INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

Clinical Review Programme

Cwm Taf Morgannwg University Health Board

Thematic Maternal Category Report
January 2021

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

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Foreword

This is the first in a series of thematic reports which will be published by the Independent Maternity Services Oversight Panel in the coming year.

The purpose of the report is to summarise the learning which is emerging from the ongoing programme of independent clinical reviews of the maternity and neonatal care previously provided by the former Cwm Taf University Health Board.

This particular report summarises the key themes and issues which emerged from the clinical review of 28 individual episodes of care[1] which were provided by the Health Board between 01 January 2016 and 30 September 2018[2]. It focuses on the care of mothers[3] who needed unplanned emergency treatment during childbirth, including some who required admission to an Intensive Care Unit.

The independent teams conducting the reviews focused on establishing whether the care and treatment provided was appropriate, whether any adverse outcomes could have been avoided and if so, whether there are any lessons which can be learned by the Health Board which would avoid the same thing happening again.

The report considers the learning from the clinical reviews in the context of the Health Board's ongoing Maternity Improvement Programme. It explains whether the underlying causes of any deficiencies which have been identified were previously highlighted by the Royal Colleges and if so, what the Health Board has done, is currently doing or still has to do, to put things right.

The women who were adversely affected by the deficiencies which were identified by the Royal Colleges lie at the heart of the clinical review process. The report explains how those who wished to, were able to contribute to the review of their care and provides an insight into the personal impact for them and their families.

It is humbling that one of the things which women and families most often say to us is that they do not want what happened to them to happen to others; it is with that important sentiment at the forefront of our minds, that we present this report.

Alan Cameron,
IMSOP Obstetrics Lead

Chris Bell
IMSOP Midwifery Lead

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[1] *The 28 episodes of care involved 27 different mothers.*
[2] *Although the majority of the episodes of care which were reviewed were provided during that period, a small number were not. That was either because the case was a self-referral which fitted the inclusion criteria or because the mother had more than one pregnancy and it was considered appropriate to review their individual episodes of care at the same time.*
[3] *In some cases, the care of the baby was also reviewed, although any learning which emerges in respect of the care of the baby will be covered in subsequent thematic reports.*

Table of Contents

1. About This Report

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

This first report focuses on 28 episodes of care[4] provided between 01 January 2016 and 30 September 2018[5] involving mothers who needed unplanned emergency treatment during childbirth. In due course, further thematic reports will be published relating to babies who sadly were stillborn and the care of babies who sadly died or required specialist neonatal care following their birth.

Once the three interim reports have been published, the Panel will then produce an overarching report which draws together the cumulative learning. At an appropriate time, in accordance with its terms of reference, the Panel will also make recommendations to the Minister for Health and Social Services about whether it is necessary to conduct further retrospective reviews of care going back in time beyond 2016 and if so, what the scope of those reviews should be.

Given that the timescales for the completion of the wider Clinical Review Programme are necessarily protracted, the Panel considered it important to produce interim thematic reports so that those who have an interest in the outcomes, particularly the women and families and Health Board staff who are most affected, are able to understand and make sense of what is emerging at an early stage.

It is also important that any learning which might improve the quality and safety of maternity and neonatal services, not only within the Health Board but also more widely across Wales, is identified, shared and acted upon at the earliest opportunity.

2. How to Use the Report

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

For those who want to understand the evidence which lies behind the conclusions in the report, a more detailed Technical Analysis Report, produced with the support of the NHS Wales Delivery Unit, is being published alongside it. The Technical Analysis Report is primarily intended for a professional audience. However, anyone who wishes to know more can access the report here.

[4] *The 28 episodes of care involved 27 different mothers.*
[5] *Although the majority of the episodes of care which were reviewed were provided during that period, a small number were not. That was either because the case was a self-referral which fitted the inclusion criteria or because the mother had more than one pregnancy and it was considered appropriate to review their individual episodes of care at the same time.*

The Panel has assumed that for the most part, those who will find this report of interest will already be aware of what lies behind the Clinical Review Programme and will be familiar with the events which led to the Royal Colleges' review of the Health Board's maternity and neonatal services as well as the key findings and recommendations contained within the Royal Colleges' report.

The Panel has also assumed that most people reading this report will have been following the regular progress reports which the Panel has been producing over the past eighteen months and as such, will already be aware of the role of the Panel and its terms of reference, including the requirement to undertake a programme of retrospective clinical reviews.

If that is the case, it may be helpful to move quickly through the early part of the report and go directly to Section 5, entitled 'What We Found'.

For anyone who is unfamiliar with the background or who wishes to refresh their memory, a brief summary is provided in:-

- Section 3 'Why We Are Doing This' (this explains the background and context);
- Section 4 'What We Did' (this explains the clinical review process).

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

3. Why We Are Doing This

In October 2018, as a result of growing concerns about the quality and safety of care being provided in the maternity services units at the former Cwm Taf University Health Board,[6] the Welsh Government commissioned an independent review by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

3.1 The Royal Colleges' Review

The Royal Colleges' report, which set out the findings of the review, was published on 30 April 2019. The report highlighted serious concerns relating to:-

- a lack of compliance with national standards;
- safe staffing levels and rotas;
- an inadequate safety culture;
- poor management of and learning from serious incidents;
- ineffective patient engagement;
- poor inter-professional relationships.

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

Those concerns were compounded by apparent weaknesses in corporate and clinical governance as well as inappropriate staff culture and behaviours which compromised the quality and safety of the care being provided.

The report contained seventy recommendations for improvement, all of which were subsequently accepted by the Health Board and the Welsh Government.

The Royal Colleges' report was supplemented by a document entitled *Listening to Women and Families in Cwm Taf*. This painted a distressing picture of the quality of care experienced by some women and families who had used the service and highlighted a lack of empathy, compassion and dignity in the care provided.

3.2 Ministerial Intervention

In response to the Royal Colleges' findings, the Minister for Health and Social Services (the Minister) announced that maternity services at the Royal Glamorgan and Prince Charles Hospitals[7] would be placed in 'special measures'.

At the same time, he appointed the Panel to provide assurance to him and the public that the necessary improvements are being delivered and that the Royal Colleges' recommendations are being addressed in a robust and timely manner, placing the women and families most affected at the heart of the process.

The Panel comprises four members, all of whom are independent of the Health Board and the Welsh Government, including a Consultant Obstetrician and a Senior Midwife, both with extensive previous experience of conducting independent clinical reviews in similar circumstances.

3.3 Health Board Progress

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

The report also concluded that all of the immediate safety concerns which were identified by the Royal Colleges in April 2019 had been addressed and that significant improvements had been made in relation to the experience of women and families who are using the service now.

A copy of the September 2020 progress report can be accessed here whilst the Panel's earlier progress reports, which provide a comprehensive timeline of the Health Board's improvement journey, can be accessed here on the Welsh Government website.

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

4. What We Did

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

4.1 The Clinical Review Programme

The primary purpose of the Clinical Review Programme is to identify organisational learning which will help to improve the quality and safety of maternity and neonatal services now and into the future and to provide answers, where answers exist, for women and families who have questions or concerns about the care they received.

The programme is not intended to apportion blame, to specifically seek out individual deficiencies or to focus exclusively on error, omission or poor practice[8]. Indeed, good practice may emerge as well as the identification of areas for improvement.

There are four discrete elements to the Clinical Review Programme, the first of which is a review of care which was provided between 01 January 2016 and 30 September 2018. For ease of reference, this element is referred to as the '2016-2018 Look-back'.

The 2016 to 2018 Look-back commenced in earnest in December 2019. This involves the clinical review of around[9] 160 episodes of care, identified by the Panel on the basis of a set of nationally recognised inclusion criteria.

In essence, these episodes of care are being reviewed because something happened during the pregnancy which had adverse and in the most extreme circumstances, sadly fatal consequences for the baby.

The 160 or so episodes of care can be broadly divided into three discrete categories as set out in the table below.

CATEGORY	DESCRIPTION OF CATEGORY
1. Maternal mortality and morbidity	Care of mothers, including those who needed admissions to intensive care
2. Stillbirths	Babies who sadly were stillborn
3. Neonatal mortality and morbidity	Babies who sadly died or needed specialist care immediately following their birth

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

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

4.2 Maternal Mortality and Morbidity Category

The 160 or so clinical reviews in the 2016-2018 Look-back are being undertaken consecutively in the order outlined in the table; the maternal mortality and morbidity category, which involves the clinical review of 28 individual episodes of care provided to mothers, has now been completed.

The Panel is pleased to advise that the majority of mothers in this category made a full recovery following treatment[10]. However, most suffered the trauma and distress of being separated from their baby immediately after birth and a much smaller number experienced serious adverse outcomes, including the loss of their baby.

4.3 Clinical Review Methodology

The methodology which has been developed to deliver the independent Clinical Review Programme is set out in the Panel's Clinical Review Strategy. The Strategy is published on the Welsh Government website and can be accessed here.

A simplified flow chart or 'pathway' has been produced to enable women and families to more easily understand the clinical review process. This is attached at *Appendix A* to this report and will aid understanding of the description which follows.

Although the process is constantly evolving through practical experience, the clinical review methodology which has been applied to the 28 maternal mortality and morbidity reviews can be broadly summarised as follows:-

- individual reviews were allocated to one of six independent[11] multidisciplinary teams (MDT's) which have been recruited and inducted to carry out the role;
- MDT's comprise as a minimum, an Obstetrician and a Midwife who are supplemented where appropriate to the circumstances of each individual review by a Neonatologist and/or an Anaesthetist;
- in order to inform the review, the MDT's were provided with relevant clinical notes and any previous local reviews or Root Cause Analysis[12] which had been conducted by the Health Board;
- the MDT's applied a common review methodology, using standardised audit tools and reporting templates[13] to ensure consistency;
- women and families were placed at the heart of the clinical review process; where they wished to be involved, women were able to tell their story[14] and this was considered by the MDT's as part of the review, alongside the clinical notes.

[10] *In most cases, the adverse outcome was a Postpartum Haemorrhage requiring admission to an Intensive Care Unit.*
[11] *None of the clinicians conducting the reviews have any connection whatsoever with the Health Board and the majority practice outside of Wales. They are all highly experienced in their professional field and have previously been involved in undertaking similar clinical reviews.*
[12] *Root Cause Analysis is a widely recognised methodology for identifying the underlying causes of adverse incidents in clinical settings in order to enable learning to be identified and shared.*
[13] *Further information about the review tools and reporting tools used can be found in the Thematic Analysis Report referred to in section 2 of the report and the Clinical Review Strategy.*
[14] *Women and families were invited to submit their stories in writing using a structured questionnaire. An advocacy service was provided by the Community Health Council to support those women who wanted help and/or emotional support.*

The role of the MDT's in assessing individual episodes of care was to review the clinical notes and any other supporting documentation and to determine, in their professional opinion, taking into account national guidelines and recognised standards of care, whether:-

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

4.4 Quality Assurance Process

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

Only then was the report considered by a Quality Assurance Panel which comprises the two Clinical Leads of the Panel, together with a Neonatologist and an Anaesthetist, both with extensive previous experience in this area of work, alongside a quality and safety specialist and a lay advisor.

The Quality Assurance Panel provided a further layer of quality assurance to the individual clinical reviews and drew out common themes and patterns from the wider programme which identified learning for the Health Board[15]. The key themes and issues which were identified are set out in Section 5 of the report.

4.5 Health Board Response

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

A robust process has been put in place to ensure that all of the required actions which emerged from the reviews are tracked and monitored. The Panel will oversee this process as part of its wider oversight role going forward.

Where appropriate, any significant actions have been incorporated into the Maternity Improvement Plan which is monitored by the Health Board's Quality and Safety Committee as well as the Maternity Improvement Board.

[15] *It is important to note that the clinical review process allows for any immediate safety concerns (whether they be related to the professional conduct of individual clinicians or to processes and systems) to be immediately escalated to the Health Board's Medical Director, Director of Nursing and the Director of Midwifery so that appropriate action can be considered and assurance provided. In this particular category, there were no such immediate concerns raised.*

At the time of writing, the Health Board has received all of the clinical review reports from the maternal mortality and morbidity category and has assessed the detailed findings in order to determine what action it needs to take beyond that which has already been taken forward as part of its ongoing Maternity Improvement Programme. The Panel is maintaining oversight of this process.

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

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

4.6 Involving Women and Families

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

- all of the women involved have been provided with an opportunity to tell their story and to have this considered as part of the clinical review process;
- where they wished to make use of the service, the Community Health Council appointed advocates to help women to tell their story and provide support;
- the women have now been notified by the Panel that the review of their care has been completed and advised them that the findings are available;
- where women and families wish to know more, the full clinical review findings are being shared on request and an opportunity is being provided to discuss the findings with the Panel and/or a senior representative of the Health Board;
- where the full clinical review findings have been requested, women have been provided with a written response from the Health Board, explaining what it has done or intends to do in response to the findings of their individual clinical review;
- in the same letter, the Health Board has provided information in terms of the emotional and psychological support which is available and to explain what options are available in terms of seeking redress where appropriate.

The Panel considers that the Health Board has taken great care to design its response in a way that ensures that it can engage with women in an open, transparent and compassionate manner and provide the opportunity to rebuild trust and confidence by supporting them and their families, through what may well be a difficult and potentially traumatic time.

5. What We Found

The findings from the clinical reviews of the maternal mortality and morbidity category are set out in the Technical Analysis Report which has been produced with the support of the NHS Wales Delivery Unit. The report is primarily intended for a professional audience. However, anyone who wishes to understand more about the basis of the broad conclusions which are set out in this report, can access it here.

A schematic, which summarises the key themes and issues which emerged from the 28 clinical reviews is provided on the following page. The content is broadly self-explanatory; however, some brief context may assist understanding.

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

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

Whilst all of the learning from the clinical review process is of value, for reasons which will be self-evident, those which are of greatest concern are the 'major modifiable' factors because:-

- the care or treatment fell below the required standards;
- it contributed to the adverse outcome for the woman or their baby;
- different care or treatment could reasonably have been expected to have resulted in a different outcome.

The key findings from the analysis are summarised in the schematic and speak for themselves. The stark fact is that the clinical review teams concluded that there was at least one deficiency in the standards of care and treatment provided in all but one of the episodes of care examined (27 out of 28) and that in over two-thirds (19 out of 28) there was a major modifiable factor which contributed significantly to the poor outcome which was experienced by the mother and/or their baby.

The quality assurance process also identified significant concerns about the systems and processes which the Health Board had in place at that time for identifying, grading and investigating serious incidents. Root Cause Analysis[16] was not well developed and there was little evidence that the learning from serious incidents was shared or that it was being used systematically to improve the safety and quality of the service. Similarly, there was limited evidence that women and families were an integral part of the process.

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[16] Root Cause Analysis (RCA) is a widely used and nationally recognised for reviewing serious and untoward incidents to establishing the underlying causes of failure in systems and process.

5.1 Maternal Mortality and Morbidity Category - Schematic

Summary of Key Findings

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

Most Frequently Reported Major Modifiable Factors

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

The Importance of Communication

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

Scope of Clinical Review

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

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

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

Assessment Criteria

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

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

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

6. Listening to Women and Families

As an integral part of the clinical review process, all of the women whose care was reviewed were invited to tell their story so that it could be considered by the MDT's as part of the review of their care. Where women raised specific concerns or questions about aspects of their care or treatment, the MDT conducting the review was asked to address them based on the information available. In instances where the questions raised were not clinical in nature, for example where they related to the environment within the hospital, the Health Board were asked to provide a response. Any answers to questions raised by women and families were included in the personal feedback provided.

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

There is real value in undertaking a thematic analysis of women's stories because they cover their whole pregnancy journey and explore their total experience of the care provided. The women's stories have been analysed and four consistent themes have emerged. From the women's perspective, these factors had an adverse impact on the overall quality of their care and from their perspective, contributed to the adverse outcomes they experienced. The four key themes which emerged are:-

- a lack of relevant and timely information to inform their choices;
- a failure to understand and cater for their individual needs;
- a failure to monitor and escalate their treatment when things changed;
- poor communication with and between those providing their care.

A more detailed explanation of what women said in respect of the four key themes is provided in the schematic on the following page. It is noticeable that the four themes are remarkably similar to those which were identified in the *Listening to Women and Families* report which was published alongside the Royal Colleges' report in 2019. That is not surprising, given that the Clinical Review Programme is assessing historical care provided during the same period - a period when we know that there were serious deficiencies in the service provided. However, the themes are also consistent with information which has been received by the Health Board more recently through their various feedback mechanisms, for example, community engagement events, complaints and concerns monitoring and other more informal sources like social media and the My Maternity My Way Forum.

It is clear from the Panel's oversight of the Health Board's Maternity Improvement Programme that significant progress has been made since 2019 in improving the quality of women's and families' experiences and addressing some of the underlying issues which historically resulted in poor outcomes. However, there is still work to be done, particularly around staff culture and behaviours and there is much that the Health Board can learn from the stories which have been, and continue to be provided by women, as an integral part of the clinical review process.

Listening to Women and Families

Theme 1 - Understanding What Women Need

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

Theme 2 - Access to Relevant & Timely Information

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

Theme 3 - Failing to Monitor Progress or Escalate Care

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

Theme 4 - Poor Communication

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

7. What Does This Mean?

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

In two-thirds of the episodes of care which were examined, the independent clinical review teams concluded that different treatment could reasonably be expected to have resulted in a different outcome for the mothers involved and/or their babies.

The reviewers also concluded that there were lessons to be learned from the majority of the episodes of care that they reviewed; in fact, in only one case did the independent teams conclude that they would not have done anything differently in the same circumstances.

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

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

And although only a small number of women came forward to share their stories in this first category, those who did, also painted a picture of poor communication, a lack of information to inform their choices, a lack of empathy or concern for their well-being and the failure to monitor their progress and escalate their care when things started to change. All of this was broadly consistent with the themes which emerged from the more extensive *Listening to Women and Families* exercise which the Royal Colleges conducted alongside their review of the Health Board's maternity and neonatal services in January 2019.

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

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

7.1 Putting the Findings into Context

Although they should not be downplayed or brushed aside, there are a number of important contextual factors that should be borne in mind when considering what the findings mean. In particular, the findings should be viewed in the following context:-

- These are exceptional events - between 01 January 2016 and 30 September 2018 (the period covered by this element of the clinical review) 9,870 women used the maternity and neonatal services at the Prince Charles and Royal Glamorgan Hospitals. The vast majority of those women gave birth to a healthy baby without significant complications or adverse consequences. The 160 or so episodes of care which will be reviewed in this phase, represent a fraction of that total. Whilst just one case of avoidable harm is clearly one too many, it is important to recognise that these cases are the exception rather than the norm;
- The episodes of care which were reviewed were not selected at random - it is also important to note that the 28 episodes of care which were reviewed in this category were selected using nationally recognised inclusion criteria which reflect long-term research about what most often goes wrong in maternity and neonatal care[17]. The episodes were selected because it appeared likely that something had gone wrong and so it is perhaps not surprising that significant deficiencies have been identified and identified in a disproportionate number of cases;
- It is precisely what the Royal Colleges predicted – most of the episodes of care which were reviewed in this category were provided between January 2016 and September 2018, a period in which it is already evident that there were significant deficiencies in the maternity and neonatal services which the Health Board was providing. As such, what the clinical review process has subsequently identified is precisely what the Royal Colleges suggested would be found when it recommended that further clinical review work should be undertaken. It has also provided further evidence, if any was needed, that the concerns which were highlighted in the Royal Colleges' report, were entirely justified;
- There are new insights but nothing fundamentally new has emerged – although the clinical review has identified learning and, in some cases, has provided new insights or added weight to the Health Board's understanding, there is nothing which has emerged from the first cohort of clinical reviews which was not broadly covered by the 70 recommendations which were made by the Royal Colleges;

[17] *The inclusion criteria adopted by the Panel are informed by the MBRRACE-UK and Each Baby Counts reporting mechanisms. MBRRACE-UK is a national surveillance programme monitoring late fetal losses, stillbirths and infant deaths, confidential enquiries into perinatal mortality and serious infant morbidity and the national Confidential Enquiry into Maternal Deaths. Each Baby Counts is the Royal College of Obstetricians and Gynaecologists national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.*

- Substantial improvements have already been made – it is important to recognise that over the past eighteen months, many of the deficiencies which were identified by the Royal Colleges have already been addressed, in whole or in part, through the Health Board's ongoing Maternity Improvement Programme. That said, some important elements remain to be delivered and the Clinical Review Programme has provided further insights which the Health Board will find valuable in shaping the next steps in its improvement journey.

The latter two points are particularly significant in terms of understanding the implications of the findings of this element of the Clinical Review Programme and are explored in further detail in paragraphs 7.2 and 7.3 below.

7.2 Correlation of Findings Against Royal Colleges' Recommendations

As previously stated, the Health Board has now received all of the clinical review reports from the maternal mortality and morbidity category and has assessed the detailed findings in order to determine what action it needs to take beyond that which has already been taken as part of its ongoing Maternity Improvement Programme.

The Panel is maintaining oversight of this process and where there is significant new learning which has not previously been identified, there is an agreed mechanism for including this within the Maternity Improvement Plan.

The Panel expects the Heath Board to shortly publish a comprehensive response which demonstrates how it is addressing the findings from this first phase of clinical reviews. In particular, it is expected that as part of that response, the Health Board will identify any new learning which was not previously identified in the Royal Colleges' review and explain how that is being addressed.

In the meantime, with support from the NHS Wales Delivery Unit and the Welsh Government, the Quality Assurance Panel has conducted its own analysis of the clinical review findings in order to identify the degree of correlation between the key themes and issues which have emerged and the 70 recommendations made by the Royal Colleges in April 2019. The results of this analysis are set out in the table at *Appendix B* to this report.

It will be seen from the table that the four key themes which emerged from the clinical review process (i.e. listening to women, identify and escalating risk, appropriate treatment and clinical leadership) correlate significantly to the Royal Colleges' recommendations. In total, the Panel identified 24 of the 70 recommendations which correlated either directly or indirectly to the four key themes.

On that basis, the Panel is reasonably assured that there is nothing significant which has emerged from this first element of the Clinical Review Programme which was not previously identified by the Royal Colleges and is not therefore already broadly reflected within the Health Board's Maternity Improvement Plan. However, it awaits the publication of the Health Board's response before reaching a firm conclusion.

7.3 Health Board Progress

It will also be seen from the table attached at *Appendix B*, that 17 of the 24 Royal Colleges' recommendations which correlate to the key themes and issues identified through the Clinical Review Programme have previously been verified as completed by the Panel whilst the other seven remain work in progress.

The following improvements, all of which have been delivered since September 2018, are particularly significant in the context of the key themes and issues which have emerged from the first element of the Clinical Review Programme:-

- guidelines, protocols and procedures have been reviewed, updated in accordance with national standards and are now readily available to all staff;
- the service has been restructured in line with the recommendations of the South Wales Programme bringing the consultant-led service together on one site;
- consultant presence has been increased, on-call arrangements strengthened and trigger lists developed to ensure appropriate responses to escalating risk;
- a multidisciplinary clinical audit programme has been implemented and a revised clinical governance framework has been established;
- nationally designed mandatory training programmes have been delivered for both nursing and medical staff with high levels of attendance;
- arrangements for sharing learning from incidents have been strengthened;
- an extensive programme of events and other mechanisms have been developed to improve engagement with women and to learn from their experiences.

When the Panel last reported the Health Board's progress in September 2020, it concluded that significant progress had been made and that 50 of the 70 recommendations made by the Royal Colleges had then been delivered[18]. However, there was no room for complacency and continued focus and momentum was required in order to deliver the 20 recommendations which remained.

Some of those outstanding recommendations relate to less tangible issues like culture change, behavioural change and leadership development which will take time to deliver and even longer to have effect.

Those issues lie at the heart of some of the more significant deficiencies which have been highlighted through the Clinical Review Programme to date and although they remain very much work in progress, they are an integral part of the Health Board's maternity improvement plans going forward.

7.4 So What Does This Really Mean?

In summary, whilst the emerging findings from this first element of the Clinical Review Programme do perhaps provide cause for concern, the Panel's advice is that those concerns need to be kept very firmly in context.

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[18] All of the Panel's progress reports, including the most recent report published in September 2020, can be viewed here on the Welsh Government website.

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

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

It is also evident that the Health Board has made significant progress in improving its maternity and neonatal services over the past two years[19]. As such, many of the issues which have been identified retrospectively through the clinical review process have already been addressed, either wholly or in part and there are realistic plans in place to address any outstanding issues going forward.

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

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

8. What Happens Next

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

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

The following paragraphs explain the next steps for the Health Board and the Panel in a little more detail.

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

8.1 Next Steps - Health Board's Response

Firstly, the Health Board is currently finalising its evaluation of the detailed feedback reports to identify what has already been done and what remains to be done to address the learning which has been identified from the maternal category reviews. It is anticipated that this evaluation will be fully completed by the end of January which will enable the Health Board to publish a formal response alongside publication of the Panel's Thematic Analysis Report.

Secondly, it is important that any new learning or new insights which are identified are assimilated into the Health Board's Maternity Improvement Plan. The Health Board has developed a standard operating procedure to determine how any actions which emerge from the clinical review process will be tracked and monitored and the Panel will provide ongoing scrutiny and challenge to that process through its existing oversight arrangements.

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

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

Not only will the Health Board need to explain what it has done since the Royal Colleges' review to make its services safer and more effective, it will also need to demonstrate that the culture of the organisation has changed too.

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

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

8.2 Next Steps - Clinical Review Programme

In the meantime, whilst it will continue to provide support and challenge to the Health Board's response to the outcomes from the maternity category, the Panel's specific focus will now shift towards concluding the next category in the 2016-2018 Look-back phase of the Clinical Review Programme, which is the stillbirth category.

This involves the review of 64 episodes of care provided between 01 January 2016 and 30 September 2018[20] where the baby sadly was stillborn. Not only is this a substantially larger cohort than the maternal category, it will inevitably be more emotive and more poignant given that all of the women and families involved in these episodes of care suffered the loss of a baby.

The current position is that the majority of the individual reviews in the stillbirth category have been completed and the analysis of the findings is about to commence. The next steps will be the validation and quality assurance processes followed by the preparation of personalised feedback for women and families which is a time consuming and necessarily pain-staking process.

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

In the background, the clinical review teams have commenced work on the neonatal mortality and morbidity category and that work will continue through the first half of 2021. A more detailed assessment of the progress which is being made in this category and the likely timescales for completion will be included within the Panel's second thematic report.

It is still too early to make recommendations to the Minister about the necessity to undertake further reviews going back beyond 2016 and this will not be considered until the '2016-18 Look-back' element is more advanced.

In the meantime, the Panel will continue to oversee the Health Board's management of the self-referral process. An update on the current position in relation to the self-referral programme will be provided in the Panel's progress report to the Minister.

There is one other area of the Panel's Clinical Review Programme, the oversight of the Health Board's post-October 2018 serious incident reviews, which is worthy of mention and this is discussed in the following paragraphs.

8.3 Post-October 2018 Serious Incident Reviews

When the Royal Colleges reported in April 2019, they identified significant concerns about the Health Board's processes for identifying, grading and investigating serious incidents. Root Cause Analysis[21] was not well developed and there was little evidence that the learning from serious incidents was shared or that it was being used systematically to improve the safety and quality of services. Similarly, there was limited evidence that women and families were an integral part of the process.

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

[21] *Root Cause Analysis (RCA) is a widely used and nationally recognised for reviewing serious and untoward incidents to establishing the underlying causes of failure in systems and process.*

Indeed, it was as a result of concerns about the way in which the Health Board recorded serious incidents that the Royal Colleges' review was initially commissioned. This resulted in a number of specific recommendations for improvement to the serious incident investigation process being included within the final report.

As identified in Section 5, the Royal Colleges' concerns about the Health Board's processes for managing and responding to serious incidents were borne out to a significant extent by the findings of the maternal category reviews. Whilst this was not specifically identified as one of the key themes by the clinical review teams, it was a cross cutting issue which emerged from the wider considerations of the Quality Assurance Panel.

When the Clinical Review Programme was originally developed, it was agreed that responsibility for managing post-October 2018 serious incident reviews would rest with the Health Board but with oversight from the Panel.

There were two reasons for that. The first and more pragmatic reason was the need to enable the Panel to focus on the 2016-18 Look-back exercise which was a specific recommendation from the Royal Colleges. The second, more principle-based reason was that it was agreed that the Health Board should take responsibility for improving its own clinical review processes and that was unlikely to happen if an independent external programme was developed to review more contemporaneous incidents.

On that basis, it was agreed that the Health Board would manage post-October 2018 serious incidents and the Panel would put in place a process to dip sample investigations at random, with a view to gaining the assurance which was necessary to advise the Minister that the processes which are currently in place are fit for purpose.

Ove the past two years, a comprehensive package of measures has been put in place to improve serious incident reporting and investigation, not only in maternity and neonatal services, but more broadly across the Health Board. This has involved, amongst other measures:-

- a package of external support from the NHS Wales Delivery Unit;
- significant investment in Root Cause Analysis training;
- the development of a new corporate policy and procedures;
- the introduction of standardised audit tools and reporting frameworks;
- improved central coordination and monitoring arrangements;
- support from peer networks to provide an element of independence.

In the early part of 2020, the Quality Assurance Panel dip sampled nine serious incident investigations as a means of gaining assurance about the quality and effectiveness of the Health Board's arrangements. Unfortunately, only two of the nine met the required standards and it was agreed that the Panel's assurance work would be suspended until the Health Board was confident that its processes would stand scrutiny.

Since that time, the Panel has received regular progress reports but has not yet been able to obtain the reassurance that is needed to sign off the outstanding investigations. In the meantime, the impact of COVID-19 on the Health Board's capacity has taken its toll and the timescales have been extended for all of the outstanding reviews to be completed by February 2021.

The Panel has escalated its concerns about the time it is taking to resolve this matter and the situation is being routinely monitored by the Board through the Quality and Safety Committee and the Maternity Improvement Board.

The Panel is planning to undertake some quality assurance work in early January with the expectation that significant progress can be reported when the Panel produces its next progress report.

The reason for highlighting this issue is to provide assurance that there is a process in place to review and quality assure serious incidents post-October 2018 albeit that it is a different process which will be reported upon separately.

9. Conclusions and Recommendations

This is the first in a series of high level thematic reports which will be prepared by the Independent Maternity Services Oversight Panel in the coming months.

Its purpose is to share the emerging themes from the first element of the ongoing programme of independent clinical reviews of the maternity and neonatal care provided by Cwm Taf Morgannwg University Health Board which arose from the publication of the Royal Colleges' review in April 2019.

More specifically, the report summarises the key themes which have emerged from the clinical review of 28 individual episodes of care which were provided by the Health Board between 01 January 2016 and 30 September 2018. These reviews explored the care of mothers who needed unplanned emergency care during childbirth, which may have required admission to an Intensive Care Unit.

9.1 Summary of Findings

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

- 28 episodes of care were clinically reviewed in this phase of the programme;
- the independent clinical review teams concluded that in two-thirds of those episodes, different treatment or care may reasonably have been expected to have resulted in a different outcome;
- there were four recurrent themes which emerged from the reviews - failure to listen to women, failure to identify and escalate risk, inadequate clinical leadership and inappropriate treatment leading to adverse outcomes;
- although these findings are concerning and will be particularly distressing for the women and families involved, they are not unexpected - it is essentially what the Royal Colleges' report suggested the clinical review process would identify;

- whilst a significant amount of learning and some new insights have emerged from the clinical review process, there is nothing substantial which was not broadly captured by the Royal Colleges' recommendations in 2019;
- although the Health Board has made significant progress in addressing those deficiencies, work still remains to be done in key areas like culture and behaviours, leadership and communication.

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

They do however, serve to emphasise the need for continued focus and momentum, if any such emphasis was needed. The imminent development of the Health Board's 'Roadmap', which sets out its ambition and milestones as well as timescales for delivering them is key to that. This will be reported on in the Panel's next progress report.

9.2 Summary of Next Steps

Whilst the first cohort of clinical reviews is now completed from the Panel's perspective, the work for the Health Board continues.

Firstly, the Health Board is currently finalising its evaluation of the detailed clinical review reports to identify what has been done, what is currently being done and what remains to be done to address the learning which has been identified from the maternal category reviews. It is expected that this evaluation will be completed by the end of January which will enable the Health Board to publish a formal response alongside publication of Panel's thematic report.

Secondly, the Health Board is working with the Panel to provide ongoing support to the women and families whose care has been reviewed, whether that be in terms of providing access to more detailed information, responding to questions or providing access to appropriate advice and practical support (for example emotional or psychological support, bereavement counselling, access to redress, etc.).

The Health Board must ensure that it continues to engage with women in an open, transparent and compassionate manner which supports them and their families through what may well be a difficult and potentially traumatic time and provides the opportunity to rebuild trust and confidence.

Having completed its work on the maternal category, the Panel is now focused on concluding the stillbirth category which involves the review of around 64 episodes of care provided between 01 January 2016 and 30 September 2018. Not only is this a substantially larger cohort than the maternal category, it will inevitably be more emotive given that all of the women and families involved suffered the loss of a baby.

It is anticipated that the emerging findings from the stillbirth category will be reported on by way of a second thematic report early in the Summer of 2021.

9.3 Recommendations

Having considered the findings which have emerged from the maternal category of the Clinical Review Programme, the Panel does not believe that it is necessary to make any recommendations in terms of adjustments to the current oversight arrangements going forward.

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

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

In particular, the response should explain what the Health Board has already done to address the learning through the delivery of its Maternity Improvement Plan and set out what it intends to do going forward, particularly in response to any new learning which has emerged from the Clinical Review Programme.

The response should also explain how it is supporting the women and families involved in the reviews and how it intends to use the opportunity presented by the Clinical Review Programme to rebuild public trust and confidence going forward.

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

Notwithstanding that the Health Board has yet to publish its more detailed evaluation, it is already clear that there is significant learning to be derived from the first phase of the Clinical Review Programme which might not only benefit the Health Board but be of wider benefit to other Health Boards in Wales.

The Panel believes that there are two particular aspects which might provide useful learning for others. The first relates to the clinical and operational learning which has emerged from the reviews themselves. The second relates to the systems and processes which the Health Board has put in place, working collaboratively with the Panel, the Welsh Government and the NHS Wales Delivery Unit to manage the implications of the Clinical Review Programme and in particular the interface with the women and families involved.

The experience which the Health Board has gained in developing these arrangements would provide a rich source of learning for others seeking to enhance their internal clinical review processes with a genuine focus on putting the needs and expectation of women and families at the heart of the process.

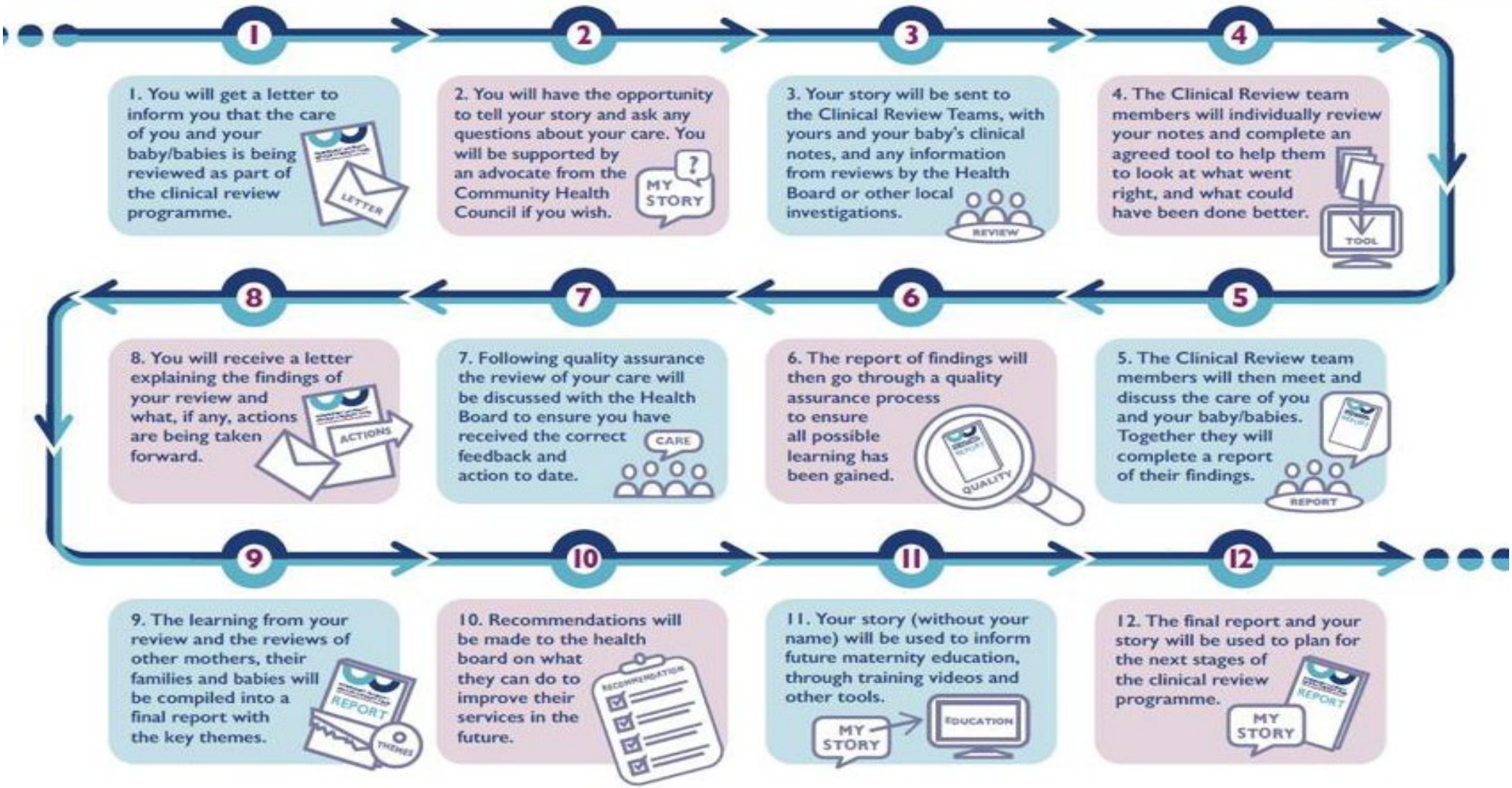
10. List of Appendices

Appendix A: Clinical Review Pathway

Appendix B: Alignment of Key Themes with Royal Colleges' Recommendations

Appendix A

Clinical Review Pathway



Correlation of Key Themes from Maternal Category Clinical Review with Royal Colleges' Recommendations

MATERNAL MORTALITY AND MORBIDITY CATEGORY				
THEME	**Identified by RCOG/RCM**	**Recommendations Completed**		**Recommendations in Progress**
Listening to women	Yes	7.49 7.52		7.7 7.42
Failure to identify risk	Yes	7.2 7.3 7.4 7.5 7.9 7.22	7.23 7.32 7.35 7.36 7.37 7.40	7.1 7.8 7.19 7.20 7.35
Inappropriate treatment	Yes	7.3 7.5 7.9 7.22 7.23 7.25	7.32 7.35 7.36 7.37 7.40	7.7 7.8 7.35
Clinical leadership	Yes	7.3 7.9 7.22 7.23 7.25 7.28	7.32 7.35 7.36 7.37 7.40	7.8 7.19 7.20 7.35 7.42
Summary	▪ There were 24 RCOG/RCM recommendations identified on review of the 28 cases in this category. ▪ Several of these recommendations were applicable to all four themes identified. ▪ 17 recommendations have been verified as complete. ▪ 7 recommendations remain work in progress.			

RCOG/RCM Recommendation: Definitions	
7.1	To review the current provision of care within maternity services in relation to national standards and indicators, as well as national reporting.
7.2	Identify nominated individuals (consultant obstetric lead and senior midwife) to ensure that all maternity unit guidelines are up to date.
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.
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.
7.7	Ensure an environment of privacy and dignity for women undergoing abortion or miscarriage in line with agreed national standards of care.
7.8	Ensure external expert facilitation to allow a full review of working practice.
7.9	Develop a trigger list for situations which require consultant presence on the labour ward.
7.12	Undertake multidisciplinary debriefing sessions facilitated by senior maternity staff after an unexpected outcome.
7.19	Ensure that a system for the identification, grading and investigation of SI's is embedded in practice.
7.20	Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from SI's.
7.22	Actively discuss the outcomes of SI's in which individual consultants were involved in their appraisal.
7.23	Improve learning from incidents by sharing the outcomes from SI's on a regular basis and in an appropriate, regular and accessible format.
7.25	Appoint a consultant and midwifery lead for clinical audit/quality improvement with sufficient time and support to fulfil the role.
7.28	Ensure that the executive level lead role for maternity will work with the maternity department and this role is effective and supported.
7.32	Ensure obstetric consultant cover is achieved in all clinical areas when required.
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.
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.
7.40	Review the skills and competencies of the senior clinical midwives covering for tier one doctors.
7.42	In conjunction with Organisation Development undertake work with all grades of staff around communication, mutual respect and professional behaviours.
7.49	Develop the range and scope of engagement with women and families.
7.52	Learn from the experience of women and families affected by events.