). The e mail attaching the report had the words "Version 1.0" in brackets. The report was not marked as draft but the IDofN considered it a draft as it said Version 1.0 in the covering e mail. It was therefore issued for comment internally on 15th October, including to the CEO, and one individual was nominated to co-ordinate comments on the draft for both accuracy checking and clarification with the author. Comments were collated and summarised by 26 October 2018, in advance of a proposed meeting with the author scheduled for 31 October 2018. This meeting did not take place.

The secondment ended, at the request of the Secondee Consultant Midwife on 7th November 2018 and no meetings were held with her before she left the organisation.

The IDofN wrote to the author of the report on 22 November 2018 regarding the report and indicating that "regrettably you will no longer working be working for Cwm Taf University Health Board and, therefore, wil not be in a position to receive or utilise the feedback to revise your draft report."

The letter goes on to say the "draft report will be utilised,,,in affirming key areas for improvement and to inform the directorate wide action plan."

A response was received on 9 January 2019, stating that the report was a final version and that the author had nothing further to add.

There is no evidence that the existence of this report was known to the full Board or its Committees.

6. REPORTING ISSUES

As outlined above there were a number of concerns regarding maternity services that were reaching key members of the Executive Team. However, on reviewing Board and Board Committee papers there is no evidence that these issues were triangulated and reported to the Board in such a way as to convey they were of a serious nature. The following comments are of note:

6.1 Transparency – On 23rd May 2019 the Chair and CEO attended the National Assembly for Wales Health, Social Care and Sports Committee Evidence Session.

In commenting on previous informal discussions with the CEO in October 2018 Dawn Bowden AM said: **"**I was left with the distinct impression that what we were

talking about was some procedural difficulties. Clearly, we are not talking about procedural difficulties, we are talking about long standing, systematic, cultural and procedural problems."

The reports to the Board/Quality, Safety and Risk Committee and briefings to Board development sessions highlight the issues of reporting of SUIs but do not provide the Board with a full picture of issues, as highlighted in the Secondee Consultant Midwife report. The reports do provide the Board with assurances that the concerns brought to the attention of the Board by Executives were being dealt with appropriately and the Welsh Government were being kept fully apprised of the issues.

There are also examples which may have been meant to remind the Board of issues but could be seen to imply the Board were aware of the commissioning of the Secondee Consultant Midwife report at the time it was commissioned**.** One example of this is the report from the IDofN to the Board in April 2019. This report reminded Board members of a 4 stage approach agreed at a Board Development session on 30th August 2018 ie:

Stage 1 Internal review of key performance information to scope the issues within the service.

Stage 2 Analysis and cross-referencing of all the information generated from Stage 1 to inform the development of an initial action plan (Maternity Improvement Plan). **This phase included the commissioning of an internal review from the Secondee Consultant Midwife to be undertaken during September 2018 (bold highlights by author of this report)**.

Stage 3 Following the completion of Stages 1 and 2, an external review to be undertaken in two sequential phases:

- Phase 1 By external experts from within NHS Wales
- Phase 2 A Royal College Review (RCOG)

Stage 4 Ongoing scrutiny of all actions arising from the various reviews

The original 4 Phase plan approved by the Board and the Plan the Chief Executive forwarded to the Chief Nursing Officer did not include the reference to the commissioning of an internal review from the Secondee Consultant Midwife to be undertaken during September 2018 as stated above under the Phase 2 plan, highlighted in bold above.

In the same report it was stated that:

"A further key piece of work that fed in to the development of the Maternity Improvement Plan, but which was not formally taken through the Health Board's normal governance process, was the internal report commissioned from the Secondee Consultant Midwife in August 2018. **This formed part of the Stage 2 review** of key performance information to scope the problem and inform future stages of the review processes." **(Bold highlights by author of this report)**.

In the April 2019 Board report the comment is made that the Board commissioned a maternity review in August 2018. It is not clear whether this refers to the Board itself or officers of the Health Board but could be seen to imply that Board members commissioned the Secondee Consultant Midwife report at this time, which they did not.

In addition, there are suggestions in Board reports that the recommendations from the Secondee Consultant Midwife report were included in the Maternity Improvement Plan immediately after the "draft" report was received in early October 2018. However, there are e mails that state that the recommendations of the report were not included in the Maternity Improvement Plan until February 2019. after the visit by the Royal College.

6.2 Risk Register - There is no reference in the Corporate Risk Register of Maternity Services/SUIs which could have been expected, given the number of unreported SUIs.

6.3 Agenda issues – Recognising that the Health Board was facing a number of challenges in Maternity Services it did not appear to be given a high profile on Board/Committee agenda's.

6.4 Tabled Papers/Presentations – There are examples of papers/presentations being tabled. Whilst this may be necessary on occasion it makes it more difficult for Non Officer Members to absorb the information and ask appropriate questions.

6.5 Referencing – Board/Board Committee reports make comments such as "the Board have previously agreed that" etc. Such comments imply that the Board were aware of issues without referencing when and what the Board actually agreed.

6.6 Timeliness of Reporting- The establishment of the Maternity Improvement Board, reporting to the Quality, Safety and Risk Committee meant that reporting to the Board on potentially serious matters was delayed due to complex reporting arrangements**.**

In addition, the CHC visit on 5th February 2018 where the issue of "spikes" in the number of still births was raised was not reported to the Quality, Safety and Risk Committee until September 2018.

A further issue to note is that, whilst the Quality, Safety and Risk Committee received Directorate Exception reports, these were included at the end of a long agenda and an exception report from the Obstetrics, Gynaecology and Maternity Directorate could not be found for September or November 2018. although e mail evidence shows a draft report was produced.

6.7 Board Development sessions - These sessions are aimed at Board development and can be used to brief the Board on key issues. These are not formal meetings of the Board and are not minuted. The Board should not make any formal decisions at such sessions as is suggested occurred at the session in August 2018.

6.8 NHS Wales Delivery Unit – Whilst undertaking this review it became apparent that the Delivery Unit had produced a report on "Serious Incidents in Maternity

Services" in December 2018 a draft of which was sent to the CEO, on 13th December 2018.

Whilst there are reports to the Board indicating Delivery Unit support was being obtained there is no reference to a report being produced or being seen by the Board or any of its Committees.

6.9 Health Improvement Wales (HIW) Unannounced visit – HIW wrote to the CEO in October 2018 setting out their draft recommendations following a recent unannounced visit to the maternity department. This was not reported to the Quality, Safety and Risk Committee until March 2019 and was then reported as part of an External Regulator report for 2018-19.

7. COMMENTARY

In considering the issues raised and the quoted "failure in governance and communication" regarding the Secondee Consultant Midwife report there are several factors to bear in mind.

Governance definitions indicate that governance relates to having the right people, processes and systems in place to ensure the organisation meets its objectives. The stated objectives of the then Cwm Taf University Health Board which would have been approved by the Board and which Executive Directors would be expected to exemplify 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.

In addition, all Board members, including Executive Directors are expected to uphold the values of NHS Wales, and the Nolan principles of public life. These are:

- **Selflessness -** Holders of public office should act solely in terms of the public interest.
- **Integrity -**Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
- **Objectivity -** Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- **Accountability -** Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

- **Openness -** Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- **Honesty-** Holders of public office should be truthful.
- **Leadership-** Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

In terms of governance relating to the events surrounding the Secondee Consultant Midwife report it is clear that, in the main, the systems and processes were effective in identifying and escalating concerns to the lead executives. In saying this it is important to note that concerns regarding under reporting were first identified when a new Head of Midwifery was appointed from outside the organisation, although the under reporting had been happening for some time. It is unclear why existing staff had not identified or escalated this issue.

The lack of transparency around the Secondee Consultant Midwife report could be explained by the fact it was considered a draft and that, at about the same time (October 2018) the Minister for Health and Social Care announced an external review would be undertaken by the Royal College of Obstetricians and Gynaecologists (RCOG). However, this does not explain why the subsequent Delivery Unit or HIW reports were not for brought to the attention of the Board or Board Committee in a timely fashion or why the Secondee Consultant Midwife report was not provided as evidence to the Royal College.

Similarly, given the number of concerns that had come to light by August 2018 it is not clear why it was decided that a “fresh pair of eyes” was required and that a further internal report was needed. The fact that a report was considered a “Draft” does not detract from the key messages in the report and the requirement to act speedily in response to such findings, in line with the Boards stated objectives and the Nolan Principles. It may be there was an expectation that the report findings were included in the Maternity Improvement Plan but there is no evidence any executive checked this was the case and advised the appropriate Committee accordingly.

Good practice would be for such information to be reported to the Board by the appropriate executive director as soon as possible to demonstrate openness and transparency and, more importantly to provide assurance to the Board that actions were being taken to improve the quality of the patient experience, in line with the Board objectives.

This issue links to organisational culture. It is the role of the Board to set the culture which is then operationalised by the Chief Executive, supported by Executive Team members.

It could be concluded from reading reports to the Board that the “ingrained punitive culture” highlighted in the Secondee Consultant Midwife report is confined to Maternity Services. In this report “missed opportunities” are highlighted ie:

“One example of a missed opportunity was an SI from 2017 which was only discovered after a formal complaint was logged in August 2018. A further area of concern, is that the first letter received by the corporate team was considered to be insignificant and closed without further exploration due to it being outside the 12-month period of ‘Putting Things Right’. As a result, a further letter of concern was filed by the family and is now being investigated as a formal complaint.”

Another case that came to light under similar circumstances was an unreported SI from 2017 relating to a stillbirth at home. This was also only identified after a negligence claim was filed, subsequently the SI was reported late in 2018. The cases highlighted above are not unique and a number of other SI’s have been identified through opportunistic phone calls as well as through complaints being logged. Concerns around complaint handling have also been identified whereby redress was supposedly paid without a robust investigation. This area requires further scrutiny.”

The Board will need to satisfy itself that everyone working in the organisation is operating in line with the stated Board objectives and that concerns are being reported, recorded and, where appropriate, escalated. To assist with this the Board may wish to consider obtaining external expertise on this matter to determine the views of staff and patients on the current culture of the organisation and what culture they would wish to see.

8. CONCLUSION

In reviewing the events surrounding the Secondee Consultant Midwife report there are several areas where good practice in governance was not followed. The most obvious example of this is the fact that this report (or at least its main findings) and the subsequent Delivery Unit and HIW draft reports were not shared with the Board in a timely manner. As a result, 2 key objectives of the Board were not fully evidenced ie:

- To **improve** quality, safety and patient experience.
- To **provide** strong governance and assurance.

It would have been good practice for the concerns highlighted in the first 2 deep dives had been brought to the attention of the Board so the Board could determine whether a further internal review was needed (“a fresh pair of eyes”) or whether to seek an external perspective. Had such openness and transparency been demonstrated by the relevant executives the Board and ultimately its patients would have been provided with some assurance and the Board would have been able to directly oversee improvements.

Failing this it would have been good practice to share the draft Secondee Midwife report, the draft Delivery Unit report and HIW unannounced visit reports as soon as possible following their receipt to either the Board or an appropriate Board Committee and not wait till they were finalised.

9. RECOMMENDATIONS

9.1 Organisational Culture

The Board should commission external support to establish an appropriate organisational culture based on listening to staff, patients and stakeholders. It is understood work has already commenced in this area.

9.2 Review of Standing Orders.

The Welsh Government have recently circulated revised model Standing orders for health bodies in Wales. The Board should specifically consider the sections on "Decisions reserved for the Board" and the "Scheme of Delegation" to ensure there is clarity on such issues as the authority to commission service reviews and Executive portfolios.

The Board could also mandate through Standing Orders that any external reports are brought to the attention of the Board or the appropriate Board Committee, possibly at draft stage. One option is for the Board to consider developing an appropriate escalation framework to set out its expectations in this area.

9.3 Board Assurance Framework

The Audit Committee should review the Board Assurance Framework and Risk Register to satisfy itself that these are robust in the light of the events set out in this report.

9.4 Non Officer member training – It is important that Non Officer Members receive the appropriate level of training and development to assist them in knowing how to ask critical questions of the executive. Consideration should be given to establishing a formal programme to include risk management. This would help them triangulate the information provided to them. This should be supported by Non Officer Member walkabouts.

The Board could also consider establishing a formal buddying arrangement between individual Non Officer Members and a designated Executive Director to share knowledge and experience.

9.5 Board Development sessions – The Board should set out how it wishes to use these sessions and ensure no decisions are made that should be made by the Board in its formal meetings.

9.6 Board Reporting

- **Sub committees –** When considering the establishment of sub committees to Board Committees the Board should consider reporting timescales and escalation arrangements to ensure the Board is advised of key issues as early as possible.

- **Referencing –** Board reports that refer to previous Board discussions should reference the minute number and previous meeting date to allow Members to cross reference information. Similarly if action plans are updated between meetings (eg the Maternity Improvement Plan) the changes should be highlighted for ease of reference.
- **Tabled reports** – The Board should set out the occasions when tabled reports are acceptable. Draft presentations should be sent out with Board/Committee papers, except in exceptional circumstances agreed in advance with the meeting Chair.

9.7 Openness – The Board should consider what issues it should consider "In Committee". Good practice would indicate that the reasons for considering a matter "In Committee" are:

- When individual patient confidentiality could be compromised;
- When a matter is commercially sensitive;
- When a draft report is being considered prior to future publication.

Consideration should be given to including the reason why a report should be considered "In Committee" in the covering paper to a report.

Appendix 1

At its meeting in April 2019, the Board was informed by the Chief Executive, that there had been a failure in the Board's usual Governance and Communication processes, in relation to the handling of the internal Secondee Secondee Consultant Midwife Report.

The Board in noting the chronology of related matters provided to the Board, **RESOLVED** to **ENDORSE** a recommendation from the Chair, that an urgent internal review is undertaken of the handling of the Secondee Secondee Consultant Midwife Report into Maternity Services and that the focus of the review will be on learning and taking forward any recommendations, in order to strengthen its governance and assurance arrangements and mitigate any potential for a recurrence.

The review will be led by an Independent external to the Health Board, former Director of Corporate Services / Governance - Board Secretary.

The review will;

- Review the chronology, including all relevant correspondence, of related matters;

- Speak with any internal staff involved and where possible, involved external staff;

- Identify what happened against what would reasonably be expected to have happened, against the Board's related Governance & Assurance processes;

- Identify recommendations for learning and strengthening the Board's Quality Governance arrangements;

- Produce a related report for the Chair and consideration by the Board.