'UNCONFIRMED' MINUTES OF THE SPECIAL MEETING OF CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB), HELD ON THURSDAY 19 DECEMBER 2019, AT YNYSMEURIG HOUSE, ABERCYNON

PRESENT:

Marcus Longley	Chair
Sharon Hopkins	Chief Executive (Interim)
Maria Thomas	Vice Chair
Mel Jehu	Independent Member
James Hehir	Independent Member
Paul Griffiths	Independent Member
Nicola Milligan	Independent Member
Dilys Jouvenat	Independent Member
Jayne Sadgrove	Independent Member
Ian Wells	Independent Member
Kieron Montague	Independent Member
Phillip White	Independent Member
Anne Phillimore	Director of Workforce & Organisational Development (interim)
Alan Lawrie	Director of Primary, Community & Mental Health Services
Kelechi Nnoaham	Director of Public Health
Steve Webster	Director of Finance & Procurement
Liz Wilkinson	Director of Therapies & Health Sciences
Nick Lyons	Medical Director
Ruth Treharne	Director of Planning and Performance

IN ATTENDANCE:

Cathy Moss	Chief Officer, CTM Community Health Council (CHC)
Joanne Harris	CTM CHC
Georgina Galletly	Director of Corporate Governance /Board Secretary (interim)
John Murray	Director, Deloitte (Observing)
David Jenkins	Independent Support to the Chair (Observing)
Steve Combe	Independent Governance Advisor
Wendy Penrhyn-Jones	Head of Corporate Administration (Secretariat)

UHB/19/174 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, in particular C Moss and J Harris, D Jenkins, S Combe and members of the public.

M Longley explained that under the Health Board's Standing Orders whilst this meeting was being held in public it was not a public meeting. He said that the Board however welcomed feedback from service users and the public regarding its services.

UHB/19/175 APOLOGIES FOR ABSENCE

Apologies were **RECEIVED** from John Beecher, Chair, CTM CHC and John Palmer, Chief Operating Officer.

UHB/19/176 DECLARATIONS OF INTEREST

There were none.

UHB/19/177 INDEPENDENT REPORT INTO THE HANDLING OF THE SECONDEE CONSULTANT MIDWIFE REPORT INTO MATERNITY SERVICES, CWM TAF UNIVERSITY HEALTH BOARD

S Combe was welcomed to the meeting. A report setting out the findings of a review into the above report was **RECEIVED.**

In introducing the report M Longley provided a brief account of the background to the commissioning of the report which had arisen following the Board becoming aware in March 2019 that the Secondee Consultant Midwife Report existed which raised issues regarding the quality of maternity care and serious incident reporting. M Longley referred Board members to the terms of reference for the review undertaken by S Combe which were appended to the review findings. These focused upon the learning that could be derived and what could be put in place to improve governance and assurance arrangements.

Marcus Longley then invited S Combe to present his report. S Combe thanked the Chair and referred the Board to the Terms of Reference for the review at Appendix 1 of the report which was focused on identifying learning. S Combe advised that the review had identified several failures in governance which although escalated to the Executive, had not reached the attention of the Board.

In terms of his key recommendations, he identified two main areas. Namely, improving organisational culture (acknowledging that work in this regard had already begun); and the development of an appropriate escalation framework

for external reports to the Board to ensure patients and staff were listened to and action taken as necessary. S Combe referred Board Members to the recommendations at the end of the report noting these aimed to strengthen governance arrangements.

Board Members expressed their dismay at what had happened and sought clarity from S Combe around particular issues within the report findings beginning with whether the Board should have expected to have been made aware of the issues within maternity in the previous year. S Combe responded that whilst some issues had been raised with the Board they were presented in a disparate form. When asked whether he would have expected the issues to have been raised at an earlier point, he confirmed he would have.

Whilst the review had been unable to reach a consensus as to why the issues had not been escalated to the Board, S Combe was asked for a view as to what he felt had happened. He said that he had seen no evidence of a deliberate attempt to withhold information. He added that the Secondee Consultant Midwife Report had been seen as a 'draft' document and this may explain why there had been a delay in coming before the Board. S Combe added that there was also the decision to ask the Royal Colleges (of Obstetrics & Gynaecology and Midwives) to undertake a joint review of Cwm Taf maternity services which may have also had an impact. From the detail provided through the review S Combe expressed his view that there had been misjudgments rather than incompetence or a deliberate act in withholding information from the Board.

Marcus Longley placed on record receipt of a letter from Andrew Morgan, Leader, Rhondda Cynon Taf County Borough Council that he had tabled for all Board Members at the outset of the meeting outlining the issues considered by S Combe's review and set out the level of concern that existed in the local community regarding health services.

Independent Members expressed their disappointment that there had been a delay in serious issues coming to their attention which had impacted upon their ability as Board Members to take appropriate action in a timely manner. As a consequence, Independent Members expressed that their position to safeguard the wellbeing of service users had been compromised and advocated further work to address the issues arising from the review.

S Combe was asked whether the maternity service issues raised by the Secondee Consultant Midwife Report had been raised as part of Executive Team meetings. S Combe advised that some of the issues had been raised as part of other separate meetings and any such discussions had therefore not been part of formal decision-making processes. He added that the

existence of robust decision-making processes were only effective when appropriate behaviours were demonstrated to ensure that matters were brought to the Board's attention. S Combe recommended that going forward it was incumbent upon Independent Members to triangulate the information they derived from reports (sponsored by members of the executive team) with other sources of information and assurance. He added that the Board also needed to ensure it had a robust development programme and suggested that consideration was given to agreeing 'ground rules' in terms of behaviors during meetings.

Members concurred that a robust response needed to be developed to address the review findings which needed to take into account those issues which the report touched upon but were not subject to report recommendations.

S Hopkins was asked by Independent Members to comment upon whether the Board was now clear about the challenges that existed within its services, and in particular, where safety issues existed the decision making processes which needed to be followed. The Chief Executive stated that although there was more work to do, such issues were aired at the Executive Team and Management Board (formerly known as the Executive Board) the latter of which now had broader membership avoiding isolated decision-making. S Hopkins stated that internal processes were being further strengthened following the appointment of a new Board Secretary with Board meetings now held in public prior to any private meeting of the Board (the latter only take place in justifiable circumstances). S Hopkins also confirmed a new system had been put into place to share, securely and in a timely way, all draft inspection reports with Board Members.

In summing-up discussions, M Longley noted the Board accepted all the recommendations contained within the report and thanked S Combe for his review. He acknowledged the importance of urgent action being taken to ensure the organisation never again responded inappropriately to difficult messages regarding the quality of care provided to the local population.

M Longley proposed that the Board commission an urgent piece of work to set out how the organisation should respond to this learning for the Board to discuss and adopt at its next meeting on 30th January 2020. He said this should be carried out by the Board Secretary working with the Chair of the Audit & Risk Committee and the Independent Member (legal) and would need to include three elements: the first of which would consist of a detailed response to each of the recommendations in the report. Marcus Longley said there was need for detailed, rigorous and robust procedures which ensured that reports such as this were always dealt with in an open, transparent and timely fashion. M Longley said the organisation had already made changes in

this area but further work was required. He said the Board welcomed and were thankful for all information regarding the care that was being provided, however difficult the messages.

Secondly, M Longley stated that the way the senior leadership team worked together needed to be addressed. This would set out the values they need to live and how an open, self-critical team behaved which was integral to the values and behaviours work that was currently being rolled-out across the Board. Finally, M Longley proposed that the Board consider any further action required in relation to the particular events described in the report.

M Longley reflected upon the opportunities this matter provided for learning and the importance of welcoming information and feedback in order that any deficiencies could be addressed.

M Longley paid tribute, on behalf of the whole Board, to Emily Brace (the then Secondee Consultant Midwife) and Kerri Feeney (the then Head of Midwifery) who had played a crucial, professional role in discovering important issues around the reporting of serious incidents within maternity and a number of other matters which were having a significant negative impact upon the quality of care being provided to mothers and their babies. He said that both individuals had investigated the issues and raised their concerns in an appropriate, persistent and courageous fashion in 2018. M Longley stated that he was delighted that both individuals had accepted his request to remain involved in the work to make procedural and cultural changes with a view to ensuring that the Board never again failed to respond appropriately to important information regarding care quality issues.

In closing the meeting, M Longley stated that the Health Board was deeply sorry and remorseful that Maternity Services over many years were not of the standard that they should have been. He extended his thanks to those members of the public who had taken the time to attend the meeting stating that the organisation would be taking further steps to gather feedback on services from service users.

RESOLVED:

- the report was **NOTED;**
- the Board receive an action plan arising from the review recommendations to its January 2020 meeting.

UHB/19/178

There was no further business and the meeting was closed noting that the Board would next meet on 30th January 2020.

SIGNED:.....
M Longley, Chair

DATE:.....