CWM TAF MORGANNWG UHB RESPONSE TO IMSOP STILLBIRTH THEMATIC REPORT

Clinical Review Programme

October 5 2021

Written in conjunction with: Maternity and Neonatal Services and The Maternity and Neonatal Improvement Team

Foreword

This is the second of a series of report responses, which will be published by Cwm Taf Morgannwg University Health Board (our Health Board). The purpose of this report is for our Health Board to respond to the findings identified by the Independent Maternity Services Oversight Panel's (the Panel's) Thematic Review of Stillbirths.

The Panel is undertaking a series of external case reviews across three categories:

- Maternal mortality and morbidity - Care of mothers, including those who needed admissions to intensive care
- Stillbirths - Babies who sadly were stillborn
- Neonatal mortality and morbidity - Babies who sadly died or needed specialist care immediately following their birth

The findings from these reviews have informed the work that was already in progress since the Welsh Government commissioned an independent review of Maternity Services by the Royal College of Obstetrics and Gynaecologists (RCOG) and the Royal College of Midwives (RCM). The Royal Colleges' report in April 2019 identified a number of serious concerns relating to the maternity service, which we have been working to address since this time.

The first of our Health Board's reports in the series, was published in January 2021, and focused on responding to the review of the care of mothers who required emergency treatment during childbirth, referred to as the Maternal Category Thematic Report.

This response focuses on the Panel's Thematic Stillbirth Category Report which includes findings relating to the care of 63 individual episodes of care at both the Royal Glamorgan Hospital and Prince Charles Hospital between January 1 2016 and September 30 2018, of mothers and babies where the pregnancy sadly ended in stillbirth.

Our Health Board has received the reviews from each individual stillbirth clinical review case and acknowledges the findings, which have been identified through the reviews. We continue to be committed to ensuring that the Maternity and Neonatal services at Cwm Taf Morgannwg University Health Board are of the highest standard and that the women and families accessing our services are provided with care that is safe and effective, as well as the best possible experience.

We understand how difficult revisiting these experiences may be for many women and families, but hope that this report will provide reassurance to our communities that we have learned from past events. We continue to be committed to being open and honest about what went wrong and how the learning that has been identified is the foundation for meaningful improvement

We are truly sorry for what happened in our maternity services and want to offer our sincerest apologies to those families who have been affected by the care provided at both the Royal Glamorgan and Prince Charles hospitals. We cannot change the experiences of the women and families at the heart of this report, but we will ensure these experiences continue to drive our commitment to develop and sustain a maternity service of which our communities and staff can be proud. We will never forget what our families have told us

about their care and what we have learned from these reviews. We will continue to listen and learn, and work alongside our communities to make sure these experiences are never repeated.

Paul Mears

CEO, Cwm Taf Morgannwg UHB

Professor Marcus Longley

Chair, Cwm Taf Morgannwg UHB

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1. Introduction and Background

In April 2019, the Royal College of Obstetrics and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) published the findings of their joint Independent Review of Maternity Services at the former Cwm Taf University Health Board. This report contained 70 recommendations for improvement. Through its own, internal processes, our Health Board identified a further nine recommendations, bringing the total to 79. At that time, the Health Minister made a commitment to women whose babies had sadly died between January 2016 and September 2018 that their cases would be reviewed to identify if the care provided was appropriate and, if not, what learning could be identified for our Health Board.

This is the second of a series of reports that Cwm Taf Morgannwg University Health Board (CTM) will be publishing in response to the release of the IMSOP thematic reports of clinical review findings. This 'Response Report' focuses on the care of 63 individual episodes of care of mothers and babies where the pregnancy sadly ended in stillbirth, involving 58 families.

The Response Report provides details of how we are responding to the themes identified in the IMSOP thematic report into the stillbirth category in the context of an overview of how our Health Board continues to manage the ongoing improvement of maternity and neonatal services in light of the RCOG/RCM report published in April 2019.

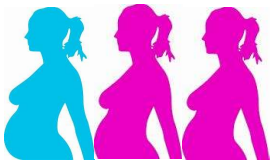
The Panel identified a number of recommendations, key findings and areas for wider learning, as described in their Thematic Stillbirth Report. The Panel Identified:

- Seven Key Findings
- Eight Wider Learnings
- Nine Recommendations

This report will summarise the learning undertaken by our Health Board in relation to those findings. Details of our Health Board's internal processes for managing the review findings will be referenced throughout this report, with more details contained in the appendices.

2a. What the Panel Found: Key Findings

The Panel reported seven Key Findings, which are discussed in more detail in our response to the recommendations on pages 15 to 25.



KEY FINDING 1 – 1 in 3 episodes of care reviewed were assessed as having a major modifiable factor that contributed significantly to the poor outcome. Different management may have altered the outcome.

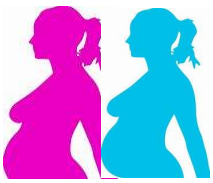
KEY FINDING 2 – Areas for learning were identified in 59 of the 63 episodes of care reviewed.

KEY FINDING 3 – Inadequate or inappropriate treatment and diagnosis or recognition of a high risk factor were the issues, which most often contributed significantly to a poor outcome. These two factors appeared in combination in 11 (17%) of the 63 episodes of care reviewed.

KEY FINDING 4 – In those episodes of care where inadequate or inappropriate treatment was identified as a major modifiable factor, fetal growth, fetal movement and fetal heart monitoring were notable issues. These two factors appeared in combination in 11 (17%) of the 63 episodes of care reviewed.

KEY FINDING 5 – In those episodes of care where diagnosis of a high-risk status was identified as a major modifiable factor, risk factors like smoking cessation or high blood pressure, monitoring baby's growth and delays in diagnosis were notable issues.

KEY FINDING 6 – The majority of major modifiable factors occurred during the antenatal period with almost half of the episodes of care having being graded as poor. Care was only assessed as being optimal at any stage of the care period in a very small number of episodes of care.



PMRT Supporting high quality local perinatal reviews

KEY FINDING 7 - 38% of all episodes of care reviewed did not have a local review undertaken by the Health Board. Where local reviews were conducted, they were not always of a high quality.

2b. What the Panel Found: Wider Learning Points

WIDER LEARNING POINT 1 - The seemingly high proportion of episodes of care with major and minor modifiable factors described in this thematic report are largely consistent with other UK reviews. Details of our response can be found in recommendation two on page 15.

WIDER LEARNING POINT 2 – Improvements in stillbirth rates achieved in other areas of the UK in recent years do not appear to have been realised to the same extent in Cwm Taf Morgannwg. Our response to this point can be found under recommendation two, page 15.

WIDER LEARNING POINT 3 – Population health issues like smoking and social deprivation are factors linked to stillbirth in UK populations. These factors are disproportionately prevalent in the communities served by our Health Board and there may be opportunities to learn from successful examples elsewhere in Wales and the UK in addressing this. We have responded to this wider learning point aligned to recommendation three on pages 16- 18.

WIDER LEARNING POINT 4 – Guidelines were not always in place and where they were, they were not consistently used in practice or audited. We recognise the importance of clinical practice being underpinned by up to date guidelines in support of providing high quality, evidence based care. Details of our improvement work can be found in response to recommendation four on page 19 to 20.

WIDER LEARNING POINT 5 – Using the Perinatal Mortality Review Tool to good effect will ensure that all perinatal deaths are reviewed in an objective, robust and standardised way. Our response is aligned to recommendation five on page 21.

WIDER LEARNING POINT 6 – Inadequate fetal surveillance was a major modifiable factor in a significant number of the episodes of care review in the stillbirth category. Our response to this wider learning point can be found under recommendation four, pages 19 to 20.

WIDER LEARNING POINT 7 – Adequate numbers of trained staff are needed to improve care after a stillbirth occurs. This should include the appointment of a dedicated bereavement midwife with cover for periods of absence and a Consultant Obstetric lead for stillbirth and pregnancy after loss.

WIDER LEARNING POINT 8 – Frontline staff should receive training in communication skills relating to the death of a baby and provision of care after stillbirth. Please see recommendation eight for details of our response to recommendations seven and eight, pages 25.

2c. What the Panel Found: Recommendations

Recommendation 1 – The Health Board should publish a formal response to the learning, which has emerged from the stillbirth category.

Recommendation 2 – In the context of the work which is already underway around population health and the 2020 All-Wales data review, the Health Board should seek to understand why the reduction in stillbirth rates achieved in other areas of the UK in recent years do not appear to have been realised in the Health Board and take action to address the issues (*Wider Learning Point 2).*

Recommendation 3 – The Health Board should review and strengthen its approach to smoking cessation in pregnancy (*Wider Learning Point 3).*

Recommendation 4 - The Health Board should review its current practice guidelines to ensure that they are consistent with national evidence-based practice in smoking cessation in pregnancy; detection and management of small-for-gestational-age and fetal growth restricted babies; management of pregnancy-induced hypertension/pre-eclampsia; management of reduced fetal movements; fetal monitoring; care after stillbirth. The review should also ensure that the guidelines are disseminated, that staff are trained to apply them and compliance is audited on a regular basis (*Wider Learning Point 4*).

Recommendation 5 – The Health Board should review its use of the Perinatal Mortality Review Tool (PMRT) to ensure that there are systems and processes in place to ensure that it is used for all incidences of stillbirth and neonatal deaths. These reviews must be multidisciplinary including external peer input. Parental input should be encouraged (*Wider Learning Point 5*).

Recommendation 6 - Compliance rates for mandatory training programmes (e.g. PROMPT, GAP and GROW, All Wales Fetal Surveillance Bundle) should be restored to meet Health Board compliance standards (*Wider Learning Point 6*).

Recommendation 7 – The Health Board should review its capacity to provide care after stillbirth to ensure that it has adequate numbers of trained staff to cater for out of hour's situations and periods of absence of specialist staff, and include a Consultant Obstetric lead for stillbirth (*Wider Learning Point 7*).

Recommendation 8 – The Health Board should review the plans it is currently developing for communications training to all staff to ensure that it specifically provides the delivery of training to frontline staff, relating to care following the death of a baby and provision of care after stillbirth; (*Wider Learning Point 8*).

Recommendation 9 - The Health Board should work with the Welsh Government and Maternity and Neonatal Network to ensure the wider learnings, which have emerged from the stillbirth reviews, are shared on an all-Wales basis.

The main body of this report focusses on our Health Board's response to Women's Experience of Care and the above Recommendations.

3. Women's Experience of Care

Of the 58 women and families included in the Stillbirth Category of the Clinical Review Programme, 20 shared their stories and questions about their care as part of the review process, 11 with the support of Cwm Taf Morgannwg Community Health Council's (CHC) advocacy service.

The experiences of women and their families are vitally important in learning from the past, and are essential in understanding what went wrong. They supplement the findings from the reviews, and help us to understand the information from another perspective. IMSOP analysed the information as a part of their process for making recommendations to our maternity and neonatal services. We wholeheartedly acknowledge the importance of listening to women as a core component of designing the service in a way that ensures it meets the needs of our families.

As described in our response to IMSOP's Thematic Report of the Maternal Mortality and Morbidity Category, since the release of the RCOG RCM Report in 2019, we have continued to engage with women, families and the wider community to ensure our services align with the needs and values of the those we serve.

As part of understanding women's experience of care, IMSOP identified five key themes, as shown below, along with details of our Health Board's improvements.

3.1- Monitoring, missed opportunities and escalation

The Panel described experience of women having care postponed without explanation, and we are truly sorry for any distress these changes may have caused. We have undertaken a significant amount of work to improve the way in which we value those who use our service as partners in their care, and understand how important it is that they are listened to, and understood as individuals.

Obstetricians now support 60 hours of prospective cover per week at Prince Charles Hospital in line with RCOG recommendations and 40 hours per week at Princess of Wales Hospital, to ensure decision-making is supported at a senior level. The rota is largely filled by permanent staff with minimal locum cover in the consultant rota. We now have clear guidelines in place, including an Escalation Policy and Jump Call policy, which identify the conditions, which require Consultant Obstetrician presence, as well as making clear their responsibilities for oversight of the care of high-risk women.

Job plans have been updated to reflect the expected roles from Consultant Obstetricians. We ensure our working practices in the maternity service align with the Health Board's Values and Behaviours.

3.2- Failure to listen and value women's concerns

The Panel shared women's experiences of a lack of engagement with Consultant Obstetricians, with some women reporting never having met their named consultant. Women also reported that they were unable to share their concerns with professionals.

In order to understand the experience of our women and families, the PREM (Patient Reported Experience Measure) was launched in September 2021. The survey is sent out to the majority of women (other than some exclusions such as those who have experienced a loss), in addition to their partner/birth partner. This is a series of four surveys, plus a partner survey, which will capture experience data from service users throughout their maternity journey. This asks specifically about whether they have been involved in care planning, choices, listened to, treated with kindness, compassion and understanding. The findings from this survey will form a key part of the foundations of planning a service, which aims to meet the needs of those who use the maternity service. A separate process is being developed for women and families who have suffered a loss to share their experiences via a dedicated sub-group of My Maternity My Way.

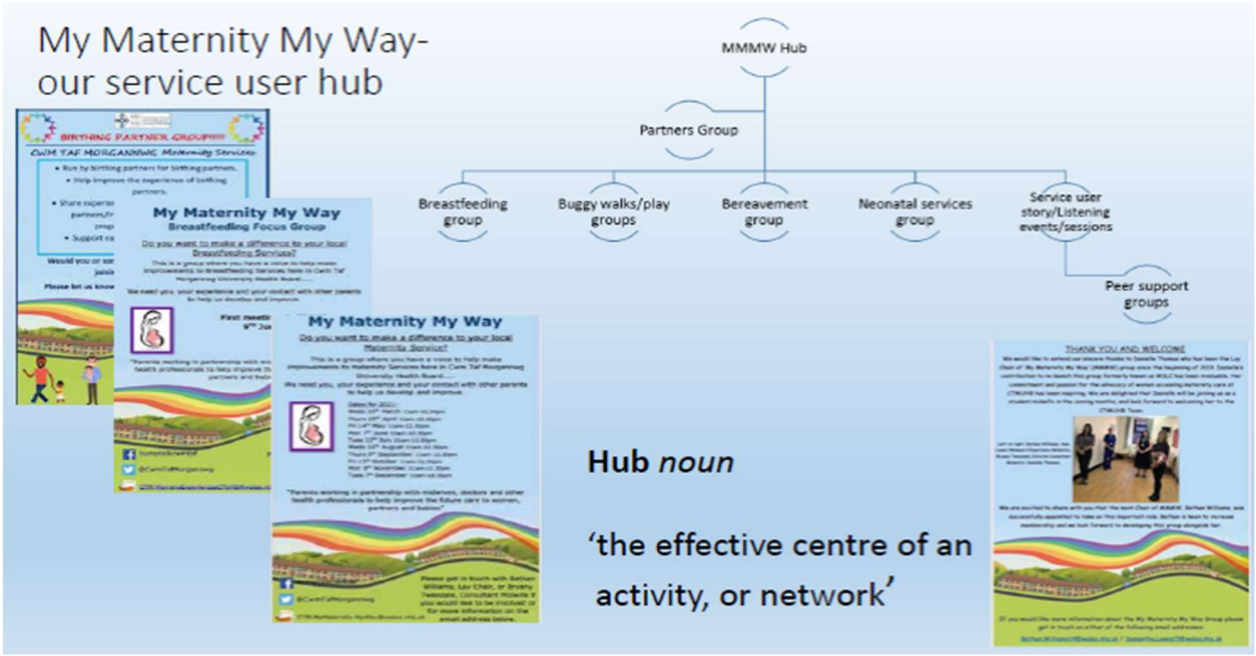
All women are given details and offered the opportunity to have a formal debrief of their experience after their birth, if they so wish. We have developed a reflection clinic, which is run by Consultant Obstetrician and Midwife, to ensure debriefing is available for all women who wish to take up the offer. A letter is given to all women at discharge with details of how to access the reflections service. The offer is inclusive and open to any woman and family using our services. The service is supported by Obstetricians and Midwives across all of our sites. If appropriate, any feedback received during debrief sessions is used to underpin improvements in our service.

Our Health Board has appointed a Women's Experience Lead Midwife, as a key part of our work to ensure that the families that use our maternity service feel listened to, well informed and valued partners in their care, as well as being integral to service design and development.

Kelly Godwin-Francis,
Women's Experience Lead Midwife, CTM

"We achieve engagement through various methods including social media groups, our 'Birth Reflections Service, focus groups and one-to-one contact. We work closely with families to ensure we are able to plan and provide a service that our families want and need. We also use the feedback received through the 'My Maternity My Way' focus group and sub groups that include a Birth Partner Group and an Infant Feeding Group. Membership of these groups has been growing, which we are so pleased to see. We are working to launch more sub groups soon to be inclusive of anyone in our communities who wishes to talk about our maternity service, but in particular will be prioritising a specific group for those women and families who have suffered bereavement.

"We work closely with the Communications and Engagement Team to ensure the new information and resources we publish are based on the most up to date evidence and research and are designed with the families' feedback in mind. We are currently working on a new website, information leaflets, blogs and our social media sites, to continue to engage with the women and families who use our services".

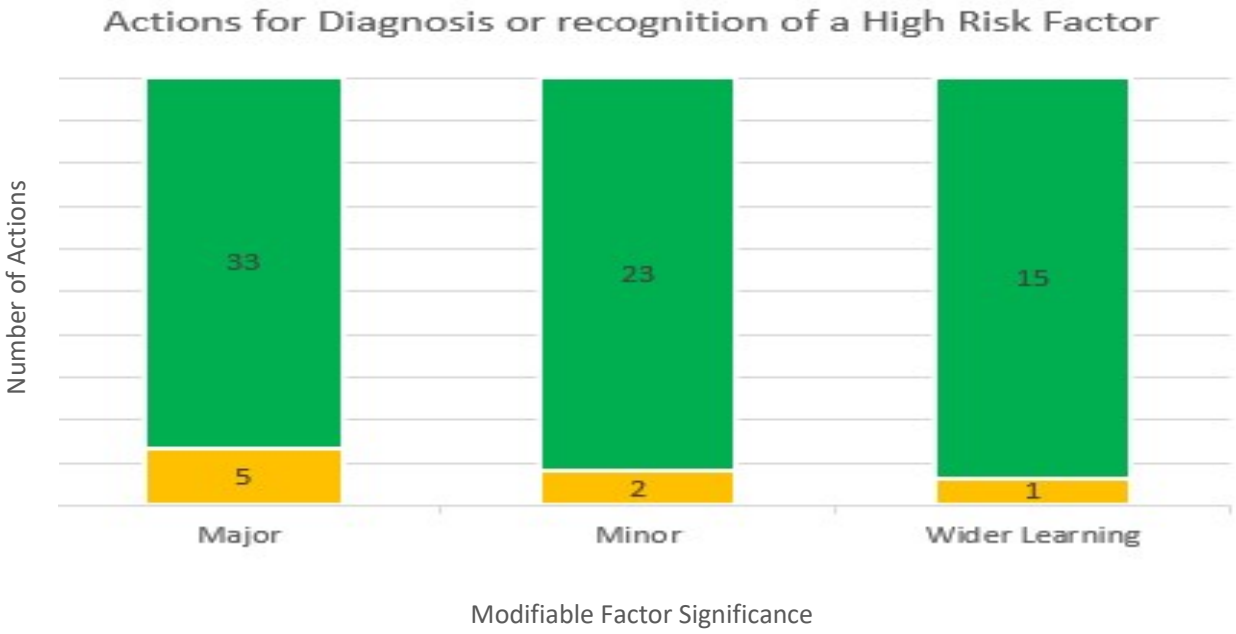


Just some of the positive words and experiences shared with us by our women and families.

3.3 Diagnosis and high risk status

Under this theme, there were 79 actions for improvement identified through our Health Board's process (appendix 2). 71 actions (89%) have been completed, meaning they have been implemented fully within the service. All of the remaining open actions are underway and will be completed by December 2021.

The chart below shows the number of completed actions (green) and actions in progress (amber) in this category.



Examples of improvements

Guidelines and Risk Assessments

A significant number of guidelines, risk assessments and trigger lists have been updated and implemented to support improved recognition of clinical risk factors. These may be risk factors, which exist at booking, or may emerge at any time during pregnancy, labour or the postnatal period. The Antenatal care guideline has been reviewed and updated in line with national guidance to support the provision of optimal care. The new and updated Antenatal Care Guideline (2020) now includes a trigger list for all high-risk women who will require an appointment with their named consultant during their pregnancy, and also makes reference to those women who require an early appointment with their named consultant.

The updated processes importantly also include, not only tools for ongoing assessment of risk, but improved processes for appropriate intervention when risk is identified. A key part of this work has been recognising the importance of listening to women's

concerns as an essential part of the overall clinical picture when making decisions about care planning.

How Can I Help?

We are developing a 'How can I Help?' campaign, with our service users. Held within a bedside brochure, they welcome our users and families into our service areas. The brochure introduces the team, to the area, and explains the high standards that should be expected, and encourages our users to identify and share any concerns they have as they arise. The campaign will include manager walkabouts in the clinical areas to speak to our users and their families about their experiences of our service.

Diabetes Care

"I was appointed in March 2019 as the Diabetes Specialist Lead Midwife. My role includes attending medical antenatal clinics on all sites to provide support and information for those with diabetes in pregnancy. We now use an approach, in which service users feel valued and understood and have an opportunity to discuss any aspect of their care with the multidisciplinary team, in both hospital and community settings.

"Written information is now provided in respect of how to prepare for pregnancy, birth and the postnatal period to ensure service users are well informed in order to make decisions about their care. Diabetes Champions in the antenatal clinic and acute care settings have been appointed to offer support to colleagues in the care of service users with diabetes.

"In hospital, care planning is undertaken in conjunction with a specialist diabetes team, who will support individualised choice. Teaching sessions have been implemented to underpin optimal care, and during the COVID 19 pandemic, online training presentations were made available to ensure standards continued to be met. Care standards are monitored through audit
"We now take a truly multidisciplinary approach to care planning and supporting choice".

Lisa Grant,
Diabetic
Specialist Lead
Midwife

Dr Helen Lane,
Consultant
Physician

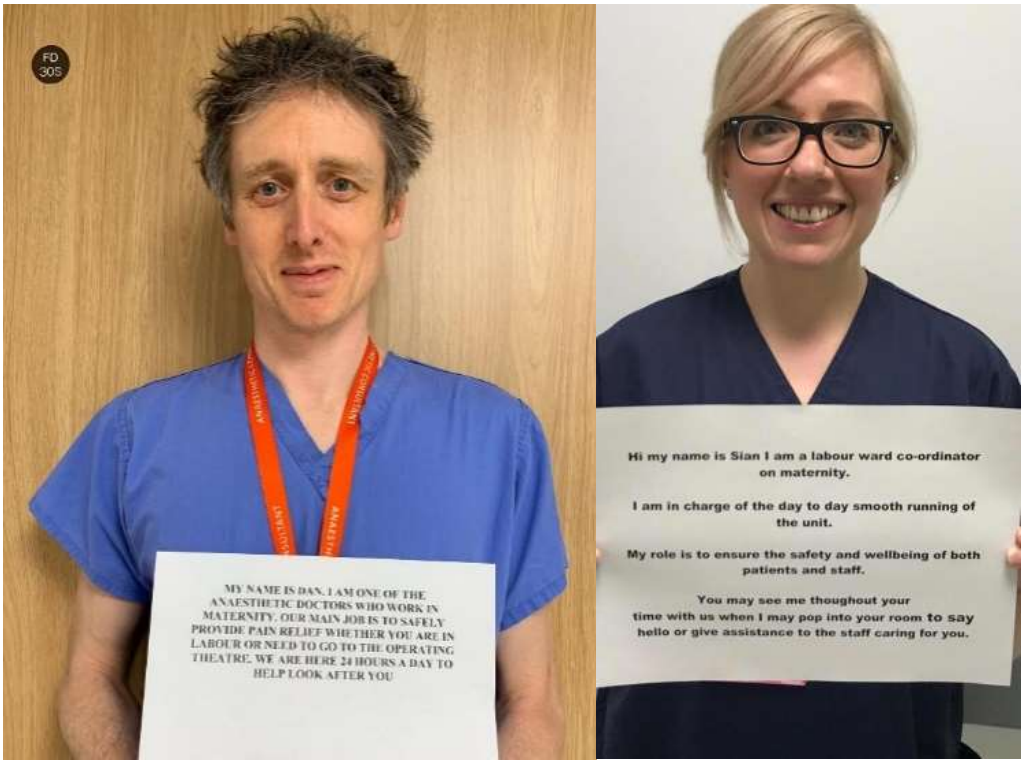
3.4 Staff attitudes and language

The Panel's report highlighted that women and families remember what was said and how it was said, and fed back many instances of unsupportive communication, which often lacked empathy.

Our Health Board recognises the importance of kind, compassionate and sensitive communication, and we now receive overwhelmingly positive feedback from our

families. We have appointed an Engagement and Experience Lead, who will offer bespoke training to maternity staff, focussing on providing excellent service, managing on the spot concerns, kindness and compassion and understanding concerns shared by service users and families. This programme will be inclusive of a training package co-produced by MMMW members around sensitive language, kindness and compassion to highlight what good communication looks like, and evidence how negative communications can impact significantly on experience of care. The Engagement and Experience Lead will also ensure the service addresses concerns and makes improvements when they are identified.

The 'We are still here' campaign will be launched on social media, encouraging women to access care despite the pandemic, ensuring women are encouraged to seek advice, care and/ or assessment if they have any concerns relating to the well-being of themselves or their babies. The campaign also introduces maternity staff to women, in support of creating trusting relationships between women, families and Healthcare Professionals.



3.5 Bereavement support and care after birth

The Panel shared women's experiences of the bereavement support previously provided following the loss of their baby. Families described the need for a flexible and accessible bereavement service that provides support, information and counselling.

We have undertaken a full review of the bereavement services and staff training in relation to pregnancy loss, which can be found in more detail in our response to recommendations seven and eight, on page 24.

Our My Maternity My Way (MMMW) hub has broadened and will soon include a specific supportive sub-group for women who have used the maternity bereavement services within Cwm Taf Morgannwg. We anticipate inviting women who have sadly suffered a bereavement within the last one-two years, to understand their specific experiences about the maternity and maternity bereavement services in order for us to develop a service that truly meets their needs.

4. Learning from the Clinical Reviews

The Independent Maternity Services Oversight Panel made nine specific recommendations in their thematic review. Below, we share details of our response to each of these recommendations.

Recommendation 1 – *The Health Board should publish a formal response to the learning, which has emerged from the second phase of the Clinical Review Programme (the stillbirth category).*

Our Health Board agreed that this would be crucially important for our families, communities and the wider public, to avoid any delay in receiving the answers they have been waiting for. We are publishing this report alongside the Panel's thematic report.

Recommendation 2 – *In the context of the work which is already underway corporately around population health and the 2020 All-Wales data review, the Health Board should seek to understand why the reduction in stillbirth rates achieved in other areas of the UK in recent years do not appear to have been realised in the Health Board and take action to address the issues raised;*

Much of the improvement work relating to this recommendation is already well underway, and is described in recommendations 3, 4 and 6. Our maternity service is now engaging in systems work in collaboration with key stakeholders to support the work in relation to addressing health inequalities, such as smoking, weight management and optimising health for pregnancy.

As the Panel reported, the crude (or unadjusted) stillbirth rate at CTM has usually been higher than the rate in Wales. The crude rate is the number of deaths per 1000 births within each organisation- this is a commonly used measure and describes exactly what happened. This rate fluctuates quite a lot because of the comparatively low numbers of births at our Health Board per year.

To understand whether a particular maternity unit has a higher or lower stillbirth rate than expected, the numbers are stabilised and adjusted. The stabilised and adjusted

rate gives a more reliable estimate of the underlying stillbirth rate, taking into account key factors known to increase the risk of stillbirth such as levels of economic deprivation, smoking and obesity in the population served by the hospital. When considering the population served by CTM, the stabilised and adjusted stillbirth rate is lower than that of Wales as a whole. This reflects that CTM serves an economically deprived area with higher than average rates of smoking and obesity.

In CTM, the stabilised and adjusted stillbirth rate has remained at around 1 in 300 births and in Wales as a whole, it was about 1 in 250 births between 2013 and 2018. The stabilised and adjusted rate for CTM is lower than the national average for Wales because of the higher than average rates of deprivation in our Health Board. It is important to note that over the same time period, the crude stillbirth rate across the UK has fallen from 1 in 214 births to 1 in 285 births (a reduction of 16%), meaning that in recent years the stabilised and adjusted stillbirth rate at CTM is now more than 5% *above* the national UK average.

Our Health Board is continually working to understand and reduce our stillbirths as a matter of priority, and have already strengthened the work in progress in this area. The improvement work detailed in this report is a demonstration of our continued commitment to ensure our stillbirths are as low as they can possibly be, to avoid any family having to unnecessarily face such a tragic event. We are working in closely with colleagues in the wider health care system to plan and implement programmes of work, which aim to improve the quality, safety and experience of maternity services in Wales.

Recommendation 3 – *The Health Board should review and where necessary, strengthen its approach to smoking cessation in pregnancy based on successful programmes elsewhere in Wales and other parts of the UK;*

The Model for Access to Maternal Smoking Cessation Support (MAMSS) and 'Help Me Quit for Baby' are now available across the whole of our Health Board to support women to stop smoking in pregnancy. This is a core service and is supported by three health care support workers with specialist training and expertise. Women and their families can now access smoking cessation support, including pharmacotherapy (medication to support with stopping smoking), from conception through until 28 postnatal days. This service is provided on an opt-out basis, as per NICE PH26 guidance.

Routine questions about smoking habits are now always asked at the first community midwife appointment, and now at every antenatal appointment, as well as on admission to hospital, so that we can continue to offer help to quit at every opportunity. Brief intervention on the risks of smoking is provided, and referral to smoking cessation services is offered. This has also more recently become a part of routine postnatal care, recognising the importance of the first 1000 days, as well as an opportunity to be a non-smoker for any future pregnancy. Smoking is now embedded into the post-natal pathway pro forma and the service can now be accessed

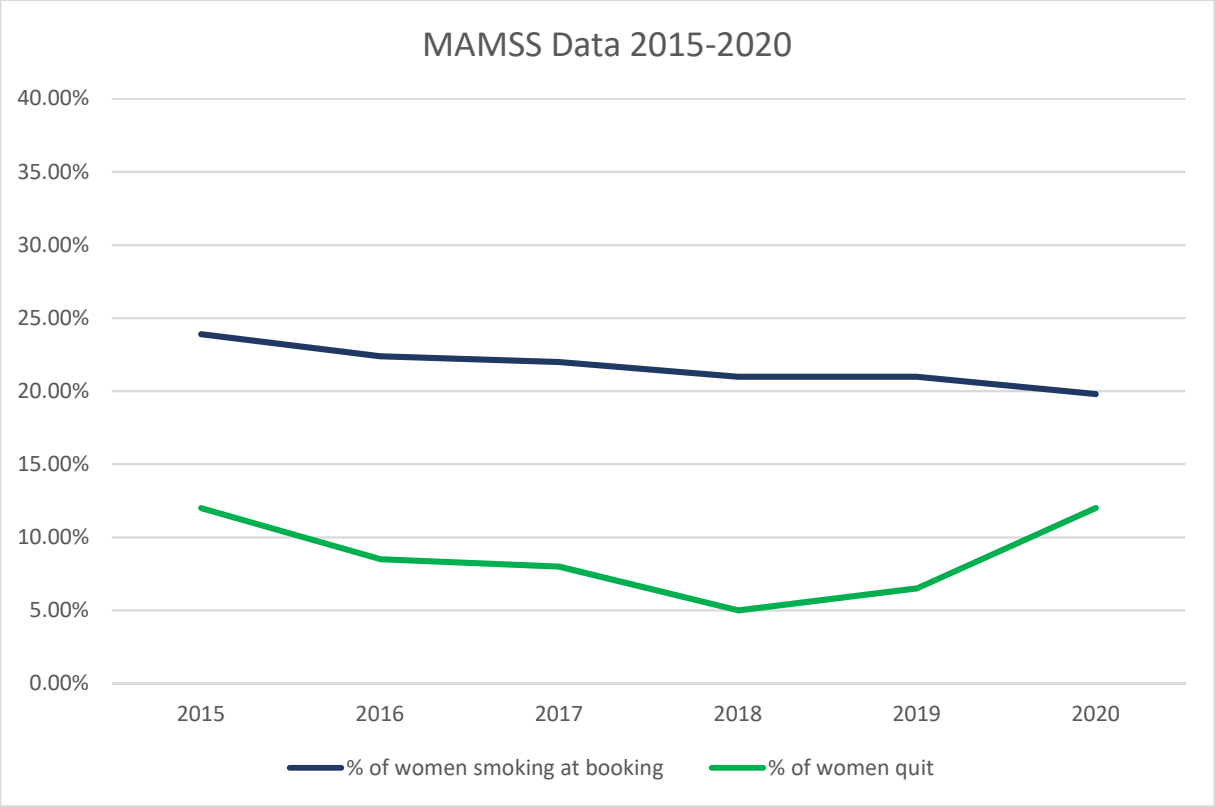
up to 28 days postnatal. Postnatal engagement will be reported in next year's data. The MAMSS team now also records data on Wales-wide QuitManager system (a database that collects details of smoking interventions and outcomes).

Due to the restrictions of COVID 19 safety measures, smoking services across Wales are not currently being delivered face-to- face, with plans currently being considered for safely reinstating the in-person service. The MAMSS team will be commencing Attend Anywhere virtual appointments as soon as appropriate devices are purchased. This will improve communication and engagement, and will allow a choice even when home visits recommence.

Smoking cessation training is now on mandatory training programmes completed on a yearly basis. The smoking in pregnancy documentation is audited twice a year to ensure continued high standards.

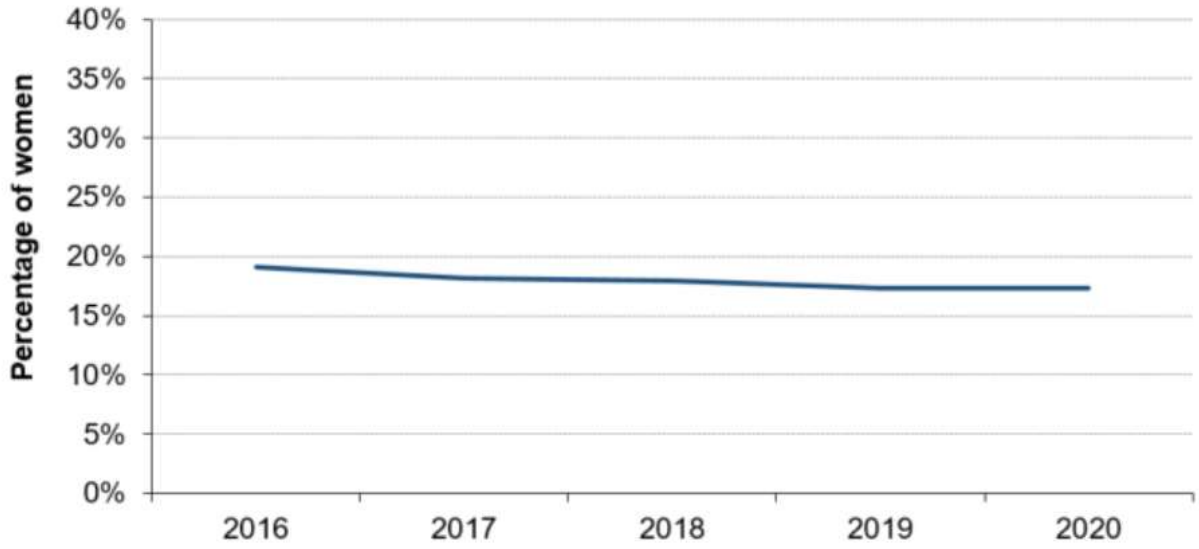
The number of pregnant smokers at the initial visit is declining over time, which is encouraging. The number of pregnant smokers successfully supported through the MAMSS programme to quit smoking in pregnancy declined during the period covered by the review, but now has a renewed focus and is steadily increasing again, as per diagram below.

CTMUHB Smoking in Pregnancy Data 2015-2020



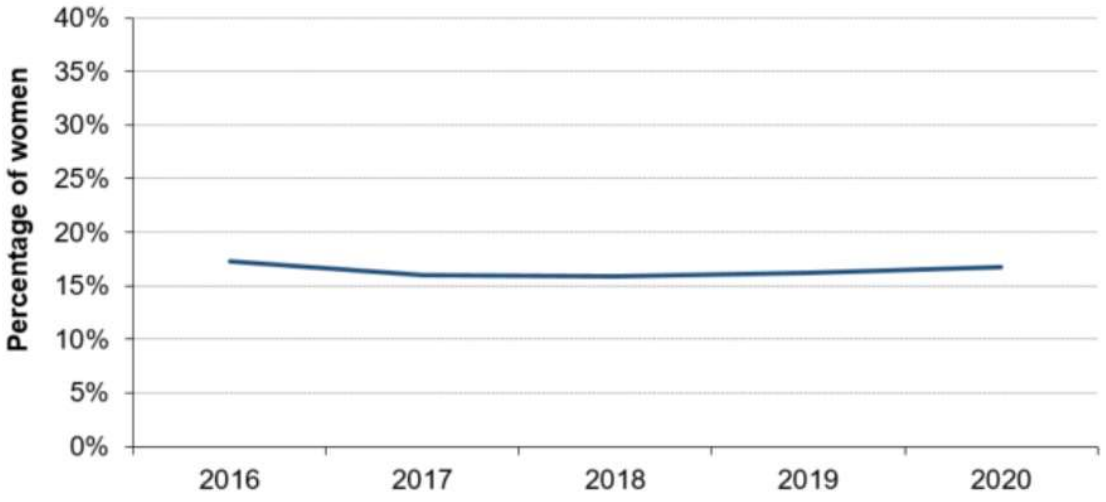
All Wales Smoking Cessation Data 2016-2020, as reported by Gov.wales Maternity and Birth Statistics 2020 (released 13th May 2021).

Chart 9: Percentage (a) of women who were recorded as smokers at initial assessment (b), 2016 to 2020



Source: Maternity Indicators dataset

Chart 11: Percentage (a) of women who were recorded as smokers at the time of giving birth (b), 2016 to 2020



Source: Maternity Indicators dataset

Future Improvements

As a part of our continuous improvement work, we have plans to make Nicotine Replacement Therapy (NRT) patches available in acute settings and antenatal clinics to reduce barriers for those women wishing to make a quit attempt. We are also in the process of making brief intervention training and Make Every Contact Count (MECC) training mandatory for maternity staff. Progress is continuing in relation to the work being undertaken to address the challenges of smoking in pregnancy within CTM in line with the overall programme of work to reduce the stillbirth rate. This continues to be a priority going forward; in particular with the COVID pandemic seeing the universal offer of CO (carbon monoxide) readings paused since February 2020. CO readings are a measure taken when a person blows into a CO detector to assess the level of carbon monoxide in their system. When restrictions ease, there will be a relaunch of CO monitoring and Point of Care training will be delivered to staff.

Jane O'Kane,
Strategy Director
Preconception to
1000 days

"Our Health Board has embarked on a population based health approach, with prevention of ill health and sustainable health improvements as key.
"From an early years perspective, a programme of work is being developed that will prioritise activity relating to need, and will aim to fit together with the socioeconomic factors relating to ill health and poverty.
"Areas for prioritisation include developing a preconception strategy that raises awareness and understanding of preconception health in order to normalise planning and preparing for pregnancy. A new Consultant led service is being established that will link with maternity led smoking and obesity interventions. Planned work will review current models and build future life-course interventions pathways and services."

Recommendation 4 - *The Health Board should review its current practice guidelines to ensure that they are consistent with national evidence-based practice in the following areas:-*

- ***smoking cessation in pregnancy;***
- ***detection and management of small-for-gestational-age and fetal growth restricted babies;***
- ***management of pregnancy-induced hypertension/pre eclampsia;***
- ***management of reduced fetal movements;***
- ***fetal monitoring;***
- ***care after stillbirth.***

The review should also ensure that the guidelines are disseminated, that staff are trained to apply them and compliance is audited on a regular basis;

We recognise the importance of clinical practice being underpinned by up-to-date guidelines to ensure the provision of high quality, evidence based care. Our Health Board has undertaken a programme of reviewing, updating and ratifying maternity clinical guidelines, inclusive of those identified through the reviews, to ensure they are

in line with national guidance. The draft guidelines are widely disseminated for discussion and comments during the development process, overseen by the multidisciplinary Guideline Group, who meet regularly to review, quality assure and ratify the new guidelines, as well as a refreshed programme of staff education and training.

The guidelines are available on WISDOM (Wales Information System for the Dissemination of Obstetrics, Gynaecology and Midwifery Material), for staff to access and utilise in support of best practice. Staff are notified of new or refreshed guidelines and information is also shared with staff through a regular programme of 'Lunch and Learn' events, which are well attended. Additionally, our Clinical Supervisors for Midwives (CfSMs) support implementation.

Continued Improvements

We regularly review clinical records to ensure our guidelines are followed appropriately. A number of audits to ensure compliance with guidelines have been included in the Maternity Service's Forward Audit Plan (FAP), which is managed on the recently acquired audit database AMaT (Audit Management and Tracking) and are reviewed in our monthly assurance meetings.

"All midwives complete a mandatory four hours of supervision per year facilitated by a Clinical Supervisor for Midwives (CSfM). In line with the All Wales Model of clinical supervision, this includes a group supervision session, a yearly documentation audit as well as a professional update. During group supervision sessions, women's stories are shared, themes and trends in learning are discussed and a documentation audit is performed. During 2020/2021 the CSfMs achieved a 97% attendance rate in group supervision across our Health Board.

AMaT gives instant access to results from audit with, the ability to identify themes and trends in order to implement timely improvements. We work alongside risk and governance, as well as the specialist midwives to identify themes for shared learning, which are disseminated via our 'Lunch and Learns'. These sessions initiate live discussions and are an opportunity to promote best practise".

Ria Jenkins,
Clinical Supervisors for Midwives

- **Smoking Cessation**

As detailed above in response to recommendation three (page 15), the MAMSS programme is in a cycle of continuous improvement, based on best practice guidance, and monitored through regular audit.

- **Fetal Surveillance: detection and management of small-for gestational-age and fetal growth restricted babies; management of reduced fetal movements and fetal monitoring.**

Our Health Board has significantly improved the detection rates of Small for Gestational Age (SGA) babies, with a large programme of work relating to reviewing standards and strengthening MDT working. Further details can be found on page 21.

More recently, the Wales Maternity and Neonatal Network has recently ratified its guidance for the management of small for gestational age (SGA) and growth restricted babies, which our Health Board is now working towards implementing. There are plans to review sonography capacity to implement the guidance fully.

Our Health Board is compliant with the All Wales Guideline for the Management of Altered Fetal Movements, managed by the Wales Maternity and Neonatal Network. The All Wales guideline has recently been reviewed and updated, and is due to be ratified in October 2021. Once ratified, it will be implemented fully within CTM UHB.

We work to the All Wales Intrapartum Fetal Surveillance Standards. Practice against these standards is monitored through audit. This is overseen by the Fetal Surveillance and Wellbeing Specialist Midwife and Clinical Supervisors for Midwives, and reported through our assurance mechanisms. Further details can be found in our response to recommendation six on page 21.

- **Management of pregnancy-induced hypertension/pre eclampsia**

Our Health Board's 'Guideline for the Management of Hypertensive Disorders in Pregnancy' was reviewed and updated in line with national guidance and ratified by our Guideline Group in August 2020. An algorithm to guide staff through the steps for the effective and timely management of pre-eclampsia is available in every labour room. Practice is audited to ensure compliance, and remains on our Forward Audit Plan (FAP) to ensure ongoing monitoring of standards. All women are now are continually risk assessed to ensure any pre-existing or emerging health concerns are immediately recognised and escalated appropriately. We now have appropriate consultant oversight in our obstetric units and clear pathways of referral and care where any risks or concerns are identified during the antenatal, labour or the postnatal period.

- **Care after stillbirth**

In order to ensure families are cared for in a compassionate and sensitive way following a stillbirth, our Health Board developed a Bereavement Pathway in 2019, which is based on the National Bereavement Care Standards, as well as the needs of families. More details about our Bereavement Care improvement work can be found in our response to recommendations seven and eight on page 24.

Recommendation 5 – ***The Health Board should review its use of the Perinatal Mortality Review Tool (PMRT) to ensure that there are systems and processes in place to ensure that it is used for all incidences of stillbirth and neonatal deaths. These reviews must be multidisciplinary including an independent external member. Parental input should be encouraged;***

Our Health Board has instigated routine PMRT meetings, to ensure effective learning from incidents across all relevant disciplines. We have addressed a large backlog of cases and are continuing to review and improve our processes, including inviting parental input. The service also attend the Maternity and Neonatal Network's Mortality Review Meetings, utilising the PMRT support All Wales sharing and learning from cases. We currently have an external, independent member who contributes to the reviews, and are looking to further strengthen this membership. We now monitor PMRT meetings, to ensure timely completion.

Recommendation 6 - *Compliance rates for annual mandatory training programmes (e.g. PROMPT, GAP and GROW, All Wales Fetal Surveillance Bundle) should be restored to meet Health Board compliance standards at the earliest opportunity;*

Our Health Board recognises the importance of training as a key element of the provision of a safe maternity service. We have developed a training needs analysis, which is inclusive of all statutory and mandatory training. Compliance is now closely overseen by our Health Board's senior clinical leaders in our monthly assurance meetings. The programme of training has been developed to meet national standards, and is inclusive of multidisciplinary team working. The COVID 19 pandemic created new challenges with training, which inevitably had an impact on compliance in the short term. A recovery trajectory was agreed, which the Health Board is maintaining with some areas already having achieved full compliance.

Laura Little,
Fetal Wellbeing and Surveillance Specialist Midwife

"Our Health Board has significantly improved the referral and detection rates of small for gestational age babies, overseen and reviewed by myself as the Fetal Wellbeing and Surveillance Specialist Midwife. I am responsible for supporting and educating the multi-disciplinary team with regards to growth surveillance, specifically the Perinatal Institute GAP/GROW program. All cases of missed Small for gestational age babies are investigated and reviewed to identify possible training requirements, or highlight resource needs, assessed regularly to identify themes and trends. This in turn, improves outcomes for families.

"Since the introduction of this role, multi-disciplinary Fetal monitoring training has been initiated based on best practice, in line with All Wales Fetal Surveillance standards (2018). Identified learning needs highlighted through governance processes are also supported in one to one learning reflective discussions in collaboration with Clinical Supervisors for Midwives."

- **Detecting and Managing Small Babies**

Our Health Board has undertaken a significant amount of improvement work in relation to fetal well-being and surveillance. Our referral and detection rates of small for gestational age (SGA) babies is in line with the National average. Whilst CTM is consistently above average in the number of babies born SGA (below 10th centile) at birth due to our demographic/population, during Q2 and Q3 last year, we were above

average in our referral rates for suspected SGA babies, allowing for appropriate, robust care planning.

Future Improvements

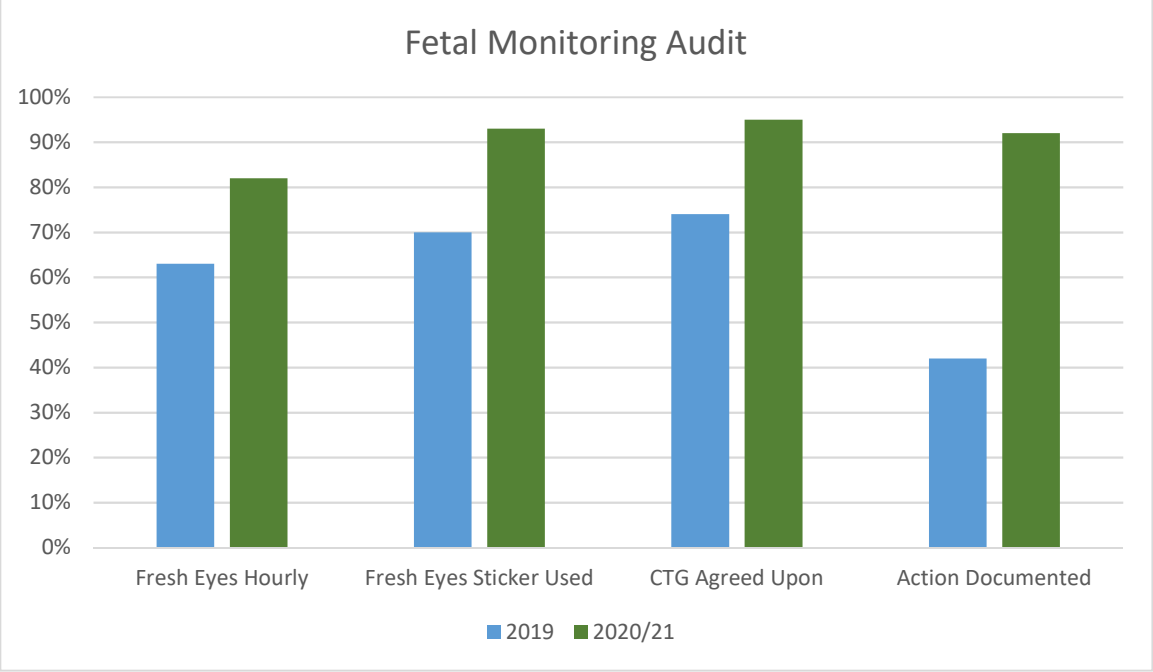
Our Health Board has plans to train midwives in obstetric third trimester sonography, to further support the current fetal wellbeing surveillance-scanning programme.

- **Fetal Heartrate Monitoring**

Fetal Monitoring training is now offered at between weekly and fortnightly sessions, held in collaboration with our Clinical Group Supervision to allow staff to achieve compliance through attendance at one day training, covering a number of key topics. Sessions last 4 hours in accordance with All Wales Fetal Surveillance standards. Multidisciplinary (MDT) attendance is encouraged and valued.

Reflection meetings take place across both acute sites on a weekly to fortnightly basis. Attendance and participation are encouraged from the whole MDT. Involvement in MDT Risk meetings across CTM help to identify learning and facilitate reflection, and further support.

The impact of this is that our Fetal Monitoring Audit 20/21 shows that compliance with fetal monitoring training has improved over the last year, despite the challenges of COVID 19 restrictions.



Future Improvements

We are currently in the process of submitting a capital bid for whole new fetal monitoring system across our Health Board. This will result in standardisation of equipment and a computerised system of interpretation, which is associated with improved decision-making.

PROMPT Training

Sarah Morris
PROMPT Wales
Lead Midwife

"PROMPT (PRactical Obstetric Multi-Professional Training) is an evidence based training package that teaches healthcare professionals how to respond appropriately to obstetric emergencies as a cohesive team. This includes recognising an emergency situation, effective team work, communication and correct and timely treatment. The programme is associated with the following benefits:

"PROMPT Wales was implemented in our Health Board in January 2019. Community PROMPT has also been introduced to enhance the skills of community based Midwives and Maternity Support Workers in managing emergency situations outside of the acute areas, including our birth centres. Paramedics have also attended this training, enhancing the multidisciplinary team working.

"We work in partnership with Obstetric Leads and Anaesthetic colleagues, as well as having a close working relationship with the Governance Team and Clinical Supervisors for Midwives to support our PROMPT programmes each year. My role also consists of maintaining training attendance records, reporting on compliance and maintaining the PROMPT Wales standards."

NB. The infographic above demonstrates the benefits of the PROMPT programme, and does not represent CTM data

PROMPT Wales compliance for CTM in 2020 was **96.4%** of all staff (unfortunately due to the pandemic, the last two courses of 2020 were cancelled). During the pandemic, all Health Boards stood down face-to-face training, however, PROMPT training recommenced in our Health Board in 2020.

For 2021, our compliance at compliance at CTM is **97%** and we have met "*PROMPT Wales Standard Four: Multi-professional participation in PROMPT Wales Training - a minimum of 95% of staff (who are required to undertake PROMPT Wales Training) will complete a PROMPT Wales training session annually".* Staffing numbers across CTM include community and Tirion staff. We have planned a similar structure for next year's PROMPT training.

Community PROMPT Wales was implemented as a pilot in June 2020 for CTM and has run for 12 months whereby it has achieved **100%** compliance. Community PROMPT Wales will continue at Tirion Birth Centre and in view of new recommendations staff who only provide care within community will attend this training day only.

Recommendation 7 – *The Health Board should review its capacity to provide care after stillbirth to ensure that it has adequate numbers of trained staff to cater for out of hour's situations and periods of absence of specialist staff. This should include the nomination of a Consultant Obstetric lead for stillbirth and pregnancy after loss;*

Our Health Board recognises how vitally important supportive bereavement care is to families who tragically lose their babies. We have made significant improvements to the bereavement support offered to families over recent years. This is overseen by a Bereavement Specialist Lead Midwife and a Consultant Obstetric Lead for bereavement to ensure our families always receive sensitive and compassionate care. Further information is provided by our Bereavement Specialist Lead Midwife in recommendation eight below.

Recommendation 8 – *The Health Board should review the plans which it is currently developing to deliver communications training for all staff to ensure that it specifically provides for the delivery of training to frontline staff, relating to care following the death of a baby and provision of care after stillbirth;*

We are very sorry that the bereavement support offered to many of our women and families involved in the review was not of the standard they deserved. Our Health Board has made a number of improvements to the bereavement support we provide to our women and families whose baby has tragically died. This includes mandatory training for all staff on how to provide sensitive care during such a distressing time.

Myscha-Dene Bates,

Specialist
Bereavement Lead
Midwife

"My role is to coordinate the care of women who sadly suffer the loss of their baby to ensure consistent, high standards of family-centred care in the most difficult of circumstances. There have been a number of changes to the bereavement service offered, with the aim of developing a service that meets all of the National Bereavement Care Standards, as well as the needs of families. Significant work has been undertaken to increase the knowledge and skills of our colleagues in providing sensitive, individualised bereavement care.

"All staff are now invited to study days, which are based on national bereavement care standards, also reflected in our new care pathways introduced in late 2019. Families' stories are shared with permission to support training.

"Post-mortem consent training sessions are offered to ensure that all professionals caring for families whose baby has died are able to have those sensitive conversations, supporting continuity of care wherever possible. Many community midwives have now undertaken this training, which enables us to offer families the opportunity to talk about post-mortem at home, if they do not feel ready to make such difficult decisions whilst in hospital.

"I coordinate postnatal follow up, working closely with obstetric consultant colleagues to provide timely and sensitive follow up. All women and families now receive an individualised letter to inform them that their care will be reviewed via the Perinatal Mortality Review Tool (PMRT) process. PMRT initiates a standardised, multi-disciplinary review, through which women and families are offered an opportunity to raise questions and share their stories. The final report from this process is shared with families at a debrief appointment. We are now working towards developing a bereavement debrief clinic, with designated consultant colleagues, to ensure continuity and consistency in the approach taken to sharing results and planning for future pregnancies."

Recommendation 9 - *The Health Board should work with the Welsh Government and the Maternity and Neonatal Network to ensure that the opportunities for wider learning which have emerged from the stillbirth element of the Clinical Review Programme are identified and shared on an all-Wales basis.*

Our Health Board has continued to strengthen our relationships with other Health Boards in Wales, the Welsh Maternity and Neonatal Network and the wider health network throughout Wales, to be in an effective position to share and learn from one another. We have plans to share the findings of this report, as well as how our Health Board has responded, in both local and national forums, such as the Maternity and Neonatal Network Board, as well as the RCM National Conference.

5. What Do The Findings Mean for Our Service Now?

The findings emerging from the review confirm some of the concerns emerging from the RCOG RCM Report. Through the process of receiving the feedback from each case where a baby sadly died, we have developed individual action plans that are specific to their care. Through this process, we have been able to identify a number of common themes, which has enabled us to plan and implement a wide range of changes to our service, with almost 90% now embedded in practice. Receiving the feedback from the Panel has supported us to review previous actions following the RCOG RCM Report, with a new understanding and perspective based on the findings of the Panel, and crucially the perspective of the families involved.

Whilst most of the improvements to the service have already begun, we are actively engaged in working collegiately with our partners to understand the health inequalities that exist in the population we serve and to identify and implement improvements to address them effectively and sustainably.

A Network Perspective

Health Inspectorate Wales (HIW) has published its national review of Maternity Services Phase One: National Review of the Quality and Safety of Maternity Services. This review found that the quality of care being provided across Wales was generally good, and that the majority of women and families reported positive experiences, however, there were a number of recommendations to take forward at health board and network level. The network is currently considering whether a similar transformation programme of Quality Improvement work is required and should be recommended for Wales as in other UK nations. The Maternity Care in Wales: A five-

year vision for the future, published in 2019, provides clear direction for maternity services. Should the Network recommend a transformation programme for Wales an important consideration will be how our Health Board can support this agenda moving forward, resulting in improved outcomes for pregnant service users, babies and their families.

Despite the challenges of the pandemic, our clinical staff, Senior Leadership Team and improvement team remain committed to ensuring the mistakes of the past are not repeated, and we use the learning to ensure we are providing the highest standards of care at CTM. We are also indebted to the support of our user group My Maternity, My Way who continue to work alongside us.

With the support of IMSOP and Welsh Government, CTM will continue to work towards its improvement plans, which are now enhanced as a result of the findings of the external reviews.

"Health Inspectorate Wales (HIW) has published its national review of Maternity Services Phase One: National Review of the Quality and Safety of Maternity Services. This review found that the quality of care being provided across Wales was generally good, and that the majority of women and families reported positive experiences, however, there were a number of recommendations to take forward at health board and network level. The network is currently considering whether a similar transformation programme of Quality Improvement work is required and should be recommended for Wales as in other UK nations. The Maternity Care in Wales: A five-year vision for the future, published in 2019, provides clear direction for maternity services."

Buffy Gallagher,

Welsh Maternity and Neonatal Network Manager

6. Conclusion

This is the second in a series of Health Board reports published in response to the Independent Maternity Services Oversight Panel's Thematic Reports. We hope that this response report has provided our community with renewed assurance of the significant improvements achieved within the maternity service, as well as our continued commitment to ensure review and improvement is an ongoing and continuous process embedded within the service.

The overwhelmingly positive feedback from women and families through the course of the pandemic is a clear signal of the continued determination of our staff to provide high standards of compassionate care despite challenging circumstances. It is this feedback, which continues to motivate, encourage and sustain our teams. Work is ongoing to understand the impact of the pandemic on the experience of women and families, so that we can remain responsive to the ongoing changes and maintain the standards the teams have worked so hard to achieve.

Our Health Board acknowledges the distressing findings of the report, and hopes that this response demonstrates the ongoing dedication of the teams to never repeat the mistakes of the past, and to continually strive for better.

Though the pandemic has undoubtedly presented some challenges, the improvement programme has continued to work at a pace, which has seen many improvements achieved, and others sustained and further built upon.

Our Health Board acknowledges the contribution and learning from The Panel's reviews, but is especially thankful to all those families who have shared their experience and those who, despite tragic outcomes, continue to work alongside us.

Our Health Board will never forget the women, babies and families who were involved in these cases and will continue to work tirelessly to contribute to excellence in maternity services at Cwm Taf Morgannwg and across the UK.

APPENDICES

Appendix 1: Supporting Families

Whilst recent feedback from women and families has been broadly positive, it is not underestimated the impact, the reviews have had, not only on the women and families involved, but also on the wider communities who use our services, or plan to in the future.

Since the commencement of the clinical review programme in November 2019, our Health Board has worked closely with an external counselling agency to offer independent and confidential emotional support those families in the clinical review. This service continues to be available to women, their partners and wider family members where requested, as it is understood the impact a poor experience can have on a whole family.

There is a dedicated Health Board contact line for women and families to use to raise any questions or concerns relating to all aspects of the review process and findings. Our Health Board has developed information leaflets to answer frequently asked questions and to signpost to further support (appendix 5, 6).

If and when the families involved in the review request the full details of their IMSOP clinical review, our Health Board then writes to the families acknowledging the findings and outlining the improvements made, ongoing or planned that relate to their care, and also the progress of those actions. It is our aim to provide reassurance that we have learned from the mistakes made in each case.

If families have further questions or concerns, they are offered a meeting with senior staff from the Health Board and if appropriate or members of the independent Panel (IMSOP) depending on the nature of their questions.

In accordance with our Health Board's commitment to acknowledge, review and accept IMSOP's findings, CTM also has an obligation to consider if an investigation is required as set out under the National Health Service (Concerns, Complaints and Redress Arrangements)(Wales) Regulations 2011 and our Putting Things Right Guidance. If they so wish, families are being fully supported in this process by CTM's Concerns Team and the Community Health Council.

A number of those women who have been in contact with CTM through the review process are now working closely with us as lay partners in service development and design, to ensure they are meeting the needs of women and families.

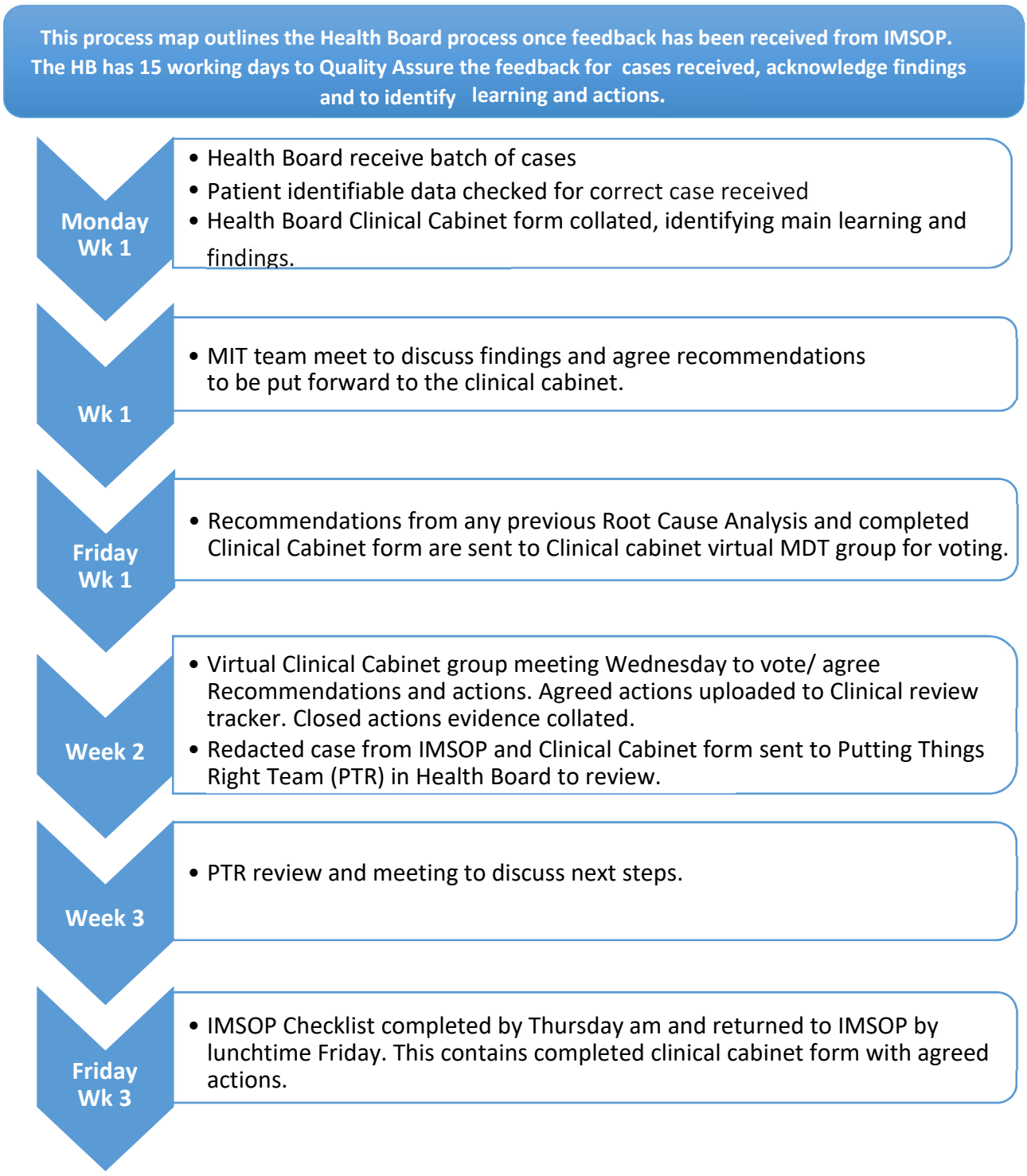
Having a baby during the current pandemic continues to be a very different and challenging experience for women, their partners and families. Our Health Board is aware that the findings in the IMSOP clinical review may increase the level of concern, and women and families are encouraged to seek support from their midwife, or to contact a member of the Maternity and Neonatal Improvement team who will answer questions or identify further avenues of support if necessary.

The Maternity and Neonatal Improvement Team (MNIT) can be contacted on **01685 728741** (Monday- Friday 9am-5pm, excluding bank holidays - a voicemail option is also available out of hours) or email **CTM_maternityimprovementprogramme@wales.nhs.uk** so that we can take this forward with you.

Appendix 2: How the Clinical Review Findings are Managed

The findings arising from each individual case have been reviewed initially by the Maternity and Neonatal Improvement Team, who collate and identify the learning and findings, which are populated into a feedback form. Using the information provided, the case is then reviewed by a multidisciplinary team (MDT) including Consultant Obstetricians, Anaesthetists, Midwives, Midwifery Senior Managers, Clinical Supervisors of Midwives and Paediatricians. The purpose of this process is to identify appropriate actions for improvement relating to the findings. Once agreed, these actions are then managed by the clinical MDT for implementation. A number of clinical forums are involved in this process, including the Antenatal, Labour Ward and Postnatal Forums, as well as the Clinical Guidelines Group, to support the progress and completion of relevant actions. For the purpose of sustainability, these will continue to be monitored and managed by the relevant clinician or forum.

All improvement actions are collated onto the programme's clinical review tracker for oversight. Progress against these actions is monitored by the Maternity and Neonatal Improvement Team. This is a collaborative process with the MNIT and clinical MDT through a monthly cycle of evidence assurance. Once completed, actions closure is reported at the Maternity and Neonatal Improvement Board. A number of overarching themes have been identified across all cases, which are cross-referenced with the main Maternity and Neonatal Improvement Plan for oversight and monitoring. The process map below further describes how the review findings are managed by our Health Board.



Appendix 3: Supporting Staff When Failings are Identified

A staff support and information pack has been developed, providing information on the review process as well as how to access further information and well-being resources. This has been reviewed and updated as the reviews progress and new information is received by our Health Board.

A program of staff engagement through Clinical Supervision has also been established to provide regular updates on the review process, as well as to answer any queries or

concerns staff may have in a responsive way. This has been received positively and will remain in place until the review process is complete. This also presents an opportunity to further engage staff in the improvement program.

It is important to reiterate that CTM shares the ethos of both IMSOP and Welsh Government that this is not to be a punitive process, but one of learning and improvement in a restorative and constructive way. All staff details have been anonymised throughout the review process.

Where there are serious concerns about an individual's professional competency or conduct; training and support will be provided by our Health Board both for the individual and wider team where appropriate. Our Health Board also has developed its own internal processes should any serious professional concerns arise, and may refer to professional bodies if necessary.

It is recognised how staff continue to be impacted by both the RCOG RCM Report and the IMSOP Thematic Reports. A package of wellbeing has been developed to ensure that staff are well informed and well supported throughout the review process. Staff are regularly updated on the progress of the reviews, and are encouraged to engage in improving the service, through mechanisms such as Clinical Supervision, Audit and Governance meetings and Lunch and Learn events.

A staff engagement plan is in place for autumn 2021 to share the findings of the Stillbirth Thematic Report.

Appendix 4: The Clinical Review Programme

The Clinical Review Programme is overseen by the Independent Maternity Services Oversight Panel (IMSOP). The review of the 63 included cases assesses the standard of care provided by the Health Board, to identify if the quality and safety of practice was of an acceptable standard, using a standardised review tool.

The Health Board has worked in close collaboration with the Panel since the Clinical Review process began in November 2019 to ensure that detailed information has been provided to the Panel to support the thorough review of cases.

Once completed, our Health Board receives feedback from each case review that details the findings in relation to the assessment of the care provided. If any care is identified as falling below the expected standard, it is then assigned a level of significance in terms of likely impact on the overall outcome, as per the table below

Definitions of Modifiable Factors		
If the care provided to mothers and their babies did not meet the standards expected, the clinical review teams referred to this as a "*modifiable factor*". Four categories were used to grade the significance of each modifiable factor:		
0	**No Modifiable Factor**	No lessons can be learned.
1	**Wider Learning Factor**	Although lessons can be learned, the issue did not affect the overall outcome.
2	**Minor Modifiable Factor**	The issue was a contributory factor, but different management is unlikely to have changed the overall outcome.
3	**Major Modifiable Factor**	The issue contributed significantly to the poor outcome. Different management may have altered the outcome.

Through its review processes, the panel also identified areas of good or optimal practice. These were identified in over half of all cases reviewed. It is important to share this feedback, in order that our Health Board can continue to build on this.

The assessment of each episode of care was based on a systematic review of twelve separate areas related to the woman's care during pregnancy and birth as follows:

- Women and family
- Pre-pregnancy care
- Assessment/point of entry to care
- Diagnosis/recognition of high risk
- Referral to specialist
- Treatment
- Clinical leadership
- Education, training and knowledge
- Documentation
- Discharge or transfer from care
- Communication
- Policies and procedures

Women's stories were also taken into account where they had come forward to share them with us.

Many of the findings had previously been addressed through the recommendations that had already been completed. However, the process of sharing and reviewing the findings with the clinical teams enabled our Health Board to review these improvements and consider them anew leading to refreshed actions and plans which

enabled continuous and sustained improvement. The number of individualised open and closed actions on the stillbirth clinical review tracker are listed in the table below:

Total number of Findings identified from Clinical Review individual cases:	**553**
Open Action total	**77**
Completed Action total	**476 (86%)**

It is important to note that when the same findings emerged from separate cases, this resulted in the same action being identified and counted more than once, therefore there are not 553 separate actions for improvement. 219 are repeated actions, occurring in more than one case. Critically, these improvements are identified and led by CTM's clinical staff whose commitment to the process and determination to continue with improvement has not been diminished by the impact of the COVID-19 pandemic. The pandemic however, has inevitably slowed the pace of action completion whilst clinical staff continue to provide a safe service during challenging times. It is anticipated that all actions in this category will be completed by December 2021.

Appendix 5: FAQs for Families (English)

Independent Maternity Services Oversight Panel (IMSOP)

Clinical Review Programme - Frequently Asked Questions

I have questions about the letters I have received and the information they contain. How can I get answers to my questions?

We want to ensure we can answer any questions you may have so please contact us to let us know what they are so that we can ensure the most appropriate people can respond. Representatives of IMSOP and our Health Board would be happy to meet with you virtually together to discuss your queries if this would help. Please contact a member of our Maternity Improvement Team **01685 728741 (Monday- Friday 9am-5pm, excluding bank holidays** - a voicemail option is also available out of hours**)** or email CTM_maternityimprovementprogramme@wales.nhs.uk so that we can take this forward with you.

If you can please **leave your name**, **contact number** and a **suitable time** for us to call you back, where we will aim to get back to you within five working days and, if needed, with a dedicated appointment time once we have liaised with the IMSOP representatives.

I would like to understand more about the improvement work that the Health Board has described in the letter. I have some questions about it.

The Health Board would be very happy to offer a virtual meeting to discuss the improvements we are taking forward and to ensure we learn from your experience.

Please contact our Maternity Improvement Team on **01685 728741 (Monday-Friday 9am-5pm, excluding bank holidays)** or email CTM_maternityimprovementprogramme@wales.nhs.uk at any time to arrange an appointment. You can also find information about our maternity improvement journey on our website: cwmtafmorgannwg/our-maternity-improvement-journey/

I have specific questions about the clinical review conducted by IMSOP.

Please contact us to let us know what your questions are so that we can make sure that you receive the answers you need. We appreciate you may also want the opportunity to meet to discuss your questions, in which instance, representatives of IMSOP would be happy to meet with you virtually to discuss these. You can contact our Maternity Improvement Team via **01685 728741** (a voicemail option is also available out of hours) or email CTM_maternityimprovementprogramme@wales.nhs.uk so we can take this forward for you. If you can please **leave your name**, **contact number** and a **suitable time** for us to call you back, we will aim to get back to you within five working days.

If I have a meeting to discuss any questions or queries I have, can I arrange for a member of my family or another representative to be present with me?

Of course. You can have support from whomever you feel will be most beneficial to you and your family. The Community Health Council (CHC) is able to provide you with guidance and support and can help you to prepare the questions you may wish to raise during the meeting. If you want to discuss this further, you can contact either our Maternity Improvement Team or Sam Perrett and Helen Hardcastle of the Community Health Council directly by phoning **01443 403590** or emailing Samantha.perrett@waleschc.org.uk helen.hardcastle@waleschc.org.uk.

How soon will a meeting be arranged for me to discuss my queries and what days and hours are available for these meetings?

When you have made contact with a member of our Maternity Improvement Team, your details will be noted and you will receive a reply within five working days with a proposed meeting date within a three-week period. We will try our best to arrange this meeting as soon as possible for you as we appreciate you will not want to delay this and add to any distress you may be feeling. The meetings will normally take place Monday - Friday between the hours of 9-5pm. If this is difficult for you please let us know, and we will arrange a time that is convenient for you.

I do not wish to have a meeting but want to ensure my experience is shared. Is this possible?

Yes we would very much welcome this. We also welcome any ideas you may have on how we can improve our services. Your experience and feedback will be shared to help shape our ongoing improvement journey. As all cases are anonymised (we will

not share your name or details), we will be using the learning from the review of your care to feed back to our staff. For example, this could include staff examining case studies (anonymised) during training days. This will ensure that we continue to learn from the experiences of women and families as well as embed the necessary improvements within our service.

The review of my and my baby's/babies' care has identified that some aspects of our care were below the standard expected. What are the Health Board's next steps?

We are sorry that the care you received was below the standard expected. Our Health Board is now ensuring that the learning is being incorporated into our Maternity Service's ongoing improvement work. If you wish to discuss the individual actions we are taking specific to your care, our Director of Midwifery and the Lead Midwife will be happy to do this. You can contact our Maternity Improvement Team to discuss this via **01685 728741 (Monday- Friday 9am-5pm, excluding bank holidays -** a voicemail option is available**)** or emailing CTM_maternityimprovementprogramme@wales.nhs.uk.

If you can please **leave your name**, **contact number** and a **suitable time** for us to call you back, our team will aim to get back to you within five working days.

Please also contact us if you have questions about our Health Board's **Putting Things Right** process and potential next steps for your case.

I have questions about the clinical review letter and do not wish to speak to the Health Board.

We appreciate you may not wish to have further correspondence from our Health Board, and we fully respect your decision. You have the alternative option to contact the IMSOP team directly by emailing OversightPanelMaternity@gov.wales.

I do not wish to have any further letters or emails from IMSOP or the Health Board. How do I stop these from being sent?

We completely understand if you do not want to receive further correspondence. If this is your wish, please let us know by contacting **01685 728741 (Monday-Friday 9am - 5pm, excluding bank holidays)** or emailing CTM_maternityimprovementprogramme@wales.nhs.uk to confirm this and we will update our records accordingly.

Why is Cwm Taf University Health Board now being referred to as Cwm Taf Morgannwg University Health Board?

On April 1st 2019 the new Cwm Taf Morgannwg University Health Board was formed. The Welsh Government decision saw the transfer of responsibility for the commissioning of healthcare in the Bridgend area from the then Abertawe Bro

Morgannwg University Health Board to the newly created Cwm Taf Morgannwg. Cwm Taf UHB no longer exists in its former identity.

We have put together these FAQ's in case you have further questions from the letters you have received.

Please do not hesitate to contact us if you have any other questions, we will be more than happy to help.

You can do this by contacting our Maternity Improvement Team via the contact details listed above.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Appendix 6: Y Panel Trosolwg Annibynnol ar Famolaeth (IMSOP) Rhaglen Adolygu Clinigol

Mae cwestiynau gyda fi am y llythyrau rydw i wedi eu derbyn a'r wybodaeth sydd ynddyn nhw. Sut alla i gael atebion i fy nghwestiynau?

Rydyn ni am sicrhau y gallwn ni ateb unrhyw gwestiynau sydd gyda chi, felly cysylltwch â ni i roi gwybod i ni os oes cwestiynau gyda chi, er mwyn i ni allu sicrhau bod y bobl briodol yn ymateb. Byddai cynrychiolwyr o IMSOP a'n Bwrdd Iechyd yn fwy na bodlon cwrdd â chi ar lein i drafod eich ymholiadau, os bydd hyn o gymorth. Cysylltwch ag aelod o'n Tîm Gwella Mamolaeth trwy ffonio **01685 728741 (Dydd Llun - Dydd Gwener 9am-5pm, ac eithrio gwyliau'r banc -** mae modd gadael neges lais y tu allan o oriau**)** neu e-bostio CTM_maternityimprovementprogramme@wales.nhs.uk, fel y gallwn ni roi cymorth i chi.

Hefyd, a fyddwch chi cystal â gadael **eich enw** a'ch **rhif cyswllt** a **nodi pryd** hoffech chi i ni ffonio'n ôl. Fe fyddwn yn ymdrechu i ddod yn ôl atoch o fewn pum diwrnod gwaith unwaith i ni gysylltu â chynrychiolwyr o IMSOP.

Hoffwn i ddeall mwy am y gwaith gwella mae'r Bwrdd Iechyd wedi ei ddisgrifio yn y llythyr. Mae ychydig o gwestiynau gyda fi amdano.

Byddai'r Bwrdd Iechyd yn fwy na bodlon cynnig cyfarfod ar lein i drafod y gwelliannau rydyn ni'n eu gwneud er mwyn sicrhau ein bod yn dysgu o'ch profiad chi. Cysylltwch â'n Tîm Gwella Mamolaeth trwy ffonio **01685 728741 (Dydd Llun - Dydd Gwener 9am-5pm, ac eithrio Gwyliau'r Banc),** neu e-bostiwch CTM_maternityimprovementprogramme@wales.nhs.uk i drefnu apwyntiad. Mae gwybodaeth ddwyieithog am ein taith at well gofal mamolaeth ar gael ar ein gwefan hefyd:

cwmtafmorgannwg/our-maternity-improvement-journey/

Mae cwestiynau penodol gyda fi am yr adolygiad clinigol a gafodd ei gynnal gan IMSOP.

Cysylltwch â ni i roi gwybod i ni pa gwestiynau sydd gyda chi, er mwyn i ni allu sicrhau eich bod yn cael yr atebion sydd eu hangen arnoch chi. Rydyn ni hefyd yn cydnabod eich bod o bosibl am gael y cyfle i gwrdd er mwyn trafod eich cwestiynau. Os felly, bydd cynrychiolwyr o IMSOP yn fwy na bodlon cwrdd â chi ar lein i'w trafod. Cysylltwch ag aelod o'n Tîm Gwella Mamolaeth trwy ffonio **01685 728741** (mae modd gadael neges lais y tu allan o oriau**)** neu e-bostio CTM_maternityimprovementprogramme@wales.nhs.uk , fel y gallwn ni roi cymorth i chi. Hefyd, a fyddwch chi cystal â gadael **eich enw** a'ch **rhif cyswllt** a **nodi pryd** hoffech chi i ni ffonio'n ôl. Fe fyddwn yn ymdrechu i ddod yn ôl atoch o fewn pum diwrnod gwaith.

Os oes cyfarfod gyda fi i drafod unrhyw gwestiynau neu ymholiadau sydd gyda fi, alla i drefnu i aelod o fy nheulu neu gynrychiolydd arall fod yno gyda fi?

Wrth gwrs. Fe allwch chi ofyn i unrhyw un fod yn bresennol a fydd yn eich barn chi o'r budd mwyaf i chi a'ch teulu. Mae'r Cyngor Iechyd Cymuned yn gallu rhoi canllawiau a chymorth i chi, a bydd yn gallu eich helpu i baratoi'r cwestiynau i'w gofyn yn y cyfarfod.

Os ydych chi am drafod hyn ymhellach, gallwch chi gysylltu â'n Tîm Gwella Mamolaeth neu â Sam Perrett a Helen Hardcastle o'r Cyngor Iechyd Cymuned yn uniongyrchol trwy ffonio **01443 403590** neu e-bostio Samantha.perrett@waleschc.org.uk helen.hardcastle@waleschc.org.uk.

Pa mor fuan fydd cyfarfod yn cael ei drefnu i fi allu trafod fy ymholiadau, a pha ddiwrnodau ac oriau sydd ar gael ar gyfer y cyfarfodydd hyn?

Unwaith i chi gysylltu ag aelod o'n Tîm Gwella Mamolaeth, byddwn yn gwneud nodyn o'ch manylion a byddwch chi'n derbyn ymateb o fewn pum diwrnod gwaith gyda dyddiad posibl ar gyfer cyfarfod o fewn cyfnod o dair wythnos. Byddwn yn gwneud ein gorau i drefnu'r cyfarfod hwn cyn gynted â phosibl, gan ein bod yn deall na fyddwch chi am oedi a gwneud y cyfnod hwn hyd yn oed yn fwy gofidus. Bydd y cyfarfodydd yn cael eu cynnal fel arfer rhwng Dydd Llun - Dydd Gwener rhwng 9am-5pm. Os bydd hyn yn anodd i chi, rhowch wybod i ni ac fe fyddwn ni'n trefnu amser sy'n gyfleus i chi.

Dydw i ddim eisiau cyfarfod, ond rydw i am wneud yn siŵr bod fy mhrofiad yn cael ei rannu ag eraill. Ydy hyn yn bosibl?

Ydy, bydden ni'n croesawu hyn yn fawr. Rydyn ni hefyd yn croesawu unrhyw syniadau sydd gyda chi am sut y gallwn ni wella ein gwasanaethau. Bydd eich profiad a'ch adborth yn cael eu rhannu er mwyn llywio ein taith at ofal gwell. Gan fod pob achos yn ddienw (fyddwn ni ddim yn rhannu eich enw na'ch manylion), fe fyddwn ni'n defnyddio'r gwersi yn yr adolygiad o'ch gofal i roi adborth i'n staff. Er

enghraifft, gall hyn gynnwys gofyn i staff archwilio astudiaethau achos (di-enw) yn ystod diwrnodau hyfforddiant. Bydd hyn yn sicrhau ein bod yn parhau i ddysgu o brofiadau menywod a'u teuluoedd, wrth i ni wneud y gwelliannau angenrheidiol yn ein gwasanaeth.

Mae'r adolygiad o'r gofal a dderbyniais i a fy mabi wedi tynnu sylw at rai agweddau o'n gofal a oedd yn is na'r safon ddisgwyliedig. Beth yw camau nesaf y Bwrdd Iechyd?

Mae'n flin gyda ni fod y gofal a dderbynioch chi islaw'r safon ddisgwyliedig. Mae'r Bwrdd Iechyd bellach yn gwneud yn siŵr fod y gwersi i'w dysgu'n rhan fawr o'r gwaith sydd ar y gweill i wella ein Gwasanaethau Mamolaeth. Os ydych chi'n dymuno trafod y camau penodol rydyn ni'n eu cymryd yn sgil y gofal a dderbynioch chi yn bersonol, bydd ein Cyfarwyddwr Bydwreigiaeth a'n Bydwraig Arweiniol yn fodlon gwneud hynny. Gallwch chi gysylltu â'n Tîm Gwella Mamolaeth i drafod hyn trwy ffonio **01685 728741 (Dydd Llun - Dydd Gwener 9am-5pm, ac eithrio Gwyliau'r Banc)** - bydd modd gadael neges lais) neu drwy e-bostio CTM_maternityimprovementprogramme@wales.nhs.uk.

Hefyd, a fyddwch chi cystal â gadael **eich enw** a'ch **rhif cyswllt** a **nodi pryd** hoffech chi i ni ffonio'n ôl. Fe fyddwn yn ymdrechu i ddod yn ôl atoch o fewn pum diwrnod gwaith.

Cysylltwch â ni hefyd os oes cwestiynau gyda chi am broses **Gweithio i Wella** ein Bwrdd Iechyd, ac am gamau posibl nesaf eich achos.

Mae cwestiynau gyda fi am y llythyr ynghylch yr adolygiad clinigol, ac dydw i ddim am siarad â'r Bwrdd Iechyd.

Rydyn ni'n deall nad ydych chi efallai am dderbyn rhagor o ohebiaeth gan ein Bwrdd Iechyd, ac rydyn ni'n llwyr barchu eich penderfyniad. Mae opsiwn amgen gyda chi, sef cysylltu â thîm IMSOP yn uniongyrchol trwy e-bostio OversightPanelMaternity@gov.wales.

Dydw i ddim am dderbyn unrhyw lythyrau neu e-byst pellach gan IMSOP na'r Bwrdd Iechyd. Sut alla i sicrhau fy mod i ddim yn derbyn rhagor o ohebiaeth?

Byddwn ni'n deall yn iawn os nad ydych chi am dderbyn rhagor o ohebiaeth. Os felly, rhowch wybod i ni trwy ffonio **01685 728741 (Dydd Llun - Dydd Gwener 9am - 5pm, ac eithrio Gwyliau'r Banc)** neu drwy e-bostio

CTM_maternityimprovementprogramme@wales.nhs.uk. Byddwn ni wedyn yn diweddaru ein cofnodion yn unol â hynny.

Pam mae pobl yn galw Bwrdd Iechyd Prifysgol Cwm Taf yn Fwrdd Iechyd Prifysgol Cwm Taf Morgannwg?

Ar Ebrill 1 2019, cafodd sefydliad newydd Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg ei ffurfio. Yn dilyn penderfyniad gan Lywodraeth Cymru, trosglwyddodd y cyfrifoldeb dros gomisiynu gofal iechyd yn ardal Pen-y-bont ar Ogwr yn ardal

Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg fel yr oedd gynt i sefydliad newydd Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg. Dydy BIP Cwm Taf ddim yn bodoli mwyach.

Rydyn ni wedi llunio'r Cwestiynau Cyffredin hyn rhag ofn y bydd rhagor o gwestiynau gyda chi ar ôl darllen y llythyrau rydych chi wedi eu derbyn.

Mae croeso i chi gysylltu â ni os bydd rhagor o gwestiynau gyda chi, a byddwn ni'n fwy na bodlon eich helpu.

Gallwch chi wneud hynny trwy gysylltu â'n Tîm Gwella Mamolaeth gan ddefnyddio'r manylion cyswllt sydd uchod.