REPORT

Review of Maternity Services at Cwm Taf Health Board.

On 15-17 January 2019

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Contents

1. EXECUTIVE SUMMARY 4
2. INTRODUCTION 6
2.1 Timeline of previous reports 7
3. TERMS OF REFERENCE 8
4. CONTEXT 9
5. CASE NOTE REVIEWS 11
6. GENERAL FINDINGS 11
7. RECOMMENDATIONS 35
8. SIGNATURES AND CONFLICTS OF INTERESTS 45
9. APPENDIX 46
9.1 Timetable of Interviews: 46
9.2 Full Terms of Reference 48
9.3 Biographies 53

1. EXECUTIVE SUMMARY

The RCOG was commissioned by the Welsh Government to undertake an external review to investigate the care provided by the maternity services of Cwm Taf University Health Board.

The review took place on 15-17 January 2019. The assessors visited both the Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) sites and met with many staff. In addition to this, a number of teleconference calls were made to allow people from other sites to speak to the assessors (Please see appendix 1).

The assessors found a service working under extreme pressure and under sub-optimal clinical and managerial leadership. The identification by the Health Board of the under-reporting of SIs had resulted in increased internal and external scrutiny, highlighting that basic governance processes were not yet properly in place. The service was also expected to imminently merge two separate consultant led units onto one site with a freestanding midwifery led unit on the other site, with no evidence that clinical teams were engaged and supportive of this decision and process. This was compounded by a shortfall in the midwifery establishment, sub-optimal senior clinical leadership, a significant use of locum medical staff at both junior and consultant level and a lack of established standards of practice. The service was also seen to be operating under a high level of public and media scrutiny.

As part of the RCOG review, a patient and public engagement event was held as a public meeting. In addition to this, an online survey was developed (hosted by the RCOG) that remained open for six weeks and one to one telephone interviews were conducted. Families who had used maternity services and families affected by events leading to this review were invited to participate using all methods of engagement. Attendance at the public and patient engagement event was extremely good, reflecting the level of public concern about the service. The assessors heard stories which were distressing, difficult and sometimes shocking to listen to. The overriding message from women and their families was a desire to prevent similar things happening to anyone else. A full report of the findings from the public engagement is in a separate report entitled *Listening to women and families about maternity Care in Cwm Taf.*

An earlier report, prompted by the identification of the unreported SIs, was submitted to the Health Board in September 2018. This review was undertaken by a consultant midwife. The report provides an in depth review of the shortfalls of the service and has produced very similar findings to this report. The existence of this 2018 report was only discovered and made available to the assessors when on site. The significance attached to this report by the Executive Team and what actions have been initiated remains unclear.

The immediate concerns regarding the safety of the maternity service were escalated by the assessors at 13:00 on 16 January to the Welsh Government and the RCOG. Feedback was provided to the Welsh Government and key members of the Health Board's Executive Team on areas of concern requiring immediate action to ensure patient safety at 14:00 on 17 January 2019.

The RCOG and the assessors are aware that since the publication of this report, that the move of services has taken place (9 March 2019). The Health Board must consider the findings of this report and the proposed recommendations in seeking assurance, in the context of this change. The Health Board must be confident that the concerns raised have been addressed in the decision making and implementation of the changes.

The details of the immediate concerns

These concerns were agreed by all members of the assessor team. They are applicable to both the Royal Glamorgan and Prince Charles sites unless shown otherwise.

1. The lack of availability of a consultant obstetrician to support the labour ward. Although cover is shown on rota schedules, there is often no actual presence and difficulty in making contact.

2. There is fragmented consultant cover for the labour ward with frequent handovers, with up to 4 in 24 hours.

3. There is inadequate support provided for trainee and middle grade doctors within the obstetric service and particularly on the labour ward.

4. The availability of consultants during out of hours cover is unacceptable, with return times of up to 45 minutes.

5. The service has a high usage of locum staff at all grades and specialities. There is no effective induction programme for these staff.

6. There was a lack of awareness and accessibility to guidelines, protocols, triggers and escalations. (There was no guidance for common pregnancy complications e.g. pre-eclampsia, which may present to the day unit). This is particularly relevant given point 5 above.

7. The lack of a functioning governance system does not support safe practice.

8. The practice of accepting neonates onto the neonatal unit at the Royal Glamorgan site from 28 weeks of gestation is out of line with national guidance and should stop with immediate effect, reverting to the standard cut off for this level of unit of 32 weeks of gestation.

9. The high risk obstetric antenatal clinic must be attended and led by a consultant obstetrician with the relevant skills.

10. The midwifery staffing levels are not compliant with the findings of the Birthrate plus® review in 2017. The Health Board needs to monitor this in real time at a senior level, to assess if the established escalation protocols need to be invoked to ensure patient safety.

11. The culture within the service is still perceived as punitive. Staff require support from senior management at this difficult time.

At the time of the review, the assessors wish to highlight concerns below which, while not immediate, are still important regarding the proposed merger of the two consultant led maternity units onto the Prince Charles site, and the establishment of a freestanding midwifery led unit at the Royal Glamorgan site, as proposed for 9 March 2019.

The areas of concerns which the assessors have identified include:

- Concerns about in-patient bed capacity in the antenatal and postnatal period,
- Lack of shared intrapartum care guidelines,
- Lack of agreement about senior medical staff cover (There was no clarity as to how the rota system worked, cover for holidays or absence or what was expected from the consultants e.g. when they were expected to be present on labour ward or when they should attend out of hours),
- A robust escalation policy when the maternity unit is full (The policy was written and ratified in September 2018 and is still being embedded),
- Process by which risk will be assessed and managed (the criteria and process) to allow for the transfer of women in established labour from midwifery led to consultant led care,
- Provision of emergency cover when unit is busier on PCH site,
- Process to reduce length of stay,
- Ability to self-assess state of readiness for merger at both sites.

This demonstrates the need for a much more detailed review and revision of all aspects of this service before assurance can be given to the Health Board that the maternity services of Cwm Taf University Health Board are without safety concerns and fit for purpose for the future.

The look back exercise for SI's was undertaken from present to January 2016. The assessors suggest that this should be extended beyond January 2016 to 2010, or further depending on its findings, to determine the extent of the under-reporting and provide assurance to the Health Board. This is relevant in light of the findings set out in the report by the consultant midwife. The system for reporting data to national surveys e.g. MBBRACE and Each Baby Counts should also be urgently reviewed for accuracy.

2. INTRODUCTION

This review has been commissioned by the Welsh Government, in order to assess aspects of the maternity service provided by Cwm Taf University Health Board as agreed in the Terms of Reference. This was initially prompted by the discovery of under-reporting of SI cases by the maternity service. A look back exercise to January 2016 had identified 43 cases for review. The assessors would consider the output from that review process, but would not undertake a further clinical review of the cases. (Please see Appendix 2 for full ToR).

The assessors requested specific information and data from the Health Board prior to the review, which was made available to them via a secure and password protected online link. Further documents and data were also supplied to the assessment team during the visit and over the subsequent weeks, prompted by specific questions which arose during the visit. (Please see Appendix 3).

The assessors visited the Royal Glamorgan and Prince Charles sites within Cwm Taf University Health Board on 15-17 January 2019. Interviews were conducted with members of staff. These varied in their format; some individual meetings, others large group sessions. In addition to this, a number of teleconference calls

were made to allow staff from other sites to speak to the assessors. The assessors believe they were spoken to openly and honestly by staff, all of whom were passionate about their service. Staff were concerned that the situation was not ideal due to the identification of the under reporting of SI cases and the pending move of consultant led obstetric services from RGH to PCH, but indicated their complete inability to make any effective changes. They reported that senior executive management did not listen to their concerns, which they had voiced repeatedly over a long period of time.

This report will be based on information provided by the Health Board and on interviews undertaken during the visit. All information given was corroborated from multiple sources. No individual opinions have been cited.

2.1 Timeline of previous reports

Date	Organisation	Comments
2012	GMC Survey - national trainee feedback	Concerns with induction for trainees and handover
2015	Healthcare Inspectorate Wales	Unannounced inspection, concerns raised around the quality of the patient experience, delivery of safe and effective care, and quality of management and leadership, although several areas of improvement were identified.
2016	Internal report by Workforce and Organisational Development Team 'what's work like for you?'	Internal report to understand the issues raised in October and November 2016. The response rate was 39% overall and identified some significant issues, including the perception of a blame culture and lack of time.
2017	GMC – Deanery visit	Six areas of concerns highlighted including failings in educational contract.
2018	GMC Survey	Concerns with induction of new trainees and clinical supervision.
Oct 2018	Healthcare Inspectorate Wales	Unannounced inspection Concerns included staffing shortages and skill mix leading to concerns about the sustainability of the service and the impact on staff.
2018	Internal Report by Associate Medical Director	Governance review and improvement plan produced and not implemented.
May 2018-Sept 2018	Look back exercise through undertaking 3 deep dives into reported and unreported Datix's.	Led to commissioning of RCOG review.
Sept 2018	Internal report by Consultant Midwife	Various concerns brought to the attention of the Health Board regarding the under reporting of SI's

3. TERMS OF REFERENCE

1. To review the current provision of care within maternity services in relation to national standards and indicators, as well as national reporting.

2. To assess the prevalence and effectiveness of a patient safety culture within maternity services including
    - the understanding of staff of their roles and responsibilities for delivery of that culture;
    - identifying any concerns that may prevent staff raising patient safety concerns within the Health Board;
    - assessing that services are well led and the culture supports learning and improvement following incidents.

3. Review the Root Cause Analysis (RCA) investigation process, how SIs are identified, reported and investigated within the maternity services; how recommendations from investigations are acted upon by the maternity services; how processes ensure sharing of learning amongst clinical staff, senior management and stakeholders and whether there is clear evidence that learning is undertaken and embedded as a result of any incident or event.

4. Review how, through the governance framework, the Health Board gains assurance of the quality and safety of maternity and neonatal services.

5. Review the current midwife and obstetric workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.

6. Review the working culture within maternity including inter-professional relationships, staff engagement and communication between health care professionals and their potential impact on improvement activities, patients' safety and outcomes.

7. Identify the areas of leadership and governance that would benefit from further targeted development to secure and sustain future improvement and performance.

8. Assess the level of patient engagement and involvement within the maternity services and determine if patient engagement is evident in all elements of planning and service provision. Assess whether services are patient centred, open and transparent.

9. Consider the appropriateness and effectiveness of the improvement actions already implemented by the Health Board.

10. To make recommendations based on the findings of the review to include service improvements and sustainability. Advise on future improvements, future staffing and maintenance of quality, patient safety and assurance mechanisms.

4. CONTEXT

Cwm Taf University Health Board was established in 2009 and serves a population of approximately 300 000 people. The population served by the Health Board is the second most densely populated Health Board in Wales, and many areas covered by it are amongst the most deprived in Wales (Healthcare Inspectorate Wales (HIW) report June 2015). A third of the women booking at Cwm Taf have a BMI of 30 and over 20% continue to smoke in pregnancy.

The South Wales Plan consultation was initiated due to significant and persistent challenges with recruitment and the safe staffing challenges associated with multiple units. Service change was agreed through the South Wales Plan in 2014. The service reconfiguration decision followed a period of extensive public engagement and consultation and was made by the 5 Health Boards working together on the regional configuration of services. It was agreed that paediatric services, and hence maternity, would not be provided from RGH and alternative local services would be developed. This led to the building of new accommodation to cater for a joint consultant led service on the PCH site that was due to open in August 2018 but has been deferred until March 2019. The deferral of the opening of the PCH Unit was due to the need to undertake additional unexpected capital works on the external building infrastructure.

There are currently two consultant led units with approximately 1 764 births annually on the Prince Charles site and approximately 1 929 on the Royal Glamorgan site. The sites are 22 miles apart (up to 55 minutes travelling time).

It is currently planned that on 9 March 2019, a single consultant led service will be provided from the Prince Charles site, with the Royal Glamorgan site becoming a freestanding midwifery-led unit. Gynaecology services will continue to operate from the RGH site. It is proposed that in the near future, as part of a plan to align NHS and Local Authority boundaries, consultant led maternity services at the Princess of Wales Hospital will come under the management of CT health board.

Both units (RGH and PCH) provide level two local neonatal care, with University Hospital of Wales in Cardiff being the nearest neonatal intensive care unit. This is approximately 25 miles (47 minutes) from Prince Charles and 12 miles (40 minutes) from Royal Glamorgan. Prince Charles currently has a gestation cut off for care of babies of 32 weeks of gestation and Royal Glamorgan site has a cut off of 28 weeks of gestation.

HIW undertook an unannounced inspection of Women and Child Health services in June 2015 which included both sites. Following that visit a letter of assurance was issued for each of the three areas of review: i) Quality of the patient experience, ii) Delivery of safe and effective care, and iii) Quality of management and leadership, although several areas of improvement were identified.

There was an unannounced inspection by HIW of the Royal Glamorgan Hospital that reported in October 2018 after some specific concerns had been raised. This identified several areas of urgent concern and a letter was sent to the Health Board highlighting the areas which needed immediate remedial action to be taken within 7 days. This included staffing shortages and skill mix leading to concerns about the sustainability of the service and the impact on staff wellbeing, health and safety, as well as a lack of checking on drugs and equipment to be used in emergencies.

The Welsh Deanery had already visited on several occasions in response to concerns from trainees and had indicated they were considering the removal of trainees but agreed to continue monitoring as a consequence of the subsequently reported improved experience of trainees. The GMC National Trainees Survey 2018 for obstetrics and gynaecology had a red flag (significantly below the national average) for

induction of new trainees on both sites; there was also a concern about clinical supervision on the PCH site. Review of the GMC data suggests these have been below average at Cwm Taf for induction and handover since 2012; 2017 was particularly poor with six areas scoring as below the national average by trainees. The poor results in 2017 were reviewed by the Welsh Deanery as part of their series of review visits which identified failings in the educational contract on a recurring basis. There is no named RCOG College tutor on the RGH site.

The total obstetric consultant establishment is currently 12 whole time equivalents with one extra post currently out to advertisement. The assessors were given a number of differing descriptions of the consultants' working arrangements and found it difficult to understand the complexities which appear to exist within this tier. These included part time working, job shares, commitment to holiday cover for colleagues, daytime work only, no on-call commitments, resident on-call beyond job plan requirement and the role of long-term locums together with evidence of many job plans in dispute.

Rotas showed that a consultant presence was scheduled on the labour ward from 08:30 to 17:00 Monday to Friday with no other commitments for that individual. An on-call system operates overnight. Consultant attendance at day time handovers was also scheduled. A proposed rota for single site working from 9 March 2019 was shown, maintaining a 1:8 on-call commitment by having two consultant's on-call overnight; one for obstetrics and the second to cover gynaecology for both sites.

The service reported a high use of locum medical staff at all grades, with locums employed at the RGH site to cover reduced on-call commitments of 3 of the 6 consultants due to sickness. Training grade locums were a regular feature of both sites.

The size of the shortfall from establishment of midwifery staff was difficult to quantify accurately. As with many areas of this service the assessors questioned the accuracy of the Health Board's data, which they felt could not be relied upon. The assessors were provided with a number of differing figures. The latest Birthrate Plus® report supplied was not completed. A varying range of values for midwife: birth ratio were seen in documents and given verbally during interviews.

There was a continuing commitment by the Health Board for the recruitment of permanent midwifery staff. To cover shortfalls in midwifery staffing, bank staff (made up of current substantive staff) were being used and individuals were working extra time and over planned holidays.

Examination of the maternity dashboard (December 2018) reveals the service to be an outlier in a number of significant areas including induction of labour at 43%, elective caesarean section rate of 17%, overall caesarean section rate around 30% (consultant midwife data) and term delivery admission to neonatal unit of more than 5% (this is different to the figure used in the consultant midwives report which suggests that 30% of neonatal unit admissions are from postnatal wards) all of which suggest fundamental problems with decision making and standard setting at a clinical service level.

The induction of labour rate is currently above 40%. There is no work implemented operationally to reduce this and no clear action plan in place.

The 2018 report by the consultant midwife covered many of the same areas as were set out by the Welsh Government in the ToR for the RCOG review. The consultant midwife had the opportunity to spend a significant amount of time in the unit, carrying out a detailed review of reporting systems and previous reporting rates, particularly of SIs and stillbirths. The consultant midwife reported that three separate 'deep dives' into archive data of maternal and neonatal events had also been undertaken. The Deep Dives

were multidisciplinary involving anaesthetics, obstetrics, neonates and midwifery staff. In each case there is a case-note review; a proforma is completed and, where relevant, the perinatal mortality tool is also completed. Deep dive one was conducted in May 2018 which related to the time period March – Sept 2017. Deep dive 2 was undertaken in August 2018, initiated by the Senior Management Team and looked at events for 2016-2017 and deep dive 3 was undertaken in September 2018. It was unclear who had undertaken these.

The consultant midwife also reported that, having looked at the findings from a Datix trawl for stillbirths going back to 2010, 67 stillbirths had not been reported by the Health Board via Datix. There is a great deal of carefully collated and referenced high quality information contained within this report. It is a very clear and stark statement of the chronic issues which have affected the Health Board. There is a shared concern from the report and the assessors that the inaccurate reporting of outcomes results in local data being incorrectly interpreted against national data, e.g. MBRRACE perinatal mortality reports.

Of most concern to the assessors, was that they saw no evidence of this internal report being used to bring about immediate and necessary change which covered many aspects of the urgent safety feedback recommendations given to the Health Board on 17 January 2019 by the RCOG team. The assessors were dismayed that the Health Board had received information highlighting areas of unsafe practice but there was no evidence of this information having been accepted at executive level or of any action having been taken, thereby continuing to expose women to unacceptable risks. The implications of this must be carefully considered by the Welsh Government.

5. CASE NOTE REVIEWS

A review of a random selection of case notes is usually a component of an RCOG review. On this occasion, it was agreed with the Welsh Government this would not take place, as it seemed unlikely to offer any information relevant to the ToR. It was agreed that the assessors would review the proformas of the 43 SI reviews carried out as a result of the recent exercise and give comments on the effectiveness of the process now in place. Due to time constraints the case notes for these SI cases were not reviewed therefore no assessment could be made of the clinical validity of these reviews, only the process used. The team had the opportunity to review two case notes and output proformas which covered management of the newborn baby.

Further details are discussed under ToR 3.

6. GENERAL FINDINGS

ToR 1: To review the current provision of care within maternity services in relation to national standards and indicators, as well as national reporting.

Data Collection

The assessors found this a difficult task as the data provided by the Health Board were in some cases incomplete and the assessors were subsequently given conflicting information on the data during interviews. This made an accurate assessment against national standards impossible to complete.

The assessors were also unable to determine how information from the service was validated before being provided to national surveys such as MBRRACE, which makes the exercise of benchmarking unclear. This is described in detail in ToR 4.

The maternity dashboard does show rates of clinical interventions and outcomes which are beyond those expected if national guidance and best practice were being followed. In particular, the very high rates of induction of labour, admission of term infants to neonatal care and elective caesarean section require further audit and clinical evaluation before any assessment can be made. The dashboard is RAG rated, and showed target thresholds.

Clinical Standards and Guidelines

To ensure that practice meets national standards, a system of agreed guidelines and standard operating procedures must be in place, which must be regularly reviewed and its application monitored by clinical audit. The assessors were provided with examples of clinical guidelines used by the service, which followed a standard format. However, some were out of date showing that review was required in 2016. The assessors were told that all of these guidelines were available online. The assessors were not able to find any evidence that these were consulted on by any staff groups or that staff were involved in setting the standards for practice. The assessors found no evidence of any clinical audit of performance against guidelines.

This is particularly important in a service when using locum staff who may not be aware of the standards operating in a particular unit and tend to revert to their own ways of working. The assessors found no evidence that locum staff were made aware of these guidelines.

The lack of compliance with core, mandatory training was a particular concern. The Health Board appears to accept annual attendance at a CTG workshop or a review of 5 cases as evidence of CTG training. The training does not include a competency assessment. The table below (dated 11 December 2018) shows compliance for doctors and midwives with the identified core training.

Core training needs	Number of midwives compliant	Percentage of midwives compliant	Percentage of Doctors compliant
GAP and GROW	46	23%	22%
CTG or 5 cases	142	72%	100%
Neonatal resuscitation	93	48%	26%
NLS	59	30%	N/A
PROMPT	93	48%	26%

However this is in conflict with a document dated 14 December 2018 titled 'Medical Training compliance' as indicated below.

Core training needs	Percentage of Doctors compliant
CTG	100%
PROMPT	35%
NLS	35%
GAP and GROW	13%

This is a high risk area of practice and the low compliance with attendance for core training is worrying, particularly in light of the planned service reconfiguration. The section included within the annual PROMPT programme on CTG interpretation would also provide supplementary training for staff but is not sufficient on its own. Documented evidence of annual CTG training is also one of the key recommendations from the Each Baby Counts report.

The assessors are familiar with the benefits of using a well-structured and contemporaneous risk register in maternity. This was not the case in this Health Board, with many of the risks identified not even being listed on the register and some of the listed risks being historic. The support HoM (the HoM from Abertawe Bro Morgannwg University Health Board who was recruited in October 2018 to provide support to the substantive HoM) had worked to significantly reduce the number of historical risks on the register and maintain an up to date record of new risks.

During the visit the assessors became aware that women having an abortion or being admitted for care for a miscarriage were not able to be cared for on a dedicated ward with suitably trained staff but rather were admitted wherever there was a bed space. This is not in keeping with standard good practice.

Conclusions

The assessors are not able to give assurance that care is being provided in line with national standards or guidelines.

The assessors are not able to give assurance that the system in place for informing national reports provides an accurate picture of the performance of the service and the clinical outcomes.

Women undergoing abortions and spontaneous miscarriage are entitled to privacy and dignity; this needs to be managed to ensure the service meets national standards of care.

ToR 2: Assess the prevalence and effectiveness of a patient safety culture within maternity services including:

a) The understanding of staff of their roles and responsibilities for delivery of that culture;

The assessors found little evidence among staff at all levels and professional backgrounds, of a coherent approach towards patient safety, or an understanding of their roles and responsibilities towards patient safety beyond the care they provided for a specific woman or group of women. This perception extended to senior members of midwifery and medical staff.

There was no evidence of a standard list of situations for which the consultant obstetrician, anaesthetist or paediatrician would be expected to attend. This is essential in a service that is reliant on locum and non-training grade staff.

The only meetings where patient safety was discussed were not attended by front line staff. This is detailed in ToR3.

There were no mechanisms in place and no standard process for staff dissemination of learning or feedback from incidents, e.g. patient safety bulletins, newsletters or alerts to bring patient safety to the attention of clinical staff. There were no immediate debriefs in the maternity areas after adverse incidents, but these did occur in the neonatal departments and in A&E.

Many staff told the assessors that they were not able to attend meetings or teaching sessions because of the pressure of work and shortfalls in staffing. Clinical attendance at the clinical governance meetings relied heavily on the Clinical Director due to lack of attendance by the consultant obstetricians.

There was no evidence of a systematic multidisciplinary approach to patient safety or of this being a concern which was ever discussed.

b) Identifying any concerns that may prevent staff raising patient safety concerns within the Health Board;

During interviews and in group sessions the assessors were repeatedly and consistently told by staff of a reluctance to report patient safety issues because of a fear of blame, suspension or disciplinary action. This was said to be a longstanding issue. Concerns about a punitive culture, lack of recognition of patient safety incidents and escalation is a constant feature with under-reporting and investigation of incidents, but it is also reflective of ineffective multi-disciplinary team (MDT) working.

There was no evidence that the trainee doctors were made aware at induction of the Health Board process for submitting a Datix report or that they were ever involved in an investigation. Those who did make reports relied on their experience from working in other organisations. The process of risk management was not valued by the senior medical staff.

Other professional groups working in maternity had tried to raise concerns about quality and safety but had been rebuffed and felt excluded from subsequent reviews. For example, staff had expressed concern about the process of getting women out of the birthing pool in an emergency and felt its significance was not appreciated by senior members of midwifery and medical staff.

c) Assessing that services are well led and the culture supports learning and improvement following incidents.

The assessors found little evidence that the maternity services are well led or that the culture supports learning and improvement. There is a perception that the specialty and associate specialist (SAS) group of doctors who have worked at the Health Board for a long time do not need consultant help, which has resulted in their failure to recognise when a situation is deteriorating in order to call for help in a timely manner.

The distance that needs to be travelled by the consultants when on-call can be up to 45 minutes.

The assessors were presented with two versions of the proposal for the amalgamation of the consultant led unit at PCH. One proposal by the Health Board's management with many charts, spreadsheets and confident statements that all would be well and a second version, given by the medical staff who had played no part in the planning of the move, had not agreed any rotas, place of work or job plan changes and did not know what their roles would become after the move. The same applied to the readiness for safe midwifery led care at The Royal Glamorgan site. The lack of appreciation by the senior management team that the consultants are not signed up to the new unit or methods of operating is of deep concern and suggests that safety is not a priority of the organisation.

The assessors were informed that the risk register was out of date. The risk register provided had active items from 2014. Dates for review are listed but there is no evidence of them being reviewed. Current risks relating to medical or midwifery staffing and the proposed merger are not recorded on the risk register. The HoM and DoN were aware of the risk register not being fit for purpose but the work was not complete and the documents presented to the assessors were not an updated version.

ToR 3: Review the RCA investigation process, how SIs are identified, reported and investigated with the maternity services; how recommendations from investigations are acted upon by the maternity services; how processes ensure sharing of learning amongst clinical staff, senior management and stakeholders and whether there is clear evidence that learning is undertaken and embedded as a result of any incident or event.

The assessors found a lack of clarity in both the documents provided and during interviews regarding the workings of RCA investigation. The Quality and Patient Safety Framework follows a standard format. A flow chart for the grading of SIs was seen but there were no clear instructions as to who was responsible for the grading decision and the standard National Patient Safety Agency (NPSA) grading grid or any other tool was not used. The RCA template was acceptable but was not to a standard format and would be difficult to use in an audit process.

The assessors were provided with a clinical governance framework structure for maternity services which included meetings and terms of reference. However, engagement by the MDT was reported as infrequent whereas this process should be embedded into the service. Work is required to address the culture in relation to governance and supporting all staff with their accountability in incident reporting, escalation of concerns and review of Datix in a timely manner to embed the new governance structures.

The use of the Datix system was described as being a midwifery role. There was no medical oversight about decisions as to whether or not to recommend an investigation. The Datix's historically were not regularly reviewed. Of over 600 recent Datix forms listed, only two had been completed by medical staff and neither concerned a clinical matter. How to report a serious incident using the Datix system is not covered during medical staff induction and not discussed with the locum staff.

A number of SI investigation outcome forms used in the new review process were reviewed. The panel was not seen to be multidisciplinary or to include an external independent member. There was no involvement of colleagues from anaesthetics and involvement of paediatrics was infrequent and minimal. Details of the quality of the process could not be determined due to time constraints so no assessment could be made other than a review of the two cases for neonatal management; the neonatal assessor identified concerns in one case which had not been identified in the initial investigation. Overall, the outcomes suggested were mainly centred on discussions to take place at future governance meetings. Minutes of a number of these meetings were seen, which were attended by the same small number of senior staff. No front-line medical or midwifery staff are recorded as attending any of these meetings. Some meetings had no medical staff in attendance. There was no attempt to involve trainee doctors in investigations, despite this being a core part of their training programme plus they had experience of the process working well in other units. There was no information given as to the criteria for when such meetings would be quorate.

Perinatal mortality and review meetings have long been an established part of obstetric practice but there was no evidence that they were held on a regular basis, were run in a structured format, key learning points being captured and practice modified if required.

The assessors found no evidence in documents or during interviews of the outcome of clinical incident investigations having been used in feedback to front-line clinical staff to assist learning and change in practice. Nothing was made known across the service or included in any kind of report, newsletter or update. A number of staff confirmed that they had never seen any information regarding the outcome of SI investigations, even ones in which they had direct involvement.

There was no apparent requirement for the outcomes and learning from SI investigations that consultants had been involved in to be included in a consultant's annual appraisal data file.

The assessors were told that women or their partners were not involved in the investigation process and did not always receive a copy of the final RCA report. The assessors were told that all SIs were signed off by the Chief Executive before they went to the Welsh Government, which sometimes delayed the process, but the assessors saw no standing instruction to that effect.

Very few staff had had training in RCA methodology within the last year. Of the staff interviewed only one person had received RCA training.

Conclusions

The assessors concluded that the system which had been in place for Datix reporting, the grading of SIs and their investigation was not functional nor embedded in practice. Under-reporting of SIs for at least 4 years is openly acknowledged by the senior midwives and it was repeatedly expressed that the reluctance to engage with the process was because of a fear of blame.

The RCA investigation process which was in place was not robust or well understood, however, the assessors acknowledge that the current midwifery governance lead is struggling with a very high workload. It appears she receives some support from the Clinical Director and the Welsh Delivery Unit but very little support from the Health Boards corporate clinical governance team. Support from within the directorate and from an identified clinical lead within the senior medical staff would be welcomed. The maternity service investigating team was not seen to be inclusive or multidisciplinary and did not include independent external members or trainees. There is no system evident for identifying learning, distributing findings or embedding and monitoring change.

ToR 4: Review how, through the governance framework, the Health Board gains assurance of the quality and safety of maternity and neonatal services.

The assessors were able to consider a wide range of documents including minutes from a variety of group and directorate governance meetings, board reports and presentations, charts showing lines of accountability and reporting and the mechanisms used to provide information to the Health Board. The assessors requested further information which was supplied during the visit, and were able to further question how these systems were designed to work during the interviews with staff.

The assessors were repeatedly told that these systems of governance were not working. One year ago, prompted by concerns from clinical staff, an Associate Medical Director had carried out a review of the governance system in the maternity service and had produced an improvement plan but this was never implemented.

Minutes of meetings show that attendance was usually made up of the same small group of individuals, with little or no recorded attendance by front-line clinical staff and limited multidisciplinary mix. There was no statement of when a meeting was to be judged quorate.

The assessors found no evidence of a functioning system of clinical audit and, therefore, could not be assured that any of the data supplied to the current governance system gave a true picture of the service or had undergone any clinical scrutiny or validation. There was no evidence of a functioning clinically led system for assessing the quality or safety of the service. There was no evidence of any audit process of any kind being in routine use for simple tasks such as hand washing, VTE prophylaxis or catheter care. There was no evidence of a system being in place for ensuring the published outcomes obtained electronically genuinely reflected the performance of the maternity service.

Conclusions

The standard systems of data collection, validation and clinical audit, which the assessors would expect to see in a maternity unit, were not in place. There was no senior clinical ownership or leadership for these vital functions. Because of this significant deficiency at the most basic level of data collection and validation, the assessors were not confident that any of the reports supplied through the governance systems to the Health Board and beyond can be relied upon to provide a true picture of the safety, quality and performance of the service. Following a meeting with the independent members of the Board it appeared they had gained false assurance from information provided to them. They described to the assessors a view of this service which was far removed from the reality. They were not able to describe an awareness or understanding of the significance of core data relevant to maternity services. They showed

little understanding of how the data informing board reports was gathered or that there were major shortfalls in the validity of that data. They described no knowledge of the importance of clinical audit within maternity services or of the use of national benchmarking surveys. Indeed it appears that the independent members of the Board had gained a false level of assurance from recent presentations. No assurance can be gained by the Health Board from these reports. For the same reasons, the Health Board cannot gain assurance of the performance of the service by considering national benchmarking exercises and surveys.

Both executive and non-executive board members must be more involved with the maternity service on a regular basis to better understand what has not worked well and to work collaboratively with the team to remedy the situation. The Health Board cannot rely on data currently provided as outlined above. The role and actions of external agencies such as HIW, the Welsh Deanery and the Welsh Government must be channelled through a single person at senior executive level to ensure priorities remain focussed.

ToR 5: Review the current midwife and obstetric workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.

As described in ToR 4, the assessors found it extremely difficult to review or reach conclusions under this ToR. The assessors were provided with many conflicting figures, projections, plans, job plans and staffing schedules. At interview, working patterns were repeatedly described which did not correspond to the information provided by the Health Board.

Maintaining adequate midwifery staffing levels has been a long-term challenge for the Health Board and was recognised to be a problem for all Welsh maternity units.

Consultants

This review was not required to consider any aspect of gynaecology practice. From the information provided it would appear that the maternity service has a very generous establishment of consultants for its size (12 consultants for a rate of approximately 3,700 births per annum), therefore, it is difficult to assess why governance responsibilities cannot be fulfilled. Even when medical staff were rostered to be present, it appeared they were not where they were scheduled to be. This appears to be an area where custom and practice, together with a job planning system that no-one feels works for this service, have created a complex and inflexible impasse.

While recognising the commitment to satellite clinics, the consultant timetable appeared extremely complicated and difficult to follow. There appeared to be periods of time in the working week when the consultant cover within both the acute sites was very low, e.g. Friday afternoon.

The assessors were informed that there was very limited obligation to provide cover for colleagues' holidays or absences and the rule to provide adequate notice of planned absence was not enforced. There was no rule regarding how many consultants could be absent at one time, resulting in a lack of consultant cover at high risk clinics.

The on-call arrangements were complicated because of individual working patterns and job sharing arrangements. The use of locum consultant staff to cover the out of hours aspect of the service at RGH was a near permanent feature but does not enhance the delivery of consistent quality of clinical care or training.

The assessors were told that the job planning system did not meet the needs of this maternity service and could not reflect its complexities. None of the consultants have a signed off job plan that the assessors could view. This is not consistent with successful appraisal and GMC revalidation but the assessors understand that currently all consultant staff are revalidated with deferral only for health reasons.

There is no consensus as to what activities should be included in Supporting Professional Activity (SPA) time and how the use of this should be monitored. Nearly all of the consultant staff took no responsibility for anything beyond core clinical activity, which includes audit, governance, incident review or clinical supervision because time had not been allocated in job plans.

Consultant time on the labour ward was timetabled (9-5 Monday to Friday and weekend mornings (48 hours)). The interpretation of this varied, with the assessors being told that some consultants never visited the labour ward and others making it their base for that session. Consultant attendance at handover was described as variable. Despite the low volumes of labour ward activity on each site, the only update training (for skill maintenance) required was an annual PROMPT course and CTG interpretation training. Following the appointment of the new HoM, and informed by the findings of the three 'deep dive' exercises, the need for further targeted training in the recognition and interpretation of CTGs and neonatal resuscitation techniques was recognised. A programme to include PROMPT training and neonatal resuscitation was put in place with a target of all staff completing it by March 2019. Compliance against this trajectory was seen to be low and it was stated that this could not be achieved.

Trainees described extremely varied levels of clinical supervision. Several described never having been supervised or observed by a consultant while performing a practical procedure. Some had returned to their previous place of work in order to have a competency assessed and signed off as they could not find a Cwm Taf consultant willing to do this. Trainees described several occasions when the next duty doctor did not arrive requiring them to stay on duty – on occasions for a whole extra overnight shift. Trainees described being unable to attend teaching or study sessions because of a lack of clinical cover.

An unusual working arrangement was described, whereby the morning antenatal ward round was performed by the middle grade who had been on duty overnight before they left; this could be a locum doctor. The consultant went with the senior house officer (SHO) to do a gynaecology ward round as this was a Deanery requirement. This meant that the potentially most complex women were not seen by a consultant, but by a possibly tired trainee who was not a permanent member of staff.

Consultant attendance out of hours was also said to be variable. A few were described as living in of their own initiative and being immediately available, others as being 45 minutes away. The assessors were told that some consultants expected to be called to discuss every planned operative intervention, others did not expect to be called at all.

The assessors were told that, because of consultant absence and a lack of cross cover, the high risk antenatal clinic was often staffed only by registrars, staff grades and SHOs. A schedule was shown to the assessors suggesting that on a large number of occasions this was the case in the last year. The registrars and SHOs who see these women, often make clinical judgements without recourse to a senior doctor. The assessors were told that the middle grade doctor is also often called away to the labour ward leaving the SHO alone. The feedback from women with high risk pregnancies was that they wanted to see better continuity during antenatal care so they see the same consultant and do not experience so many different opinions and conflicting advice. Several women who had experienced poor or tragic outcomes described this as an area of concern.

The assessors saw no standing orders or escalation plans for when consultant attendance was required on the labour ward.

The proposed ways of working on a single site appear to be a perpetuation of current working practices. The working arrangements for the move to single site working had not been agreed. At the time of the assessment, the assessors felt that opportunities to review the way in which the unit functioned and to consolidate it for future development were lost.

Junior doctors

The out of hours cover at night (for maternity) for tier 1 is provided by senior clinical midwives (SCM) on both sites and junior doctors (GP, FP and ST1-2) have no-on call duties at night. The assessors were not clear what the trigger for this change was and were concerned that the SCMs are viewed as part of the medical establishment. It is not clear why midwives are providing cover for junior doctors when the Health Board still has a significant shortage of midwives. The training programme for the SCM is unclear and the assessors do not properly understand what level of gynaecological competencies have been achieved. The consultants do not seem to have been involved in the training programme or in defining what skills are required. At present, three of the SCM posts-holders are affected by long term sickness resulting in a further need for locum medical staff.

If a locum middle grade doctor is employed overnight there is no mechanism for formal review of their skills and competencies. When they arrive on the unit it is the responsibility of the doctor going off duty, who could also be a locum, to orientate them to the layout and working principles of the unit.

Midwives

The assessors recognised the extreme pressure under which the midwives were working due to a longstanding shortfall in staffing. They were repeatedly described as being at breaking point. The actual recommended shortfall of midwifery staff was difficult to quantify as the Birthrate plus® report (March 2017) was supplied after the review and was incomplete.

The Birthrate plus® report was based on 1861 deliveries at PCH (currently 1764) and 2174 at RGH (currently 1929). The total clinical and non-clinical time required was 194.21 whole time equivalent (WTE) midwives. For direct clinical time, the report suggested 160.66 midwives and 17.85 maternity support workers to allow for the 90:10 split in the provision of postnatal care. However the report is incomplete as it did not demonstrate the variance between the Birthrate plus® recommended and the actual funded WTE at the time the analysis was undertaken. The service confirmed the funded midwifery establishment was 122 WTE midwives in circa March 2018 and is currently 148.88 WTE midwives. These findings indicate that the Health Board is not compliant with the Birthrate plus® recommendations.

Senior midwives advised that the midwife to birth rate was funded at 1:31 (148.88 WTE) and the current vacancy factor was 8 WTE midwives. The assessors were advised that the Health Board plans to undertake a Birthrate plus® assessment in February 2019. The obstetric strategic action plan (v16) reviewed by the assessors only refers to the number of WTE midwives as 148.88 but makes no reference to the agreed midwife to birth rate or to a Birthrate plus® methodology planned review.

The actual retention rates were not available to the assessors. However, during staff interviews the assessors heard that *'high numbers of midwives are leaving en masse'*. This was in reference to 9 midwives who all left at the same time. The assessors were told that they had sought other jobs as they did not want to work in the new units as the travelling time to PCH was prohibitive.

The assessors were informed that midwives currently in a substantive post within the Health Board are also covering bank shifts. This sometimes involves midwives working many hours over their contracted 37.5 hours per week to ensure safe staffing levels. However, this increases the risk of potentially unsafe practice and burnout amongst the midwives.

The delivery of community based antenatal care was frequently commended by women and their families.

Senior midwifery leadership

Senior midwifery management roles have been described as a challenge over the past four years with cover being provided by a number of 'acting up' positions. The lack of robust clinical governance systems appears to have only been challenged when the current HoM commenced her post in March 2018. The concerns about the quality and safety of the maternity services were escalated to the Health Board which resulted in 'deep dives' 1 to 3 between May and September 2018.

An interim midwifery management structure was approved during the summer of 2018 where additional posts were appointed to; this included a consultant midwife, part time consultant midwife, seconded clinical supervisor for midwives and an interim risk manager.

A new midwifery management structure for post-merger was developed by the HoM; however its implementation was delayed as the service was awaiting funding approval. A consultation process is currently in place for the senior midwives to be 'slotted in', which must be finalised prior to the merger of the units in March 2019. Some of the senior midwives affected by the consultation advised that they had been verbally informed but had not seen the proposed new structure and therefore were unclear of their roles in the organisation from March 2019.

A support HoM was appointed in October 2018 to lead on maternity unit operational issues two days a week, to provide support for the substantive HoM and to enable her to lead on the review of the backlog of serious untoward incidents. While the appointment of a second HoM was with the intention of supporting the substantive HoM, this could result in a blurring of boundaries for staff and may undermine the HoM role.

From interviews with senior midwives (8a and above) it is apparent that they are not functioning as a cohesive team. This may have resulted in undermining behaviours between midwives and senior midwives, a lack of a unified approach to service delivery and improvement at a senior midwifery level, as well as inappropriate methods of communication and management both at maternity unit ward level and the resulting corporate response to staff engagement.

The assessors were also told about a number of inappropriate, undermining and unprofessional behaviours demonstrated by midwives which included:

A "WhatsApp group amongst midwives called 'Naughty and nice' "– this named midwives (mostly junior midwives) who were considered to be bad or good.

"Midwives were unhappy with partners staying overnight. Band 7 Midwives met with a member of the executive team who immediately stopped this innovation in January – February 2017 and staff whooped with joy".

Women's notes *"go missing"* and this makes it difficult to review cases or incidents. This comment is supported by many of the women and families who spoke to the assessors. There were a surprisingly high

number of families that had experienced difficulties not only in seeing notes but also reported inaccuracies or missing elements from the records. There was a significant loss of trust in the ability of the Health Board to maintain comprehensive and accurate records.

Focus Group for Midwifery Staff (all levels)

At the focus group for midwifery staff of all grades, their key concerns included staff shortages, a punitive management culture and a lack of multidisciplinary working. They were also concerned about senior managerial posts being filled without advert or interview. They felt they had raised their concerns many times with no apparent response from the senior midwifery team or the Health Board Executive team.

While it is clear from the midwives that they take enormous pride in their service they also agreed they were aware of the undermining and unprofessional behaviors cited by the women and some staff members whom the assessors spoke with. The staff expressed concern that this level of unprofessional behaviour was occurring and they all acknowledged that this should not happen whatever the perceived case. They informed the assessors of an internal report undertaken in 2016 by the Workforce and Organisational Development Team to clarify "what's work like for you?" This was done to understand the issues which had originally been raised in October and November 2016. The response rate was 39% overall and identified some significant issues, including the perception of a blame culture and lack of time.

It is of concern that the reason why front line staff do not report incidents has been continually cited as a perception of punitive action and a lack of time. This historical, deep-rooted and engrained culture has resulted in poor learning from incidents and a lack of ownership, accountability and leadership within the maternity services. This has not been helped by the lack of continuity of ownership and the frequent changes in senior midwifery leadership roles.

Midwifery led units (MLU) at PCH and RGH

An interim consultant midwife was appointed in February 2018 on a part time basis to lead on the development of the freestanding midwifery unit (FMU) at the RGH. Her remit did not include the alongside midwifery unit (AMU) at PCH as the intention was that development of this service would be led by a seconded consultant midwife appointed to a full time post in July 2018. Following a request by the Health Board to undertake a review of the maternity services in August 2018 her report was submitted to the Health Board in September 2018. The secondment came to an end in October 2018.

It is of concern that at the time of the RCOG review, work on the AMU at PCH had not progressed and little work had been undertaken to integrate the midwifery pathways and facilitate staff engagement and training to ensure a state of readiness for March 2019.

Difficulties with staff to undergoing training for working in the new unit were identified, due to short staffing and resistance to participate in staff training by some senior midwifery and medical staff.

The assessors were provided with operational pathways and MLU guidance for the RGH site only when requested during the visit. However, they did not demonstrate a clear implementation plan for user engagement, staffing, training, anticipated birth activity figures or flows between Cwm Taf Health Board, Bridgend and Cardiff University Hospital. Various figures for births anticipated in each midwifery led unit were quoted during the visit but appear to show an over estimation of the number of women who will choose to use the FMU, which will potentially compound the concerns over capacity on the PCH site. The assessors were concerned about the over estimation of predicted births in midwifery led units, as the

clinical dashboard for 2018 has demonstrated that only 9% of women had births in their midwifery led units.

In-service training

In response to the themes arising from deep dive 1 and 2, in-service training was reinstated in July 2018 with the development of PROMPT, CTG, Growth Assessment Protocol (GAP) and Gestation Related Optimal Weight (GROW) and Newborn Life Support (NLS) training. It was reported that midwives had not had the basic fundamental skills or update training for years, e.g. many had not undertaken NLS. 60 staff attended the training but unfortunately 20% failed the NLS assessment. Compliance rates were supplied, which had a range of compliance for GAP and GROW training between 8 to 22% for midwifery and medical staff. NLS and PROMPT training compliance was 26% for medical staff and 30% and 41% respectively for midwifery staff.

It was identified that many of these sessions were being cancelled due to the facilitators not arriving and releasing clinical midwifery staff for training continues to have its challenges. Staff training was underway during the RCOG review. It was being facilitated by the Practice Development Midwife (PDM) who has the sole responsibility to coordinate this across the sites. It should be noted that a number of staff members commented on how supportive the PDM was and that she was clearly struggling with her workload. A part time band 6 midwife had recently been seconded to work with the PDM to help with training, as there appeared to be a recognition that this vital part of the reconfiguration of services had not been appropriately addressed.

Robust in-service training programmes and mandatory attendance by all staff are an integral component of maintaining up to date knowledge and skills in order to inform the quality assurance of any maternity service.

Senior Clinical Midwife Role

There is a cohort of senior clinical midwives who undertake the role of the tier 1 doctors. There were previously six Band 8A's in post who had been undertaking this role, with some undertaking ventouse deliveries, which is clearly outside a midwife's sphere of practice. With the support of Organisational Development the job description for the role was reviewed and the responsibilities of the role substantially changed; the role was then re-graded as a Band 7 role.

It is of concern that, from a brief view of some of the SIs and also from the women's stories, it appears there is evidence of poor decision making and inappropriate decisions around care, without appropriate medical review and unsafe practice associated with the senior clinical midwife role.

Neonatal Care

There is a high level of excitement for moving into the new neonatal unit at PCH, which has been designed to deliver family-centred care. However, there have been no actions to achieve The Bliss Baby Charter accreditation[1].

[1] https://www.bliss.org.uk/health-professionals/bliss-baby-charter/what-is-the-bliss-baby-charter

While it is good practice for there to be an identified neonatal lead consultant and this consultant is active in delivering multidisciplinary training, this consultant is looked upon as being the one who 'deals with' neonatal issues and that others are not required or welcome to be involved.

It is of great concern that paediatric staff and clinical and non-clinical leadership were aware of the number of SIs involving live born babies, but did not become involved in reviews of such cases and did not raise concerns. The paediatric staff are not aware of the outcomes of the SI reviews.

The clinical and non-clinical paediatric leadership had a minimal role in planning where babies are born in the new services, and did not perceive that they had a role in assessing readiness for a freestanding MLU to go live, or had a responsibility to voice any concerns.

The pressure on labour wards on both sites was not recognised by the paediatric leadership and therefore they had not become engaged in discussions to mitigate for the additional pressure of, for example, continuing to provide care for babies born at 28-32 weeks of gestation. In any event, the assessors could not confirm that the rotas are staffed to provide reliable competences to care for such pre-term babies and suggest that the Health Board works with the Neonatal Network to provide the necessary assurance.

There have been very few audits of unexpected admissions to the neonatal units or of transfers out, and paediatric leadership could not give a credible account of the reasons for these events, or attempts to work with maternity services on quality improvement in this regard. Reasons for term admissions were given as being "*perhaps related to the high caesarean section rate"*.

From the two sets of notes and investigation pro formas reviewed for neonatal care, there was minimal involvement of paediatric staff in the investigation and, in at least one case, previously unidentified suboptimal neonatal care is probable.

There were highly conflicting accounts as to whether paediatric consultants attended maternity governance meetings, or if such meetings even existed. This lack of engagement of paediatric staff in maternity governance arrangements may arise from the services being in separate directorates with separate management.

Paediatric consultant staff vary in how proactive they are when on call. For example, *"call me if you need me"* versus proactive attendance if there is an awareness of potential difficulties. There are no guidelines as to when to call a paediatric consultant. Reports from other staff and an initial review of some of the SIs indicates that late paediatric consultant attendance at neonatal emergencies out of hours is a concern, but not universal. There have been no formal audits or reviews to assess this.

There is variable consultant presence on the neonatal units and support for doctors in training, which mirrors what the assessors were told about obstetric support on the labour ward.

The assessors were informed that all consultants on the rotas providing neonatal care are maintaining competences, but there is no documentation of this.

The proposed single site for obstetric and neonatal units allows much improved paediatric cover at all levels. However, anaesthetic and paediatric staff were not confident that all midwives will be competent for 'unsupported' newborn life support when the FMU opens.

There was less overall concern regarding midwives' competence in safeguarding, but paediatric leadership did not consider that such competences were the business of paediatric leadership, which may present further evidence of poor joint working and is of concern.

Overall, the paediatric leadership did not perceive that the planning for safety and quality of care of babies at the proposed FMU were in any way their responsibility.

Anaesthetic Care

The obstetric anaesthetic service is provided by consultant staff on both sites supported by trainees on RGH and by SAS doctors at PCH. Not all sessions have dedicated consultant cover. This is not in keeping with national guidance[2]. Elective procedures are only done on sessions where a consultant is present. There were concerns that anaesthetists are not always included in incident reviews, despite having a unique position to provide oversight. Concerns were raised about the checking of emergency equipment and drugs by midwives and about their basic skills in resuscitation. The anaesthetists have tried to cascade training to all staff but this has been frustrating. The anaesthetists would be keen to attend routine perinatal mortality and review meetings but were told it is not of interest to them.

The consultant anaesthetists expect to be called if a general anaesthetic caesarean section is to be done. There is no dedicated operating department assistant (ODA) for maternity theatre out of hours and if they are busy elsewhere this may result in delays or less skilled practitioners being called to maternity theatre. There is a concern from anaesthetists that the senior obstetric medical staff are not engaged with what is happening in obstetrics. The assessors were told that some of the senior obstetric medical staff are 'blind to the risks' and some middle grade staff are reluctant to ask for help in a timely manner. Some consultant paediatric staff can take over an hour to come if required urgently and the consultant obstetric staff attendance is variable, with some living at least 45 minutes away.

On the PCH site there is a very specific problem with the theatre currently being located some distance (a 3 minute walk at a good pace and a change of floor via lift) from the labour ward; this was intended as a temporary decant but the situation has now gone on for longer than expected. This results in the anaesthetist being absent from the labour ward for around 2 hours for an elective case. The planning for the new unit has been going on for some time but many of the key people who were the initial decision makers have left and new members do not understand why some things are being planned the way they are. There is limited clinical involvement in the planning meetings.

[2] https://www.aagbi.org/sites/default/files/obstetric_anaesthetic_services_2013.pdf

Conclusions

There are significant issues relating to the staffing of the maternity units within all professional groups at all levels. Many of these have a long and deeply embedded history and are compounded by a lack of engagement with and lack of faith in the management structures.

ToR 6: Review the working culture within maternity including inter-professional relationships, staff engagement and communication between health care professionals and their potential impact on improvement activities, patients' safety and outcomes.

When considering a ToR such as this, there is usually little information which can be obtained from written sources. The 2018 report produced by the consultant midwife examines this area of working culture and inter-professional relationships in depth. It is based on a much broader understanding of the working of this Health Board and a wider sampling than could ever have been determined by the 3-day review visit.

This Health Board has a very hierarchical structure and it seems that the model of care is very medical and prone to intervention (e.g. induction of labour, caesarean section). This applies despite the lack of consultant presence in clinics and on the labour ward, suggesting that practice remains historic custom rather than evidence based and multi-professional. It was described that senior midwives did not feel able to challenge any medical staff over areas of obviously poor practice, e.g. hand hygiene and the wearing of jewellery during operative procedures.

Migration of patient care from 'consultant led' care to 'midwifery led' needs inter-professional respect and trust but the assessors found many examples where this did not exist. Examples include verbal undermining of one group by another and a failure to agree uniform standards of conduct and performance.

The consultants appeared to feel let down by the midwives on the lack of reporting of SIs and yet were singularly disengaged from any follow up with women who had a poor outcome; on some occasions they promised women and their families a robust investigation but failed to follow through.

Conclusions

The working culture in the maternity services is not as it needs to be, to allow for good engagement and communication between health care professionals and their potential impact on improvement activities, women's safety and outcomes.

ToR 7: Identify the areas of leadership and governance that would benefit from further targeted development to secure and sustain future improvement and performance.

As described elsewhere in this report, the assessors concluded that this was a dysfunctional maternity service with many deficiencies in the way it was delivered at the time of their visit.

It became very clear to the assessors that the role of the Clinical Director needs review. The person in this role appears to single-handedly attend all meetings and act as the point of consultation with management. But at departmental level, there was no evidence of the planned changes being actively discussed and disseminated with consultant colleagues, especially on the PCH site. This has resulted in an absence of any

feedback to senior management about the lack of engagement and support for the plans. The consultants do not feel involved and valued in the planning process for the new units and senior management appear unaware of their concerns and degree of disengagement.

Areas where immediate and obvious changes were needed were given as the safety critical feedback on the 17 January 2019. Other areas requiring a longer term and considered approach are given within this report.

Findings

The assessors found little evidence of effective clinical leadership at any level. No-one in clinical leadership roles described having received any training in leadership or management skills. The assessors found no evidence of any Board level plan to teach clinical leadership skills or any competency based appointment system for individuals taking on these difficult roles. However, it should be noted that a small number of staff are trying to "do the right thing" in very difficult and onerous circumstances, often singlehandedly. These members of staff are to be commended for their commitment to women and the service.

The assessors also found little evidence of effective medical involvement in governance processes at any level. The role of Clinical Director across two sites is unmanageable and medical leads should be appointed in a structure that supports the service and the Clinical Director, including when obstetric led services are delivered on a single site.

There needs to be regular meetings involving clinicians, with improved dissemination of decisions. Some individuals have a leadership title (e.g. Labour ward lead) but did not appear to have a role description or recognition in their job plan to help them deliver the work required of them.

There is no evidence of any long-term strategy for the future of this service. No-one described having undertaken any clinical leadership training.

The Practice Development Midwife would benefit from support from an identified medical lead to deliver multi-disciplinary training, including team working, emergency responses and CTG interpretation in a multi-disciplinary forum.

There was no line of visible accountability between the maternity service and the Health Board and beyond, indeed the Health Board, and others with accountability, appeared to have received false assurance. The quality assurance process from the Welsh regulator (HIW) seems relatively light touch. However in an unannounced visit in 2018 several immediate concerns were raised which should have prompted deeper review at the Health Board. There does not appear to be an active process of senior leadership by example and role modelling of preferred behaviours despite such issues being identified in the 2016 report entitled *What's Work Like for You?*.

ToR 8: Assess the level of patient engagement and involvement within the maternity services and determine if patient engagement is evident in all elements of planning and service provision. Assess whether services are patient centred, open and transparent.

This section examines the way the Health Board listens to the views and experiences of women and families about maternity services and care.

Alongside the engagement event, a range of methods including a survey, confidential phone interviews, and group discussions were used to understand what was important to women and families using maternity services, what they thought about the way their views were being heard and acted upon and their views on the responsiveness and openness of the organisation.

This section highlights some of the key messages from the thematic analysis of all the engagement feedback; the complete analysis is set out in the full report *Listening to women and families about Maternity Care in Cwm Taf.*

Maternity Services Liaison Committee (MSLC)

The Maternity Services Liaison Committee (MSLC) is the main vehicle for sharing developments with service users in maternity care and hearing service user views. The number of service users involved in the MSLC varies but there is an imbalance between health professionals, Health Board staff (12) and lay representatives (3). MSLC members are aware that there needs to be a change to increase the number of service users involved. There have been moves to appoint a Lay Chair but this has not happened to date.

The lay representatives have been looking at ways to reach out to women and families in communities, with ideas being put forward for meeting mothers in Baby and Toddler Groups or cafés and to explore a range of communication methods, including social media platforms. None of these approaches are in place yet.

The MSLC minutes reveal high levels of reporting on issues such as the planned service changes, staffing levels, community midwifery and infant feeding. However, there is limited discussion about patterns of issues emerging.

Findings

The MSLC provides real opportunities to shape the new services and to act as a mechanism to contribute to quality improvements and service change. Currently the MSLC acts more as a forum for reporting and discussion rather than a lever for action.

The enthusiasm of the lay representatives for engagement with women and family's needs to be supported and the balance of the membership should be addressed with the appointment of a Lay Chair.

Community Health Council (CHC)

The CHC has established a range of activities and functions to monitor the quality of services, including a programme of quality monitoring visits to obstetrics and gynaecology services. The CHC also provides feedback on the way that patients and families are engaged and how the issues raised are addressed and how the Health Board responds to their findings. Review of the CHC's minutes and reports reveal that it has been active and engaged in terms of monitoring the development of obstetrics and gynaecology services. The strength of CHCs is the right to have a response from the Health Board. In February 2018 a CHC team visited maternity and neonatal wards at PCH. They questioned whether patient satisfaction surveys had revealed any dissatisfaction with the temporary arrangements and asked the Health Board to respond. The response describes the process for patient satisfaction but does not identify any specific areas of dissatisfaction. However, women and families are sometimes unaware of the CHC's existence and information on their role is missing from key locations, which needs to be addressed.

Conclusions

The CHC is in a key position to act as a monitor for the way in which the Health Board responds to those families affected by the issues emerging from this review. Their independence will be valuable in ensuring that the Health Board provides the right level of access to advice, counselling and support.

It is important that the Health Board responds fully, openly and honestly to issues raised by the CHC, particularly where there are recurring patterns of failures in care.

Engagement with women and families

The Health Board had already set up a system of public forums across localities in Cwm Taf and the forums provided an effective way to engage with local communities, with the aim of keeping members of the public updated on changes in all health services delivered by Cwm Taf.

Over the past year, pregnant women and mums with young families have become engaged through contact with community midwives. This approach is seen as key to the outreach work with women and families and one of the midwives has been focused on going to local groups where families meet.

The *Communication and Engagement Plan for Implementation of Changes to Obstetrics, Neonatal and Paediatric Services November 2018* outlines a programme of communication and opportunities for engagement. The strategy and activity is focused on communicating changes in the way the service is delivered.

All women using maternity services are invited to participate in a patient satisfaction survey following their experience of birth. The Patient Advisory Liaison Service (PALS) team undertakes 'Care to Share' sessions held in obstetrics and gynaecology wards and units. Their reports describe experiences shared by women and families and record how the feedback was passed on and any action taken.

The draft 2018 *Quality and Patient Safety Governance Framework* includes details of 'Internal assurance activity' and methods of reporting from 'Ward to Board' plus 'Unannounced Partnership Dignity Visits led by the Vice Chair'.

Conclusions

It is not clear how engagement with women using services following the reconfiguration will take place, although this seems to be based around continuous promotion of the changes through use of videos, online and printed materials and social media.

There is a need for meaningful dialogue with the public through the programme of community engagement. This would benefit from an increase in outreach to existing forums and community activity and the development of innovative methods that meet the needs of all communities and women.

The initiatives being taken to increase the influence of patient experience on quality and safety of maternity and other services are certainly welcome. However, following the feedback from women and families regarding failures in the quality and safety of care and poor communication, it is vital that there are opportunities to build an even wider range of appropriate methods and approaches in order to gain insight into patient experience.

Evidence of the way in which feedback from patient experience is translated into action was not always clear and the line of accountability to the Board was missing. The monitoring of the outcomes of patient

experience is a key part of the governance structure and must be addressed as a priority. The outcomes of all engagement should be fed back to women and families.

Responding to concerns

The description of the process for recording, managing and responding to concerns raised by women and families would seem to follow a thorough path and reflect good practice. The *2018 Quality and Patient Safety Governance Framework* highlights the value of an open, learning culture that enables people receiving care and people providing care to be heard and affect change. The assessors heard that work is taking place to learn from the experiences of women and families and to review and improve the governance and handling of concerns and complaints.

Conclusions

Clearly, the review of the process for handling and responding to complaints and concerns and governance is a priority; interviews and engagement with women and families revealed serious issues about the way that concerns and complaints were investigated and responded to. Issues included:

- Failure to respond to 'on the spot' concerns expressed and examples of dismissive attitudes regarding issues raised by women on the ward or during appointments, with many women not being listened to or taken seriously.
- Poor communication in follow up meetings to discuss concerns and failure to apologise
- Lack of comprehensive investigation resulting in incomplete responses to concerns and lack of access to all appropriate information, notes being unavailable, missing elements from the record or inaccuracies, missing reports from the clinicians involved.
- Focus on providing responses that were formulaic and seemed to be more interested in defending the reputation of individuals and the Health Board. Letters of response often provided a summary of what 'should have happened' but did not provide answers to all of the concerns raised.
- Responses received that did not demonstrate how learning had been translated into action to ensure that this did not happen again.

Engagement and communication with families directly affected by poor experience or outcomes.

The *Communications Handling Plan* produced in September 2018 is focused mainly on 'managing the message' with information set out regarding the helpline for families directly affected, briefings on the 'script' and the approach for meetings with women and families directly affected, together with signposting to offers of support. It is acknowledged that women who are currently pregnant will also have concerns about the safety and quality of the service and the strategy suggests that there will be opportunities for them to discuss matters with their midwife.

Findings

The recommendations made in this report highlight the need not only to learn from the experience of families affected but to review the way that support, counselling, and engagement takes place now and in the future.

It is important that the Health Board works with the families affected and looks at how it can build more effective engagement and communication, in particular following the publication of this review and its findings.

Themes from engagement

The key emerging themes are set out in the full report *Listening to women and families about Maternity Care in Cwm Taf.* A summary is included here to support and amplify the findings in this section.

Being listened to and valued

Women repeatedly stated they were not listened to and their concerns were not taken seriously or valued. Often, their suspicions and concerns reflected a genuine problem but they were dismissed.

Communication, compassion and empathy

Although there was good feedback in the survey about the excellence of individual staff, sadly, many women felt that communication was extremely poor, that they were treated without compassion and that staff were not empathetic in their response. There was a lack of kindness and empathy in sharing bad news or that a pregnancy was at risk.

Staff attitudes, behaviour and language

Throughout discussions and in written accounts women and families recalled the impact of overhearing staff talking about women and swearing. There was also a sense that staff morale was undermined and that the difficulties may have been made worse by staff shortages.

A key issue for many women was the way they were addressed by staff. Ignoring or dismissing the concerns that women and families raised has been highlighted in this thematic analysis. One element of that communication failure would seem to be an attitude that some women were exaggerating their symptoms or pain.

High risk pregnancy – management and support

Repeatedly, women told the assessors that they did not always believe that the right level of skills and expertise were available at the right time. Women were told that their pregnancy was high risk and that specific care plans were in place. However, their subsequent attendance at the antenatal clinic and their reception on attending A&E or the maternity unit in an emergency did not reflect this.

Skills and experience, escalation

A number of the experiences focused on a failure to seek a second, more senior opinion, and to escalate concerns, especially in the case of women with multiple complex conditions. Women and families repeatedly reported that they trusted midwives and doctors and assumed they had the skills and experience that would support the advice they were being given.

What did good care look like?

The prime issue for most people sharing their experiences was for the service to be personal, focused around the needs of women and to listen to women and to be responsive. Continuity of care and carer was highly valued by women using maternity services.

Women and families would also value better access to advice and information with less ambiguity about which number to ring or where to go when they need help or reassurance. There seemed to be stronger satisfaction and support for community midwifery and more positive comments were heard.

Variation in the standard of care
Women deserve consistent, high quality care every time they use maternity services. They want continuity and consistency and did not always experience either. Care should be woman centred and built around her personal needs and wishes.
From feedback there was a sense that experience was wholly informed by:

- The time of contact with services
- Which team or member of staff was on duty at the time
- Whether staffing levels were low or met the needs of the woman being cared for at the time
- Whether staff had good or poor communication skills
- The effectiveness of the relationship between members of the team

Impact of poor experience
The impact of traumatic experiences has been long lasting for many families. Families reported that they felt that they continued to experience emotional and physical problems and a number of families feel that they have experienced post-traumatic stress disorder. Many women carry guilt about their experiences and believe that it was their fault that action was not taken at an appropriate time.

Support, environment, bereavement counselling
A variety of experiences regarding support after the loss of a baby were reported. At the time when families needed the services there were clearly gaps in provision and variation in how they were supported. Many women and families received no bereavement counselling or support and continue to experience emotional distress. All of the family are affected by the loss of a baby and support for fathers is also needed.

Families wanted to ensure that the bereavement service had the right level of personnel, with sufficient expertise to meet their needs. In some cases, families did not find out about the range of support and advocacy from organisations such as Sands and the CHC.

Maternity service changes and relocation
Overwhelmingly women have said throughout consultation and engagement on maternity services that they want safe, high quality, accessible services in Cwm Taf. The changes to the service model and location of maternity services continues to be of major importance.

ToR 9: To consider the appropriateness and effectiveness of the improvement actions already implemented by the Health Board.

The commitment to appointing more permanent midwifery staff is vital and shows a recognition of the pressures under which this service is running. However, it should be noted that the assessors were informed that many recently appointed midwifery staff are currently planning to leave.

The new process in place for reviewing SIs since the look back exercise is an improvement on the old system but is not yet as it needs to be. Details are described under ToR 3.

The Board has started to plan a strategy for maternity services. Given what has been described above, this will be a challenging exercise but must ensure participation of all staff groups and service users.

The overhaul of the Board Assurance Framework with Quality and Safety reports to the Health Board is an important step. However, this must be viewed in the light of the concerns outlined about the quality of data collection and the lack of clinical scrutiny stated under ToR1.

The assessors noted the external support now in place for the establishment of the freestanding MLU. However, the assessors have concerns as to whether the necessary training and experience of midwives attending existing MLUs can be put in place by the proposed date of 9 March 2019.

The timing of the assessment visit means that the planned move will have taken place before the final report is available. These comments are therefore made by the assessors to provide their views of how they believe the new combined service could seek an opportunity to develop further. In the assessor's opinion, the development of a single site consultant led unit at PCH in line with the South Wales Plan is certainly the correct development for this service. However, the assessors believe simply planning to make a bigger service delivering care in the same way as before is a missed opportunity to develop more innovative models of care in line with best practice for the UK.

Concerns about the capacity of the PCH following the merger were repeatedly expressed during interviews by all staff. This included the number of beds, models of working and physical space (offices and safe secure spaces for confidential notes). The new model relies on reducing length of stay and increased use of the FMU at RGH. There is no evidence that there has been any attempt to implement this prior to the move (length of stay is still above national average and the maternity dashboard suggests that over 60% of women are still being booked for and give birth under consultant led care and only 9% give birth in the AMU). There is no-one within the service acting as a champion for this change in care. A desire to reduce length of stay may well be the right approach, but without the support of front line staff it cannot succeed. Without support this will result in a significant risk to safety and reputation following the merger of the services from the repeated need to close the unit to admissions if no beds are available.

ToR 10: To make recommendations based on the findings of the review to include service improvements and sustainability. Advise on future improvements, future staffing and maintenance of quality, patient safety and assurance mechanisms

This report demonstrates that there is a large amount of work required to allow the Health Board to provide a safe, effective, evidence based, patient centred, responsive and multi-disciplinary service.

The assessors found no evidence of any shared strategic vision for the future. Staff of all grades and professional backgrounds described that they were so busy keeping the service running from day to day there was no time to pause and look ahead.

Although opportunities were in place, (for example The Maternity Voices Forum, Director of Nursing 'Listening clinics' and open staff forums) staff felt they could not contribute ideas or make suggestions. Many staff said that they had never been asked for their opinions and that all of the changes had simply been done by the Health Board.

The imminent service changes present a great opportunity to carry out a fundamental review of how the Health Board plans and delivers care to its population. There are many examples of similar service changes

elsewhere in the UK where innovative models for consultant delivered care have been successfully developed and which could be incorporated into the model for Cwm Taf. However, there is very little evidence of defined criteria for readiness of the impending merger of CLU's to the PCH Site and the FMU at the RGH Site, nor an assessment of the readiness e.g. midwifery training. None of these specific issues are currently on the risk register.

There are some pockets of talent and expertise which should be identified and nurtured. There are also some pockets of discontent which should be identified and discussions on how to proceed with these should take place. Overall the assessors viewed this to be a dysfunctional maternity service.

7. RECOMMENDATIONS

The RCOG and the assessors are aware that since the publication of this report, that the move of services has taken place (9 March 2019). The Health Board must consider the findings of this report and the proposed recommendations in seeking assurance, in the context of this change. The Health Board must be confident that the concerns raised have been addressed in the decision making and implementation of the changes.

TOR 1: To review the current provision of care within maternity services in relation to national standards and indicators, as well as national reporting.

7.1 Urgently review the systems in place for:

- data collection,
- clinical validation,
- checking the accuracy of data used to monitor clinical practice and outcomes,
- what information is supplied to national audits.

7.2 Identify nominated individuals (consultant obstetric lead and senior midwife) to ensure that all maternity unit guidelines:

- are up to date and regularly reviewed,
- are readily available to all staff, including locum staff and midwifery staff,
- have a multi-disciplinary approach,
- are adhered to in practice.

7.3 Mandate and support a full programme of clinically led audit with a nominated consultant lead to measure performance and outcomes against guidelines.

7.4 Ensure monitoring of clinical practice of all staff is undertaken by the Clinical Director and Head of Midwifery:

- to ensure compliance with guidelines,
- to ensure competency and consistency of performance is included in annual appraisal.

7.5 Agree a CTG training programme that includes a competency assessment which is delivered to all staff involved in the care of pregnant women, both in the antenatal period and intrapartum.

7.6 O&G consultant staff must deliver:

- a standard induction programme for all new junior medical staff
- a standard induction programme for all locum doctors.

7.7 Ensure an environment of privacy and dignity for women undergoing abortion or miscarriage in line with agreed national standards of care.

TOR 2: Assess the prevalence and effectiveness of a patient safety culture within maternity services including

- **the understanding of staff of their roles and responsibilities for delivery of that culture;**
- **identifying any concerns that may prevent staff raising patient safety concerns within the Trust;**
- **assessing that services are well led and the culture supports learning and improvement following incidents;**

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.

7.9 Develop a trigger list for situations which require consultant presence on the labour ward [3] which must be:

- agreed by all consultants in obstetrics, paediatrics and anaesthetics and senior midwives,
- audited and reported on the maternity dashboard.

7.10 Introduce regular risk management meetings which must be:

- open to all staff,
- conducted in an open and transparent way,
- held at a time and place to allow for maximum attendance

7.11 Ensure mandatory attendance at the following meetings for all appropriate staff. Attendance must be recorded and included in staff appraisals. Ensure that meetings are to be scheduled or elective clinical activity modified to allow attendance at:

- governance meetings,
- audit meetings,
- perinatal mortality meetings.

7.12 Undertake multidisciplinary debriefing sessions facilitated by senior maternity staff after an unexpected outcome.

7.13 Identify a clinical lead for governance from within the consultant body. This individual must:

- be accountable for good governance,
- attend governance meetings to ensure leadership and engagement.

[3] https://www.rcog.org.uk/globalassets/documents/guidelines/goodpractice8responsibilityconsultant.pdf

7.14 Consultant meetings should:

- be regular in frequency,
- have a standing agenda item on governance,
- be joint meetings with anaesthetic and paediatric colleagues.

7.15 Educate all staff on the accountability and importance of risk management, Datix reporting and review and escalating concerns in a timely manner. Include this at:

- junior doctor induction,
- locum staff induction,
- midwifery staff induction,
- annual mandatory training.

7.16 Urgent steps must be taken to ensure that consultant obstetricians are immediately available when on call (maximum 30 minutes from call to being present).

7.17 Ensure training is provided for all SAS staff to ensure that they are:

- up to date with clinical competencies,
- skilled in covering high risk antenatal clinics and out-patient sessions.

7.18 Agree cohesive methods of consultant working after the merger with input from anaesthetic and paediatric colleagues.

ToR 3: Review the RCA investigation process, how SIs are identified, reported and investigated with the maternity services; how recommendations from investigations are acted upon by the maternity services; how processes ensure sharing of learning amongst clinical staff, senior management and stakeholders and whether there is clear evidence that learning is undertaken and embedded as a result of any incident or event.

Work is required to address the culture in relation to governance and supporting all staff with their accountability in relation to incident reporting, escalation of concerns and review of Datix in a timely manner.

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.

7.20 Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from SIs.

7.21 Improve incident reporting by:

- delivering training on the use of the Datix system for all staff,
- encouraging the use of the Datix system to record clinical incidents,
- monitor the usage of the incident reporting system.

7.22 Actively discuss the outcomes of SIs in which individual consultants were involved in their appraisal.

7.23 Improve learning from incidents by sharing the outcomes from SIs on a regular basis and in an appropriate, regular and accessible format.

7.24 Identify a clinical lead from senior medical staff within the directorate to support the current midwifery governance lead.

ToR 4: Review how through the governance framework the Health Board gains assurance of the quality and safety of maternity and neonatal services.

7.25 Appoint a consultant and midwifery lead for clinical audit/quality improvement with sufficient time and support to fulfil the role to ensure:

- that clinical audits are multidisciplinary,
- that there is a clinically validated system for data collection,
- that the lead encourages all medical staff to complete an audit/quality improvement project each year to form part of their annual appraisal dataset,
- sharing of the outcomes of clinical audits and the performance against national standards.

7.26 Agree jointly owned neonatal and maternity services audits of neonatal service data including

- neonatal outcome data,
- perinatal deaths,
- transfer of term babies to SCBU,
- babies sent for cooling,
- Each Baby Counts reporting,
- MBRRACE reporting,
- breast feeding rates,
- skin to skin care after birth,
- neonatal infection,
- Baby Friendly accreditation
- Bliss baby charter accreditation

7.27 Consider extra resource to the Maternity Governance and Risk team to ensure:

- workload is manageable,
- that Datix are reviewed, graded and actioned in an appropriate and timely manner.

7.28 Ensure that the executive level lead role for maternity will work with the maternity department and this role is effective and supported. This individual should

- have a direct progress reporting responsibility to the Board, in particular while the issues raised in this report are being resolved
- understand and facilitate improvement in the reporting of safety issues and clinical risk,
- provide a single point of reference for liaison with external agencies,
- ensure all reports from external agencies and regulators are channelled through a single pathway to ensure priorities remain focussed.

ToR 5: Review the current midwife and obstetric workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.

7.29 Closely monitor bank hours undertaken by midwives employed by Cwm Taf, to ensure:

- the total number of hours is not excessive,
- the Health Board complies with the European Working Time Directive,
- these do not compromise safety.

7.30 Ensure the Medical Director has effective oversight and management of the consultant body by:

- making sure they are available and responsive to the needs of the service,
- urgently reviewing and agreeing job plans to ensure the service needs are met,
- clarifying what is to be covered as part of SPA activity (audit, governance, teaching, guidelines, data assurance, train more consultant obstetricians as appraisers),
- ensuring the most unwell women are seen initially by a consultant and all women are seen by a consultant within 12 hour NCEPOD recommendation[4] (national standard).

7.31 Ensure a robust plan of births anticipated in each midwifery led unit and consultant led unit is undertaken

- ensure involvement of paediatric staff for all future service design reviews and actions

7.32 Ensure obstetric consultant cover is achieved in all clinical areas when required by:

- reviewing the clinical timetables to ensure that 12 hour cover per day on labour ward is achieved,
- undertake a series of visits to units where extended consultant labour ward presence has been implemented.
- considering working in teams to ensure a senior member of the team is available in clinics and provide cross cover for each other,
- considering the creative use of consultant time in regular hours and out of hours to limit the use of locums.

[4] https://www.ncepod.org.uk/2007report1/Downloads/EA_report.pdf

7.33 Actively share the findings of this RCOG review with the Welsh Deanery and urgently encourage them to revisit the Health Board to:

- reassess the quality of induction, training and supervision in obstetrics,
- seek assurance on the suitability of this service for trainees,
- appoint a named RCOG College tutor to provide support for the trainees currently on the RGH site with adequate time and resource to fulfill this function.

7.34 Allocate all trainees currently in post a clinical and educational supervisor

- the role of clinical supervisor and educational supervisor should be documented and closely monitored by the Director of Medical Education,
- the competency assessments for trainees must be provided in-house under the supervision of the RCOG College Tutor.

7.35 Undertake a training needs assessment for all staff to identify skills gaps and target additional training.

7.36 Clinical supervision and consultant oversight of practical procedures must be in place for all staff including specialist midwives and staff doctors.

7.37 Develop an effective department wide multi-disciplinary teaching programme.

- this must be adequately resourced and time allocated for attendance by all staff groups including specialist clinical midwives and SAS doctors.
- attendance must be monitored and reviewed at appraisal

7.38 Ensure the consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period of call.

- this must involve the antenatal ward round being performed by the consultant.

7.39 Review the working practice for how consultant cover for gynaecology services will be delivered after the merger.

- a risk assessment must be performed to determine the case mix of planned surgery on the Royal Glamorgan site when there is no resident gynaecology cover.

7.40 Review the skills and competencies of the senior clinical midwives covering for tier 1 doctors to ensure:

- their scope of practice is clearly defined,
- the Health Board and the individuals are protected against litigation risk for their extended roles.

ToR 6: Review the working culture within maternity including inter-professional relationships, staff engagement and communication between health care professionals and their potential impact on improvement activities, patients' safety and outcomes.

7.41 Consider the impact of the planned merger on the current culture of the organisation. The Board needs to carefully consider whether the planned merger of two units, both of which are described as having significant issues with their working culture, is likely to compound the problems rather than correct them.

7.42 In conjunction with Organisation 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.

ToR 7: Identify the areas of leadership and governance that would benefit from further targeted development to secure and sustain future improvement and performance.

7.43 Undertake an in-depth assessment of the service as it moves into the future with its new ways of working and the likelihood of an increased demand for services.

- This can determine the structures and competencies of clinical leadership and governance that will support the service.

7.44 Support training in clinical leadership.

- The Health Board must allow adequate time and support for clinical leadership to function.

7.45 Provide mentorship and support to the Clinical Director

- define the responsibilities of this role,
- ensure there are measurable performance indicators,
- ensure informed HR advice to consistently manage colleagues' absence and deployment of staff to cover the needs of the service,
- consider buddying with a Clinical Director from a neighboring Health Board.

7.46 Appoint clinical leads in a structure that supports the service with defined role descriptions and objectives to include an individual responsible for each of the following:

- governance and clinical quality to include guideline updating,
- data quality,
- medical staff education and training,
- multi-disciplinary training,
- audit,
- risk management,
- incident review,
- complaints handling.

ToR 8: Assess the level of patient engagement and involvement within the maternity services and determine if patient engagement is evident in all elements of planning and service provision. Assess whether services are patient centred, open and transparent.

7.47 Develop and strengthen the role and capacity of the MSLC to act as a hub for service user views and involvement of women and families to improve maternity care:

- Appoint a Lay Chair as a matter of priority and increase lay membership numbers with appropriate support and resources,
- Support lay members to engage with women using services in the FMU at RGH and at PCH to assess satisfaction and to identify issues relating to choices,
- Enhance the MSLC monitoring role in order to assess whether patterns of concerns are found and to ask for regular feedback on action taken.

7.48 Utilise the role and strengths of the Community Health Council:

- Ensure appropriate resources to act effectively as an independent advocate,
- Ensure that information is available to families regarding its role and contact details,
- Explore provision of CHC to act as point of contact and provide direct support for women and families, in addition to acting as a conduit referring to other agencies and support,
- Involve the CHC in the early implementation of the new maternity facilities at PCH and the FMU at RGH so they can be assured regarding the impact on access and satisfaction with maternity services.

7.49 Develop the range and scope of engagement with women and families.

- review the effectiveness of patient experience methodology and its impact on service change and improvement as a result of feedback,
- as a priority, review and address the monitoring of the outcomes of patient experience as a key part of the governance structure,
- feedback the outcomes of all engagement to women and families,
- explore methods to hear directly from women and families about their experience including patient stories, diaries, 'mystery shopper' or observation techniques.

7.50 Continue to work with and build on the community based engagement approaches being suggested by the MSLC.

- explore working with external partners, including the CHC and community based organisations.

7.51 Ensure responses to complaints and concerns is core to the work being undertaken to improve governance and patient safety:

- Review and enhance staff training on the value of listening to women and families,
- Review the process of investigation of concerns, compiling responses, handling 'on the spot' issues and ensure that all responses and discussions are informed by comprehensive investigations and accurate notes,
- Prioritise the key issues that women and families have highlighted to improve the response,
- Ensure that promises of sharing notes and providing reports to families are delivered,
- Clarify the process regarding the triangulation of the range of information sources on patient experience, SIs, complaints and concerns and other data and ensure that there is a rigorous approach to make sense of patterns of safety and quality issues,
- Review the learning from the SIs in relation to misdiagnosis, failure to seek a second opinion and inappropriate patient discharge.

7.52 Learn from the experience of women and families affected by events

- Respond and work with families in the way they require,
- Feed the learning into the design of a comprehensive training and support programme that will give women and families confidence in the skills, expertise, communication, safety and quality of maternity care.

7.53 Review the communications, support and engagement approach and strategy.

- Ensure that the focus is not solely on management of key messages,
- Demonstrate openness, honesty and transparency, admission of fault, and learning from this.

7.54 Prioritise an engagement programme with families at its heart.

- Women and families affected by events should be part of the improvement, co-design and culture change of the new service,

7.55 Review the level and effectiveness of the bereavement service.

- Ensure that appropriate support and counselling is available for all families as required,
- Consider implementing the National Bereavement Care Pathway[5] which has been developed by Sands in collaboration with stakeholders including women and their families, RCOG and RCM.

7.56 Provide training for staff in communications skills, in particular on:

- Empathy, compassion and kindness.

ToR 9: Consider the appropriateness and effectiveness of the improvement actions already implemented by the Health Board.

7.57 Continue with efforts to recruit and retain permanent staff.

7.58 Seek expert external midwifery and obstetric advice for support in developing the maternity strategy and use the opportunity of change to explore new ways of working.

7.59 Urgently carry out a full risk assessment before committing to the merger on 9 March 2019 to ensure women's safety, including:

- Ensuring that length of stay is reduced safely to allow for sufficient capacity in the new merged unit.

7.60 Monitor the effects of the reduced inpatient capacity to avoid any adverse effects on the safety or quality of the service.

7.61 Develop a plan to increase inpatient capacity if that is seen to be required.

7.62 Independent Board members must investigate the lack of action by the Executive Team and Board following receipt of the consultant midwife's report in September 2018.

- Independent Board members must challenge the executive over the contents of this report,
- Independent Board members must ensure they are fully informed on the monitoring of planned improvements.

7.63 Independent Board members must challenge the quality of the data which informs the reports which they receive and rely upon for assurance.

[5] http://www.nbcpathway.org.uk/

7.64 Independent Board members should receive training in the implications of The Corporate Manslaughter and Corporate Homicide Act 2007 to better understand their role in ensuring the safety of the services which the Board provides.

ToR 10. To make recommendations based on the findings of the review to include service improvements and sustainability. Advise on future improvements, future staffing and maintenance of quality, patient safety and assurance mechanisms

7.65 Ensure that criteria for the opening of the new FMU have been agreed by a multidisciplinary maternity guidelines group and that readiness for the merger is assured.

7.66 Update the risk register and review regularly at Board level.

7.67 Develop a strategic vision for the maternity service and use the current opportunity of change to create a modern service which is responsive to the women and their families and the staff who provide care.

7.68 Consider examining other UK maternity services to seek out models for delivery which could better serve their population regarding:

- methods of service delivery,
- consultant delivered labour ward care,
- the role of and function of a resident consultant,
- achieving a balance between obstetrics and gynaecology commitments,
- reducing the use of SAS doctors for out of hours service delivery and developing their in hours role.

7.69 Identify and nurture the local leadership talent.

7.70 Ensure that any future service change for the development process of the maternity service as a whole is inclusive for all staff and service users.

- Ensure the service is adequately staffed to ensure that all staff groups are able to participate in developing the vision
- Consider an externally facilitated and supported process for review.
- Consider seeking continued support from HIW and the Royal Colleges to undertake a diagnostic review of the service particularly in relation to changes in service provisions.

8. SIGNATURES AND CONFLICTS OF INTERESTS

In formulating and signing this report the assessors confirm that the conclusions and recommendations are based solely on the information provided and on interviews that took place during the assessment visit described. The assessors also certify that they have no prior knowledge of the individuals concerned, and have not worked previously with them. The assessors have no relevant conflicts of interest to declare in respect of these matters.

[redacted]

Dr David Evans Date 16 April 2019

[redacted]

Dr Sheila Macphail Date 16 April 2019

[redacted]

Dr Jane Hawdon Date 16 April 2019

[redacted]

Ms Mai Buckley Date 16 April 2019

[redacted]

Ms Joy Kirby Date 16 April 2019

[redacted]

Ms Catherine Broderick Date 16 April 2019

9. APPENDIX

9.1 Timetable of Interviews:

RCOG Maternity Review – Programme		
Date	**Time**	**Title / Name**
15/01/19	08.15-08.55am	**Meet Executive Team – Set the scene**
	08.55-9.15am	CEO
	9:15-9:35am	Interim Medical Director
	9:35-9:55am	Clinical Director - O&G
	9.55-10.15am	Free
	10.15-10.35am	Vice Chair
	10.30-10.50am	Consultant Physician & Lead
	10.35-10.55am	Neonatal Lead,
	11.05-11.25am	Focus Group Maternity Support Staff (RGH)
	11.25-11.40am	Lead for Junior Doctor Rotas (RGH)
	11:40-12.05pm	Lead Consultant Anaesthetist
	12.05-12.25pm	Assistant Director of Surgery, O&G,
	1.10-1.30pm	Labour Ward Senior Midwife (RGH)
	1.30-1.50pm	Directorate Manager
	1.50-2.10pm	Senior Nurse, Child Health,
	2.00-2.20pm	Support HOM
	2.15-3.05pm	Focus Group Of Trainee RGH Doctors
	3.00-3.25	HOM,
	3.10-4.05pm	Focus Group of RGH Midwives – open invitation
	4.05-4.35pm	O&G Consultants (RGH) Focus Group
	4.35-4.55pm	Assistant Director Quality & Patient Experience
	4.55-5.25pm	Independent Member Focus group
	5.30pm	Return to Hotel
16/01/19	8.00-8.20am	Lead for Junior Doctor Rotas (PCH)
	8.20-8.40am	Independent Board Member
	8.40-9.00am	College Tutor / Consultant O&G Lead for Training
	9.00-9.20am	Medical Director
	9:00-9.20am	Lead Consultant Anaesthetist
	9:25-9:45am	Head of Patient Experience
	9.45-10.00am	**Rest / Coffee Break**
	10.00-2.00pm	Public Engagement Event
	2.00-2.15pm	*Consolidation Time*
	2.15-2.35pm	Consultant O&G (RGH),
	2.35-2.55pm	Labour Ward Senior Midwife PCH,
	2.55-3.15pm	Lead Risk and Governance, Maternity,
	3.20-3.40pm	Practice Development Midwife,
	3.40-4.00pm	Infant Feeding Lead Midwife,
	4.00-4.20pm	Labour Ward Lead Consultant,
	4.20-4.50pm	SAS Doctor Focus Group
	4.50-5.20pm	Focus Group Maternity Support Staff (PCH)

	5.30m	Return to hotel
17/01/19	8.00-8.40am	O&G Consultants (PCH) Focus Group
	8.40-9.00am	Consultant Midwife,
	9:00-09:20am	Clinical Director Paediatrics,
	9.20-9.40am	Lead Nurse for Neonatal Unit,
	9.40-10.00am	MSLC Service User,
	10.05-11.05am	Focus Group Of Trainee PCH Doctors
	11.15-12.15pm	Focus Group of PCH Midwives open invitation to all midwives
	12:15-12:35pm	Consultant O&G,
	12.35-12.55pm	*Consolidation time*
	1.35-2.00pm	
	2.05-2.25pm	
	2.25pm-3.30pm	Consolidation Time – No interviews
	3.30-3.50pm	**High Level Feedback for Executive Team**
	4.00pm	Assessors leave hospital site

Teleconferences were arranged with:

Consultant Midwife
Consultant Obstetrician Cardiff and Vale Health Board

9.2 Full Terms of Reference

Terms of Reference
Review of Safety of Cwm Taf University Health Board Maternity Services 2018
Commencing 13 November 2018

This document sets out the terms of reference for a review of Cwm Taf University Health Board maternity services with the aim of describing the quality and safety of the service offered to expectant women and newly born infants, the events leading to the identification of a cohort of serious incident reports, and to provide insight on any improvements required.

BACKGROUND

The maternity service at Cwm Taf University Heath Board identified, in summer 2018, a low rate of reporting of incidents of potential harm. A look back exercise from 1 January 2016 to end September 2018 indicated that a number of clinical incidents had gone unreported. The look back exercise was undertaken to understand if the quality of the investigations undertaken had been robust and in line with the expectations set out in the Putting Things Right arrangements and that any identified improvements had been implemented. A cohort of 43 clinical events was identified, including stillbirths, neonatal deaths and possible harm to mothers and new born infants. Further clinical events identified since the end of September 2018 are being investigated in the usual way, and the external review will include a view on the governance of the investigation and learning from these events.

The key question for the Health Board, Welsh Government, families using maternity services and the general public is the safety and sustainability of the service. The Cabinet Secretary for Health and Social Services requested an external investigation to determine the scale and nature of any patient safety concerns the reasons for these concerns, and what action may be required to ensure safe and effective maternity services in future.

The review is required to identify any situations in which the care provided was below the expected standards, including errors or omissions in care, and whether the organisation and its staff had been supported to learn from mistakes or problems of the past. It is also needed to offer assurance about whether learning has been translated into sustained improvements in safety and quality of maternity services, outcomes for women and newly born infants, system learning and governance within the health board, especially in light of the proposed transfer of service locations in March/April 2019.

PURPOSE

The purpose of this review is to describe the quality, safety, accountability and governance arrangements of the health board maternity services during the period between 1 Jan 2016 to November 2018,

- advise on the need for any review of earlier events,
- and provide insight on what is needed to support the reconfiguration of Cwm Taf University Health Board maternity services in 2019 (in particular the move to Prince Charles Hospital and addition of the Bridgend area).

The review will document from the evidence considered:

- how professional cultures, staffing and skill levels have impacted on clinical practice;
- whether services are woman and person centred, open and transparent and delivered in line with national standards;
- how the Health Board, through its governance framework, gains assurance of the quality and safety of maternity and neonatal services;
- whether appropriate learning is openly shared with service users and staff and incorporated into the service with a focus on continuous improvement;
- whether there are any gaps remaining in practice, governance and accountability.

SCOPE AND OBJECTIVES

- Seek the views of staff, service users, stakeholders, including conducting interviews with key personnel to establish facts and sources of quantitative and qualitative data, including service user views.
- Review relevant Health Board records and documents to consider the performance of the current service, supported by data and where possible benchmarked against national standards.
- Describe and analyse aspects of maternity services and relevant neonatal services, in terms of professional culture, staffing levels and skill mix, skills within the team, clinical practice, routine data collection, incident reviewing and reporting, care pathways, standard operating procedures, safety measures.
- Define and assess the framework of clinical and managerial governance and accountability and how this has changed and developed, making suggestions about adding strength to the current framework if necessary.
- Review externally reported data and a random sample of the investigations undertaken of the cohort of 43 cases, subsequently reported incidents, and any others if the review team deem necessary.
- Describe the safety and the experience of care provided to women and their babies by the Health Board's maternity and ancillary neonatal services over the time period 1 Jan 2016 to November 2018. However, the review should look back as far as the team determine necessary to understand what has led the recent position.
- Advise on any requirements for extension of the retrospective case review (prior to January 2016) to ensure that the duty to be open and candid to patients has been fulfilled.
- Advise on any quality and safety changes required to care practice and pathways in light of the reconfiguration of Cwm Taf University Health Board maternity services in 2019 (the move of obstetric led care to Prince Charles Hospital and the addition of Princess of Wales Hospital, Bridgend).
- Identify any practical or cultural barriers within the service (or the wider organisation) that might inhibit progress and make recommendations for mitigating actions and improvements.
- Advise on future improvements and maintenance of quality, patient safety and assurance mechanisms

KEY DELIVERABLES

- A descriptive and analytical report with recommendations suitable for publication.
- Advice on an assurance framework for quality and safety, which may be transferable to the rest of the organisation and NHS Wales.

MEMBERSHIP

Members of the Review Team to be nominated by the Royal College of Obstetrics and Gynaecology and include obstetricians, midwives, neonatology and service user representation.

METHODOLOGY

As agreed between Welsh Government and the Review Team in line with the scope and objectives outlined above, including an inception meeting with Welsh Government. Please also see later section under Terms of Reference.

EXPECTATIONS FROM THE REVIEW

It is expected that the Review Team will:

- Have regular contact with Welsh Government officials during the process of the review to share any immediate patient safety concerns;
- Escalate any immediate concerns that might be identified during the review process to Welsh Government in real-time so that remedial action can be taken as appropriate;
- Produce a written report with key recommendations for action and improvement as soon as possible after the conclusion of the review that will be agreed with Welsh Government prior to publication. The review report will need to be suitable for publication and as such would need to ensure that no patient or staff-identifiable information is included. The Review Team must ensure that the report is shared with all relevant organisations and individuals for factual accuracy before submitting their final report.

If the Review Team wishes to draw to the attention of Welsh Government any concerns about individuals who could be identifiable, this will need to be included in a separate Annex which would be appropriately excluded from any publication.

Terms of Reference:
RCOG Invited Review of Cwm Taf University Health Board
Site visits 15-17 January 2019

1. Review the current provision of care within maternity services in relation to national standards and indicators as well as national reporting.

2. Assess the prevalence and effectiveness of a patient safety culture within maternity services including

    - the understanding of staff of their roles and responsibilities for delivery of that culture;
    - identifying any concerns that may prevent staff raising patient safety concerns within the Trust;
    - assessing that services are well led and the culture supports learning and improvement following incidents;

3. Review the RCA investigation process, how serious incidents (SI) are identified, reported and investigated with the maternity services; how recommendations from investigations are acted upon by the maternity services and how processes ensure sharing of learning amongst clinical staff, senior management and stakeholders and whether there is clear evidence that learning is undertaken and embedded as a result of any incident or event.

4. Review how through the governance framework the Health Board gains assurance of the quality and safety of maternity and Neonatal services.

5. Review the current midwife and obstetric workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.

6. Review the working culture within maternity including inter-professional relationships, staff engagement and communication between health care professionals and their potential impact on improvement activities, patients' safety and outcomes.

7. Identify the areas of leadership and governance that would benefit from further targeted development to secure and sustain future improvement and performance.

8. Assess the level of patient engagement and involvement within the maternity services and determine if patient engagement is evident in all elements of planning and service provision. Assess whether services are patient centred, open and transparent.

9. Consider the appropriateness and effectiveness of the improvement actions already implemented by the Health Board.

10. Make recommendations based on the findings of the review to include service improvements and sustainability, advise on future improvements, future staffing and maintenance of quality, patient safety and assurance mechanisms.

Timescales

Who	What	By when
WG	Initiate commission of external review	9 Oct 2018
WG	Draft ToR and share with CTHB	16 Oct 2018
CT	Identify data sets, documentation and key stakeholders	Start of review
WG	Agree ToR , deliverable and timescales, formal commission	13 Nov2018
Review team	Accept commission, costs and report timescale	13 Nov 2018
Review Team	Identify visit dates and stakeholder events	Nov 2018
Review Team	**Review commencement date**	**13 Nov 2018**
WG/Review Team	Interim progress meeting(s) and safety briefing	Monthly ftf wkly phone
Review Team	Site visit to Cwm Taf Health Board and Bridgend, including public engagement, with immediate verbal feedback and advice to WG and HB to inform service change plans	15-17 Jan 2019
Review Team	Present draft report to WG and CT for fact checking	16 Mar 2019
WG /CT	Factual feedback to Review Team	23 Mar 2019
Review Team	Present final report to WG with recommendations	29 Mar 2019
Cab Sec WG	Publish report and response	April 2019
Health Board	Publish response and improvement plan	April 2019

9.3 Biographies

RCOG Invited Review
Biographies

David Evans Consultant O&G

Dr Evans qualified from Newcastle University in 1978 and trained in Obstetrics & Gynaecology in the Northern Region, The Royal Infirmary of Edinburgh and Simpson's Maternity Pavillion. Dr Evans spent a year as Wyeth Research Fellow at the MRC Human Reproduction & Growth Unit in Newcastle.

Dr Evans has been a Consultant Obstetrician & Gynaecologist at Northumbria NHS Foundation Trust for 27 years and involved in Medical Management for over 20 years having served for 8 years as Clinical Director and 12 as Medical Director. Dr Evan's work has included developing major service change & re-configurations, clinical leadership, consultant recruitment methods, clinical governance, clinical standards and patient safety.

Dr Evans was an NCAS assessor for 12 years and a member of the assessor training team for 7 years.
He was a member of and trainer for the RCOG Invited Reviews Team and Revalidation lead for its UK Board.
Dr Evans became Chief Executive at Northumbria NHS FT in November 2015. He retired from clinical practice in November 2017.

Sheila Macphail Consultant O&G BM, PhD FRCOG

Dr Macphail was an undergraduate at Southampton Medical School qualifying in 1981 and undertook her postgraduate training in the North East of England. Following a fellowship in Maternal Fetal medicine in Toronto she was appointed to a consultant post in Obstetrics and Fetal Medicine in Newcastle from 1995 until 2015 when she retired from clinical practice. From 1998- 2002 she was clinical sub-dean of the Newcastle Medical School and was Director of Medical Education in the Newcastle Hospitals Foundation Trust from 2004-2013. She was Clinical Director of the Women's Service Directorate and an Assistant Medical Director of the trust.

Since retirement Dr Macphail has undertaken work as a Specialty advisor for the CQC and has undergone training as an NCAS Assessor. She has led RCOG service reviews and undertaken several independently commissioned reviews. She was a member of the RCOG Quality and Safety Committee and is a reviewer for MBRRACE. She worked with the NHS(I) led project to reduce term admissions to the neonatal unit (ATAIN) and chaired the asphyxia sub-group resulting in the development of the labour ward leaders programme hosted by the RCM and guidance on Handovers and Huddles for maternity units which will be published shortly.

She has a long standing interest in training and education and in ensuring patients are at the centre of the care we provide in all situations.

Dr Jane Hawdon Consultant Neonatologist

Dr Hawdon is a Responsible Officer and Consultant Neonatologist at Royal Free London NHS Foundation Trust. She has previously held consultant and clinical leadership posts at University College London Hospitals NHS Foundation Trust and Barts Health NHS Trust. She is the neonatal clinical lead for the National Maternity and Perinatal Audit (HQIP programme).

Dr Hawdon has been member of the board of trustees of the charity Bliss, Independent Reconfiguration Panel and NICE guideline development groups, and has chaired the neonatal hypoglycaemia working group of the NHS Improvement Patient Safety programme. She is a qualified coach and facilitator.

Mai Buckley - Director of Midwifery and Gynaecology and a Supervisor of Midwives - Royal Free Hospital NHS Trust

Mai qualified as a Registered General Nurse at Whipps Cross Hospital in 1986 and as a Registered Midwife in 1988 at St Mary's Hospital – Paddington. She was appointed as a Supervisor of Midwives in 1994 and in 1995 completed her Master's Degree in Advanced Midwifery Practice.

In 1996 she took up her first Midwifery Manager position at the Whittington Hospital NHS Trust. In June 2000, she was appointed as Head of Maternity Services at Barts and The London NHS Trust. In April 2008 Mai took up the post of Director of Midwifery and Gynecological Nursing at the Royal Free Hampstead NHS Trust which included the acquisition of Barnet and Chase Hospitals in July 2014 where she continues to be employed.

In 2005 following a request by the London SHA, Mai was seconded as the Head of Midwifery at Northwest London NHS trust (NWLH) for 2 days a week for 9 months and again in 2011, was seconded for two days a week for 6 months to Barking, Havering and Redbridge Hospitals (BHRUT). This was to support the Maternity Services to implement robust clinical governance structures and address the key failures of the services following the implementation of "special measures" in the case of NWLH and the care Quality Commission (CQC) notice issued to BHRUT in September 2011.

She has maintained a passion for Midwifery and delivers a safe effective service for women and their families'. She has developed expertise in implementing and maintaining effective clinical governance structures in Maternity Services.

Joy Kirby RM RN BSc (Hons) PgCert MA, Regional Maternity Lead for Midlands and East. (Previous Local Supervising Authority Midwifery Officer).

Joy has been a practising midwife for 37 years, and continues to provide clinical care for pregnant women and their babies. Between 1996 and April 2017 she was employed by NHS England (Midlands and East) as the Local Supervising Authority Midwifery Officer. Her current role is Regional Maternity Lead for NHS England Midlands and East. She provides strategic midwifery leadership and professional guidance regionally, and across the health system. She works with a broad range of stakeholders including commissioners improving quality of care, supporting the regional Chief Nurse on matters relating to maternity providers and the provision of specialist subject knowledge relating to midwifery and Maternity services.

Joy has a have a broad range of experience relating to maternity services and midwifery practice and has maintained her clinical skills and currently works in a Midwifery Led Unit and postnatal ward. She is particularly interested in 'normal' birth and the philosophy which supports women who wish to birth at home or in a Midwifery Led Unit.

Mrs Cath Broderick

Cath is an independent consultant and director of We Consult. She has a real passion for change in women's health and for working with people to make sure that their involvement makes a difference and influences improvement in organisations. In 2013 Cath made the HSJ's list of the top 50 inspirational women in health.

Cath was Chair of the RCOG Women's Network from 2011-15 and has been involved with the RCOG's patient and public engagement activities since 2007. She is now Chair of the RCOG Equality and Diversity Committee.

She has worked extensively in the field of patient and public engagement and large scale, complex consultation for NHS reconfiguration, and in national projects including highly acclaimed engagement programme in the consultation on the reconfiguration and development of health services for children and young people, maternity services and neonatal intensive care in Greater Manchester.

Cath has been commissioned to work with Salford Together across health and social care to design and deliver Experienced Based Co-design methods for the transformation of Home Care and partnership working with the voluntary, community and social enterprise sectors. She worked with the NHS and a wide group of organisations, parents and the public in Cumbria and Morecambe Bay to build effective engagement in the design of maternity services.

As a member of the Independent Reconfiguration Panel she was involved in many reviews regarding contested reconfiguration proposals across the country. She has worked with many NHS organisations to build understanding of the needs for effective engagement in service change.

Cath has an MSc in Strategic Leadership (Learning and Development), and a real interest in change management and supporting people to achieve their potential in times of change. Earlier in her career she was an information specialist, with a BA Hons Humanities and Social Studies and Postgraduate Diploma in Library and Information Studies.