External Independent Review of Maternity & Neonatal Services

Swansea Bay University Health Board

DRAFT

1. Introduction

This document sets out the Terms of Reference and background leading to the health board commissioning an external review of the maternity and neonatal services. An Oversight Panel, chaired by an Independent Chair, will oversee the external review and will report direct to the Health Board's Board.

2. Background

Like many Maternity and Neonatal Services across Wales and the UK, Swansea Bay UHB Maternity Services have been subject to sustained service pressures for which critical midwifery staffing levels have been a significant contributory factor.

In the last five years there have been a number of internal and external reviews of the Maternity Services in the health board:

- June 2019 - HIW Inspection: Labour Ward, Ward 18 & Ward 19 (including Antenatal Assessment Unit) and Midwifery-Led Unit, Singleton.

- October 2019 - HIW Inspection: Freestanding NPTH Birth Centre.

- May 2022 - Maternity and Neonatal Network assurance framework incorporating the three key report recommendations from:
  - Shrewsbury and Telford Hospital Trust;
  - Cwm Taff University Health Board; and
  - Healthcare Inspectorate Wales (2020) National Review: Maternity Services

- August 2022 - Maternity & Neonatal Network: Maternity Services Governance Process Review.

- January 2023 - Welsh Government Maternity and Neonatal Improvement Programme site visit.

- July 2023 - Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru - Discovery Phase Report (July 2023)

- September 2023 - HIW Inspection: Maternity Unit, Singleton of Ward 20; Ward 19; Antenatal Assessment Unit (AAU); Labour ward (including bereavement room); Bay Birthing Unit; and Low Dependency Unit.

The health board has accepted the findings of these reviews and developed improvement plans to support the services to learn and improve.

Despite this, and despite the Health Board being open and transparent about the outcomes of these reviews and the actions that have been taken, through the health boards Quality & Safety Committee, concern continues to be raised about the safety

of maternity services in the health board in the public domain land therefore it is appropriate to commission an independent review of both the maternity and neonatal services.

3. External Review

The Health Board's Board agreed to commission an external independent review of the maternity and neonatal services which will focus on outcomes and quality in the service since 2021 using the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), data and cases.

The rationale for this focus is twofold: firstly, because this is when the NPT Midwifery-Led Unit closed as a result of staffing concerns; and secondly because of the outcomes for this period reported by MBRRACE showed the service as an outlier.

'MBRRACE-UK' is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP) which continues a national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths.

The aims of the review are to:

- Consider the cases for 2021, 2022 and 2023 to understand whether there is any action which could have been taken to prevent the events;
- Consider the internal reviews undertaken by the health board to determine if any further learning can be identified;
- Consider themes and whether the learning and action taken has had an improvement on outcomes and has been embedded;
- Consider the current leadership, quality culture and governance arrangements in the services and whether there is any support and or learning for the health board to provide/take forward;
- Consider the working relationship between the maternity and neonatal services and how they interlink and whether there is any support/learning for the health board to provide/take forward in this respect; and
- Consider user and staff experience of the service from 2021 to date.

The outcome of the review will be a report which will identify good practice and make recommendations to the Health Board to take forward learning.

4. Oversight Panel

An Oversight Panel will be appointed by the Chair of the health board which will be consist of an Independent Chair and independent representatives. The aim of the Oversight Panel is to provide independent scrutiny to the actions proposed to address recommendations of the external review and oversee implementation of the actions against agree milestones.

5. Purpose

The purpose of this external independent review, focussing on the outcomes of the MBRRACE-UK audits for 2021 and 2022 to understand whether:

- there is any action which could have been taken to prevent the events;
- the internal reviews undertaken by the health board were appropriate or whether further learning can be identified;
- there are any themes from the cases and whether the learning and action taken has had a positive impact in the services;
- there are any leadership, quality cultural or governance issues in the services and whether there is any support and or learning for the health board to provide/take forward;
- Consider the working relationship of the maternity and neonatal services and how they interlink and whether there is any support/learning for the health board to provide/take forward in this respect; and
- Consider user and staff experience.

6. Methodology

6.1 External Clinical Review - the external clinical review team will:

- prior to the review starting, the team will meet with the clinical teams within the maternity and neonatal service regarding the purpose and reasons behind the review and also with key members of the Executive Team and Service Group;
- comply with the health boards Information Governance Policies;
- review the health records for the MBRRACE cases to review the antenatal care and intrapartum care of the women and the neonatal care;
- prepare a report which will focus on overall themes and include highlighting areas of good clinical practice, as well as areas of learning;
- highlight any case in which the review team judge that the outcomes or standard of care was compromised due to difficulties in accessing care, availability of care or quality of care;
- consider the deaths recorded and whether it was reported in a timely manner and the cases were investigated using the Perinatal Mortality Review tool;
- review the Mortality & Morbidity reports produced for each death by the local team and comment on the standard of the review;
- produce a report with recommendations to facilitate the health board in developing an action plan;
- to support the health board in communicating the findings to the service users and clinical teams; and

6.2 Engagement

An external engagement review lead will capture the service user and staff experience. For service user experience the feedback captured will be for the last 5 years (since January 2018) and for staff experience this will be from January 2021.

Feedback will be captured using a template and 1 to 1 feedback meetings as requested.

This work will be presented in a report and considered by the health board in terms of actions and learning and the final version will be reported to the Oversight Panel.

7. Reviewers

The review team will consist of:

- xxxxxxxxxxxx (Consultant Obstetrician);
- xxxxxxxxxxxx (Midwifery Lead);
- xxxxxxxxxxxx (Neonatal Nursing Lead); and
- xxxxxxxxxxxx (Neonatologist Lead)
- xxxxxxxxxxxx (Engagement Lead)

8. Governance and Reporting Arrangements

It is expected that the Review Team will:

- Submit a monthly report on progress against key milestones to the Oversight Panel and the Executive Director of Nursing & Patient Experience and Interim Executive Medical Director ;
- Escalate any immediate concerns that might be identified during the review process to the Executive Director of Nursing & Patient Experience and Interim Executive Medical Director in real-time so that remedial action can be taken as appropriate;
- Produce a written report with key recommendations for action and learning and identify areas of good practice within two months of completion of the review for the Oversight Panel to consider.
- Produce a report suitable for publication and as such would need to ensure that no patient or staff-identifiable information is included. The Review Team must ensure that the report is shared with all relevant individuals for factual accuracy before submitting their final report to the Oversight Panel.
- Where any issues in care have been identified the review team will notify the health board to enable them to contact the patient and meet with them and members of the review team can be included in this meeting at the request of the patient.
- Present the report and recommendations to the Oversight Panel.

9. TIMESCALES

It is expected that the review team from starting the review will take no longer than ten months to finalise the report and share it with the Oversight Panel and Health Board in final form.

Signatures