INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

Cwm Taf Morgannwg University Health Board

Thematic Stillbirth Category Report September 2021

 WG43495 Digital ISBN 978-1-80195-970-4

Foreword

This is the second in a series of thematic reports to be published by the Independent Maternity Services Oversight Panel about our ongoing programme of independent clinical reviews of the maternity and neonatal care provided by the former Cwm Taf University Health Board.[1]

This particular report focuses on the care of mothers and their babies who sadly, were stillborn. It summarises the key themes and issues which emerged from the clinical review of 63 individual episodes of care[2] which were provided by the Health Board between 01 January 2016 and 30 September 2018.[3]

The independent teams conducting the reviews focused on establishing whether the care and treatment provided to the mother and their baby 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 or the NHS more broadly, which would avoid the same thing happening again in the future.

The report considers the learning from the clinical reviews in the context of the Health Board's ongoing Maternity and Neonatal 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 and families 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 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; they want their experience to make a difference for women and families using maternity care in the future. It is with that important sentiment in mind, that we present this report.

We would like to express our thanks to Professor Alex Heazell, MBChB(Hons) PhD MRCOG, Professor of Obstetrics at the University of Manchester, who analysed the review findings and drew out the key areas of learning on our behalf.[4]

---

[1] 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.

[2] The 63 episodes of care involved 58 different mothers. The Thematic Maternal Category Report indicated that there were 64 episodes of care included within the stillbirth category. However, it has always been made clear that numbers within the Clinical Review Programme can be subject to change given the flexibility needed as episodes of care are explored in more detail. It is precisely for this reason that approximate figures are used. In progressing the clinical review of the stillbirth category, the total number of episodes of care has been adjusted from 64 to 63.

[3] A small number of the episodes of care occurred outside that time period. They were included in the programme either because the episode of care was a self-referral which fitted the inclusion criteria or because the mother had more than one pregnancy and it was appropriate to review their care from a wider perspective.

[4] Professor Heazell's biography can be found here.

Table of Contents

1 Introduction and Background

This is the second in a series of thematic reports to be published by the Independent Maternity Services Oversight Panel (the Panel).

Cumulatively, these reports provide an evolving picture of the learning 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).

It is important that any learning which might improve the quality and safety of maternity and neonatal services, both within the Health Board and more widely across Wales, is identified, shared and acted upon at the earliest opportunity. It is also important that where the Clinical Review Programme provided further information to unresolved questions for women and families, this is shared at an appropriate time. That is why the findings of the Clinical Review Programme are being published incrementally as they emerge and why women and families are informed of the outcome of their individual review before the wider findings are made public.

The first report in the series was published in January 2021 and focused on the care of mothers who needed unplanned emergency treatment during childbirth. A copy of that report, which was referred to as the Thematic Maternal Category Report, can be found here.

This second report focuses on the care of mothers and their babies who sadly, were stillborn. It identifies the key themes and issues which emerged from the clinical review of 63 individual episodes of care which were provided by the Health Board between 01 January 2016 and 30 September 2018. For ease of reference, it is referred to as the Thematic Stillbirth Category Report.

A further thematic report will be published once the reviews relating to the care of babies who sadly died or required specialist neonatal care following their birth are complete. Once the three individual reports have been produced, the Panel will develop an overarching report which draws together the cumulative learning from the programme.

2 How to Use the Report

It is important to emphasise that this report provides only a high-level summary of the learning which has emerged from the stillbirth category. It is written very much with the women and families who have been most affected by the Health Board's previous deficiencies in mind. For that reason, and in order to make the key messages as clear as possible, the body of the report does not include detailed analysis, complex statistics or detailed clinical information.

For those who want to understand the evidence which lies behind the conclusions in the report, a more detailed technical analysis, produced with the support of the NHS Wales Delivery Unit, is included at *Appendix A*.

The Panel has assumed that for the most part, those who will find this report of interest will already be very much 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.[5]

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 two and a half years 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.

The Panel is publishing its September 2021 Progress Report alongside this report. This provides a current assessment of the progress the Health Board is making in terms of delivering its Maternity and Neonatal Improvement Programme. It also signposts to supporting documents which provide further background information. A copy of the report can be accessed here.

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 would like to know more.

3 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.

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, specifically seek out individual deficiencies or focus exclusively on error, omission or poor practice.[6] Indeed, some areas of good practice have been observed in addition to the areas identified for improvement.

Further information regarding the wider Clinical Review Programme, why we are doing it and the approach we are taking, can be found within the Panel's Clinical Review Strategy which can be accessed here.

---

[5]The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives were commissioned by the Welsh Government to undertake a review of the maternity and neonatal services at the Prince Charles and Royal Glamorgan Hospitals. The Royal Colleges' report was published in April 2019 and made 70 recommendations for improvement.

[6] If information emerges which would need to be escalated to professional bodies or organisations, 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.

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

Around 160[7] episodes of care are being reviewed as part of the 2016-2018 Look-Back. The reviews have been divided into three categories which are being undertaken consecutively in the order outlined in the table below.

Table 1: *Description of Clinical Review Categories*

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

The stillbirth category, which involves the clinical review of 63 individual episodes of care, is the second to be completed.

The episodes of care which were reviewed in this category were selected by applying the Each Baby Counts (EBC)[8] inclusion criteria developed by the Royal College of Obstetricians and Gynaecologists (RCOG).

This includes babies born after 37 weeks of pregnancy who were thought to be alive at the start of labour but were born with no signs of life. However, in order to optimise the learning from this category, the Panel went beyond the EBC criteria to include all instances where a baby was stillborn after 24 weeks of pregnancy.

4 How We Did It

The methodology 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.

4.1 Clinical Review Methodology

A simplified flow chart or 'pathway' has been produced to enable women and families to more easily understand the clinical review process. This can be accessed here and will aid understanding of the description which follows.

[7] 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.
[8] Each Baby Counts was RCOG's 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.

Although the process is constantly evolving through practical experience, the clinical review methodology applied to the 63 stillbirth reviews can be broadly summarised as follows:-

- individual reviews were allocated to one of six independent[9] multidisciplinary teams (MDT's) which have been recruited and inducted to carry out the role;
- MDT's comprised as a minimum, an Obstetrician and a Midwife who are supplemented where appropriate to the circumstances of each individual review by a Neonatologist, a Neonatal Nurse 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[10] which had been conducted by the Health Board;
- the MDT's applied a common review methodology, using standardised audit tools and reporting templates[11] 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[12] and this was considered by the MDT's as part of the review, alongside the clinical notes.

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

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

Each episode of care was assessed in twelve different areas related to the woman's care during pregnancy and birth, as follows:-

- pre-pregnancy care;
- assessment and point of entry to care;
- diagnosis and recognition of a high-risk status;
- referral to a specialist;
- treatment;
- clinical leadership;
- education, training and knowledge;
- documentation;
- discharge or transfer from care;
- communication;
- policies and procedures;
- woman and family.

[9] *None of the clinicians conducting the reviews have any connection 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.*

[10] *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.*

[11] *The tool used to record the assessment of care was developed from Confidential Enquiries into Stillbirths pioneered by the Centre for Maternal and Child Enquiries.*

[12] *Women and families were invited to submit their stories including questions to be responded to 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.*

Where possible, care was assessed against contemporaneous clinical practice guidelines or standards expected of health professionals.

4.2 Assessment Criteria

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 for the mother and/or her baby. Each of the modifiable factors was then given one of four classifications which are explained in Table 2.

Table 2: *Definitions of Modifiable Factors*

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

It is important to emphasise that the use of the term '*minor*' or '*wider learning*' categorisations is not intended to minimise the significance of the issues, nor does it indicate and disregard the impact that these may have had on the experience of the mother and her family. Rather, it seeks to make clear that in the professional opinion of the review teams, these issues did not directly result in the babies being stillborn. That important distinction is something which should be borne very firmly in mind when reading the key findings set out in Section 5 of the report.

4.3 Quality Assurance

Once the review had been 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 comprised the four Clinical Leads of the Panel, together with an Anaesthetist 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.[13]

4.4 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 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 are incorporated into the Maternity and Neonatal Improvement Plan which is monitored by the Health Board's Quality and Safety Committee as well as the Maternity and Neonatal Improvement Board.

5 What We Found

The analysis in this section of the report was undertaken on behalf of the Panel by Professor Alex Heazell, MBChB(Hons) PhD MRCOG, Professor of Obstetrics at the University of Manchester. The Panel is enormously grateful for the clinical insight and academic rigour that his involvement has brought to the process.

The analysis is based upon the information obtained from the clinical reviews of the 63 individual episodes of care, combined with the themes which have emerged from the families' stories submitted as part of the clinical review process. It is from this information that conclusions have been drawn and learning has been identified.

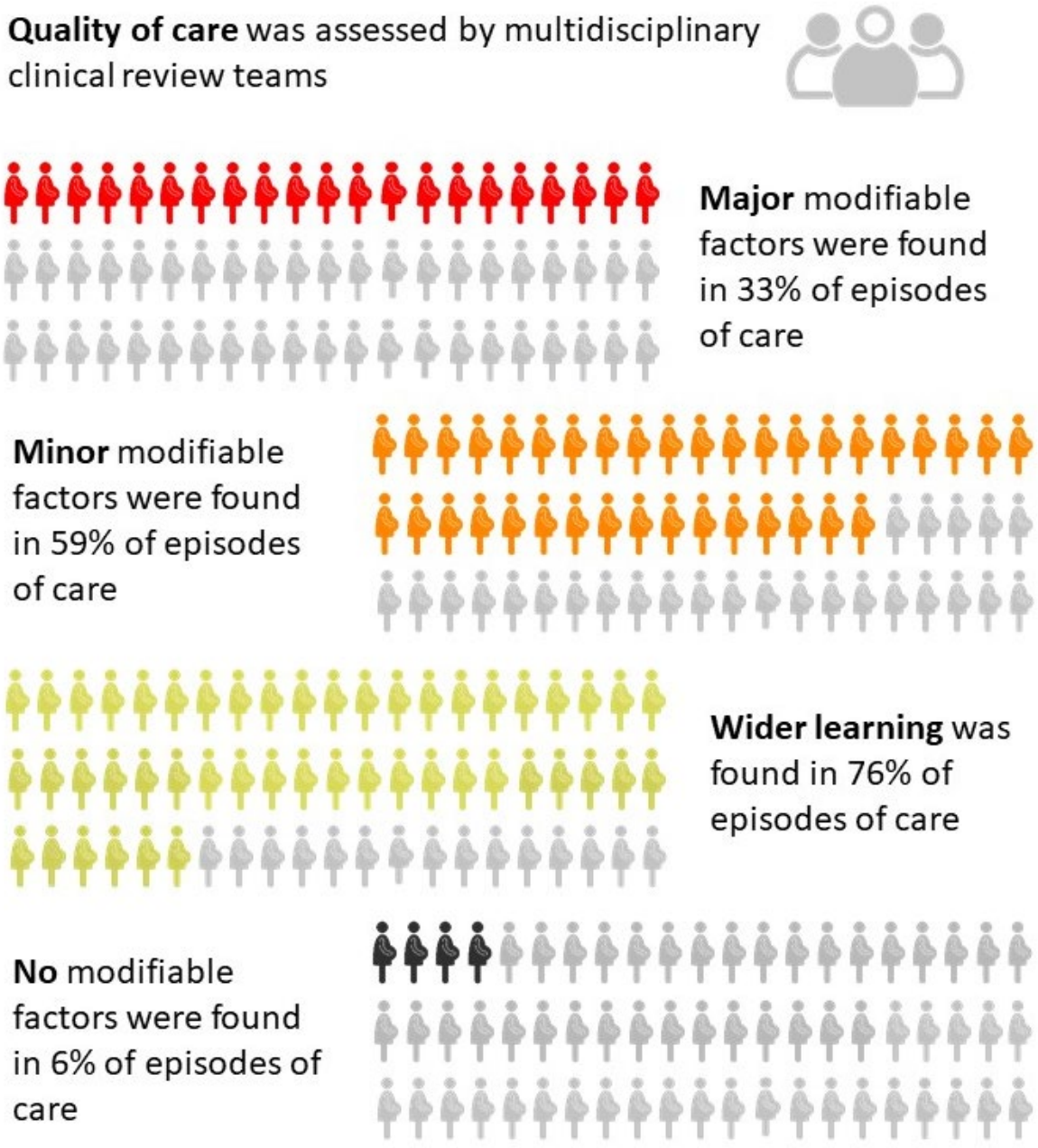
This report seeks to present the overall findings drawn from all episodes of care reviewed. However, particular focus has been given to major modifiable factors because different care provided in these areas may have changed the overall outcome. Equally, the learning identified could result in improved outcomes for women seeking to use services now and in the future.

[13] *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 five such immediate concerns raised.*

KEY FINDING 1 – One in three (33%) episodes of care reviewed were assessed as having a major modifiable factor that contributed significantly to the poor outcome. **Different management may have altered the outcome.**

Of the 63 episodes of care reviewed, 21 (33%) had at least one major modifiable factor present. A further 37 (59%) had one or more minor modifiable factors, while 48 (76%) had wider learning factors. Four (6%) episodes of care had no modifiable factors recorded. This is represented in Figure 1.

Figure 1: *Distribution of Modifiable Factors in all Episodes of Care*



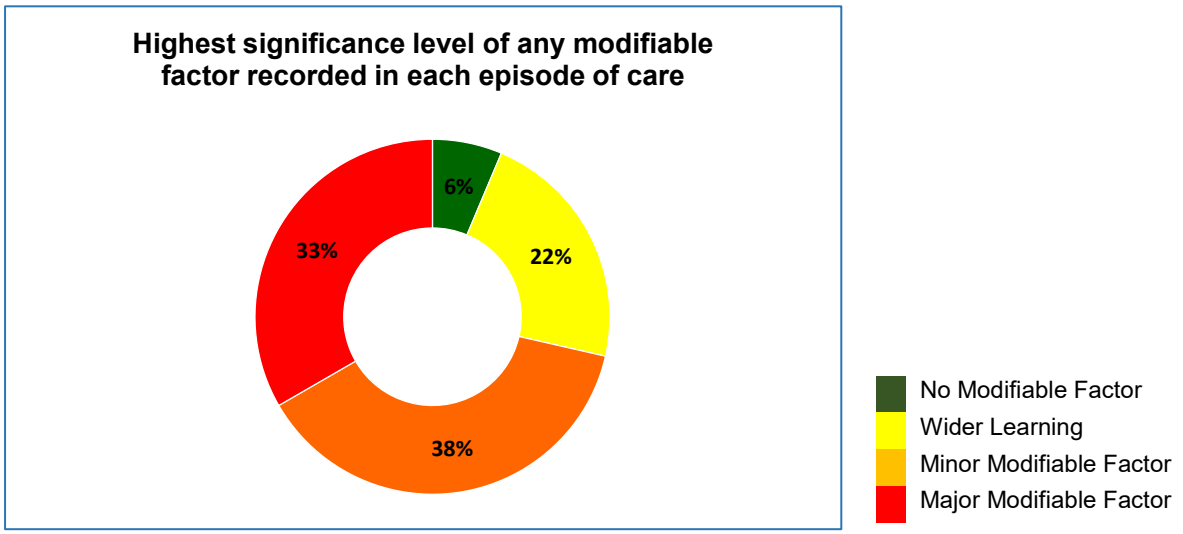
KEY FINDING 2 – Areas for learning were identified in 59 of the 63 episodes of care reviewed.

The clinical review teams identified combinations of major, minor and wider learning factors in 59 episodes of the care they reviewed. In order to provide an indication of the scale and significance of the learning which was identified, it is helpful to understand the highest factor (i.e. major modifiable, minor modifiable, wider learning or no factors) in each of the 63 individual episodes of care. This was as follows:-

- a major modifiable factor was the highest level of significance in 21 (33%);
- a minor modifiable factor was the highest level of significance in 24 (38%);
- wider learning was the highest level of significance in 14 (22%);
- there was no learning identified in four (6%).

This information is presented in Figure 2.

Figure 2: *Highest Significance Level of Modifiable Factors*[14]



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

The number of major modifiable factors identified in a single episode of care ranged from one to seven factors. The two most frequent areas where major modifiable factors were identified were as follows:-

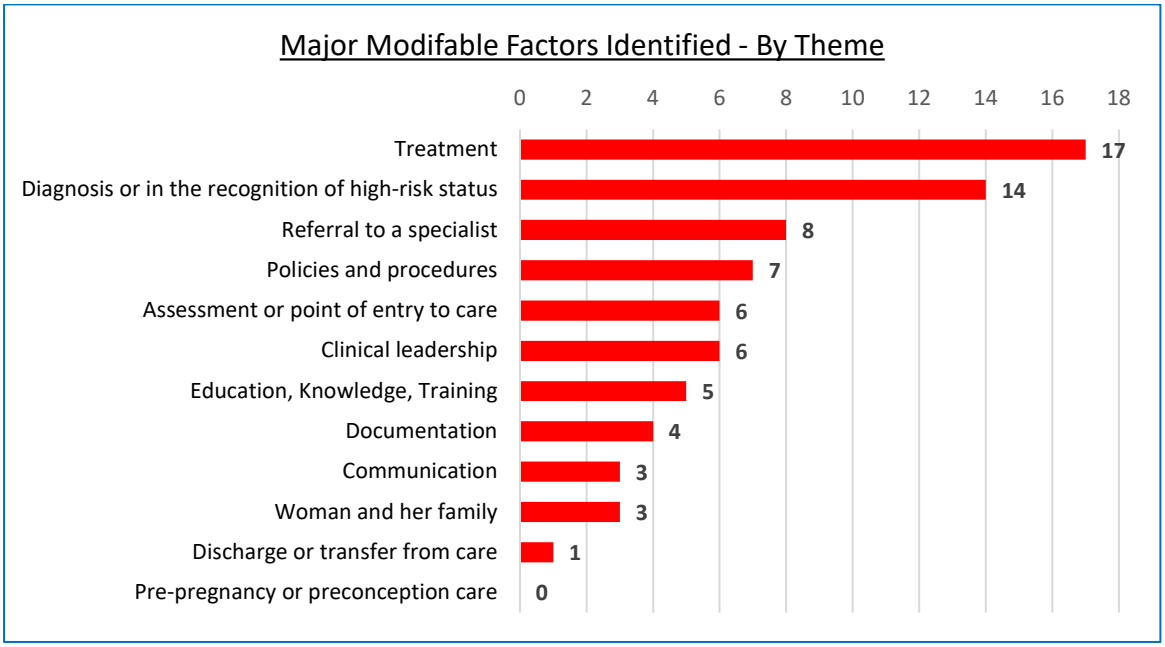
- **inadequate or inappropriate treatment** was identified as a major modifiable factor in 17 (27%) of the episodes of care.
- **diagnosis or recognition of high-risk status** was identified as a major modifiable factor in 14 (22%) of the episodes of care.

[14] *The percentages within Figure 2 do not equal 100% due to rounding up/down.*

These two factors occurred in combination in 11 (17%) of the 63 episodes of care where a failure to make a diagnosis or recognise a high-risk clinical situation led to inadequate or inappropriate treatment.

This can be seen in Figure 3 which shows the number and types of factors identified in the 21 episodes of care where there was at least one major modifiable factor.

Figure 3: *Major Modifiable Factors Identified by Theme*



The lack of multidisciplinary team working during an obstetric emergency situation was a contributory factor in a number of these episodes of care.

When these areas were broken down in more detail, the most frequent categories of major modifiable factors relating to **treatment** were:-

- a failure to treat appropriately (eight episodes of care);
- a delay in treatment (seven episodes of care);
- a lack of treatment plan (six episodes of care);
- inappropriate treatment (six episodes of care).

KEY FINDING 4 – In those episodes of care where inadequate or inappropriate treatment was identified as a major modifiable factor, fetal growth, fetal movement and fetal heart monitoring were notable issues.

There were also instances when specific clinical scenarios did not prompt action including:-

- fetal growth restriction (when a baby does not grow at the rate expected);
- the mother reporting a reduction or change in fetal movement;
- where there was an abnormal fetal heart rate monitoring.

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

With regard to instances where **diagnosis and recognition of high-risk status** was identified as a major modifiable factor, this most frequently related to:-

- a failure to recognise and act on risk factors (including cigarette smoking or high blood pressure);
- inadequate monitoring of the baby's growth;
- delay in making a diagnosis.

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

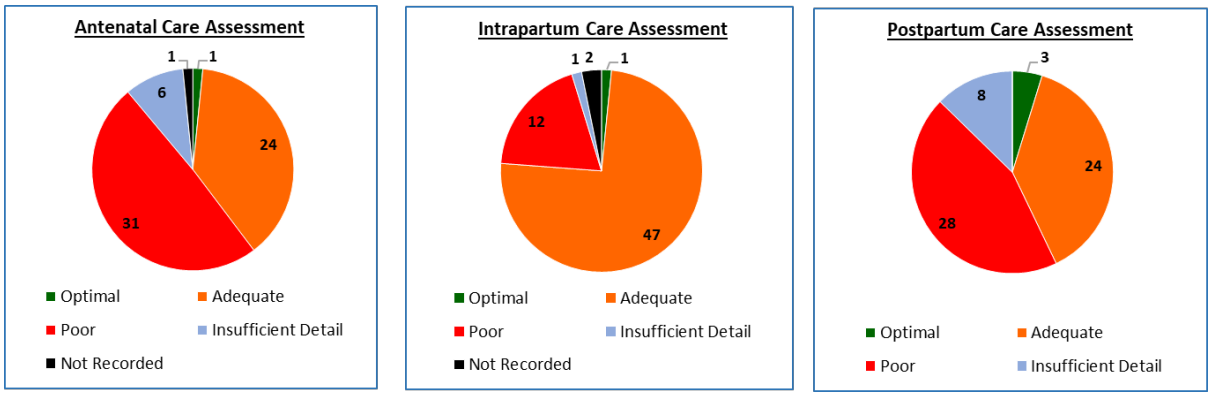
Instances of major modifiable factors occurred throughout the care provided for women from the pre-pregnancy period through to postnatal care.

Given that in the majority of the episodes of care reviewed the stillbirth occurred before the onset of labour (also referred to as antepartum stillbirths), it is unsurprising that the majority of the major modifiable factors occurred in the antenatal period. This is reflected in the fact that of the 63 episodes of care, the review teams concluded that:-

- antenatal care was poor in 31 (49%), adequate in 24 (38%), optimal in 1 (2%);
- care in labour was poor in 12 (19%) adequate in 47 (75%), optimal in 1 (2%);
- postnatal care was poor in 28 (44%) adequate in 24 (38%), optimal in 3 (5%).

This information is further highlighted in Figure 4. It should be noted that in all three areas there were occasions where the level of care could not be graded either because there was insufficient information in the notes or where grading the level of care was not applicable.

Figure 4: *Assessment of Care*



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

Following the all-Wales One Day inquiry into Stillbirths by the Welsh Government in 2013,[15] it was recommended that all stillbirths should be reviewed to a minimum standard. It is important for Health Boards to review why babies die to determine whether improvements in care are needed.

It was therefore concerning that only 62% of the 63 stillbirths subject to a clinical review had been investigated by the Health Board at the time they occurred.

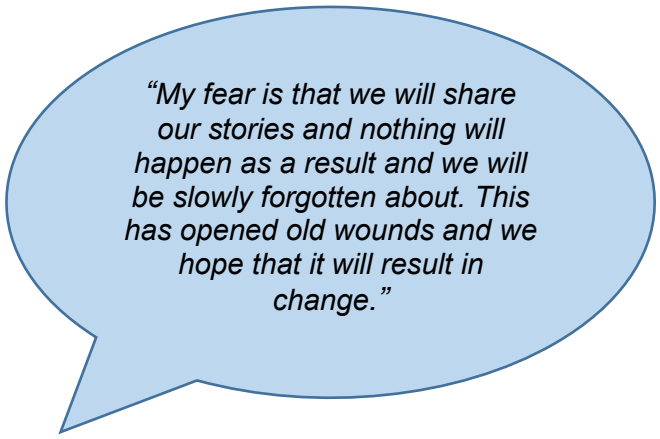
Where reviews were undertaken, they were not always of a high quality and lessons were not always identified. The review teams did not agree with the conclusion of the Health Board's internal review in 51% of those episodes of care where a local review had been undertaken by the Health Board.

6 Women's Experiences of Care

Of the 58 women and families involved in this cohort of the Clinical Review Programme, 20 shared their stories and questions about their care as part of the review process. Of those, 11 did so with the support of Cwm Taf Morgannwg Community Health Council's advocacy service.

These stories contain powerful narratives that the Health Board must take on board if it is to ensure that the maternity and neonatal care it provides meets the needs and aspirations of service users in the Cwm Taf Morgannwg area.

The experiences shared by women and families complement the quantitative analysis of the reviews and should not be regarded as conflicting or contradictory. Rather, they reflect the modifiable factors identified by the clinical review teams from another unique perspective; that of the woman experiencing care. As one woman wrote:

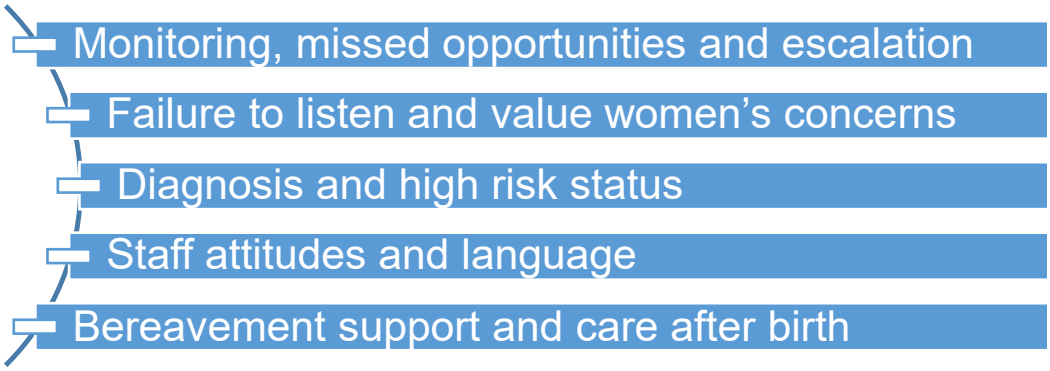


[15] Microsoft Word - FINAL WISR report mat programme 1000 lives i March 14.doc (wales.nhs.uk)

Consequently, stories from women and families have been carefully analysed and the information used to make recommendations for improvements to maternity and neonatal services.

These stories correlate broadly with the findings of the clinical review teams, stressing the importance of listening to what women and their families are saying; not just when things go wrong but as a fundamental part of service design and delivery.

The text from these stories was analysed by a process called thematic analysis to identify the key messages ("themes") which describe women's experiences of care. Through this process, five key themes were identified which have been summarised below.



These issues were often experienced as problems in communication, a factor which was highlighted in 31 of the 63 episodes of care by the clinical review teams.

Women most frequently experienced this as their concerns being dismissed or them being sent home after presenting with symptoms or signs. The themes reported by women in their stories will be described below and have been accompanied by representative quotes shown in italics.

6.1 Monitoring, Missed Opportunities and Escalation

In some of the episodes of care reviewed, mothers were having increased monitoring due to complications that had developed during their pregnancies. However, mothers reported that intervention was sometimes postponed without adequate explanation.

"I continued to attend weekly, at each appointment it was clear that I was not at all well and finding the pregnancy difficult. When I got to 32 weeks I attended my appointment hoping that I would be given a date for induction, instead I was told that to leave it for another week and see how things go, much to my frustration."

6.2 Failure to Listen to and Value Women's Concerns

There seems to have been a particular issue around engagement with Consultant Obstetricians with some mothers having never met a senior clinician or feeling there was a lack of engagement. This often led to a lack of experienced clinical oversight.

"[I was]… consultant-led but never actually met them until I had my baby and they had died."

"When I asked a question I did feel a lack of interest from my consultant, however as I was consultant led I did see them on most visits and did feel at the time I was being monitored. I often felt the consultation was rushed when I attended the clinic."

"We had no say as our wishes were always overruled by staff."

Mothers frequently reported that they were unable to share their concerns with professionals, with one woman reporting that:

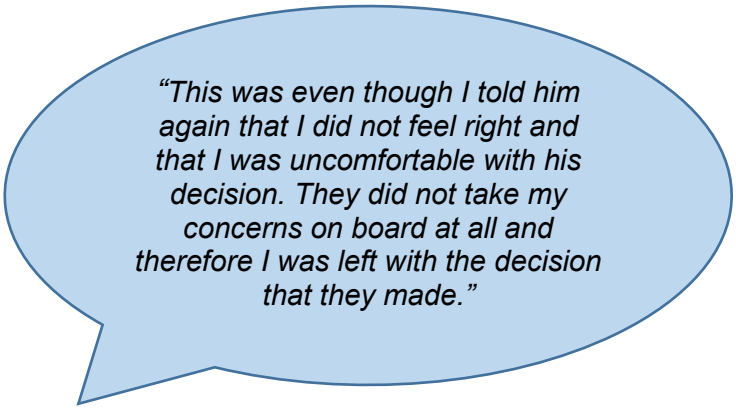
"Everything was dealt with without a sense of urgency and abruptly without us feeling that we could ask questions."

6.3 Diagnosis and Recognition of High-Risk Status

There were occasions when women knew they had "high-risk" pregnancies having had complications previously. One mother who had a history of pre eclampsia said:

"When I went in to see the consultant (a different one) I explained that I had been admitted a few days before and I was still not feeling very well. I also told him that I had noticed reduced movement too. He did not appear concerned."

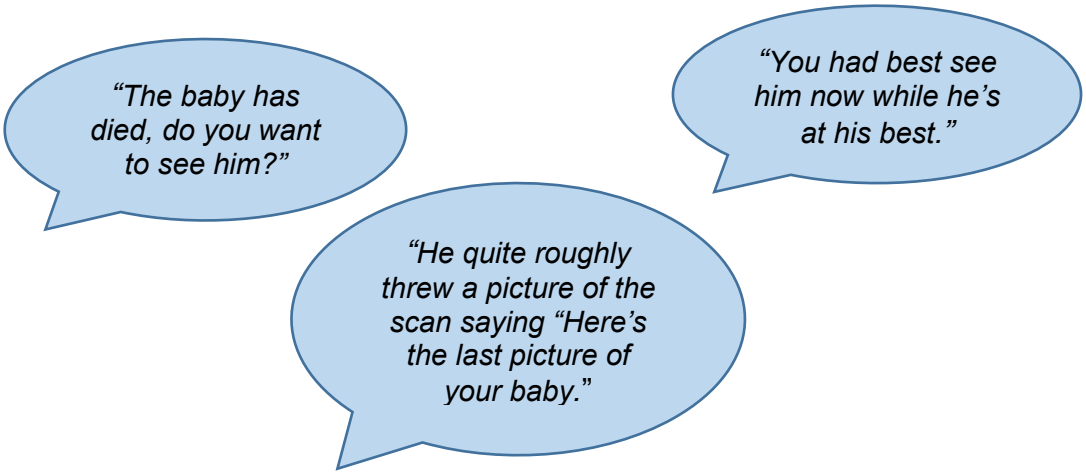
In this instance, the frequency of antenatal surveillance was reduced despite the mother's concern; she went on to develop severe pre-eclampsia and HELLP syndrome.



6.4 Staff Attitudes and Language

There were a number of instances where the language used was inappropriate or did not convey empathy or provide evidence of care for mother and baby. When a baby dies there is an even greater need for careful use of language and non-verbal communication. Women and their families remember what was said and how it was said.[16]

Some examples of inappropriate communication recalled by parents illustrate the impact of the words they heard at such a difficult time:



6.5 Bereavement Support and Care after Birth

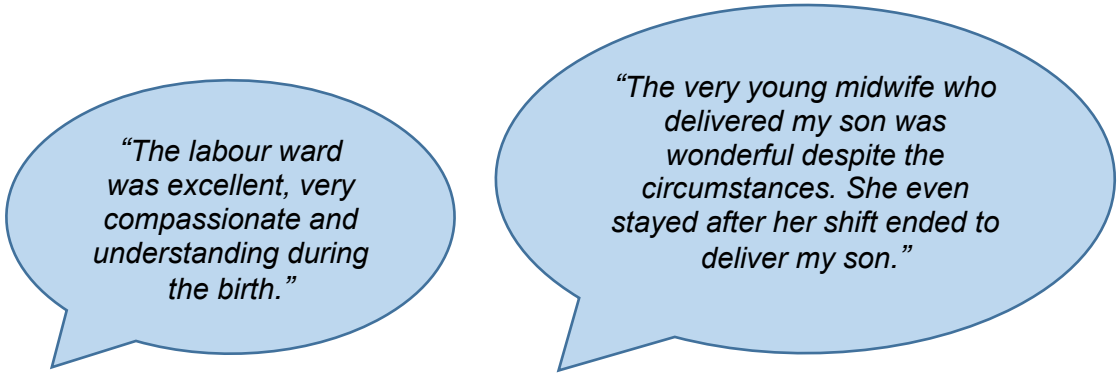
The loss of a baby had a devastating impact on the women and families who told their stories. They talk about their need for a flexible and accessible bereavement service that provides support, information and counselling. They want opportunities to talk about their experience and be heard, often in groups with others who understand what they are going through.

[16] *Downe S et al. Bereaved parents' experience of stillbirth in UK hospitals: a qualitative interview study. BMJ Open. 2013 Feb 14;3(2):e002237.*

Often, their experience reflects the variability of access to the support they needed at that time.

It should also be emphasised that despite the ultimate outcome of the death of a baby, in these episodes of care there were instances of high-quality care that made a huge positive difference to the women and families affected. This care was the opposite of what has been described previously; it was woman-focused and mothers recalled that staff took time and listened to them. Care was authentic, compassionate, kind and understanding. Women remembered the actions of individual staff and reflected on the way that their dedication to each woman's needs and how they communicated with them made a difference. They felt listened to and valued.

It should also be recognised that despite the loss that these women and families experienced and the many negative descriptions of care and communication, there were also positives which were shared as part of the review process.



7 Learning from the Clinical Review Findings

Sections 5 and 6 of the report have highlighted some of the key findings and themes which have emerged from the stillbirth category of reviews and the stories which were shared by some of the women and families involved. This section seeks to draw out the wider learning points which can be derived from that analysis.

It is important to emphasise that the 63 episodes of care which were examined in this category are now historical events, some of which occurred up to five years ago. That is not to minimise or dismiss the trauma and suffering which the women and families involved endured and in some cases, continue to endure; nor is it to suggest that there is not a rich source of learning for the Health Board and the wider NHS in Wales to tap into.

However, much has happened over the last three years in particular, not least the Royal Colleges' review, the introduction of a revised service delivery model and the progress which has been made in delivering against the Royal Colleges' recommendations. The impact of these developments and how they influence the response to the learning which has emerged from the stillbirth category of reviews is explored in greater depth in Section 8 of the report.

However, for now, rather than think in terms of recommendations for action, this section of the report focuses on what can be learned from the review of the 63 episodes of care in the stillbirth category, particularly within the context of wider understanding at a national and international level. The following paragraphs draw out the key learning points from the Panel's perspective.

7.1 Relevance of the Findings in a Wales and UK Context

A UK Confidential Enquiry of 85 incidences of stillbirth occurring before labour found that improvements in care were identified as a major factor where different care may have made a difference to the outcome;[17] where stillbirth had occurred during labour, the proportion of episodes of care where improvements in care may have made a difference to the outcome was slightly increased.[18]

In the most recent report into patient safety concerns in maternity services in England, the Healthcare Safety Investigation Branch (2021)[19] also identified similar themes to those which have emerged from the analysis of the stillbirth category of reviews. However, it is important to acknowledge that the methodologies adopted here and elsewhere in the United Kingdom were different and therefore are not directly comparable.

---

[17] *Draper ES, Kurinczuk JJ, Kenyon S. (Eds.) on behalf of MBRRACE-UK. MBRRACE-UK Perinatal Confidential Enquiry: Term, singleton, normally formed, antepartum stillbirth. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2015.*

[18] *Draper ES, Kurinczuk JJ, Kenyon S (Eds.) on behalf of MBRRACE-UK. MBRRACE-UK 2017 Perinatal Confidential Enquiry: Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death. The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester: Leicester, 2017.*

[19] *The Healthcare Safety Investigation Branch's report can be accessed here.*

WIDER LEARNING POINT 1 - The seemingly high proportion of episodes of care with major and minor modifiable factors described in this thematic report are largely consistent with other UK reviews.

The findings identified by the thematic review of the stillbirth category are largely consistent with those presented in the Thematic Maternal Category Report which was published in January 2021. Those can be summarised as:-

- diagnosis and/or the recognition of high-risk status;
- treatment;
- clinical leadership;
- communication.

Whilst this is understandable as the care provided has an impact on both mothers and babies, the proportion of episodes of care with major modifiable factors was lower in the stillbirth category (33%) when compared to the maternal category (68%). This reflects the fact that severe complications for the mother arguably reflect the most serious consequences for the baby where optimal care has not been given.

The findings from the stillbirth category further highlight issues raised by the Royal Colleges' review in 2019. This is unsurprising because the episodes of care reviewed included the period of the Royal Colleges' review.

Of particular relevance to the episodes of care described here was the Royal Colleges' finding of a lack of senior involvement in complex episodes of care (both in care during pregnancy and labour) and the lack of use of evidence-based guidelines and protocols. This was particularly evident here in instances of fetal growth restriction, pre eclampsia and in stillbirths occurring in labour.

7.2 Incidence of Stillbirth

WIDER LEARNING POINT 2 – Since the improvements in stillbirth rates in other areas of the UK have not been observed in CTMUHB there remain ongoing opportunities to implement further quality improvement methodologies to lower stillbirth rates.

In considering the analysis presented here, it is important to recognise that 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.[20] For brevity, both will be referred to here as the Health Board.

To understand whether a particular maternity unit has a higher or lower stillbirth rate than expected, the numbers are standardised for the ethnic mix, levels of economic deprivation in the population served by the hospital and the type of hospital. This produces a stillbirth rate that is termed the *stabilised and adjusted stillbirth rate.*

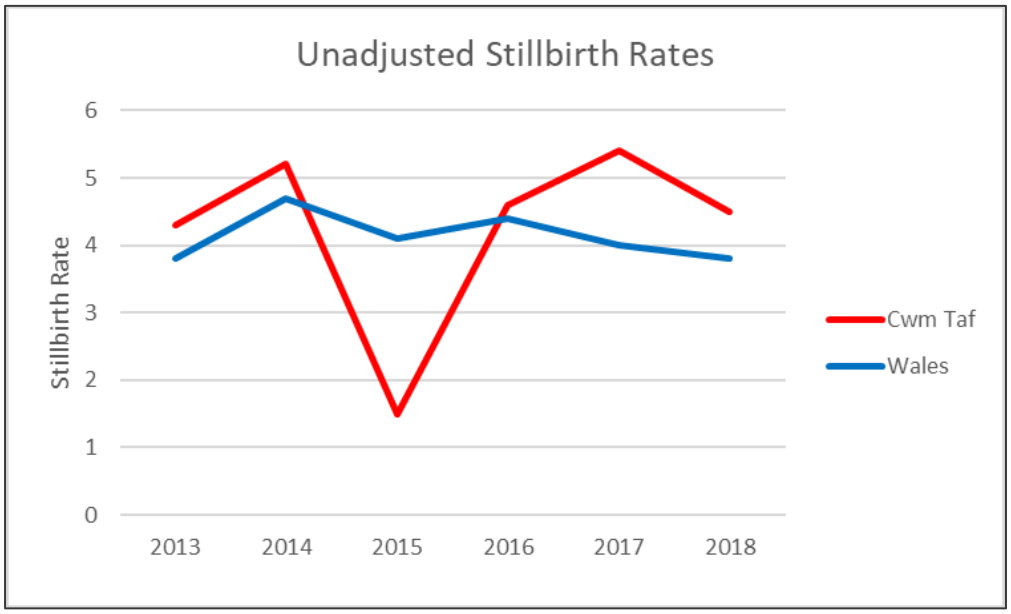
[20] *The newly formed Cwm Taf Morgannwg University Health Board was created on 01 April 2019 following re-alignment with the Bridgend County Borough Council area and the transfer of the Princess of Wales Hospital from the former Abertawe Bro Morgannwg University Health Board.*

When considering the population served by the Health Board, the stabilised and adjusted stillbirth rate is lower than that of Wales as a whole. This in part reflects that the Health Board serves an economically deprived area[21] and this is a secondary maternity service whereby more complex pregnancies are referred elsewhere (for example, to tertiary services in Cardiff or Bristol).

When the Health Board's stillbirth rate is examined it has usually been higher than the rate across Wales. The stillbirth rate can fluctuate due to the comparatively low numbers of births per year (approximately 3,000 – 3,500). Because of this, alongside the fact that it serves a relatively deprived population, it is important to look at the stabilised and adjusted stillbirth rate.

Figure 5 presents the crude (unadjusted) stillbirth rates in the Health Board in red compared to those in Wales from 2013 to 2018.

Figure 5: *Unadjusted Stillbirth Rates*



In the Health Board, the stabilised and adjusted stillbirth rate has remained at around 1 in 300 births and in Wales as a whole it was about 1 in 250 births between 2013 and 2018. The stabilised and adjusted rate is lower than the national average for Wales because of the higher than average rates of deprivation within this area and the fact that some women with more complex pregnancies do not give birth there.

It is important to note that over the same time period, the stillbirth rate across the UK has fallen from 1 in 214 births to 1 in 285 births (a reduction of 16%), meaning that in in the reporting time period (2013-2018) the stabilised and adjusted stillbirth rate was more than 5% *above* the national UK average. This can be seen in Figure 6 where the Health Board is indicated by a red dot.

[21] *Draper ES, Gallimore ID, Smith LK, Fenton AC, Kurinczuk JJ, Smith PW, Boby T, Manktelow BN, on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2018. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2020.*

Figure 6: *Stabilised and Adjusted Stillbirth Rates 2013-2018*

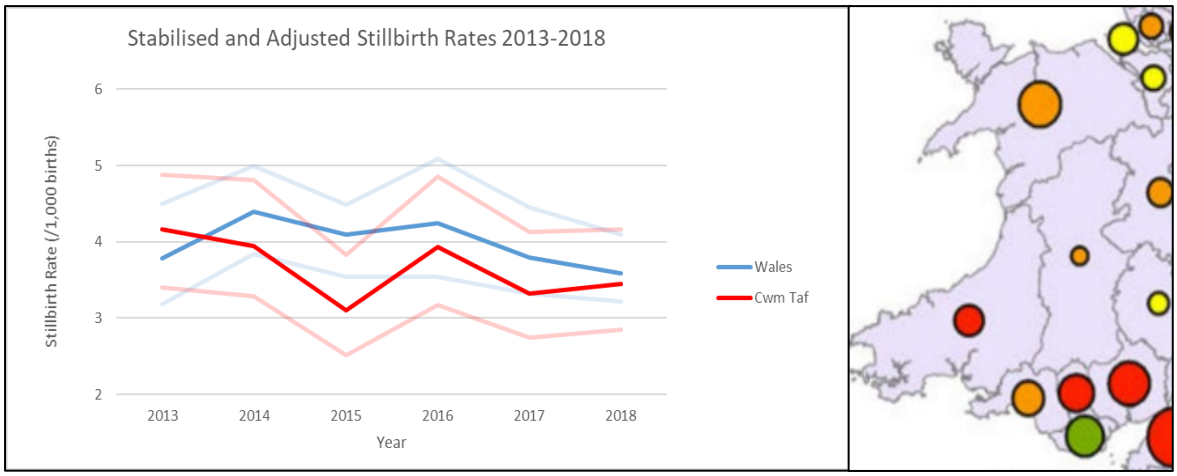


Figure 6 shows the stabilised and adjusted stillbirth rates in the Health Board (shown in red) and Wales (shown in blue) from 2013 to 2018. The 95% confidence intervals are shown in light colours.

The map uses data extracted from the MBRRACE Perinatal Surveillance Report published in 2020.[22] This shows stabilised and adjusted stillbirth rates for Welsh health boards in 2018. Those shown as:-

- yellow dots are between 5 to 15% *lower* than the UK national average;
- orange dots are between 5% *lower* and 5% *higher* than the UK national average;
- red dots are more than 5% *higher* than the UK national average stillbirth rate.

It can be seen that the Health Board is shown with a red dot and is therefore more than 5% higher than the UK national average based on adjusted rates.

This lack of a significant improvement in stillbirth rates continues a trend dating back to the mid-1990s and a widening gap has also been described by epidemiological studies.[23] Ultimately, this means that improvements in stillbirth rates achieved in other areas of the UK do not appear to have been realised by the Health Board or in Wales as a whole; an inequity which needs to be explored and addressed.

7.3 Population Health Issues

WIDER LEARNING POINT 3 – Population health issues like smoking and social deprivation are factors linked to stillbirth in UK populations. These factors are disproportionately prevalent in the communities served by the Cwm Taf Morgannwg University Health Board and there may be opportunities to learn from successful examples elsewhere in Wales and the UK in addressing this.

[22] *See footnote 21. All other MBRRACE reports can be accessed here.*
[23] *Bailey HD et al. Comparison of stillbirth trends over two decades in Wales, United Kingdom and Western Australia: An international retrospective cohort study. Paediatr Perinat Epidemiol. 2021 May;35(3):302-314.*

One area that emerged as a strong theme from the analysis of the stillbirth category was cigarette smoking; 22.4% of women served by the Health Board stated that they smoked cigarettes when they booked for maternity care compared to an average of 17.8% for Wales and 13.4% in the best performing health board.[24] Identifying these areas for improvements in care is important because all have recognised associations with incidences of stillbirth.[25, 26]

When considering the findings of this report it is important to take the local context into account so that the recommendations which emerge can address local issues. The Health Board serves a population who are generally economically deprived, who have high rates of pregnancies amongst women under the age of 20, who are above the recommended body mass index and has a high proportion of women who smoke cigarettes.[27] All of these factors are linked to stillbirths in UK populations.[28, 29]

Women who smoke cigarettes in pregnancy have increased risk of stillbirth and other pregnancy complications; if smoking is stopped before 16 weeks of pregnancy the risks of stillbirth are similar to women who do not smoke.[30]

While some of these factors are outside the capacity of the Health Board to address alone, they need to work proactively with partners to ensure that the needs of their service users are met appropriately and opportunities are taken to improve the health of women before, during and after pregnancy.

7.4 Clinical Practice Guidelines

WIDER LEARNING POINT 4 – Guidelines were not always in place and where they were, they were not consistently used in practice or audited.

It is important to note that some of the areas of suboptimal care identified within the analysis in Section 5 are consistent with those in UK-wide enquiries, specifically in relation to the diagnosis and management of babies who are small for gestational age and the management of reduced fetal movements or abnormal fetal heart rate monitoring.

A failure to identify abnormal fetal heart rate monitoring within the context of the wider clinical picture and to provide appropriate and timely intervention was noted in several episodes of care, particularly in stillbirths occurring in labour.
This is consistent with the message from the MBRRACE Confidential Enquiry into Intrapartum Stillbirths and Each Baby Counts programme.[31]

---

[24] https://publichealthwales.shinyapps.io/smokinginwales/#section-smoke-pregnancy.
[25] *Gardosi J et al. Maternal and fetal risk factors for stillbirth: population based study. BMJ. 2013 Jan 24;346:f108.*
[26] *Flenady V et al. Stillbirths: recall to action in high-income countries. Lancet. 2016 Feb 13;387(10019):691-702.*
[27] *Lau YZ, et al. Assessment of the quality, content and perceived utility of local maternity guidelines in hospitals in England implementing the saving babies' lives care bundle to reduce stillbirth. BMJ Open Qual. 2020 Apr;9(2):e000756.*
[28] *Heazell A et al. Association between maternal sleep practices and late stillbirth - findings from a stillbirth case-control study. BJOG. 2018 Jan;125(2):254-262.*
[29] *Heazell A et al. Associations between social and behavioural factors and the risk of late stillbirth - findings from the Midland and North of England Stillbirth case-control study.BJOG. 2021 Mar;128(4):704-713.*
[30] *Räisänen S, et al. Smoking cessation in the first trimester reduces most obstetric risks, but not the risks of major congenital anomalies and admission to neonatal care: a population-based cohort study of 1,164,953 singleton pregnancies in Finland. J Epidemiol Community Health. 2014 Feb;68(2):159-64.*
[31] *See footnote 22.*

There are established clinical practice guidelines which are covered by the NHS England Saving Babies Lives Care Bundle, the implementation of which was associated with a 20% reduction in incidences of stillbirth.[32] Public Health Wales undertook work in Wales on Models for Access to Maternity Smoking Cessation Services (2015).[33] There was also a Safer Pregnancy Wales campaign launched in 2017 in collaboration with the Maternity Network which focused on nine key messages including public health measures and life style choices. An independent review published in 2018 has reviewed the evidence for different models and has made relevant recommendations for models led by health boards in collaboration with Public Health Wales.[34]

It is known that unit guidelines for these areas of care are often of variable quality throughout the UK and do not always reflect best practice.[35] Learning from national studies suggests that Clinical Practice Guidelines should be in place and regularly reviewed to ensure consistency with national evidence-based guidelines in the following areas:-

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

Staff should receive training about the contents of these key guidelines and compliance should be audited.

7.5 Use of the Perinatal Mortality Review Tool

WIDER LEARNING POINT 5 – Using the Perinatal Mortality Review Tool to good effect will ensure that all perinatal deaths are reviewed in an objective, robust and standardised way.

The lack of consistent, high-quality reviews of incidences of stillbirth has been recurrently highlighted by Confidential Enquiries into antepartum and intrapartum-related perinatal deaths as well as the Each Baby Counts programme of the Royal College of Obstetricians and Gynaecologists.[36]

---

[32] *Widdows K, et al. Stillbirth rates, service outcomes and costs of implementing NHS England's Saving Babies' Lives care bundle in maternity units in England: A cohort study. PLoS One. 2021 Apr 19;16(4):e0250150.*
[33] *http://www.wales.nhs.uk/sitesplus/documents/888/PHW%20MAMSS%20Report%20E%2003.17.pdf.*
[34] *https://gov.wales/sites/default/files/statistics-and-research/2018-12/180612-independent-review-provision-smoking-cessation-services-en.pdf.*
[35] *Lau YZ, et al. Assessment of the quality, content and perceived utility of local maternity guidelines in hospitals in England implementing the saving babies' lives care bundle to reduce stillbirth. BMJ Open Qual. 2020 Apr;9(2):e000756.*
[36] *Royal College of Obstetricians and Gynaecologists. Each Baby Counts: 2020 Final Progress Report. London: RCOG; 2021.*

This has led to the development of the Perinatal Mortality Review Tool (PMRT) which provides a standard template for all stillbirths to be reviewed against established guidelines and also includes input from parents and external organisations which ensures parents' views and experiences are taken into account when assessing the quality of care and gives assurance that care has been assessed outside of the organisation in question.

It is intended that using the PMRT will ensure that all perinatal deaths will be reviewed in an objective, robust and standardised way and parents will receive a full explanation as to why their baby died, where this is possible.

The Health Board must dedicate sufficient time for Consultant Obstetricians and Neonatologists, Midwives and administrative staff to ensure that the PMRT can be used to review all incidences of stillbirth. In addition, all trainees should be provided with the opportunity to be involved as part of their training programme. Parents' questions and views about their care should be sought and incorporated into the review. Structures should be put in place with other health boards or maternity providers to ensure PMRT reviews receive external peer input.

In 2020, the PMRT was used to review 59% of stillbirths in Wales compared to 91% in England and 73% in Scotland.[37]

7.6 Assessment of Fetal Wellbeing

WIDER LEARNING POINT 6 – Inadequate fetal surveillance was a major modifiable factor in a significant number of the episodes of care reviewed in the stillbirth category.

The inadequate monitoring of babies' growth and the presence of fetal growth restriction (i.e. when a baby does not grow at the rate expected) was identified as a major source of modifiable factors in the stillbirth category of reviews.

The Perinatal Institute's Growth Assessment Protocol (GAP) assists clinicians with the assessment of fetal growth and includes training, guidelines and completion of growth charts in order to identify growth outside of an accepted range.

As part of fetal surveillance, the Health Board should ensure that all doctors and Midwives undergo GAP and GROW (Gestational Related Optimal Weight) training in line with guidelines and that compliance against those guidelines is audited.

A failure to identify abnormal fetal heart rate patterns via Electronic Fetal Monitoring (EFM) and Intermittent Auscultation (IA) within the context of the wider clinical picture and to provide appropriate and timely intervention was identified in several episodes of care, particularly in stillbirths occurring in labour. This is consistent with the message from the MBRRACE Confidential Enquiry into Intrapartum Stillbirths and the Each Baby Counts programme.

[37] *Kurinczuk J.J. et al. Learning from Standardised Reviews When Babies Die. National Perinatal Mortality Review Tool: Second Annual Report. Oxford: National Perinatal Epidemiology Unit. 2020.*

7.7 Care after a Stillbirth

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

Both the clinical reviews and the women's stories from the stillbirth category evidenced that there was a variation in the care experienced by parents after the death of their baby.

This ranged from very positive experiences of consistent, individualised care to fragmented, incomplete care. Specifically, parents rarely had follow-up visits to discuss the results of investigations or tests after their baby had died and to make a plan for any future pregnancies.

In their stories, women highlighted the positive impact of speaking with a Bereavement Midwife, but explained that when they were on leave, there was no cover arrangement in place. The appointment of a single Consultant Lead would allow for continuity of care and help to build up expertise in caring for parents after stillbirth and into any subsequent pregnancies.

All-Wales guidelines are being developed by the Maternity and Neonatal Network and given that women often experience care from multiple providers, this will help prevent variation in the care provided and the information given to women and their families. Regional guidelines for the care of women after stillbirth employed in other parts of the UK have reduced variation in practice and ensure high-levels of investigation (e.g. placental histopathology).

7.8 Communications Skills

WIDER LEARNING POINT 8 – Frontline staff should receive training in communication skills relating to the death of a baby and provision of care after stillbirth.

Women frequently cited problems with the language used after their baby had died, ranging from diagnosis in the ultrasound department through to postnatal care.

Training courses are available from established organisations such as Child Bereavement UK and SANDS which can address the learning needs of a diverse range of staff. Trained members of staff can then model and disseminate best-practice in their areas.

8 What Does This Mean in the Current Context?

The findings which have emerged from the stillbirth category of the Panel's Clinical Review Programme are similar in many respects to the findings which emerged from the maternal mortality and morbidity category which was reported on in January 2021.

As part of an evolving picture of the maternity and neonatal care which was historically provided by the Health Board, this will provide further 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. Every one of the women and families involved suffered the unthinkable trauma and the distress of losing a baby and for many of them, the Panel's findings will compound the sense of loss and suffering which they are already feeling.

Whilst the Panel's primary focus is quite rightly on the interests of women and families affected, it should not be forgotten that this report will make particularly difficult reading for the staff involved and their colleagues too.

The reality is that in one in three of the episodes of care which were examined, the independent clinical review teams concluded that different care or treatment might have resulted in a different outcome for the babies involved and their mothers.

The review teams also concluded that whilst the outcome may not have been any different for the mother and their baby, there were lessons to be learned from just over three in four of the episodes of care that they reviewed; in fact, in only four of the 63 episodes of care examined, did the independent teams conclude that they would not have done anything differently in the same circumstances.

In total, from the 63 episodes of care, the reviewers identified over 553 individual opportunities for learning which the Health Board is now systematically evaluating to determine to what extent it needs to improve or further improve its working practices going forward.

Not all of the learning opportunities which were identified had a detrimental impact on the safety and quality of the care and treatment which was provided. Moreover, a number of these learning opportunities were repeated across more than one episode of care. However, some common themes have been identified from those which did, namely:-

- a failure to recognise and respond to high-risk situations in a timely manner;
- inappropriate or inadequate treatment;
- failings in clinical leadership and oversight.

As explained in Section 7 of the report, these key themes are broadly consistent with those emerging from similar reviews which have been conducted in other parts of the UK and through long-range surveillance programmes like MBRRACE and Each Baby Counts.

The findings of the clinical review teams were re-enforced to a significant extent by the experiences of the women whose care was reviewed. Just under a third of women came forward to tell their story and together, they painted a disturbing picture of poor communication and a lack of empathy and support. These themes were highlighted as:-

- a failure to listen to women and value their opinions;
- inappropriate staff attitudes and behaviours;
- inadequate bereavement support and after care.

Those who told their stories also described in their own words, some of the poor clinical decision making which was identified by the review teams, most notably, the inappropriate monitoring of their progress and missed opportunities to diagnose risk and escalate their treatment accordingly. Similarly, the clinical review findings provided information which supported the women's stories.

All of this is broadly consistent with the themes which emerged from the maternal mortality and morbidity category and the more extensive '*Listening to Women and Families*' exercise[38] which the Royal Colleges conducted alongside their review of the Health Board's maternity and neonatal services in January 2019.

Familiar though they are, 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 suffered the loss of a baby; that will have had a devastating and long-lasting impact on their lives. Those people and their ongoing needs must never be forgotten. Both the Panel and the Health Board are resolute in their determination that this will not happen.

8.1 Putting the Findings into Context

Although these findings must never be downplayed or brushed aside, there are a number of important contextual factors that should be borne in mind when considering what they mean and what the Health Board should do as a result. The Panel made similar points in the first thematic report but this context is important and so they are repeated below:-

- There are inherent risks in the childbirth process - although the clinical review teams concluded that a different outcome may have been achieved in 21 of the 63 the episodes of care they reviewed, it was considered unlikely, even if the care and treatment provided had been different, that a different outcome could have been achieved in the remaining 42. That in no way seeks to minimise the gravity of the findings or dismiss the impact for these women and families.
- 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

[38] https://gov.wales/sites/default/files/publications/2019-04/listening-to-women-and-families-about-maternity-care-in-cwm-taf_0.pdf

baby without significant complications or adverse consequences. The 63 episodes of care which were reviewed, represent six in every thousand women.

- 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 fresh 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 of the improvements they must make, there is nothing which has emerged from the second cohort of clinical reviews which was not broadly covered by the 70 recommendations made by the Royal Colleges.
- Substantial improvements have already been made - it is important to recognise that over the past two and a half years, 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 and Neonatal Improvement Programme. 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 8.2 and 8.3 below.

8.2 Correlation of Findings against the Royal Colleges' Recommendations

The Heath Board is currently evaluating the detailed observations and/or recommendations made by the clinical review teams in order to determine what has already been done, what is currently being done and what remains to be done to address the issues which have been identified. If there is any significant new learning which has not previously been identified, there is an agreed mechanism for including that within the Maternity and Neonatal Improvement Plan.

In order to provide an early indication of the significance of the findings from this phase of the clinical review process for the purposes of this report, the Panel has conducted its own high-level analysis in order to identify the degree of correlation between the key themes and issues which have emerged from the stillbirth reviews and the 70 recommendations made by the Royal Colleges in April 2019. The results of this analysis are set out in the table in *Appendix B*.

It can be seen from the table that the four key themes which emerged from the clinical review process and women's stories, i.e. diagnosis and recognition of high-risk status, inappropriate treatment, clinical leadership and communication, correlate significantly with the Royal Colleges' recommendations. In total, the Panel identified 29 of the 70 recommendations which correlated either directly or indirectly to the four key themes.

Each of the four themes were covered by a number of the Royal Colleges' recommendations, for example listening to women was reflected in four of the recommendations. Moreover, some recommendations correlated to more than one of the key themes. Further analysis of this is shown in *Appendix B.*

It will also be seen that 14 of the 29 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 15 remain work in progress.

On that basis, the Panel is reasonably assured that there is nothing significant which has emerged from this second element of the Clinical Review Programme which was not previously identified by the Royal Colleges and is therefore not already reflected within the Health Board's Maternity and Neonatal Improvement Plan.

The analysis of the review findings has identified a number of new insights and has added weight to the importance of the improvement work which the Health Board is currently undertaking.

These issues are outlined in further detail in Section 7 of the report and reflected in the recommendations in Section 10.

8.3 What Does This Mean for The Health Board's Improvement Plans?

In summary, whilst the emerging findings from the stillbirth category of the Clinical Review Programme do provide cause for concern, those concerns need to be kept very firmly in context.

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.[39]

They are broadly the same issues which are currently being addressed in a structured and publicly accountable way through the special measures arrangements which have been put in place by the former Minister for Health and Social Services as well as the Health Board's ongoing Maternity and Neonatal Improvement Programme.

[39] *A copy of the Royal Colleges' original report can be accessed here.*

It is evident that the Health Board has made significant progress in improving its maternity services over the past two and a half years.[40] 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 service improvement point of view, the findings of the stillbirth element of the Clinical Review Programme 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 identify some new dimensions which require action by the Health Board and serve to emphasise the need for continued focus and attention to ensure that the remainder of the Royal Colleges recommendations, particularly the transformational elements around leadership and staff culture and behaviours are fully delivered. This involves the development of a number of Work Packages which will underpin the design and development of a Five-Year Strategic Plan for the maternity and neonatal service which will be published in December 2021.

9 What Happens Next

From the Panel's perspective, work on the stillbirth category is now largely completed and the focus has shifted to the next element of the Clinical Review Programme which is the neonatal mortality and morbidity category. However, for the Health Board, the work remains ongoing. Further detail about the next steps of the Clinical Review Programme can be found in the September 2021 Progress Report which has been published alongside this report and can be accessed here.

10 Conclusions and Recommendations

This is the second in a series of high level thematic reports prepared by the Independent Maternity Services Oversight Panel.

Its purpose is to share the emerging themes from the second element of the ongoing programme of independent clinical reviews of the maternity and neonatal care provided by Cwm Taf Morgannwg University Health Board which arise 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 63 individual episodes of care which were provided by the Health Board between 01 January 2016 and 30 September 2018. A small number of episodes of care fell outside these dates either because it was submitted as 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.

[40] *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.*

10.1 Summary of Findings

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

- 63 episodes of care were clinically reviewed in this phase of the programme;
- the independent clinical review teams concluded that in a third of those episodes, different treatment or care may 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 distressing for the women and families involved, they are not unexpected - the issues identified are broadly 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 remains to be done in key areas like culture and behaviours, leadership and communication.

In the Panel's view, the findings broadly confirm the Royal Colleges' findings. As such, they do not necessitate any significant adjustments in the Health Board's improvement plans nor in the oversight arrangements which sit alongside them.

They also identify a number of additional insights which require renewed focus or additional action by the Health Board and these are reflected in the recommendations which are set out in Section 10.2.

10.2 Recommendations

Having considered the findings which have emerged from the stillbirth category of the Clinical Review Programme (as outlined in Sections 5 and 6 of this report) and reviewed the wider learning which can be drawn from those findings (as outlined in Section 7 of the report), the Panel does not believe that it is necessary to make any recommendations in terms of adjustments to the current oversight arrangements.

Based on the learning which has emerged from the stillbirth category of reviews, the Panel makes the following recommendations for the Health Board which should be appropriately reflected in the Work Packages which are currently being developed. Further information on the development of Work Packages and the movement of the service towards a continuous improvement trajectory can be found within the accompanying progress report.

These recommendations have been derived from the eight key learning points identified in Section 7 of the report, viewed in the context of the progress which has been made by the Health Board since the Royal Colleges reported their assessment of the service in April 2019.

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

In particular, the response should explain what the Health Board has already done to address the learning through the delivery of its Maternity and Neonatal 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 explain how the Health Board 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> – In the context of the work which is already underway corporately around population health and the 2020 All-Wales data review, the Health Board should seek to understand why the reduction in stillbirth rates achieved in other areas of the UK in recent years do not appear to have been realised in the Health Board and take action to address the issues raised; (*Wider Learning Point 2 – Page 17*).

<u>Recommendation 3</u> – The Health Board should review and where necessary, strengthen its approach to smoking cessation in pregnancy based on successful programmes elsewhere in Wales and other parts of the UK; (*Wider Learning Point 3 – Page 19*).

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

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

The review should also ensure that the guidelines are disseminated, that staff are trained to apply them and compliance is audited on a regular basis; (*Wider Learning Point 4 – Page 20*).

<u>Recommendation 5</u> – The Health Board should review its use of the Perinatal Mortality Review Tool (PMRT) to ensure that there are systems and processes in place to ensure that it is used for all incidences of stillbirth and neonatal deaths. These reviews must be multidisciplinary including external peer input. Parental input should be encouraged; (*Wider Learning Point 5 – Page 21*).

<u>Recommendation 6</u> - Compliance rates for annual mandatory training programmes (e.g. PROMPT, GAP and GROW, All Wales Fetal Surveillance Bundle) should be restored to meet Health Board compliance standards at the earliest opportunity; (*Wider Learning Point 6 – Page 22*)**.**

<u>Recommendation 7</u> – The Health Board should review its capacity to provide care after stillbirth to ensure that it has adequate numbers of trained staff to cater for out of hour's situations and periods of absence of specialist staff. This should include the nomination of a Consultant Obstetric Lead for stillbirth and pregnancy after loss; (*Wider Learning Point 7- Page 23*).

<u>Recommendation 8</u> – The Health Board should review the plans which it is currently developing for communications training to all staff to ensure that it specifically provides the delivery of training to frontline staff, relating to care following the death of a baby and provision of care after stillbirth; (*Wider Learning Point 8 – Page 23*).

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

There is significant learning to be derived from the second phase of the Clinical Review Programme which might not only benefit the Health Board but also be of wider benefit to other health boards in Wales and indeed, organisations throughout the UK.

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 which is summarised in Section 7 of the report.

The second aspect 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, to manage engagement and communication 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 expectations of women and families at the heart of the process.

11 List of Appendices

Appendix A: Technical Analysis

Appendix B: Table of RCOG/RCM Recommendations

Technical Analysis

Figure 1: *Modifiable Factors Present in Episodes of Care Reviewed*

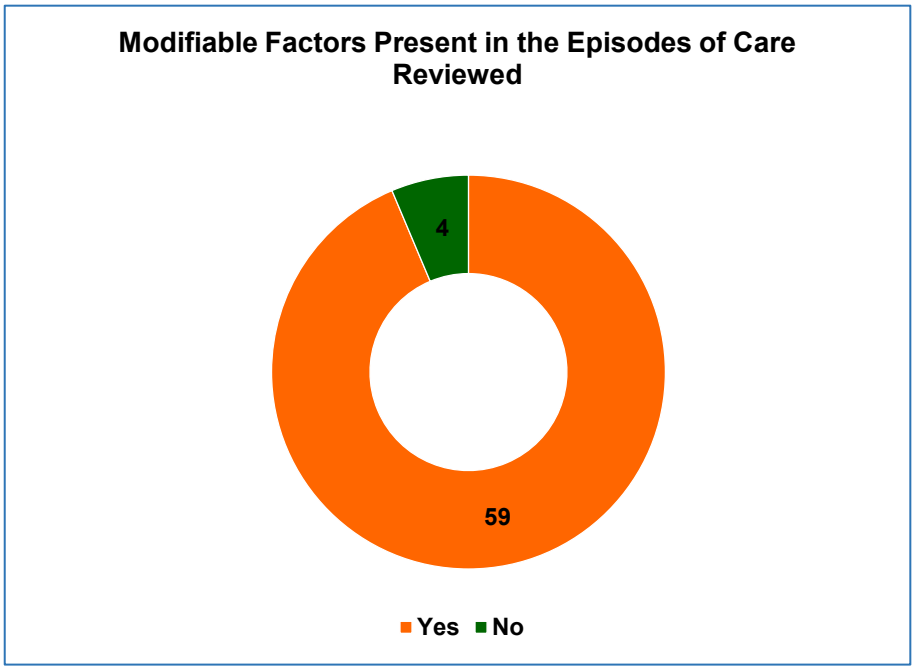
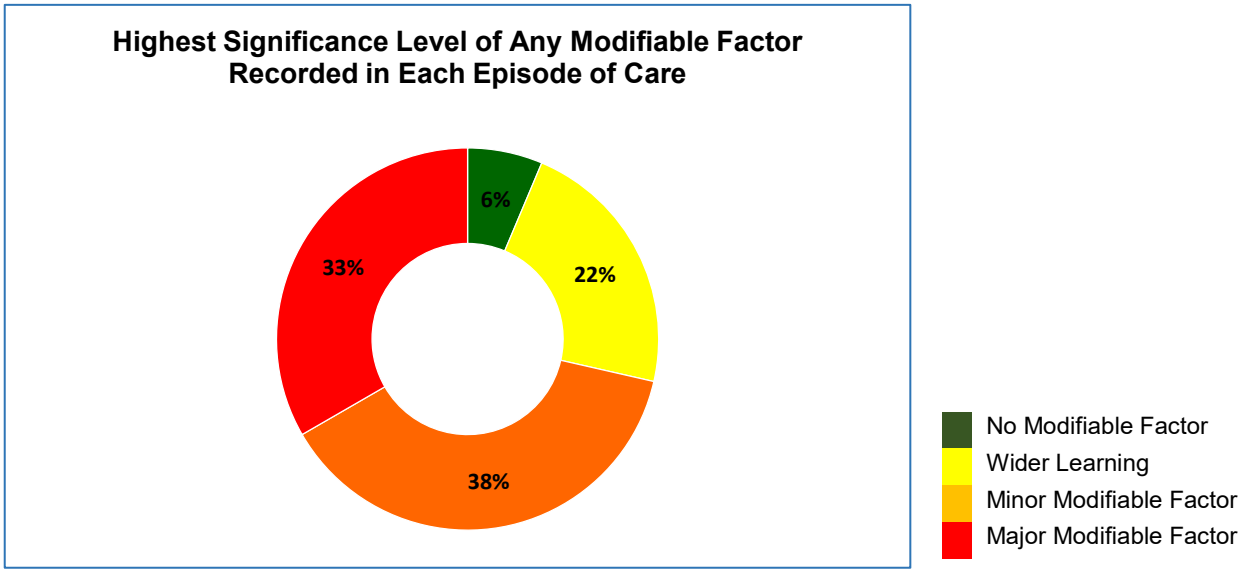
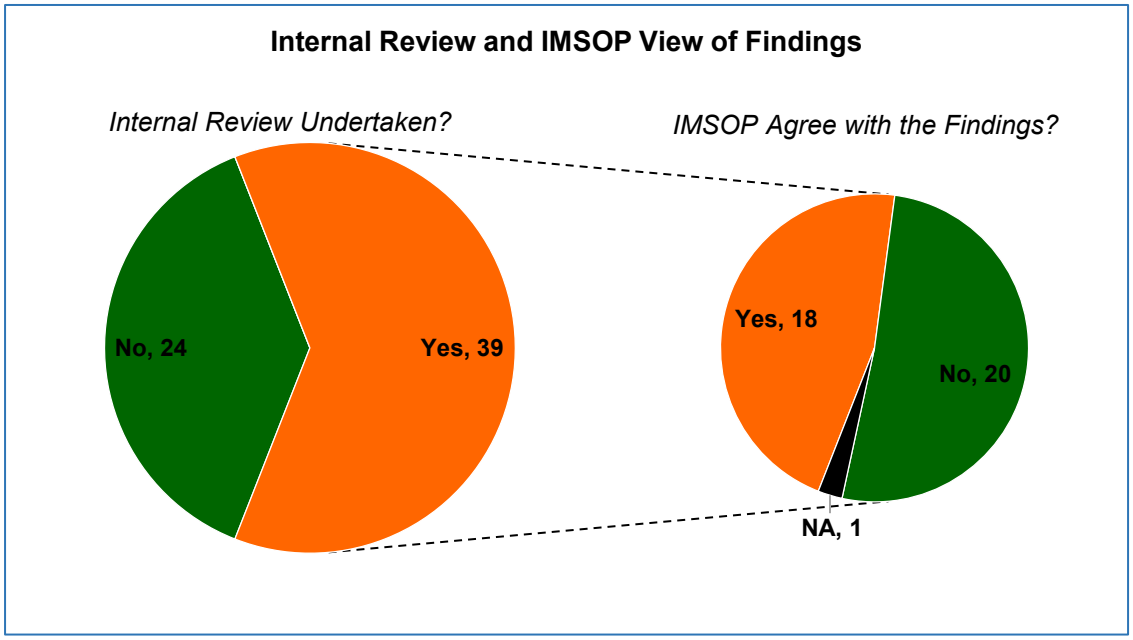


Figure 2: *Highest Level of Significance of Modifiable Factor Identified*



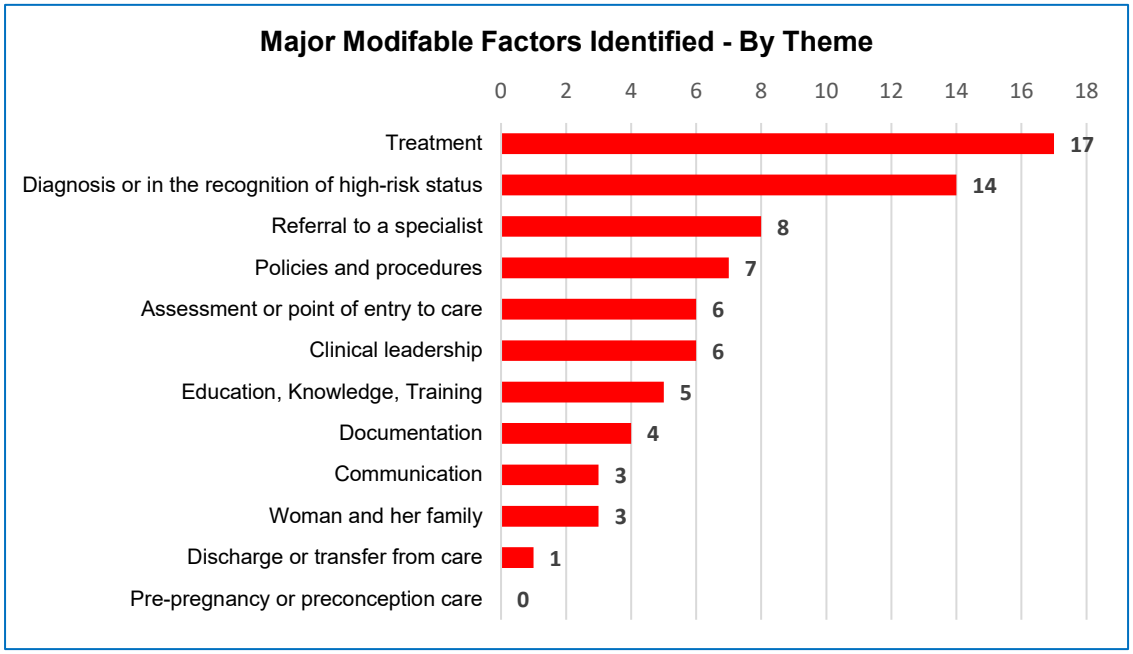
N.B. More than one modifiable factor was identified in the majority of episodes of care. 21 (33%) episodes of care had at least one major modifiable factor, with the total number of major modifiable factors identified in a single episode of care ranging from one to seven factors. The percentages within Figure 2 do not equal 100% due to rounding up/down.

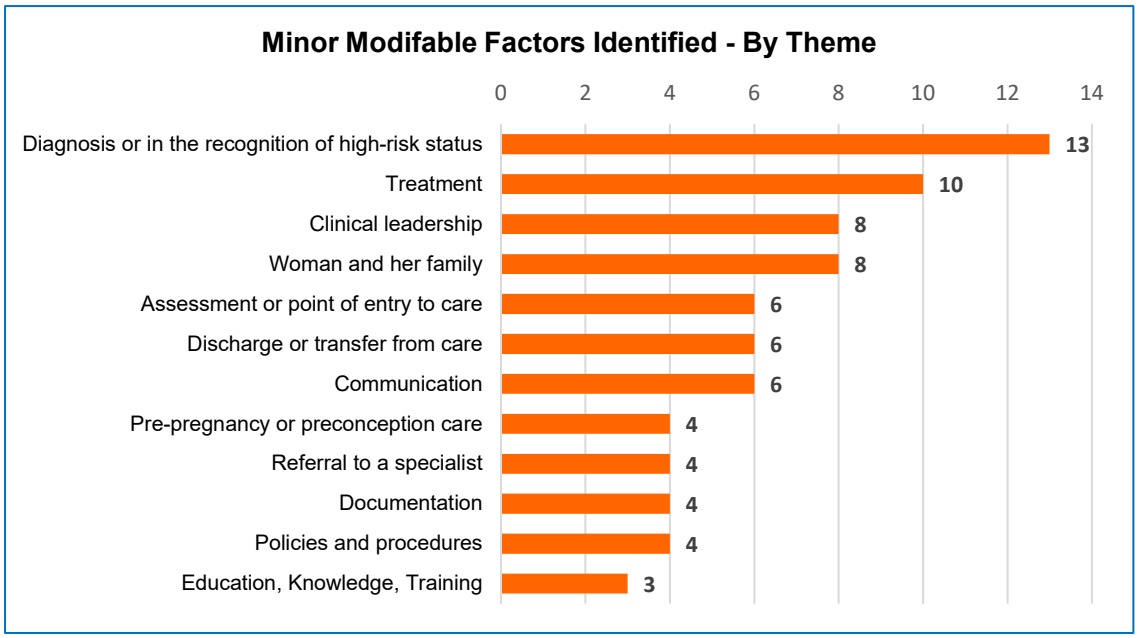
Figure 3: *Internal Health Board Review and IMSOP View of Findings*

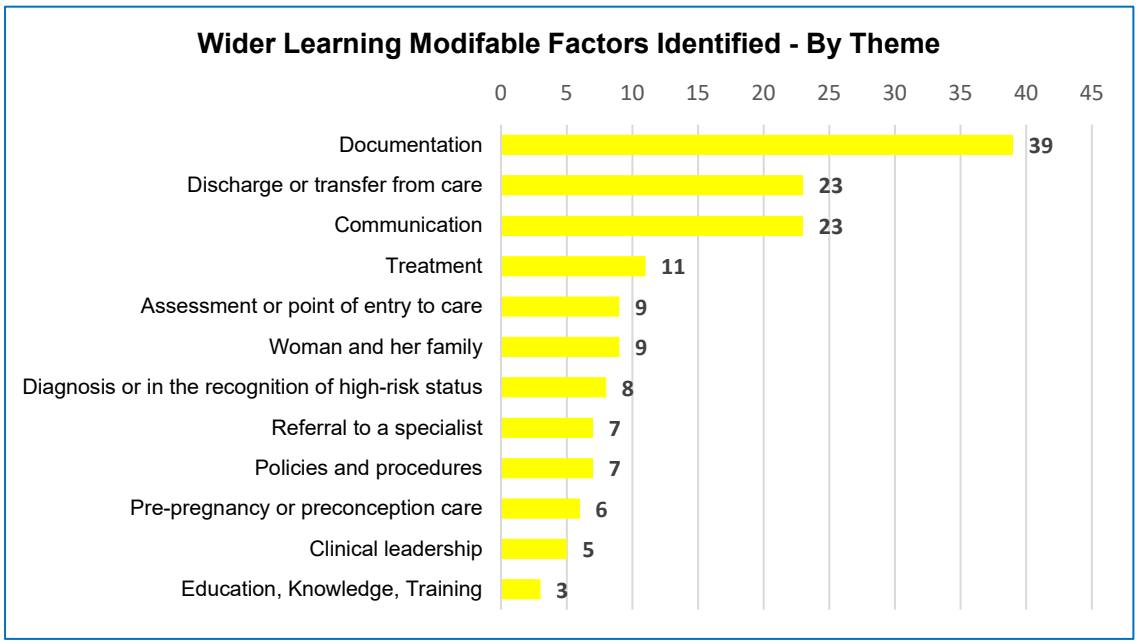


N.B. The above chart explains that only 39 of the 63 episodes of care experienced a local review undertaken by the Health Board at the time. Of these, the Panel disagreed with the review findings in more than 50% of instances.

Figure 4: *Frequency of Modifiable Factors by Level of Significance*







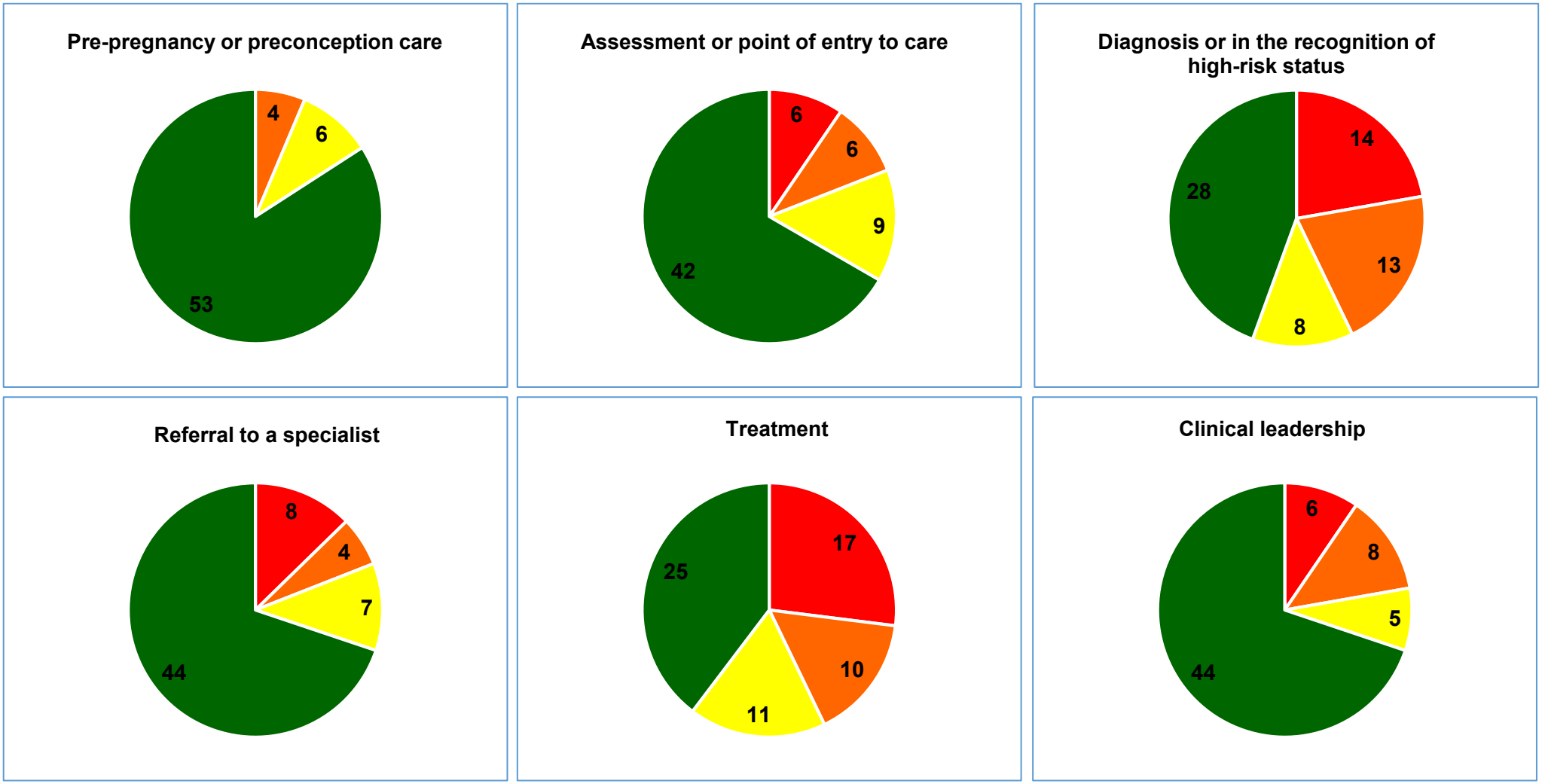
N.B. The above charts provide a thematic breakdown of each modifiable factor identified according to level of significance (wider learning, minor, major). It is important to note that more than one modifiable factor may have been identified in each episode of care reviewed. As such, the total number of modifiable factors identified is greater than the total number of episodes of care reviewed.

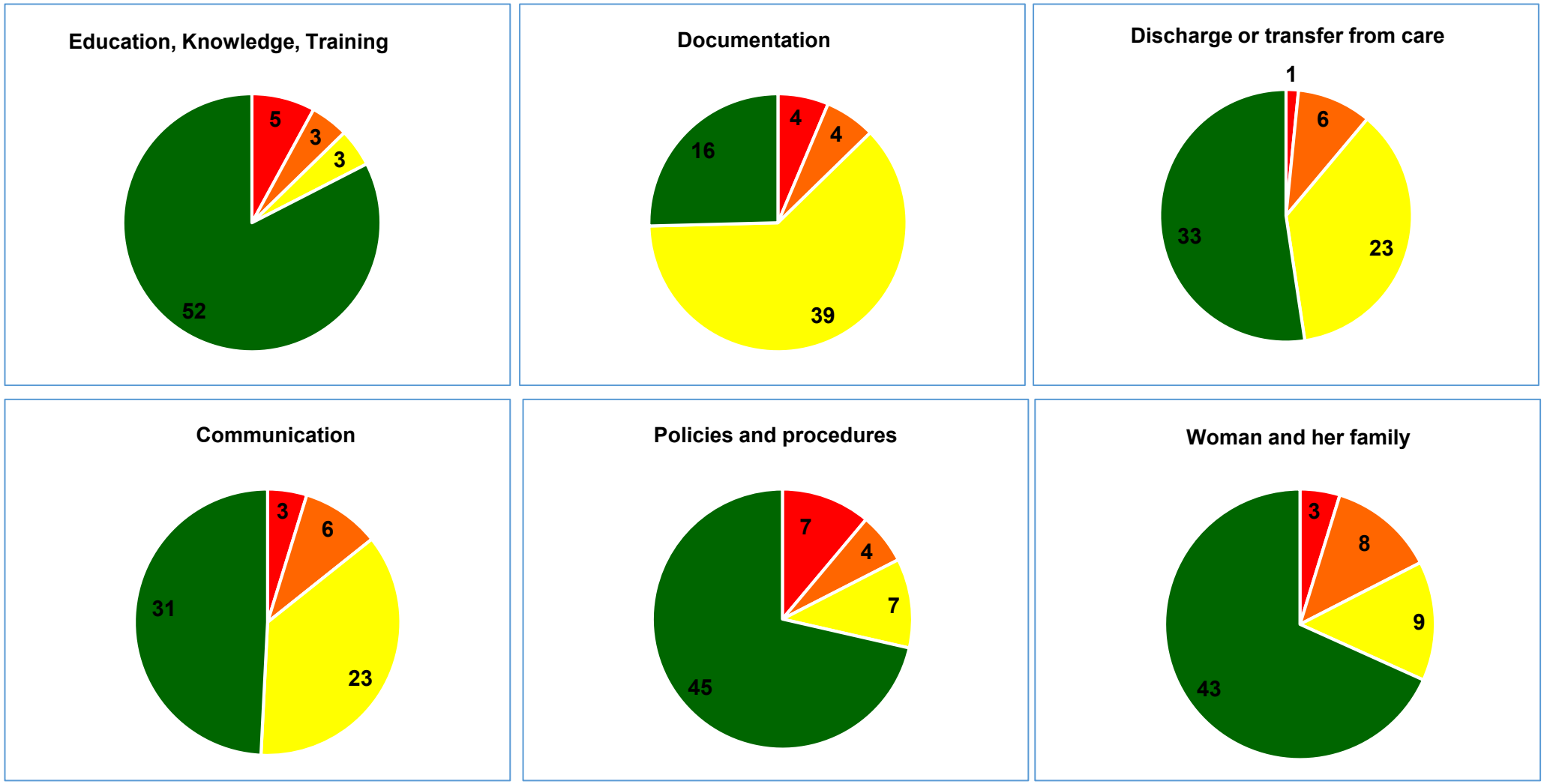
Table 1: *Breakdown of Modifiable Factors According to Review Theme*

Modifiable Factors Identified % of Episodes of Care with Modifiable Factors	Significance				Total Episodes of Care
	Major	Minor	Wider Learning	None	
Pre-pregnancy or preconception care	0%	6%	10%	84%	63
Assessment or point of entry to care	10%	10%	14%	67%	63
Diagnosis or in the recognition of high-risk status	22%	21%	13%	44%	63
Referral to a specialist	13%	6%	11%	70%	63
Treatment	27%	16%	17%	40%	63
Clinical leadership	10%	13%	8%	70%	63
Education, Knowledge, Training	8%	5%	5%	83%	63
Documentation	6%	6%	62%	25%	63
Discharge or transfer from care	2%	10%	37%	52%	63
Communication	5%	10%	37%	49%	63
Policies and procedures	11%	6%	11%	71%	63
Woman and her family	5%	13%	14%	68%	63

N.B. This table is another visual representation of the breakdown of modifiable factors against each theme. It is important to note that more than one modifiable factor may have been identified in each episode of care reviewed. As such, the total number of modifiable factors identified is greater than the total number of episodes of care reviewed.

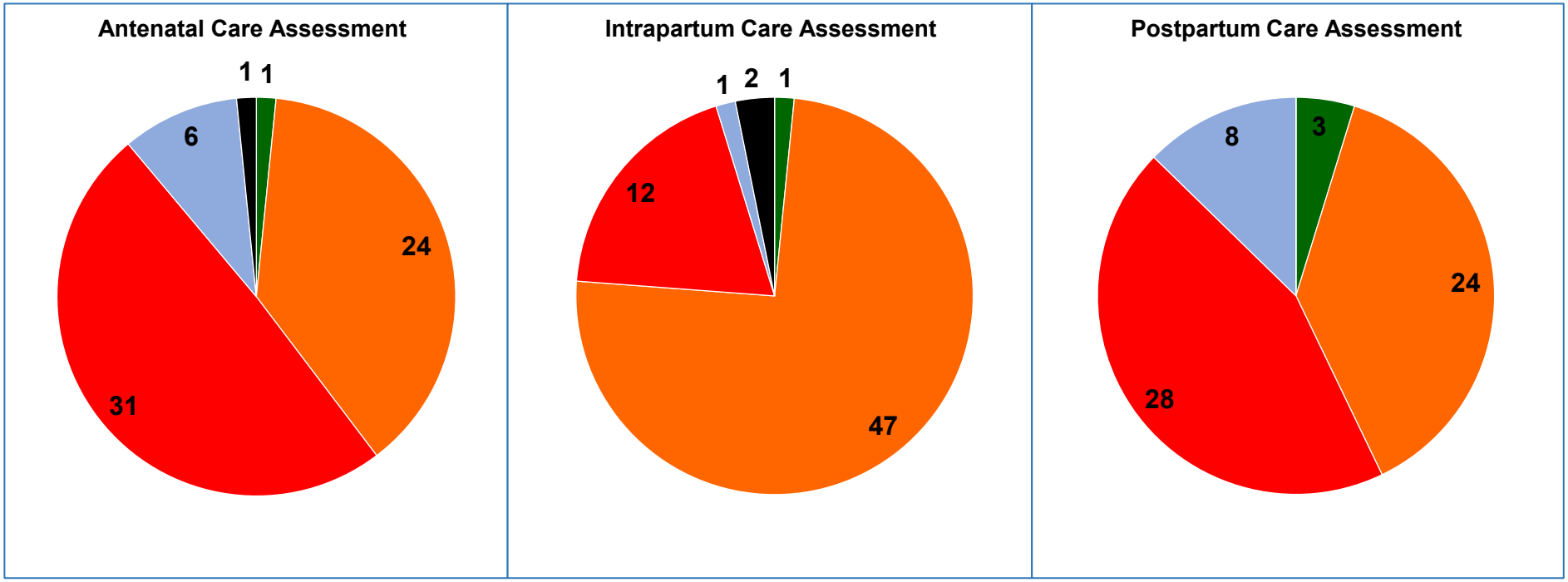
Figure 5: *Summary Charts for Modifiable Factors by Significance Level*





N.B. This table is another visual representation of the breakdown of modifiable factors against each theme. It is important to note that more than one modifiable factor may have been identified in each episode of care reviewed. As such, the total number of modifiable factors identified is greater than the total number of episodes of care reviewed.

Figure 6: *Overall Assessment of Care across all Episodes of Care*



N.B. The above chart details the clinical review team's assessments of care provided in each of the 63 episodes of care in the antenatal, intrapartum and postpartum periods.

Table 2: *Sub-Category Breakdown of Modifiable Factors*

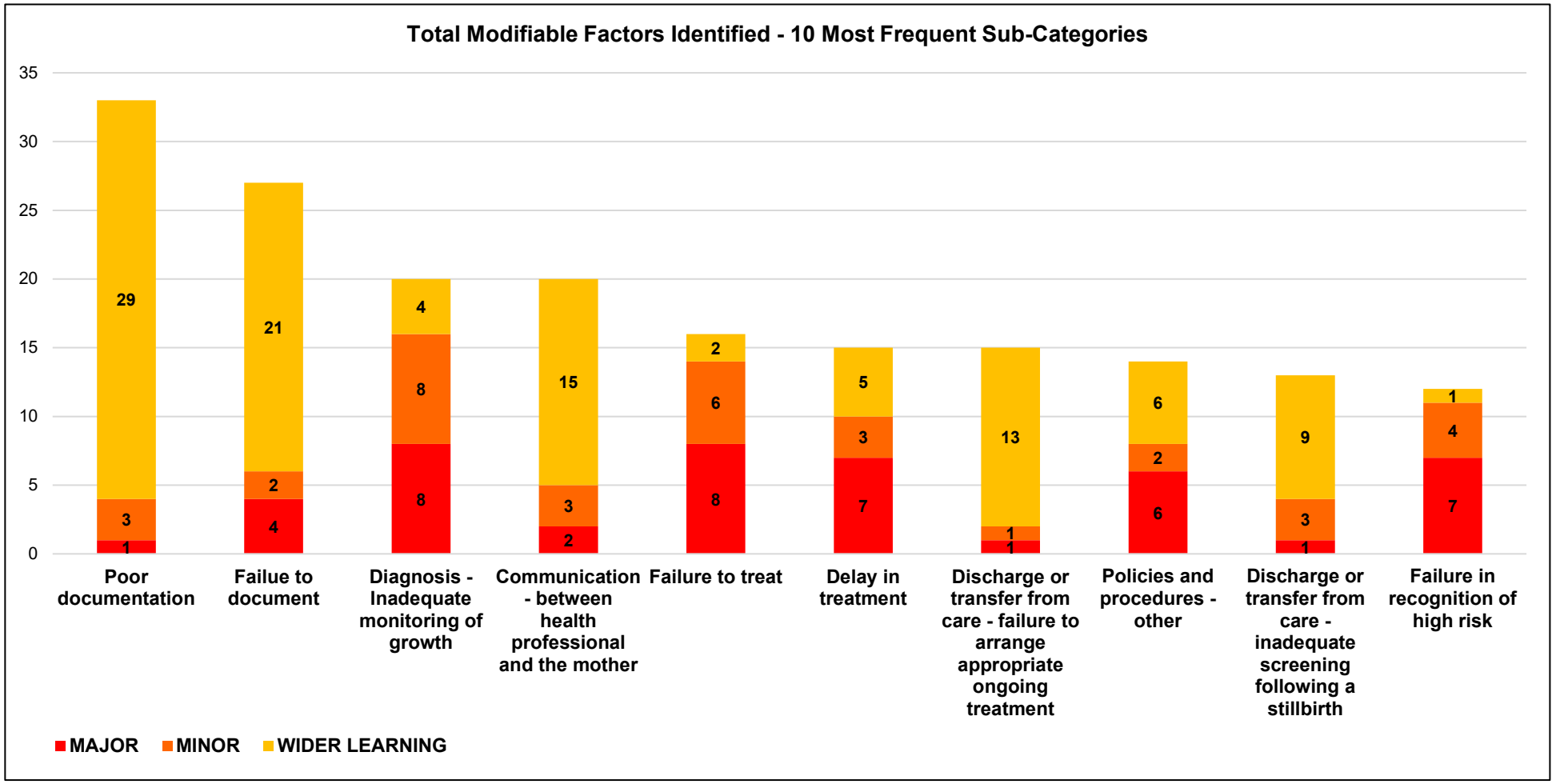
Sub-Category Breakdown of Modifiable Factors ***(please note a case may be assessed as having more than one sub-category within an identified modifiable factor theme)***		**Episodes of Care with the Sub-Category Identified as part of a Modifiable Factor**	
Pre-pregnancy or preconception care	Counselling	6	10%
	Complete Medical History	0	0%
	Other	4	6%
Assessment or point of entry to care	Access to care	0	0%
	Failed to offer preventative treatment	9	14%
	Delayed assessment	6	10%
	Failed to get complete medical history	4	6%
	Other assessment issue	7	11%
Diagnosis or in the recognition of high-risk status	Inappropriate diagnosis	5	8%
	Inadequate monitoring of growth	20	32%
	Inadequate fetal monitoring during labour	3	5%
	Delay in diagnosis	9	14%
	Delay in checking investigations	3	5%
	Delay in recognition of abnormal vitals	2	3%
	Delay in recognition of surgical complications	0	0%
	Other	3	5%
	Failure in recognition of high risk	12	19%
	Failure in ordering or checking investigations	3	5%
	Failure in recognition of abnormal vitals	2	3%
	Failure in recognition of surgical complications	0	0%
	Other	1	2%

Sub-Category Breakdown of Modifiable Factors *(please note a case may be assessed as having more than one sub-category within an identified modifiable factor theme)*		**Episodes of Care with the Sub-Category Identified as part of a Modifiable Factor**	
Referral to a specialist	Delay in referral	6	10%
	Failure to refer	10	16%
	Appropriate person not available	3	5%
	Services not available	2	3%
Treatment	No plan of care	12	19%
	Delay in treatment	15	24%
	Inappropriate treatment	12	19%
	Poor diabetic management	2	3%
	Failure to treat	16	25%
Clinical leadership	Failure to check juniors work	5	8%
	Failure to consult line manager	10	16%
	Inappropriate grade of staff	10	16%
Education, Knowledge, Training	Lack of education and training	10	16%
Documentation	Poor Documentation	33	52%
	Failure to document	27	43%
Discharge or transfer from care	Inappropriate transfer home	0	0%
	Inappropriate discharge from care	1	2%
	Failure to counsel mother	3	5%
	Failure to arrange appropriate ongoing treatment	15	24%
	Failure to follow up after transfer home	5	8%
	Inadequate screening following a stillbirth	13	21%
	Problems with the post mortem examination	7	11%
	Insufficient bereavement support	11	17%

Sub-Category Breakdown of Modifiable Factors *(please note a case may be assessed as having more than one sub-category within an identified modifiable factor theme)*		**Episodes of Care with the Sub-Category Identified as part of a Modifiable Factor**	
Communication	Between Doctors	5	8%
	Between midwives and doctors	9	14%
	Between nursing and doctors	1	2%
	Between departments/specialists	4	6%
	Between hospitals	2	3%
	Between health professional and the mother	20	32%
Policies and procedures	Lab facilities or results	1	2%
	Oversight of others	2	3%
	Scheduling and assessment	4	6%
	Emergency preparedness	2	3%
	Patient education	2	3%
	Availability of records	0	0%
	Staff workload	0	0%
	Other	14	22%
Woman or her family	Non-compliance with medical advice	1	2%
	Failure to seek care	6	10%
	Failure to attend scheduled care	8	13%
	Substance misuse	0	0%
	Other (Smoker)	10	16%

*N.B. Table 2 breaks down the modifiable factors into sub-categories. Where **other** is a designated sub-category, we have provided a brief explanation. **Pre-pregnancy** mainly relates to learning for primary care such as weight management. **Assessment** mainly relates to recognition of a high risk status. **Diagnosis** covers areas such as a failure to prescribe medication or to provide pregnancy-related information to mothers. **Policies and Procedures** can be further broken down into policies at booking or during pregnancy not being followed, or the fetal growth assessment protocol (GAP) not followed. **Woman or her Family** links directly to mothers not being referred to smoking cessation services/education or the continuation of smoking during pregnancy.*

Figure 7: *Total Modifiable Factors Identified – 10 Most Frequent Sub-Categories*



Appendix B

Table of RCOG/RCM Recommendations

STILLBIRTH CATEGORY			
Theme	**Identified by RCOG/RCM**	**Recommendations Fully Verified**	**Recommendations Requiring Follow-Up / Not Yet Verified**
Diagnosis and recognition of high-risk status	Yes	7.2 7.3 7.4 7.9 7.16 7.21 7.36	7.8 7.15 7.17 7.19 7.20 7.22 7.23 7.32 7.35 7.37 7.40
Treatment	Yes	7.3 7.4 7.9 7.16 7.36 7.38	7.5 7.8 7.17 7.19 7.20 7.22 7.23 7.32 7.35 7.37 7.40
Clinical Leadership	Yes	7.1 7.2 7.3 7.9 7.36	7.8 7.10 7.15 7.17 7.19 7.20 7.22 7.23 7.31 7.32 7.37 7.40
Communication	Yes	7.42 7.49 7.52 7.54 7.55	7.56

Summary	▪ There were 29 RCOG/RCM recommendations identified on review of the 63 episodes of care in this category. ▪ Several of these recommendations were applicable to all four key themes identified. ▪ 14 recommendations have been verified as complete. ▪ 15 recommendations remain work in progress.

RCOG/RCM Recommendations: Fully Verified	
7.1	Review the current systems in place for data collection, clinical validation of data, use of data and reporting of data to national audits.
7.2	Identify nominated individuals (consultant obstetric lead and senior midwife) to ensure that all maternity unit guidelines are appropriately updated, made available for staff and utilised 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.
7.9	Develop a trigger list for situations which require consultant presence on the labour ward.
7.16	Consultant obstetricians are immediately available when on call (within max. 30 minutes).
7.21	Improve incident reporting (including delivery of Datix training).
7.36	Clinical supervision and consultant oversight of practical procedures must be in place for all staff including specialist midwives and staff doctors.
7.38	Ensure the consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period of call.
7.42	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.
7.54	Prioritise an engagement programme with families at its heart.
7.55	Review the level of effectiveness of the bereavement service.

RCOG/RCM Recommendations: Requiring Follow-Up / Not Yet Verified	
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 and intrapartum periods.
7.8	Ensure external expert facilitation to allow a full review of working practice.
7.10	Introduce regular risk management meetings.
7.15	Educate all staff on the accountability and importance of risk management, Datix reporting and review and escalating concerns in a timely manner.
7.17	Speciality and Associate Specialist doctors to be up to date with clinical competencies and skilled in covering high risk antenatal clinics and out-patient sessions.
7.19	Ensure that a system for the identification, grading and investigation of serious incidents is embedded in practice through appropriate training and a multidisciplinary approach.
7.20	Actively seek to remove the ‘blame culture’ to allow all staff to develop a willingness to report and learn from serious incidents.
7.22	Actively discuss the outcomes of serious incidents in which individual consultants were involved in their appraisal.
7.23	Improve learning from incidents by sharing the outcomes from serious incidents on a regular basis and in an appropriate, regular and accessible format.
7.31	Undertake a robust plan of births anticipated in each midwifery led unit and consultant led unit.
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.
7.37	Develop an effective department wide multi-disciplinary teaching programme.
7.40	Review the skills and competencies of the senior clinical midwives covering for tier one doctors.
7.56	Training in communications skills (particularly empathy, compassion and kindness).