Mick Giannasi
Chair of the Independent Maternity Services Oversight Panel
Cadeirydd y Panel Trosolwg Annibynnol ar Wasanaethau Mamolaeth

Eich cyf/Your ref **IMSOP-SE-004-19**
Ein cyf/Our ref **IMSOP-SE-004-19**

Dr Dai Lloyd AM,
National Assembly for Wales,
Cardiff Bay,
Cardiff,
CF99 1NA

21 August 2019

Dear Dr Lloyd,

Cwm Taf Morgannwg Independent Maternity Services Oversight Panel

Thank you for your recent letter following on from the Panel's appearance before the Health, Social Care and Sport Committee on 17 July 2019.

Members of the Committee wanted to know how a 'serious incident' would be defined for the purposes of the Panel's Clinical Review work and having consulted with my clinician colleagues, I am pleased to be able to provide the following information.

Although the Panel is independent, it is important the Panel's work aligns with the overarching policy and guidance of Welsh Government. As such the definition of 'serious incident' which is being used is the definition provided in paragraph 9.2 of the 'Putting Things Right' guidance. The guidance states that:-

> *A serious incident is defined as an incident that occurred during NHS funded healthcare (including in the community), which resulted in one or more of the following:-*
>
> - *unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;*
> - *a never event (all never events are defined as serious incidents although not all never events necessarily result in severe harm or death);*
> - *a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;*

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- *allegations, or incidents, of physical abuse and sexual assault or abuse; and/or loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.*

As you will see, the definition is quite broad. However, the first and second elements of the definition are those which are most relevant to the Panel's work.

In order to enhance the specificity of the definition for use in a maternity care setting, the Panel's Midwifery and Obstetric Leads are developing a set of more specific inclusion criteria which are being used to scope the first phase of the clinical review programme and which will include the 2016-2018 cases identified in the Royal Colleges' report.

The inclusion criteria will be taking account of national quality improvement programmes designed to reduce the incidence of poor outcomes for mothers and babies. This includes the Each Baby Counts programme developed by the Royal College of Obstetricians and Gynaecologists and MBRRACE which is a national surveillance programme managed by the Nuffield Department of Public Health at Oxford University.

The inclusion criteria are currently the subject of consultation with Welsh Government, the Health Board and other key stakeholders. However, the information is not yet in the public domain due, in part, to the need to communicate directly with the women and families affected by the clinical review process.

It is anticipated that the criteria will be signed off shortly and included in the publication of the Panel's First Quarterly Report by the Minister for Health and Social Services. I will, of course, write to you again once the information is available.

I hope that assists. In the meantime, if there is anything further I can do to inform the Committee's deliberations, please do not hesitate to contact me.

Yours sincerely,

Mick Giannasi
Chair, Independent Maternity Services Oversight Panel

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