Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD RESPONSE TO: IMSOP MATERNAL MORBIDITY AND MORTALITY THEMATIC REPORT

Clinical Review Programme

25th January 2021

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

Foreword

This is the first of a series of report responses which will be published by Cwm Taf Morgannwg University Health Board in the coming year. The purpose of this report is for our Health Board to respond to the findings identified by the Independent Maternity Services Oversight's Panel (IMSOP) Clinical Review.

This review focuses on the maternity care provided in Royal Glamorgan Hospital and Prince Charles Hospital between January 1 2016 and September 30 2018. The findings from this review are for those care episodes which met the inclusion criteria for the maternal morbidity and mortality category. This category has reviewed the care of 28 individual episodes of care of mothers and babies where women may have required unplanned emergency treatment during childbirth or may have required admission to the Intensive Care Unit (ITU).

The findings from the reviews have supported the work that is continuing since the Welsh Government commissioned an independent review by the Royal College of Gynaecologists (RCOG) and the Royal College of Midwives (RCM). The Royal Colleges' report in April 2019 identified wide ranging concerns within the maternity service which we have been addressing since.

Our Health Board has received the findings from each individual clinical review case and acknowledges the learning which has been identified. We are committed to ensuring that the Maternity and Neonatal services at Cwm Taf Morgannwg University Health Board are of the highest standard and the women and families engaging with us have the best possible experiences.

We understand how difficult revisiting this experience may be for many families but hope that the information contained in this report helps reassure our communities that we have learned from past events. We are committed to being open and honest about what went wrong and how the learning that has been identified is underpinning meaningful improvement.

The Independent Maternity Services Oversight Panel made two specific recommendations in their thematic review:

Recommendation 1: The Health Board should publish a formal response to the learning which has emerged from the first phase of the Clinical Review programme (the maternal category) to coincide with the publication of the Panel's thematic report.

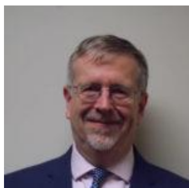
Our Health Board agreed this was vitally important for our families and the wider public to avoid delay in receiving the answers they deserve.

Recommendation 2: The Health Board should be asked to work with the Welsh Government and the Maternity and Neonatal Network to ensure that the opportunities for wider learning which have emerged from the Clinical Review Programme are identified and shared on an All Wales basis.

Our Health Board is committed to sharing these findings with all maternity and neonatal services across Wales to allow other health boards to evaluate their services for any improvements at the earliest opportunity. We currently have a well-established working relationship with the Maternity and Neonatal Network, the Heads of Midwifery Advisory Groups, the Welsh Government, as well as well-developed clinical relationships with surrounding maternity services.

We are truly sorry for what happened in our maternity services and want to apologise sincerely to those families who have been affected by the care provided at the Royal Glamorgan and Prince Charles hospitals. We cannot change the experiences suffered by the women and families at the heart of this report, but we will ensure those experiences drive our commitment to develop and sustain a maternity service our community and staff can be proud of.

We will never forget what our families have told us about their experiences, we will continue to listen and learn, and work alongside our community to make sure these experiences are never repeated.



Marcus Longley

Chair, Cwm Taf Morgannwg University Health Board

Paul Mears

Chief Executive Officer, Cwm Taf Morgannwg University Health Board

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Maternal Morbidity and Mortality Category

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

Summary of IMSOP Key Findings

- 28 episodes of care were reviewed
- At least one modifiable factor was identified in 27 out of 28 cases
- 19 cases had a major modifiable factor (68%)
- One case did not identify any modifiable factors
- Two cases identified wider learning

Women and families said... *they wanted a monthly Infographic of maternity statistics......*

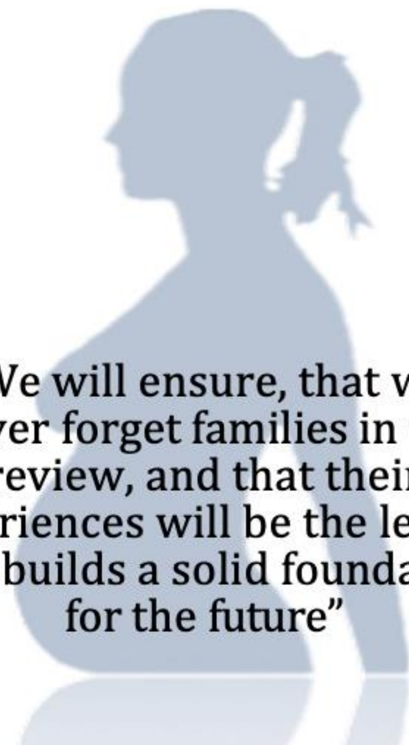
...we did...

First Statistic Infographic released August 2020, we are now backdating these to the beginning of 2020 as women have since requested backdated months for their records.

Total number of Findings identified by Health Board from Clinical Review individual cases:	**233**
Open Actions from findings:	**134** (27 of these are duplicates: same actions but mentioned in number of individual cases)
Open Action total	**107**
Closed Action total	**99**

*All Actions have a trajectory to be completed by 31st July 2021

- 50 out of 70 RCOG and RCM recommendations have been completed by the Health Board
- 24 of the 70 RCOG and RCM recommendations are aligned to the clinical review programme
- 17 of these 24 recommendations are now completed by the Health Board
- Seven recommendations remain in progress:
  - Management and reporting of serious incidents
  - Management of concerns in line with PTR
  - Engagement with women and families
  - Workforce and development relating to training, clinical support, values and behaviours.



"We will ensure, that we never forget families in the review, and that their experiences will be the legacy that builds a solid foundation for the future"

What IMSOP said….	What we did.. Health Board Improvements	Health Board Next Steps
1. Understanding what women need	• Engagement events in October 2019 and January 2020 with communities in Llantrisant, Merthyr Tydfil and Bridgend following the release of the RCOG report • My Maternity, My Way patient forum group set up, supporting and participating in improvement projects • Social media channels well established • Virtual tours of maternity services at each site made available • Exploration of visiting times, partners staying overnight on postnatal wards to provide emotional and practical support which encourages bonding • Practical support from nursey nurses and health care support workers (more staff on postnatal wards) • After Thoughts, a birth listening clinic set up to support unanswered questions and signposting if required post birth	• Achieve the All Wales Maternity Vision of family centred care • Models of care being explored to be able to offer continuity to families with complex vulnerabilities

What IMSOP said....	What we did.. Health Board Improvements	Health Board Next Steps
2. Access to Relevant and Timely Information	• Nationally recommended information leaflets now provided alongside Health Board leaflets being co-produced with My Maternity, My Way user group • Consultant Midwife clinics to support women to feel fully informed to make decisions about their care	• 6-8 week debriefs in progress of being set up for women who have experienced complex births • Exploration of pre-pregnancy counselling clinics Engagement
3. Failing to monitor progress or escalate care	• Escalation policy updated • 60 hours of Consultant presence within the service • Enhanced surveillance for monitoring of babies growth in pregnancy through GAP and GROW training programmes • Guidelines and policies updated	• Ongoing audits around the effectiveness of handovers
4. Poor Communication	• Joint decision making between Obstetricians, Anesthetists and medical teams for those women who are receiving care and treatment outside of maternity • Mandatory nationally recognised annual Prompt training for all midwives and doctors (including Anesthetists) to support improved clinical decision making and team working in emergencies	• Maternal critical care guideline in progress with inclusion of high dependency chart and training for midwives

As the Interim Consultant Midwife for CTM, I offer clinics and appointments flexibly for woman across the Health Board area. My role primarily focuses on offering supportive and evidence-based information and advice around options and choices for place of birth and mode of birth.

Whilst this service is offered for women directly, my role is also around supporting midwives in offering choices and evidence-based advice in their own clinical practice.

My philosophy is one of empowering and supporting all women to explore their choices, promoting safe active birth in whichever birth setting a woman chooses, advocating for, and instilling confidence in women, so you feel confident and inspired during your journey.

1. About this Report

This is the first of a series of reports the Cwm Taf Morgannwg University Health Board (CTMUHB) 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 mothers[1] who needed unplanned emergency treatment during childbirth, including some who required admission to an Intensive Care Unit (ITU).

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

There are four main areas:

1. How the Health Board has been addressing the failings identified in the April 2019 RCOG/RCM report (Section 5)

2. The improvements already completed by the Health Board to date (Section 5)

3. The improvements that are in progress and ongoing (Section 6)

4. The Health Board response to the themes identified in the January 2021 IMSOP thematic review 'Maternal Morbidity and Mortality' (Section 5).

[1] *In some cases, the care of the baby was also reviewed, although any learning which emerges in respect of the care of the baby will be covered in subsequent thematic reports.*

2. Introduction

Working with Women and Families

Since the release of the RCOG report in April 2019, the Health Board has prioritised working closely with families and communities to ensure services reflect the needs and values of those the Health Board serves.

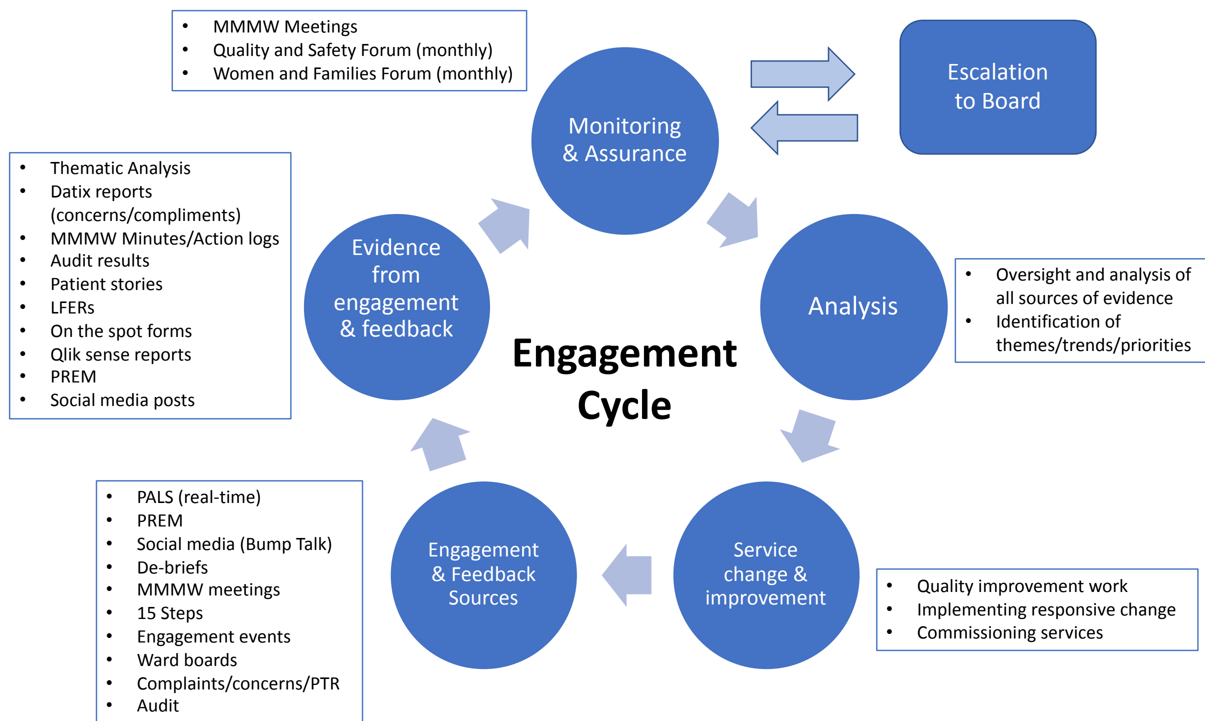
Engagement events were facilitated across the three locality areas - Merthyr and Cynon, Rhondda Taf Ely and Bridgend - bringing together women, families and communities with the maternity service. Throughout the engagement events, the Service committed to listening to those families in a way which had not previously been offered.

A number of key themes were identified:

- Infant feeding services
- Perinatal mental health services
- Understanding birth and care
- The involvement of partners and families.

Plans were developed in response to these themes and work continues in partnership to ensure families are at the centre of service developments.

CTM's Engagement Cycle demonstrates the continual cyclical process of engagement with families and shows the use of varied and multiple methodologies used to engage with service users to capture their feedback. The collation of this feedback assists the Service to identify key service user priorities, and how these are managed in order to influence quality service development and improvements



An example of this is the *My Maternity My Way* (MMMW) Group which is supporting and assisting the improvements within Maternity Services and is the former *Maternity Services Liaison Committee*. The Group comprises lay members who have previously received care within CTMUHB who are committed to working in partnership with the Maternity Service to plan, monitor and improve maternity services.

During the last 12 months, the MMMW group has developed and grown in participation and widened its scope of activities and involvement across the Service. This participation and co-production is evolving continually. Through MMMW, the Service has made a strong commitment to developing and maintaining meaningful relationships with service users, provides open communication and transparency, and ultimately places the views and needs of women and their families at the heart of every decision, change and improvement.

3.0 Supporting Families

Whilst recent engagement and feedback has been overwhelmingly positive, it is not underestimated the impact the failings have had, not only on the women and families involved in the review, but also on the wider communities. This may be those who have used the Health Board's services in the past, more recently, or those due to have their babies in the upcoming months.

The Health Board is dedicated to supporting women and families at this difficult time and again, offer a heartfelt apology for all those women and their families who received care which was below the expected standard. We are committed to being open and honest about the learning that has been identified, and to working with families, past and present, to help continually evolve CTM's maternity services.

Following the commencement of the clinical review programme in November 2019, the Health Board worked closely with an external counselling agency to support those families in the clinical review who have requested additional support. This service has been available for women, their partners and wider family members as it is appreciated the impact a poor experience can have on a whole family.

There is a dedicated Health Board contact line for families to use to raise any questions or concerns regarding the review process and findings, and have developed information leaflets to answer common questions and signpost to further support (please see appendix 3, 4 and 5). Women and families can contact the Service team on **01685 728741 which is available** from 9-5pm. A voicemail option is also available and the Team aims to respond to all calls within two working days.

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

4.0 How the Health Board Has Been Addressing the Failings Identified in the RCOG/RCM 2019 Report

4.1 The Work of the Maternity and Neonatal Improvement Team

The publication of the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) report in April 2019 identified a number of failings in the then Cwm Taf University Health Board. In response to this publication, the Maternity Improvement Team was established by the Health Board to oversee the programme of improvement and the work required by the Health Board to support the IMSOP Clinical Review Programme.

The Improvement Programme has more recently expanded to include the neonatal aspect of improvement work which is monitored through similar processes. The Maternity Improvement team is therefore now known as the Maternity and Neonatal Improvement Team (MNIT).

The Health Board's Senior Responsible Officers (SROs) for this programme are the Executive Director of Nursing and Patient Safety for maternity work streams, and Executive Medical Director for Neonatal work streams.

The MNIT are responsible for ensuring progress is made to implement the 70 Royal Colleges' recommendations and work with clinicians to improve working practices and standards. The recommendations are managed through the Maternity and Neonatal Improvement Plan (MNIP) and monitored through the three project work-streams:

1. Safe and Effective Care
2. Quality of Women's and Families' Experience
3. Quality of Management and Leadership

The work streams monitor and measure the improvement within the Maternity and Neonatal Improvement Programme and support the production of evidence, in order for IMSOP to assess progress against the agreed actions.

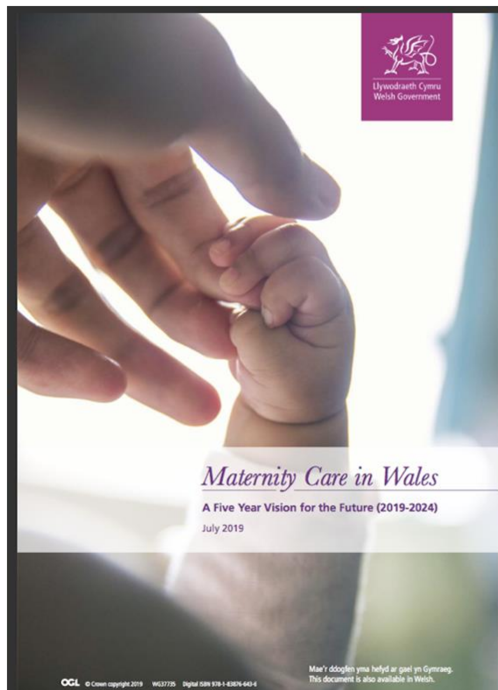
The MNIP includes clear milestones and targets to manage the recommendations and more recently, additional improvements and additions identified by the Maternity and Neonatal services.

All plans are monitored through the Health Board's Maternity and Neonatal Improvement Board and Welsh Government appointed Independent Maternity Services Oversight Panel (IMSOP). The Health Board also reviews progress at its Quality Safety Committee and Management Board.

The overarching themes within the plan predominately fall under:

- Engagement and Involvement of Women and Families
- Training and development of staff
- Working culture and communication between inter-professionals
- Management of serious incidents and concerns
- Values and Behaviours
- Clinical Audit and Effectiveness
- Leadership and Governance
- Midwifery and Obstetric workforce and staffing rotas

Plans has been developed in response to these themes and also from working with partners such as the Maternity and Neonatal Network which works to develop high quality standardised care pathways and review processes by listening to women and families across Wales. The Health Board is also working to deliver care that aligns to the All Wales Maternity Five Year Vision publication.



This All Wales policy describes how maternity services will evolve and improve between 2019-2024 to meet the needs of all women and families in Wales.

The gold standard of care will be achieved through the following five principles of maternity care:

1. Family centered care
2. Safe and effective care
3. Continuity of care
4. Skilled multi-professional teams
5. Sustainable quality services

These principles influence and shape all Health Board maternity plans and achieving the vision is woven through the Maternity and Neonatal Improvement Plan. This ensures national and local direction for improvement is aligned and seamless good quality care can be universally expected by families in the CTM area. *The Vision* (in full) can be read here.

4.2 The Clinical Review Programme

The Clinical Review Programme is conducted by the Independent Maternity Services Oversight Panel (IMSOP). The review of the identified cases assesses the standard of care provided by the Health Board, to identify if both the quality and safety of practice was adequate or below standard.

The Health Board has worked closely with the Independent Panel since the start of the Clinical Review process in November 2019. The close collaboration ensures that as much detailed information as possible has been provided to the Independent Panel to support the thorough review of cases.

Once reviews are completed, the Health Board receives feedback that details the findings and what significance (major, minor or wider learning) has been assigned by clinical review teams, dependant on whether they feel care was below standard and if different care could have altered the outcome.

IMSOP Modifiable Factor	IMSOP Significance Rating
Major	*The issue contributed significantly to the death or poor outcome. Different management would reasonably be expected to have contributed to alter the outcome.*
Minor	*The issue was a contributory factor and different management may have made a difference. However, it is unlikely that it would have changed the overall outcome.*
Wider Learning	*Although lessons can be learned, the issue did not affect the overall outcome.*

4.3 How the Clinical Review Findings are Managed

The Review findings have been reviewed initially by the Maternity and Neonatal Improvement Team who collate and extract the learning and findings into a feedback form. The case is then discussed in a fortnightly multidisciplinary team (MDT) meeting comprised of Consultant Obstetricians, Anaesthetists, Midwives, Midwifery Senior Managers, Clinical Supervisors of Midwives and Paediatricians. Each case is then shared further with a wider MDT team which is referred to as our Clinical Cabinet (colleagues of similar roles and specialities mentioned above) for voting on agreement of any actions. Actions are taken forward by all members of the MDT team and staff working within the clinical areas.

All actions are collated onto the clinical review tracker. Progress against these actions is monitored by the Maternity and Neonatal Improvement Team.

The actions are monitored through the relevant work stream meetings before progress or closure is reported at the Maternity and Neonatal Improvement Board. The overarching themes are also captured on the main Maternity and Neonatal Improvement Plan for oversight and monitoring of timely progression (please see appendix 1 for Health Board process map).

4.4 Supporting Staff When Failings are Identified

A staff support and information pack has been provided to ensure staff are aware of the processes and how to obtain further information or support.

The Health Board is working closely with staff who have been involved in the historical reviews. Robust processes have been developed with workforce colleagues to ensure timely, sensitive and comprehensive investigation and escalation pathways are in place for those staff members involved in cases where major modifiable factors have been identified.

It is important to emphasise that the Health Board 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 way. Information relating to staff is confidential and all staff names have been anonymised throughout the review process.

Where there are concerns about an individual's professional competency or conduct; training and support will be provided by the Health Board both for the individual and wider team where appropriate.

In circumstances where there are serious professional concerns, the Health Board will enact its own processes, up to and including referral to professional bodies if necessary.

5.0 Learning from the IMSOP Clinical Reviews

The assessment of each episode of care was based on a systematic review of 12 separate areas:

1. Women and family
2. Pre-pregnancy care
3. Assessment/point of entry to care
4. Diagnosis/recognition of high risk
5. Referral to specialist
6. Treatment
7. Clinical leadership
8. Education, training and knowledge
9. Documentation
10. Discharge or transfer from care
11. Communication
12. Policies and procedures

Women's stories were also taken into account where available.

Of the 28 cases reviewed, at least one modifiable factor was identified in 27 cases. Of these, 19 (68%) revealed a major modifiable factor (where different management would reasonably have been expected to alter the outcome). 12 reviews (43%) had more than one major modifiable factor.

Across the 28 cases, more than 200 modifiable factors were found in the following 10 areas:

- Pre-pregnancy or re-conception care
- Assessment or point of entry of care
- Diagnosis in the recognition of high risk status
- Referral to Specialist
- Treatment
- Clinical leadership
- Education, Knowledge and Training
- Documentation
- Discharge or transfer from care
- Communication

As has been described, many of the findings had been addressed within recommendations that had already been completed, and plans were already in place for other findings in seven of the remaining recommendations. However, and importantly, the process of reviewing the findings with the clinical teams enabled the Health Board to review these improvements and consider them anew leading to refreshed actions and more ambitious plans.

This is demonstrated in the Next Steps column in section 5. The number of individualised open and closed actions on the clinical review tracker are listed in the table below:

Total number of Findings identified from Clinical Review individual cases:	**233**
Open Actions from Findings:	**134** (27 of these are duplicates: same actions but mentioned in a number of individual cases)
Open Action total	**107**
Closed Action total	**99**

It is important to note a 'like for like' action does not always emerge from a modifiable factor. An overview of these actions are broadly outlined in Section 5. Critically, these improvements are now being identified and led by CTM's clinical staff whose commitment and enthusiasm to the process has not been diminished by the very real impact of the Covid-19 pandemic. Their determination has led to more than half of the identified actions already being completed. Timescales vary but it is anticipated that all actions within this category will be completed by July 2021.

The IMSOP Thematic Maternal Morbidity and Mortality Review Themes: A Snapshot of Some of the Health Board's Improvements and Ongoing Plans

5.1 Understanding What Women Need

Women wanted emotional and practical support from family and friends
Health Board improvements to date:
Engagement events in October 2019 and January 2020 with communities of Llantrisant, Merthyr Tydfil and Bridgend following the release of the RCOG report.
My Maternity, My Way patient forum group set up, supporting and participating in improvement projects.
My Maternity, My Way is working with seldom heard groups to encourage participation for future involvement within the Service.
Social media channels well established, content includes virtual tours of maternity services at each site.
Information flyers for partners to ensure good information sharing.
Social media channels also include a dedicated page called *Bump Talk* which offers women the opportunity to provide feedback regarding a range of services.
Parenting classes currently online and offered to all family members.
Patient feedback regularly provided to staff in departmental meetings and reflections sessions. Patient feedback displayed in ward areas. PALS[2] surveys regularly completed on postnatal wards to continually assess women focused care.
Next Steps
Commitment to developing and implementing a PREM[3] to capture women's experience data throughout their pregnancy journey.
Continue to work closely with forum to achieve the All Wales Maternity Vision of family centred care.
Further discussions with community teams around access to vulnerable families who are not able to easily access hospital facilities and appointments.
To explore further information sharing on social media and Health Board web pages.
Wide ranging engagement plan to co-produce the Cwm Taf Morgannwg roadmap to the All Wales Maternity Vision.
Models of care being explored to be able to offer continuity to families with complex vulnerabilities.

[2] PALS: Patient Advocate Liaison Service: offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and carers.

[3] PREM: Patient Reported Experience Measure: questionnaires measures patients' perceptions of their experience whilst receiving care. This data can be used for research, quality improvement projects etc.

Families were not well catered for
Health Board improvements to date:
Exploration of visiting times and partners staying overnight on postnatal wards to provide emotional and practical support which encourages bonding.
Family support when mothers are admitted to intensive care unit, named staff member on shift dedicated link for family to receive updates on condition.
Practical support with feeding which aligns with breastfeeding accreditation standards.
Transitional care project underway to avoid mother and baby separation as much as possible for those babies requiring some additional support.
Next Steps:
Continue to review risk assessments of partners' attendance restrictions due to Covid-19. Continue to work with Welsh Government regarding advice and guidance.
Dedicated pathway in development in partnership with neonatal units for care of babies when mothers admitted to intensive care. This will include dedicated leaflet for families when mothers are receiving care and treatment outside of maternity.
Re-accreditation of breastfeeding accreditation standards at Prince Charles site ongoing, assessments currently delayed due to Covid-19.
Physical Difficulties after major surgery
Health Board improvements to date:
Improved staffing levels on postnatal wards, which include more health care support workers and nursery nurses to provide additional care and support with basic needs such as feeding and washing after surgery. Staffing levels Birth rate plus[4] compliant since merge of Prince Charles Hospital and Royal Glamorgan Hospital sites.

[4] Birth Rate Plus® (BR+): A framework for workforce planning and strategic decision-making. The Royal College of Midwives [RCM] and Royal College of Obstetricians and Gynaecologists [RCOG] recommend the use of Birth Rate Plus® to assist maternity services to establish safe staffing levels across inpatient and outpatient services of maternity services.

Next Steps:
Continually receive regular feedback from families regarding the care they received to ensure high levels of satisfaction.

Emotional needs after traumatic experience, mental health support
Health Board Improvement to date:
After Thoughts Birth clinics offered in Princess of Wales and open to all women who have unanswered questions surrounding their birth experience. These sessions can identify trauma, requirement for counselling services and refer to additional support form perinatal mental health services.
Consultant Midwife dedicated clinics for those women who have experienced traumatic births with help to support with future pregnancy and birth planning.
Consultant review on postnatal wards prior to discharge for women who have had an emergency caesarean with offer of a de-brief on ward prior to going home to answer any immediate concerns or questions.
For those families who sadly suffer a pregnancy loss, dedicated bereavement suite at Prince Charles Hospital.
Lead Bereavement Midwife in post to support families, staff training and running of support groups. The role has been reviewed and has developed to include strategic oversight, service development and Quality Improvement.
New Bereavement Midwife coordinates debriefs and post mortem results for families.
Next Steps:
Establishing debrief sessions and follow-ups for those women who have received treatment in Intensive Care, to explain reasons of care provided and allow opportunity to ask questions and discuss future pregnancies. Signposting to other services should enhanced recovery services be required.
More staff receiving mental health training through All Wales investment to enable and further support women’s mental health needs.
Bereavement suite refurbishment on the Princess of Wales Hospital site.

What difference has it made?

Patient Advice and Liaison Service (PALS) - Care to Share Clinics

Women and families said… *they wanted a monthly Infographic of maternity statistics……*

…we did…

First Statistic Infographic released August 2020, we are now backdating these to the beginning of 2020 as women have since requested backdated months for their records.

Prior to the Covid-19 pandemic, the PALS had been undertaking real time women's feedback initiatives on maternity wards twice a week. This initiative provides key opportunities to resolve any issues or concerns on the spot. In March 2020 the PALS rolled out this initiative into ante-natal clinics providing opportunities to explore the experience of antenatal pathways including preparing for birth. Feedback is shared with staff, women, and their families in the form of "You Said, We Did" reports.

5.2 Access to relevant and timely information Relevant and timely information regarding their choices to allow them to make decisions and ask for help and reassurance
Health Board improvements to date
All Wales Maternity Pregnancy records include contact details for dedicated community teams and all maternity assessment and ward areas which can be contacted 24 hours a day.
Pregnancy records include information regarding pregnancy symptoms, complications to look out for and public health guidance which are also discussed at booking with the midwife.
Next Steps
All Wales Maternity Vision of exploring continuity of care for women with the same health professionals throughout pregnancy, birth and postnatal to enhance patient outcomes and experiences. This includes opportunity for an individualised birth plan around 36 weeks.
Exploration of pre-pregnancy counselling clinics for those women with complex medical needs to help plan for a safe pregnancy in conjunction with GPs.
Developing a strategy for pre-conception care, including programmes that support physical wellbeing, mental health, domestic abuse, young mums, vulnerable groups and Dads to be.

No information given or not enough information given, causing delay and confusion
Health Board improvements to date
Nationally recommended information leaflets now provided alongside Health Board leaflets being co-produced with *My Maternity, My Way* user group.
Regular audits and working groups around methods of induction of labour. Follow-up with women a number of weeks following birth who have experienced induction to explore their experiences.
Consultant Midwife clinics available for those women wishing to explore their care further, allowing them to be fully informed and be able to make decisions about their care options in a proactive and timely way.
Social media used for hospital maternity services based virtual tours.
Social media messaging and information sharing.
Next Steps
All Wales Maternity Vision engagement events to explore local wishes, for example continuity of care for women with the same health professionals throughout pregnancy, birth and postnatal to enhance patient outcomes and experiences.
Exploration of pre-pregnancy counselling clinics for those women with complex medical needs to help plan for a safe pregnancy in conjunction with GPs.
Availability of information leaflets on maternity web page and shared via social media to allow continual access and reminders of useful information for health and wellbeing in pregnancy.
Information videos in progress to explain induction of labour process for women and families.
Continue to work alongside Improvement Cymru around survey results for women's experience of induction.

What difference has it made?

Seeking Help and Reassurance

As the Interim Consultant Midwife for CTM, I offer clinics and appointments flexibly for woman across the Health Board area. My role primarily focuses on offering supportive and evidence-based information and advice around options and choices for place of birth and mode of birth.

Whilst this service is offered for women directly, my role is also around supporting midwives in offering choices and evidence-based advice in their own clinical practice.

My philosophy is one of empowering and supporting all women to explore their choices, promoting safe active birth in whichever birth setting a woman chooses, advocating for, and instilling confidence in women, so you feel confident and inspired during your journey.

5.3 Failing to Monitor Progress or Escalate care

	Number of women highlighted failure to monitor their progress and escalate their care
	Health Board improvements to date:
	Escalation policy updated with clear roles and responsibilities for staff during periods of high acuity within the service and within an emergency. This includes dedicated senior Midwifery manager on call for advice and support.
	60 hours of Consultant presence within the service to maintain oversight of all women with regular ward rounds, handovers and safety huddles. This includes trigger list for cases where consultant review is essential.
	Mandatory training compliance reported monthly and monitored at Executive Board level. Mandatory annual Prompt[5] training for all midwives and doctors of improving clinical decision making in emergencies and recognising the signs and symptoms of deteriorating patients.
	Enhanced training for Cardiotocograph (fetal heart rate) monitoring with weekly meetings and study days to discuss cases.
	Enhanced surveillance for monitoring of babies growth in pregnancy through GAP and GROW[6] training programmes.
	Standard of documentation improved with monthly assurance audits with themes and trends shared with all staff groups. NMC[7] standards and accountability discussed at staff supervision sessions.
	All guidelines and policies updated and in line with national guidance for all health care professionals to follow and shared on the All Wales guideline repository WISDOM.

[5] Prompt: Nationally recognised training programme for maternity units; helping midwives, obstetricians, anaesthetists and other maternity team members be safer and more effective.

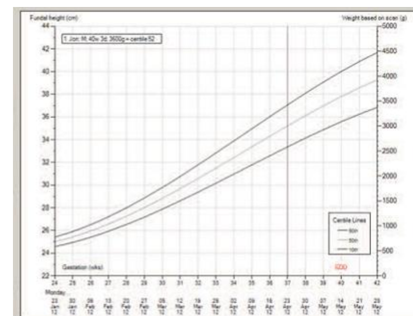
[6] GAP and GROW: Training packages formulated from the Perineal institute (A qualified provider of maternity support services, including education and training in standardised maternity records, fetal growth assessment and perinatal audit) for maternal and child health to support maternity units to correctly measure and monitor the growth of babies in pregnancy.

[7] NMC: Nursing and Midwifery Council: Professional regulators for nurses, midwives and nursing associates, ensuring professionals have the knowledge and skills to deliver consistent, quality care that keeps people safe.

	Reflection meetings available to all staff to review cases and discuss what went well and to identify any improvements.
	Multi-disciplinary team meetings weekly to discuss and learn from incidents to underpin improvements.
	Next Steps
	Ongoing audits of recognition of correct lead professional identified at booking to ensure low or high risk pathways correctly identified.
	Ongoing audits around the effectiveness of handovers to ensure vital details are passed on to relevant teams at each shift change.
	Ongoing audits of observations charts and theatre checklists.
	Risk of being left unattended without regular checks and consequence of assumptions being made by staff
	Health Board Improvements to date
	Birth rate plus compliance across sites to ensure staff workload achievable. Improved staffing levels which include more health care support workers and nursery nurses to provide additional care and support.
	Daily acuity tools completed to assess safe staffing levels across the service to ensure all women receive 1:1 care in labour.
	Next Steps
	Continued monitoring of women’s experience of care.
	Engagement events to support co-production of care pathways.

What difference has it made?

Recognition of Small for Gestational Age Babies



The Health Board has completed extensive work around the monitoring of babies’ growth in pregnancy. The Health Board has worked with the Perinatal Institutes designated GAP and GROW programs and our Fetal Surveillance Midwife has provided annual compulsory training for staff. This includes the correct technique for measuring a mother’s abdomen during pregnancy but also the correct steps that need to be followed if an issue is identified. On the Perinatal Institutes audit the Health Board has been above average in detection of small babies for the last two quarters of 2020.

5.4 Communication

Ineffective communication between teams and specialists (maternity, medical, community teams, primary care)
Health Board improvements to date
GPs having access to *Consultant Connect* to discuss Gynaecology and Obstetrics patients.
Joint decision making between Obstetricians, Anaesthetists and medical teams for those women who are receiving care and treatment outside of maternity (inclusive of Intensive Care).
All pregnant women in the hospital, not just those on maternity wards, included on daily handover and information boards to ensure robust oversight and review by Multidisciplinary team.
Ongoing conversations with tertiary centres such as University Hospital Wales for those women requiring more specialist input.
All pregnant women admitted to Intensive Care following birth are triggered on Datix Risk Management system for full review of care.
Electronic discharges process for timely referrals and information updates for community colleagues.
Next Steps:
Maternal Critical Care guideline in progress with inclusion of high dependency chart and training for midwives to provide this specialised care
Reviewing process for those women who have been discharged or transferred to neighbouring hospitals to ensure receiving regular communication updates on condition.
Poor communication between teams during the birth led to a feeling of panic and confused picture during an emergency
Health Board improvements to date:
Mandatory nationally recognised annual *Prompt* training for all midwives and doctors (including Anaesthetists) to support improved clinical decision making and team working in emergencies.
Additional staff trained to provide *Prompt* training.
Live skills drills undertaken to test emergency responses.
Next Steps:
Develop programme of assessed skills drills with clear links to *Prompt* training and Health Board guidelines.

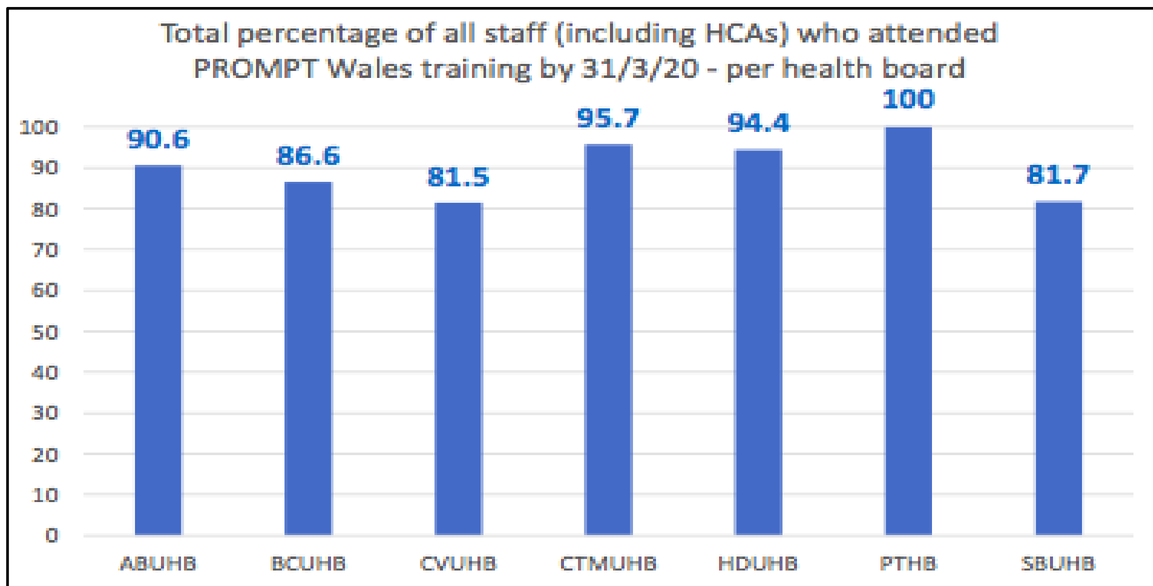
What difference has it made?

Introduction and compliance with mandatory *Prompt* Training

PROMPT Wales

Practical Obstetric Multi-Professional Training
Hyfforddiant Ami-broffesiynol Ymarferol Mewn Obstetreg

Prompt is a nationally recognised training programme for maternity units; helping midwives, obstetricians, anaesthetists and other maternity team members be safer and more effective. CTM has dedicated *Prompt* leads who support this training programme across the maternity service. This training has significantly improved relationships between the multidisciplinary teams. CTM's *Prompt* training compliance was the second highest of all services with Multi-Disciplinary Teams in Wales prior to the Covid-19 pandemic. A Wales wide recovery plan is in place to ensure staff receive this essential training.



6.0 The Improvements Already Completed To Date by the Health Board

The Maternity and Neonatal Improvement Plan contains improvement actions derived directly from the 2019 Royal Colleges' Report recommendations, and the remainder from associated reviews or new actions identified by the Health Board from its own analysis. CTMUHB regularly provides evidence to the Panel (IMSOP) to review to provide assurance that the action has been delivered. To date 50 of the 70 Royal College recommendations have been signed off by IMSOP.

The thematic report identified that modifiable factors and associated actions relates to 24 of the RCOG/RCM recommendations. Seventeen of those are included in the recommendations IMSOP has already identified and are inclusive of the actions verified below.

The bereavement service has been reviewed and improvements have been made to ensure that appropriate support and counselling is available for all families, albeit that a Task and Finish group has now been set up by the *My Maternity, My Way* forum to co-produce further enhancements (RCOG *recommendation 7.55*).

Strategic Development - Seeking expert external midwifery and obstetric advice for support in developing maternity strategy and using the opportunity to explore new ways of working (RCOG *recommendation 7.58*).

Training Environment - Actively share findings of RCOG review with Welsh Deanery and urgently encourage them to revisit the Health Board to; reassess quality of induction, training and supervision in obstetrics; seek assurance on suitability of service for trainees; and appoint named RCOG College tutor to support trainees on the RGH site (RCOG *recommendation 7.33*).

The maternity Governance and Risk team has now been appropriately resourced to ensure that workloads are manageable and that a system for recording Health and Safety related incidents are reviewed, graded and actioned in an appropriate and timely manner (RCOG *recommendation 7.27*).

All Independent Board Members have now been trained in the implications of the Corporate Manslaughter and Corporate Homicide Act 2007 to better understand their role in ensuring the safety of services provided by the Board (RCOG *recommendation 7.64*).

A mandatory training programme (including training in CTG, PROMPT, GAP and GROW) has been designed and delivered to all medical and midwifery staff and high levels of compliance have been achieved (RCOG *recommendation 7.5*).

The improvements identified by the Royal Colleges in terms of **consultant working methods, consultant cover, supervision of medical trainees and the development of multidisciplinary teaching programmes** have now been progressed to the extent that the Health Board now considers them

to be embedded in operational practice (RCOG *recommendations 7.24, 7.32 and 7.37).*

Review and update maternity guidelines. These have been developed with a robust system to ensure that revised guidelines are quality assured, regularly audited and utilised in practice on a multidisciplinary basis (RCOG *recommendation 7.2*).

Systems for incident reporting have been strengthened, through more effective use of the incident reporting system, improved training and the introduction of multidisciplinary forums to engage both medical and midwifery staff in identifying, assessing and responding to adverse incidents (RCOG *recommendations 7.15*).

Learning from serious incidents is shared with staff at all levels in regular and accessible formats and families are closely engaged with during the investigation process (RCOG *recommendations 7.22*).

The *My Maternity, My Way* forum has now been redeveloped and re-energised to the extent that it has become the effective engagement forum which the Royal Colleges identified as being absent (RCOG *recommendation 7.47*).

Particularly important is how the Health Board works alongside service users. This work is now well embedded leading IMSOP to comment in their latest report that:

> '*Sufficient progress has been made in terms of the way in which the service interacts with women and families to conclude that the* ***model of engagement*** *which the Royal Colleges recommended is now largely in place and has become 'business as usual' for the maternity service'* (RCOG *recommendations 7.49, 7.50 and 7.52*).

6.1 The Improvements That Are in Progress and Ongoing

There are currently twenty recommendations in progress which predominately relate to:

- Management and reporting of serious incidents
- Management of concerns in line with Putting Things Right (PTR)
- Engagement with women and families
- Workforce and Organisational Development relating to training, clinical support, values and behaviours

A summary of the remaining seven recommendations relating to findings from the thematic review are below. More detailed information related to these recommendations can be found in Appendix 2.

RCOG Recommendation	Summary of Recommendation
7.7	*Ensure an environment of privacy and dignity for women undergoing pregnancy loss in line with national standards of care.*
7.42	*Undertake work with all grades of staff around communication, mutual respect and professional behaviours*.
7.1	*Urgently review systems in place for data collection and checking the accuracy of data used to monitor clinical practice and outcomes.*
7.8	*Ensure external expert support to allow a full review of working practices to ensure patient safety is considered at all stages of service delivery. This includes local guidelines and further enhancing clinical leadership.*
7.19	*Ensure that a system for the identification, grading and investigation of Serious Incidents is embedded in practice.*
7.20	*Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from Serious Incidents (SIs).*
7.35	*Undertake a training needs assessment for all staff to identify skills gaps and target additional training.*

7.0 Protecting the Anonymity of Families

Safe Haven

The Health Board has maintained a secure database of families involved in the clinical review programme known as the *Safe Haven* which sits within the secure Health Board Risk Management Datix system. The *Safe Haven* is used as an information repository for the continual development of the cases and where the findings and actions plans from the review are stored. The *Safe Haven* has restricted access to a small number of senior colleagues in the Health Board. This ensures the information relating to families within the clinical review is subject to strict version control and tightly controlled access.

Information sharing with IMSOP colleagues is managed via a secure portal and each case is anonymised and allocated a unique identifying number to ensure that personal details are not identified. Assurance checks are completed at every exchange of information to ensure information is secure.

7.1 Family Feedback and Ongoing Engagement and Support

Once families have requested the details of their IMSOP clinical review, the Health Board writes to families acknowledging the findings and outlining the improvements made that relate to their care and also the progress of those actions that are ongoing.

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

In accordance with the Health Board's commitment to acknowledge, review and take on board IMSOP's findings, the Health Board 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 wish, families are being fully supported in this process by the Health Board's Concerns Team and the Community Health Council.

8.0 Next Steps

The Independent Panel's report in September 2020 identified that despite the pandemic further progress had been achieved by the Health Board. With the support of IMSOP and Welsh Government, CTMUHB will continue to work through its improvement plans which are now enhanced as a result of the findings of the eternal reviews.

As part of their ongoing scrutiny of Maternity Services, IMSOP also identified that the Health Board is making slower than anticipated progress on the post October 2018 serious incident reviews. Whilst the current process for managing serious incidents has evolved significantly, the backlog is concerning. All of the incidents have been reviewed to identify any obvious learning however the delays are very regrettable and distressing for those families waiting for answers. The Health Board is currently recruiting external experienced investigators to improve the response time without impacting on the quality of the investigations themselves. Both IMSOP and Welsh Government will continue to monitor this progress and our Health Board is very sorry that these delays continue.

9.0 Conclusion

Cwm Taf Morgannwg University Health Board is hopeful that this report goes some way to reassure our community of the extensive work that has been achieved in improving maternity services at the Health Board.

Managing the impact of the pandemic has, without doubt, resulted in delays to progress in some areas as focus has been on providing safe care in such challenging circumstances. The overwhelmingly positive feedback the Service has received from families is testament to the staff who have gone above and beyond to ensure services have continued, albeit in new and sometimes less personal ways. Their responsiveness to ongoing change and perpetual challenge is perhaps the best evidence of the changes in culture and team working in the service. The Service is so very thankful to the families who have borne the changes with such resilience and fortitude. The endless appreciation shown during this time has done much to sustain the teams. Work is ongoing with colleagues in the Community Health Council (CHC) to respond to their recent survey into families' experience of maternity care during the Covid-19 pandemic.

CTM acknowledges the shocking findings in the IMSOP report and hope this report goes some way to demonstrate the Health Board's, and particular, the Maternity Services, ongoing ambition to provide gold standard, inclusive services for its women and families.

The Health Board understands that the report may provoke emotions not only for families involved in the clinical review, but also those who may feel they have had similar experiences within the Health Board, or those currently using its services. The dedicated contact line is available for anyone wishing to discuss any questions or concerns regarding their maternity care, past or present. The contact line is open from Monday- Friday 9am-5pm and a voicemail option is available outside of these hours. A member of the Maternity and Neonatal Improvement Team will take details and a member of staff will return the call within two working days to discuss how they can best offer support. Information leaflets in Appendices 3 and 4 may be useful to read for further information and support.

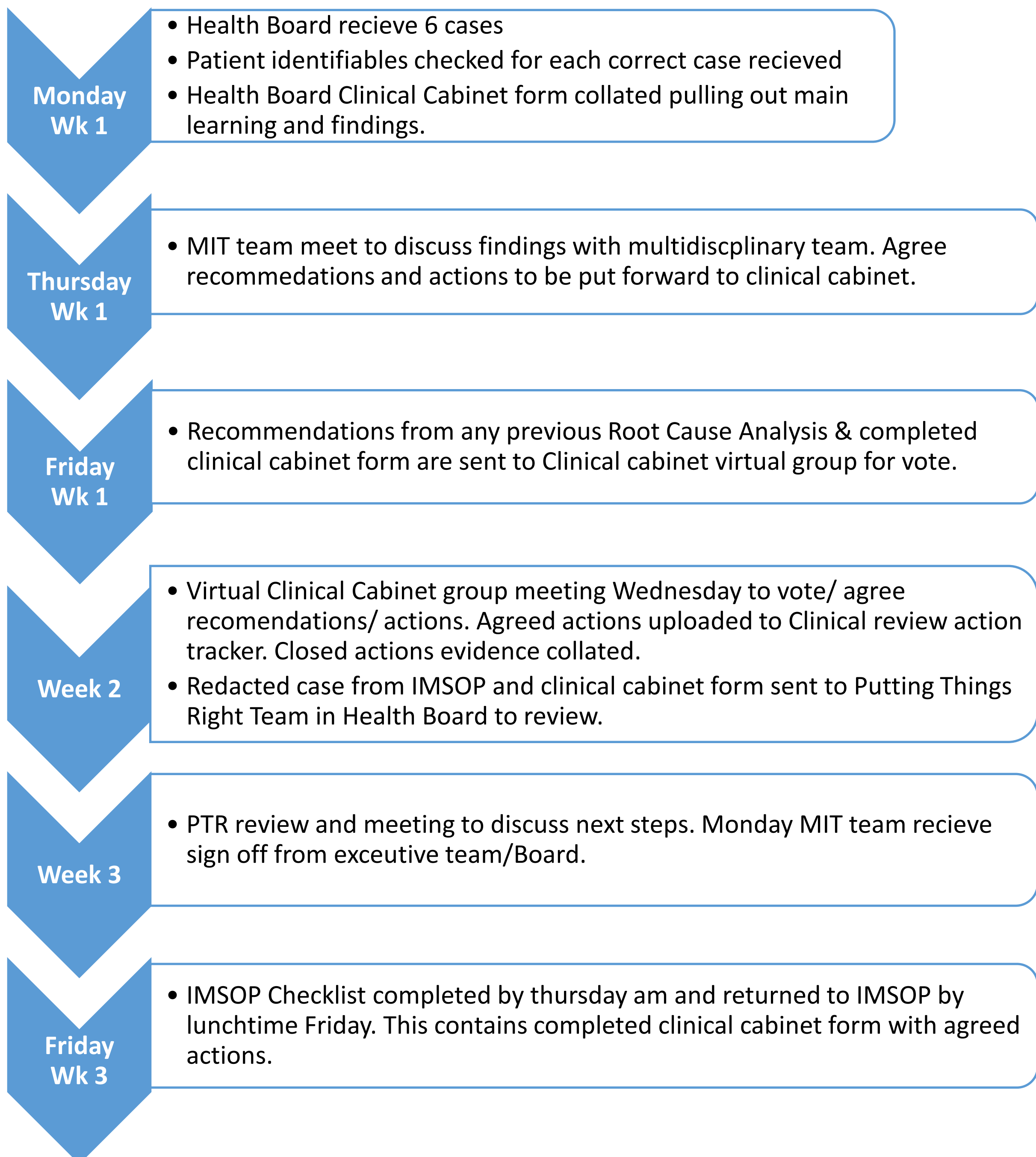
The contact number to call is **01685 728741**. Alternatively, email is: CTM_Maternityimprovementprogramme@wales.nhs.uk.

The Service continues to ensure that its women and families are at the centre and is committed to always being honest and transparent in respect of its improvement journey. This honesty will help to rebuild trust and confidence in CTM's Maternity Service.

The Health Board will never forget the women and families in the review, and that their experiences will be the legacy that builds a solid foundation for the future.

10. APPENDICIES:

Appendix 1: Health Board Clinical Review Feedback Process Map



IMSOP leads identify if correct learning has been identified.

1. **IMSOP initial letter sent.**
2. **IMSOP full detailed report letter sent if requested by family.**
3. **Health Board response letter sent 2 weeks of receipt of 2nd IMSOP letter.**
4. **Health Board additional PTR letter sent it applicable.**

Health Board response letter provides opportunity for families to meet with Health Board if they wish to discuss improvement work.

Appendix 2: Seven Remainder RCOG Recommendations in Progress

Recommendation		Response
7.7	**Ensure an environment of privacy and dignity for women undergoing pregnancy loss in line with agreed national standards of care.**	Services remain in temporary accommodation but the area is a great improvement to that previously occupied following a move in September 2020. The area has more capacity therefore allows more privacy for women in a calm and quiet environment. During the pandemic, this also increases safety for women as no longer have exposure to a general ward area. Ultrasound appointments have been rescheduled to allow more time for early pregnancy staff to spend with each woman for post scan consultation and counselling. Recurrent miscarriage clinic commenced end of 2020. This is currently telephone consultation due to pandemic.
7.42	**In conjunction with Organisational Development undertake work with all grades of staff around communication, mutual respect and professional behaviours.** • staff must be held to account for poor behaviours and understand how this impacts on women's safety and outcomes	There a number of work streams being developed in-house by the Wellbeing Service and workforce colleagues. The Health Board's Wellbeing lead has worked with maternity services to develop bespoke questionnaires. The Health Board has launched its new values and behaviours and the Head of Organisational Development is planning how this can be implemented specifically in the Service. A work plan is being developed to help ensure this is a success. There is clear messaging for all staff in respect of standards of professional behaviour that is linked to professional codes.
7.1	**Urgently review systems in place for:** • data collection • clinical validation • checking the accuracy of data used to monitor clinical practice and outcomes • information supplied to national audits	All Wales approach to managing data has been agreed in principle, however this is some time off being procured and delivered on an All Wales basis. The Health Board is currently using two Maternity IT systems for data collection: • PCH – MITS in house designed • POW – Myrddin/WPAS All Wales CTM UHB Data Analyst has developed Qlik Sense (a data system) dashboard. Data from across the Health Board Maternity Services is validated and used to provide a Health Board overview of rates against agreed measures.

Recommendation		Response
		Maternity services data for National Audits such as National Maternity and perinatal Audit (NMPA) is obtained by NWIS[8] – this data is validated by the Health Board prior to sharing externally. Neonatal Services use *Badger Net* for data collection, which is a system used in Wales by every health board for neonatal services and in some cases maternity services. The Health Board will explore the possibility of *Badger Net* for maternity services. The Health Board plans to procure a Clinical Audit and National evidence Management System and appoint a Nice Facilitator to support compliance across the organisation.
7.8	**Ensure external expert facilitation to allow a full review of working practice to ensure:** • patient safety is considered at all stages of service delivery • a full review of roles and responsibilities within the obstetric team • the development and implementation of guidelines • an appropriately trained and supported system for clinical leadership • a long term plan and strategy for the service • There is a programme of cultural development to allow true multi-disciplinary working	Evidence already shared with IMSOP includes: *Patient Safety:* • Weekly Clinical Risk Meetings • Senior Team Breakfast Club – Moderates and above • 72 hour MDT Rapid Review • Clinical Reflection Meetings • Weekly Governance Meeting • Monthly Audit and Governance Day *Obstetric Team Roles and Responsibilities:* • Role of the On Call Obstetric Consultant • Trigger list for Consultant presence • Escalation Policy • Jump Call policy for staff • Multidisciplinary Handover Guideline • Job planning by Clinical Director *Maternity Services Guidelines*: All guidelines have been updated and approved and will be monitored through the Guideline Group. A forward action plan is in place and reviewed monthly by the group. *Leadership:* Senior Teams have undertaken an externally facilitated leadership development. Teams are due to complete and present their individual projects in February 2021. *Future Plans:* Workforce and Organisational Development colleagues are planning a bespoke series of initiatives to ensure a continuing improvement in workplace culture.

[8] NWIS: National Health Service Wales Informatics Service

Recommendation		Response
		A Midwifery Lead has been appointed to lead the implementation of bespoke development plans to strengthen and develop our workforce.
7.19	**Ensure that a system for the identification, grading and investigation of SIs is embedded in practice, through:** • appropriate training to key staff members • making investigations multidisciplinary and including external assessors	There has been significant progress with the management of Serious Incidents (SIs) within CTMUHB prior to and since the RCOG report. 72 hour rapid reviews by the Multi-Disciplinary Team (MDT) supports allocation of an MDT to review and produce the SI report for all reportable incidents. The Health Board SI toolkit supports all staff involved in the planning and presentation of cases to ensure MDT involvement and to monitor timescales and process. The toolkit includes a Q and A checklist to support reports which provide the level of investigation required for sign off. The implementation of RCA training has been organisationally led. The numbers of those able to complete an RCA investigation will support a more robust and multi clinician led process with subsequent improved completion timescales. Further training dates have been provided for RCA training early in 2021 and there are a number of staff volunteering to undertake this role. This is being delivered by the Health Board Patient Safety Team. There remains a significant amount of work to address the backlog of Serious Incidents arising after Oct 18. Many of these are being revisited due to the inadequate quality of initial investigation. Covid-19 has impacted on the pace of this work and the Health Board will now procure external investigators to support early resolution of this position.
7.20	**Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from SIs.**	As previously identified, Maternity Services has significantly improved the processes around reporting and learning from incidents. Staff questionnaires were completed to identify any residual staff concerns and an action plan is in place. Senior staff are developing an MDT 'support hub' to ensure staff have access to timely support when incidents occur.
7.35	**Undertake a training needs assessment for all staff to identify skills gaps and target additional training.**	The service now has a comprehensive Training Needs Analysis (TNA) which describes statutory and mandatory training for all those involved in maternity care. Compliance against the TNA is reported monthly at the Workforce and Education Group. The Improvement Team has recruited a Senior Midwife who will undertake a review of all midwifery/health care support roles within the Service with the support of the Workforce and Organisational Development department. This will ensure that all staff at all levels will

Recommendation		Response
		have an idea of the skills that they require to undertake any additional training in line with the role that they perform. This will also enable all staff to identify what training is required if they are looking to take on future roles in the Service. This will enable the service to succession plan for roles in the future.

Appendix 3: Family Information Leaflet (English and Welsh)

Family Leaflet English

Family Leaflet Welsh

Appendix 4: Family Bereavement Information Support leaflet (English and Welsh)

Bereavement Leaflet English

Bereavement Leaflet Welsh

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

Of course. You can have support from whoever 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.

FAQs for Families (Welsh)

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

Cwestiynau Cyffredin

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.