INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

Clinical Review Programme

Cwm Taf Morgannwg University Health Board

EMBARGOED until 10:00 25 January 2021

Thematic Maternal Category Report
Executive Summary
January 2021

The Independent Panel was established by Welsh Government in response to the findings of an independent review of maternity services in the former Cwm Taf University Health Board.

OGL © Crown copyright 2021 WG41962 Digital ISBN 978-1-80082-723-3

Executive Summary

1. About This Report

This report is the first in a series of thematic reports which will be published by the Independent Maternity Services Oversight Panel (the Panel) in the coming year. The reports will provide an evolving picture of the learning which is emerging from the programme of independent clinical reviews which the Panel is conducting of the maternity and neonatal care provided by the former Cwm Taf University Health Board (the Health Board).

This first report focuses on 28 episodes of care[1] provided between 01 January 2016 and 30 September 2018[2] involving mothers who needed unplanned emergency treatment during childbirth. In due course, further thematic reports will be published relating to babies who sadly were stillborn and the care of babies who sadly died or required specialist neonatal care following their birth.

2. How to Use the Report

It important to emphasise that this report provides a high level summary rather than detailed analysis. It is written with the women and families who have been most affected by the Health Board's previous deficiencies in mind and does not include detailed analysis or complex statistics or technical information.

In order to keep the report as concise as possible, only a brief overview of the background and a relatively succinct summary of the clinical review process has been provided. However, links are provided to other documents which contain more detailed information for anyone who needs or wants to know more.

3. Why We Are Doing This

In October 2018, as a result of growing concerns about the quality and safety of care being provided in the maternity services units at the former Cwm Taf University Health Board,[3] the Welsh Government commissioned an independent review by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

---

[1] *The 28 episodes of care involved 27 different mothers.*

[2] *Although the majority of the episodes of care which were reviewed were provided during that period, a small number were not. That was either because the case was a self-referral which fitted the inclusion criteria or because the mother had more than one pregnancy and it was considered appropriate to review their individual episodes of care at the same time.*

[3] *The Cwm Taf University Health Board ceased to exist on 31 March 2019. It was replaced on 01 April 2019 by the newly formed Cwm Taf Morgannwg University Health Board following re-alignment with the Bridgend County Borough Council area and the transfer of the Princess of Wales Hospital from the former Abertawe Bro Morgannwg University Health Board.*

The Royal Colleges' report, which set out the findings of the review, was published on 30 April 2019. The report contained seventy recommendations for improvement, all of which were subsequently accepted by the Health Board and the Welsh Government.

In response to the Royal Colleges' findings, the Minister for Health and Social Services (the Minister) announced that maternity services at the Royal Glamorgan and Prince Charles Hospitals[4] would be placed in 'special measures'. At the same time, he appointed the Panel to provide assurance to him and the public that the necessary improvements are being delivered and that the Royal Colleges' recommendations are being addressed in a robust and timely manner, placing the women and families most affected at the heart of the process.

The Panel is required to report progress to the Minister on a regular basis. The Panel's most recent report, published in September 2020, concluded that whilst there is more still to do, the Health Board is making 'good progress' in delivering against the Royal Colleges' recommendations and has created solid foundations for further improvement.

As a key part of its terms of reference, the Panel is required to conduct a programme of independent clinical reviews of the maternity and neonatal care provided at the Royal Glamorgan and Prince Charles Hospitals.

4. What We Did

The primary purpose of the Clinical Review Programme is to identify organisational learning which will help to improve the quality and safety of maternity and neonatal services now and into the future and to provide answers, where answers exist, for women and families who have questions or concerns about the care they received. The programme is not intended to apportion blame, to specifically seek out individual deficiencies or to focus exclusively on error, omission or poor practice[5]. Indeed, good practice may emerge as well as the identification of areas for improvement.

There are four discrete elements to the Clinical Review Programme, the first of which is a review of care which was provided between 01 January 2016 and 30 September 2018. For ease of reference, this element is referred to as the '2016-2018 Look-back'. This involves the clinical review of around[6] 160 episodes of care, identified by the Panel on the basis of a set of nationally recognised inclusion criteria.

---

[4] The special measures arrangements apply only to maternity and neonatal services provided in the former Cwm Taf University Health Board area. They do not apply to maternity services provided at the Princess of Wales Hospital, which was not part of the Health Board at that time and therefore not part of the original Royal College review.

[5] Although the clinical review process is not designed to identify or apportion blame, it is entirely possible that information will emerge from an individual clinical review or from the clinical review process more broadly, which would need to be escalated to other bodies or organisations (for example H.M. Coroner or professional regulatory bodies like the Nursing and Midwifery Council or the General Medical Council or the Police). Section Four of the Panel's Clinical Review Strategy sets out the arrangements which have been put in place for such referrals to be made, should the need arise.

[6] An approximation is being used rather than a precise figure as the actual number may change as further information emerges from the Clinical Review Programme. Previous experience shows that precise numbers provide an unhelpful focus and confusion has previously occurred when the numbers change for legitimate reasons.

The maternal mortality and morbidity category, which involves the clinical review of 28 individual episodes of care provided to mothers, is the first category to be completed.

The Panel is pleased to advise that the majority of mothers in this category made a full recovery following treatment[7]. However, most suffered the trauma and distress of being separated from their baby immediately after birth and a much smaller number experienced serious adverse outcomes, including the loss of their baby.

The methodology which has been used to clinically review the 28 episodes of care in the maternal mortality and morbidity category is summarised in Section 4.3 of the report.

However, in summary, individual reviews were allocated to one of six independent[8] multidisciplinary teams (MDT's) which have been recruited and inducted to carry out the role. The role of the MDT's in assessing individual episodes of care was to review the clinical notes and any other supporting documentation and to determine, in their professional opinion, taking into account national guidelines and recognised standards of care, whether:-

- the care which was provided was appropriate in all of the circumstances;
- any deficiencies in care contributed to adverse outcomes for mothers or babies;
- any clinical review or root cause analysis was done to an appropriate standard;
- any learning which emerged was acted upon and reflected in practice;
- there were any lessons (good or bad) which can be learned for the future.

Once the review was completed, a report was prepared in a standard format setting out the MDT's findings. This was then subject to a peer review conducted by a different team for quality assurance purposes.

A Quality Assurance Panel provided a further layer of quality assurance to the individual clinical reviews and drew out common themes and patterns from the wider programme which identified learning for the Health Board[9]. The key themes and issues which were identified are set out in Section 5 of the report.

Following quality assurance, the completed clinical review reports were shared with the Health Board. This initiated a comprehensive response by the Health Board designed to validate the factual accuracy of the Panel's findings and identify what action needed to be taken in response to the learning which has been identified. This included careful consideration of the needs of the mother and any additional care and support which might be necessary as a result of the findings of the review.

---

[7] *In most cases, the adverse outcome was a Postpartum Haemorrhage requiring admission to an Intensive Care Unit.*
[8] *None of the clinicians conducting the reviews have any connection whatsoever with the Health Board and the majority practice outside of Wales. They are all highly experienced in their professional field and have previously been involved in undertaking similar clinical reviews.*
[9] *It is important to note that the clinical review process allows for any immediate safety concerns (whether they be related to the professional conduct of individual clinicians or to processes and systems) to be immediately escalated to the Health Board's Medical Director, Director of Nursing and the Director of Midwifery so that appropriate action can be considered and assurance provided. In this particular category, there were no such immediate concerns raised.*

The Panel expects the Heath Board to publish a comprehensive response which demonstrates how it is addressing the findings from this first phase of clinical reviews. This should outline what the Health Board has done, is doing and still has to do to address the learning from the reviews and in particular, should identify any new learning which was not previously identified in the Royal Colleges' review.

The Health Board's response should be published at the same time that the Panel's thematic report (this report) is published by the Minister at the end of January 2021.

Women and families lie at the heart of the Clinical Review Programme and the clinical review process has been designed to ensure that they can engage in the review of their care to the extent they wish to.

Further information about how women and families were involved in the clinical review of their care is set out in section 4.6 of the report.

5. What We Found

A schematic, which summarises the key themes and issues which emerged from the 28 clinical reviews is provided at *Appendix A*.

The clinical review teams assessed each of the episodes of care based on clinical records provided by the Health Board, taking account of the woman's story where this was available. The assessment of each episode of care was based on a systematic review of 12 separate areas which are set out in the schematic.

Where the care and treatment provided was found to have fallen below the standards expected, the clinical review teams recorded this as a 'modifiable factor'. Each modifiable factor was than assessed to determine the extent to which it had an adverse impact on the outcome which was experienced by the woman or baby involved. Each of the modifiable factors was then given one of three classifications which are explained in further detail in the schematic.

6. Listening to Women and Families

As an integral part of the clinical review process, all of the women whose care was reviewed were invited to tell their story so that it could be considered by the MDT's as part of the review of their care.

An advocacy service was provided by the Community Health Council to support women and families through the clinical review process, including the sharing of their stories. Four of the 28 women in this cohort chose to share their stories, most with the support of the advocacy service. Although this is a relatively small proportion, there was a high degree of consistency in terms of the themes which emerged and a strong correlation with the clinical analysis in the corresponding reviews.

It is noticeable that the four themes are remarkably similar to those which were identified in the *Listening to Women and Families* report which was published alongside the Royal Colleges' report in 2019.

A more detailed explanation of what women said in respect of the four key themes is provided in the schematic at *Appendix B*.

7. What Does This Mean?

Taken at face value, the findings which have emerged from the first cohort of the Panel's Clinical Review Programme might be a cause for concern, not only for the women and families involved but also for their wider communities and the Health Board's stakeholders and partners. It should not be forgotten that this report will make particularly difficult reading for the staff involved too.

In two-thirds of the episodes of care which were examined, the independent clinical review teams concluded that different treatment could reasonably be expected to have resulted in a different outcome for the mothers involved and/or their babies. The reviewers also concluded that there were lessons to be learned from the majority of the episodes of care that they reviewed; in fact, in only one case did the independent teams conclude that they would not have done anything differently in the same circumstances.

In total, the reviewers identified over two hundred modifiable factors as well as some areas for wider learning which the Health Board has now analysed and evaluated in order to determine whether and to what extent it needs to improve or further improve its working practices going forward.

It is important to stress that not all of those modifiable factors were safety critical and not all of them would ultimately have had a detrimental impact on the outcome or on the quality of the care and treatment which was provided. However, some significant issues were identified and some were identified repeatedly, most notably those related to poor clinical leadership, a failure to escalate in response to increased risk and poor judgment or ineffective decision making in relation to the treatment provided. Poor communication was also an underpinning theme.

And although only a small number of women came forward to share their stories in this first category, those who did, also painted a picture of poor communication, a lack of information to inform their choices, a lack of empathy or concern for their well-being and the failure to monitor their progress and escalate their care when things started to change.

These findings should not, and must not be minimised. At the heart of each of the clinical reviews, there is a woman and a family who at best endured an unpleasant and sometimes traumatic experience and at worst suffered an adverse outcome or loss which has had a devastating and long-lasting impact on their lives.

Those people and their ongoing needs must not be forgotten. Both the Panel and the Health Board are resolute in their determination that this will not happen.

Whilst the emerging findings from this first element of the Clinical Review Programme do perhaps provide cause for concern, the Panel's advice is that those concerns need to be kept very firmly in context. The reasons for that advice are set out in some detail in section 7.1 of the report.

The clinical review teams have essentially identified what the Royal Colleges predicted they would find when they recommended that a further programme of clinical review be undertaken. In other words, the issues which have emerged from the Clinical Review Programme are broadly the same issues which were previously reported and debated in a very public way when the Royal Colleges initially published their Review in 2019.

They are also broadly the same issues which are currently being addressed in a structured and publicly accountable way through the special measures arrangements which have been enacted by the Minister and the Health Board's ongoing Maternity Improvement Programme.

It is also evident that the Health Board has made significant progress in improving its maternity and neonatal services over the past two years[10]. As such, many of the issues which have been identified retrospectively through the clinical review process have already been addressed, either wholly or in part and there are realistic plans in place to address any outstanding issues going forward.

The significance of this is that from a performance improvement point of view, the findings of the first element of the clinical review are largely confirmatory in nature and do not necessitate any significant adjustments or substantial additions to the improvement plans which are currently in place.

They do however, serve to emphasise the importance of this work, if any such emphasis was needed and highlight the need for continued focus and attention to ensure that the remainder of the Royal Colleges' recommendations are delivered.

8. What Happens Next

From the Panel's perspective, work on the maternal mortality and morbidity category is now largely completed. As such, its focus will now shift towards completing the clinical reviews of the stillbirth and neonatal mortality and morbidity categories, both of which are currently in train but at different stages of the process.

It is anticipated that letters will be sent out to women and families in the Spring of 2021 and the emerging findings from the stillbirth category will be reported upon by way of the publication of a second thematic report early in the Summer of 2021.

[10] *The Panel believes that the evidence which justifies this conclusion is contained within the series of incremental progress reports which it has previously prepared and which are published here on the Welsh Government website.*

In the meantime, the Health Board still has further work to do in relation to the outcomes from the maternal mortality and morbidity category whilst at the same time preparing to respond to the findings of the stillbirth and neonatal mortality and morbidity categories as those are completed by the Panel.

In particular, the Health Board is working with the Panel to provide ongoing support to the 27 women whose care has been reviewed, whether that be in terms of providing access to more detailed information, responding to specific questions, providing access to appropriate advice and practical support (e.g. emotional or psychological support, bereavement counselling) or supporting them through the Putting Things Right or redress arrangements.

When the findings of the first cohort of clinical reviews are publicly reported, this will undoubtedly be a difficult and potentially distressing time, not only for the women and families involved but also for Health Board staff members. The Health Board will need to ensure that all of the necessary resources and mechanisms are in place to provide the emotional, practical and administrative support which may be required.

In particular, it will need to demonstrate that the women and families who have been most affected by its previous deficiencies are at the forefront of its thinking and display a genuine commitment to putting things right in an open, transparent, responsive and compassionate manner.

The Board and the senior leadership team have identified the publication of the Panel's first thematic report as an opportunity to rebuild public trust and confidence and have developed their plans accordingly. The Panel will report further on the effectiveness of those plans when it next reports progress to the Minister.

9. Conclusions and Recommendations

The key messages which can be drawn from the report are as follows:-

- 28 episodes of care were clinically reviewed in this phase of the programme;
- the independent clinical review teams concluded that in two-thirds of those episodes, different treatment or care may reasonably have been expected to have resulted in a different outcome;
- there were four recurrent themes which emerged from the reviews - failure to listen to women, failure to identify and escalate risk, inadequate clinical leadership and inappropriate treatment leading to adverse outcomes;
- although these findings are concerning and will be particularly distressing for the women and families involved, they are not unexpected - it is essentially what the Royal Colleges' report suggested the clinical review process would identify;
- whilst a significant amount of learning and some new insights have emerged from the clinical review process, there is nothing substantial which was not broadly captured by the Royal Colleges' recommendations in 2019;
- although the Health Board has made significant progress in addressing those deficiencies, work still remains to be done in key areas like culture and behaviours, leadership and communication.

In the Panel's view, subject to what might emerge from the Health Board's more detailed evaluation of the individual clinical review reports, the findings of this phase of the Clinical Review Programme broadly confirm the Royal Colleges' findings. As such, they do not necessitate any significant adjustments in the Health Board's improvement plans or the oversight arrangements which sit alongside them.

However, the Minister is invited to consider two recommendations as set out in the following paragraphs.

<u>Recommendation 1</u> - 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.

<u>Recommendation 2</u> - 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.

10. List of Appendices

Appendix A: Infographic: Maternal Reviews - Key Themes and Issues

Appendix B: Infographic: Listening to Women and Families

5.1 Maternal Mortality and Morbidity Category - Schematic

Summary of Key Findings

- 28 episodes of care were reviewed;
- At least one ***modifiable factor*** was identified in 27 of the 28 reviews;
- 19 reviews (68%) revealed ***at least one major modifiable factor*** where different management would reasonably have been expected to alter the outcome;
- 12 reviews (43%) revealed ***more than one major modifiable factor;***
- Only one of the 28 episodes of care revealed no modifiable factors whilst two others revealed only wider learning.

Most Frequently Reported Major Modifiable Factors

- **Diagnosis and/or the recognition of high-risk status** was identified as a major modifiable factor in half (50%) of reviews;
- **Treatment** provided was identified as a major modifiable factor in a quarter (7) of the 28 episodes of care reviewed;
- **Clinical leadership** was identified as a major modifiable factor in 5 of the 28 episodes of care.

The Importance of Communication

- In total, across the 28 reviews, 239 separate modifiable factors were identified;
- Of the 239 modifiable factors identified, 148 (62%) were major modifiable factors which could reasonably have been expected to contribute to the poor outcome;
- Of the 148 major modifiable factors identified, 31 (21%) related to **poor communication** with women or between health professionals.

Scope of Clinical Review

The clinical review tool assesses each episode of care in 12 different areas:

- Woman 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 available.

Assessment Criteria

Where care was found to have fallen below the expected standard, the issue was classified as a **'modifiable factor'**.

A significance rating was then attached which determined the extent to which each 'modifiable factor' could reasonably be expected to have contributed to the poor outcome and/or experience. Classifications used are:-

- ***Major modifiable factor***:
  The issue contributed significantly to the poor outcome. Different management would reasonably have been expected to alter the outcome.
- ***Minor modifiable factor***:
  The issue was a contributory factor and different management might have made a difference. However, it is unlikely that it would have changed the overall outcome.
- ***Wider learning factor:***
  Although lessons can be learned, the issue did not affect the overall outcome.

Listening to Women and Families

Theme 1 - Understanding What Women Need

- Women told us that having emotional and practical support from family and friends was an important aspect of their wider care; this was not recognised by staff which meant that the needs of families and friends were not well catered for.
- Some women experienced physical difficulties which made caring for their baby a challenge and these were not addressed.
- Others described increased emotional needs following a traumatic experience, suggesting the need for improved access to mental health support.

Theme 2 - Access to Relevant & Timely Information

- Women told us that they wanted access to relevant and timely information which identified their choices, enabled them make decisions and explained who they could contact when they needed help or reassurance.
- Too often women and their families were left with no information or were given too much information, both of which resulted in delay and confusion.

Theme 3 - Failing to Monitor Progress or Escalate Care

- A number of women highlighted the failure to monitor their progress and/or the failure to escalate their care in a timely manner as being central to their adverse experience.
- The risk of women being left unattended without regular checks and the consequence of assumptions being made by staff that all was well were a significant feature in these accounts.

Theme 4 - Poor Communication

- Women told us that ineffective communication between different teams and specialists (e.g. maternity, community midwives and district nurses) had an adverse impact during their pregnancy and especially in relation to their aftercare.
- Poor communication between different teams during birth created a confused picture resulting in a sense of 'panic' and a requirement for emergency intervention.