Vaughan Gething AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref Petition P-05-1132
Ein cyf/Our ref VG/01585/21

Janet Finch-Saunders MS
Chair
Petitions Committee

10 February 2021

Dear Janet,

Thank you for your letter of 20 January.

While the report from the independent review from the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists into maternity services at the former Cwm Taf University Health Board published in April 2019 identified wide ranging concerns about the quality of care, it also raised significant concerns and questions about the effectiveness of wider board leadership and governance.

I took very seriously the broader concerns about governance highlighted within the report and considered these to be a significant factor in contributing to the failures that had come to light in maternity services. These include concerns in respect of quality governance, data accuracy, serious incident reporting and critically leadership and organisational governance. A similar level of concern was expressed through the tripartite escalation and intervention group, comprising my officials, Audit Wales (AW) and Healthcare Inspectorate Wales (HIW), in relation to the Board's governance arrangements for quality. This included matters highlighted through serious incident reporting and regulator visits. Consequently, I accepted the advice of the tripartite group to increase the organisation's overall escalation to targeted intervention in April 2019, whilst also placing maternity services into special measures.

It is also important to note that prior to this, the then health board was placed into enhanced monitoring (level 2) of the escalation framework in January 2019, following advice from an exceptional meeting of the tripartite group. This was due to a number of issues, including maternity services, but also other emerging areas of concern in respect of organisational governance.

In addition to the specific actions I took following the publication of the Royal Colleges report to seek immediate improvements and assurance about the quality of maternity services and Board governance, the regulators, HIW and AW, confirmed that they would undertake a joint review of quality governance arrangements in place within the health board. This reported in November 2019 and confirmed there were a number of fundamental weaknesses in governance around patient safety and the quality of care. They expressed

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Gohebiaeth.Vaughan.Gething@llyw.cymru
Correspondence.Vaughan.Gething@gov.wales

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1SN

concern that the weaknesses were compromising the health board's ability to identify and respond to quality of care and patient safety problems.

They found that whilst there has been a strong focus on financial balance and meeting key targets, less attention had been paid to the overall quality and safety of its services. They highlighted the need for stronger and broader leadership in respect of quality and patient safety and worryingly, pointed to a culture of fear and blame in some parts of the organisation that had prevented staff from speaking out and raising concerns. This was similar to that identified in maternity services.

More broadly, the review found gaps in key governance arrangements associated with the management and identification of risk, and the provision of information to support effective scrutiny by the board and its committees. The need for improvements in the way incidents were classified and reported was also highlighted.

Whilst the review highlighted a significant number of concerns, it did note that the health board has started to take actions to address them. It also highlighted the impact that the new leadership was starting to have in tackling what was a considerable set of challenges. AW and HIW are currently undertaking a follow up review to assess progress.

All of these issues point to underpinning weaknesses in the governance of the organisation and which in turn enabled problems in maternity services to go unnoticed by the Board and sadly, therefore not addressed before significant concerns in the quality of care had arisen. Our focus now must be on ensuring that sustainable improvements are made to ensure the Board can never again be unsighted on such a level of concern amongst any of its services.

Yours sincerely,

Vaughan Gething AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services