
WRITTEN STATEMENT BY THE WELSH GOVERNMENT

TITLE **Cwm Taf Morgannwg University Health Board – Interim findings from the Independent Maternity Services Oversight Panel’s deep-dive review of neonatal care**

DATE **07 September 2021**

BY **Eluned Morgan MS, Minister for Health and Social Services**

In recent months, the Independent Maternity Services Oversight Panel (IMSOP), which was set up to oversee improvements in maternity and neonatal care at Cwm Taf Morgannwg University Health Board, has increased its focus on neonatal care.

In March, Dr Alan Fenton, a consultant neonatologist and Ms Kelly Harvey, a neonatal nurse, joined the panel. In May, supported by a small team of clinical reviewers, it began a deep dive review into the neonatal service at Prince Charles Hospital, in Merthyr Tydfil. The terms of reference were agreed with the health board, which welcomed this development. The aim was to take stock of the current neonatal service and the existing improvement plan to seek assurance that services are safe, effective, well led and importantly, integrated with maternity to provide a seamless service for women and babies.

This comprehensive exercise is being informed by evidence gathered from a range of sources including:

- Feedback from families who have experienced neonatal care, with more than 100 families responding to a listening exercise the panel undertook during July.
- Conversations with staff and wider stakeholders.
- Case reviews of the sickest infants presenting to the neonatal unit during 2020.
- A review of a wide range of documentation relating to clinical outcomes, safety and effectiveness data as well as clinical governance and assurance.

From the evidence reviewed to date, the panel has identified some areas, which it determined were impacting on the consistent provision of safe and effective care that would be expected of such a unit in the UK.

It took the decision to advise the health board of its interim findings and escalate a range of issues for immediate and short-term action. It has worked closely with the health board and my officials over the past week to ensure appropriate steps are taken at pace. This includes:

- Immediate improvements to medicines prescribing and administration with pharmacy support and daily checking of prescriptions. Further work will be carried out over the next month to develop a standard operating procedure, checklists and audits.
- An audit has been initiated to ensure the timely transfer of babies needing referral to a tertiary unit and reducing inappropriate admissions to the Prince Charles Hospital unit.
- Increasing the intensity of consultants overseeing the unit and increased time allocated to the unit. Closer working with and support from the specialist neonatal unit in Cardiff. The recruitment of an additional two consultant posts is already underway, with one taking up post in November.
- Establishing a specialist centre support programme for neonatal nursing staff.
- Improving specific aspects of clinical practice, including urgent review of the approach to therapeutic cooling of babies and for those requiring intubation.
- Improvements to the standard of documentation, including the introduction of a revised observation chart.

Securing closer working with the Wales maternity and neonatal network and support from neighbouring units, will be key in helping to embed these improvements.

I am mindful of the pressures currently facing staff and neonatal services are no exception - these findings will be difficult and upsetting. However, the openness of the unit's staff and their ideas about what needs to change have been welcomed by the panel.

It is important staff are supported to make these improvements and their wellbeing is a key consideration in the health board's improvement plan.

Equally, while these findings will be concerning for families using the service, I hope they will see that their voices and involvement really do matter and can effect change. Many of the improvements in train have been informed by their feedback and I am assured that the health board want to work with families to ensure that communication and support is improved and that parents have greater involvement in decisions about their baby's care.

The panel and my officials will be working closely with the health board to support and monitor the improvements. The panel will be producing a report when this part of their work is concluded and I will make this available to Members when I receive it later this year.

I will continue to keep Members updated and will make a further statement after I receive the next progress report from IMSOP on all aspects of its work and its assessment of the health board's overall progress.

The panel is finalising its analysis and findings from the second element of the clinical review look back programme, involving babies who sadly were stillborn. I will also make this report available.

This statement is being issued during recess in order to keep members informed. Should members wish me to make a further statement or to answer questions on this when the Senedd returns I would be happy to do so.