Briefing paper on Maternity and Neonatal Services in Swansea Bay University Health Board – September 2024

Background

On 12 December 2023, Swansea Bay University Health Board's maternity and neonatal services were escalated to level 3 (enhanced monitoring) in line with the oversight and escalation framework. This decision followed twelve months of officials offering support, scrutiny and challenge to the service and the outcomes following an unannounced inspection by Healthcare Inspectorate Wales (HIW) of the maternity services provided at Singleton hospital.

On the same day, the health board announced it would be commissioning an independent review of its maternity and neonatal services. It confirmed that an independent Chair and oversight panel would be appointed, supported by a clinical review team. The health board stated that the focus of the review team would be on quality and outcomes in the service between 2021 and 2022 using MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) data and cases, which includes maternal deaths, stillbirths and neonatal deaths, which indicated they were an outlier for neonatal deaths in 2021. This would be supported by service user feedback dating back to January 2019 and staff feedback dating back to 2021.

A n escalation framework has been agreed with the health board along with a set of de-escalation criteria. The oversight and governance linked to the Review will form part of the escalation/de-escalation decision making process. As part of the escalation process, meetings take place monthly, and the health board provide a report to support discussion and evidence of progress. To strengthen midwifery leadership there has recently been successful appointments into the Director of Midwifery (July 2024) and into the substantive post for the Head of Midwifery (April 2024).

Independent review into maternity and neonatal services in Swansea

In order to ensure independence of the Review, the health board have engaged Bevan Brittan and Niche Consulting to manage the recruitment of the oversight panel and manage the communications and engagement function. A FOI in August revealed that the review had cost £170,000 to date. This will have since increased.

Bevan Brittan played a key role in the appointment of the Chair of the Oversight Panel and recruitment of appropriately qualified Oversight Panel members.

On 31 January 2024, the health board announced Margaret Bowron KC as chair of the Oversight Panel for the Independent Review of Swansea Bay Maternity and Neonatal Services. As chair of the Oversight Panel, she appointed its members with advice and support from Bevan Brittan LLP. Her appointment drew criticism from some of the families affected.

The role of the oversight panel is to undertake ongoing assurance of the review process, providing independent scrutiny to ensure the Review is completed in line with its Terms of Reference. The Review has three parts: a review of clinical outcomes, a review of patient and staff experience and a review of leadership and

governance. The Review is supported by an engagement lead who will ensure that service user and staff voices are heard throughout the review process.

The first version of the Terms of Reference for the review (published on 12 December 2023) were heavily criticised, as some families felt that they had been developed by the health board without proper engagement. A listening exercise was then undertaken by the Oversight Panel (between 19 April and 24 May).

On the 12 June 2024, the revised Terms of Reference for the review were published which reflected input of service users and staff during the listening period. The terms of reference have been further revised to include broadening of staff engagement to include all disciplines, removal of the 5-year time limit for self-referrals and all babies that received intensive care. Further refinements have been made to the terms of reference on the 15 August and 5 September 2024.

On Tuesday 25 June 2024, Swansea Bay UHB announced a new interim chair of the oversight panel for the Independent Review of maternity and neonatal services in Swansea following the announcement that Margaret Bowron was standing down from her role of Chair with immediate effect as she felt she had become a distraction. This followed a sustained period of lobbying, media scrutiny and a number of letters around this appointment and perceived progress. The health board responded quicky and appointed Dr Denise Chaffer (who was on the original oversight panel) on an interim basis for three months, whilst a substantive appointment process is undertaken.

Dr Chaffer is an executive clinical nursing/maternity patient safety leader with over 15 years executive director board level experience. This includes working for providers, commissioners, two acute trusts, a London teaching hospital and a recent national role for patient safety. She was also a director lead for the Early Notification Scheme (ENS) in maternity and the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. Previously Dr Chaffer was the President of Royal College of Nursing (RCN) from July 2021 to December 2022.

She was initially appointed until the 25 September however this has now been extended until the end of December 2024, whilst the health board are making arrangements for the recruitment of a permanent Chair.

Welsh Ministers have and continues to receive correspondence from families raising concerns about the proposed scope of the independent review, the lack of family input and they question its independence. One of these families has been in regular contact with officials for the past 24 months, has been publicly named by Members during Plenary on multiple occasions and has formed a group of affected and interested families. In addition, a number of freedom of information requests have been received by Welsh Government and a number of NHS organisations relating to both the service and the review.

The family’s concerns have been picked up by a number of key individuals within the UK maternity safety space, including those involved in the maternity service reviews conducted at Morecambe Bay, Shrewsbury and Telford, East Kent and Nottingham NHS Trusts. The families concerns relate to the viability of the review moving

forward. One of the key individuals issued a statement in August questioning the viability of the review.

Llais (the citizen voice body for patients in Wales) has recently issued a statement indicating that 'It is clear from what we are hearing that the review in its current form is not working for people. We do not run the review, but things need to change so that families can have confidence that any review will put them at the centre.' They have also subsequently written to the health board on 3 September outlining a number of concerns. Llais were also critical of the role Niche Consulting have played in the review to date and we have been sighted on the response from Niche to Llais on this issue.

Llais are undertaking a survey of service users' experiences of Maternity Services in Swansea Bay which will run until end of September 2024. An external company will also be facilitating three face-to-face workshops with up to 20 women in each focusing on their experiences of maternity care. The data gathered from these and the survey results will be analysed and used by Llais to produce a substantive report in October 2024.

There is concern that after announcing the review last December, that only limited progress has been made, there is no permanent Chair, family engagement is challenging, trust and confidence in the health board appears to be low and senior leaders are questioning the viability of this process.

The health board wrote to stakeholders at the end of August 2024 including the Welsh Government and member of the Senedd with an update on progress, which highlighted:

- Family and Community Voices Steering Group is in the process of being established.
- Communications between the review team and Llais are being enhanced for the duration of the review.
- New independent website and dedicated email address has been established.
- Clinical Review Team – first tranche of review letters were sent out in August to the individuals and families involved in 2022 cases with further tranches of letters will be sent out during September.
- Bereavement and emotional / psychological support is being put in place to support those currently being contacted and those who self-refer.
- Self-referral process for anybody who believes their case should be reviewed is now available (although this has not been publicised yet)
- Comprehensive governance pack has been developed
- Regular updates to be provided to stakeholders and shared on health board and review websites.

<u>Timescale</u>

The Oversight Panel have set out the project plan timeline of the review in three parts with the review aiming to conclude in May 2025:

<u>June to November 2024 - Setting up safe and controlled fieldwork</u>

- Develop GDPR compliant and safe communication methods
- Develop clinical review and triage protocols

- Agree escalation principles
- Establish family engagement and self-referral portals
- Establish key stakeholder steering group
- Start to reach out to seldom heard groups
- Develop and send out first tranche of letters to families
- Establish psychological support processes for families accessing the review
- Commence clinical reviews
- Extensive information gathering
- Governance Review and report on current safety

June to March 2025 – Fieldwork

- Clinical case reviews and case studies
- Self-referral reviews / women/family experience
- Data analysis / demographic and contextual data
- Thematic review of feedback
- Staff surveys / interviews / focus groups
- Analysis and triangulation
- Report drafting

Reporting – March to May 2025

- Draft report checks / legal review / comments
- Feedback on final report and any amendments
- Drafting of abridged, translated and easy read versions
- Final report publication (estimate)

A family led independent review of maternity and neonatal services in Swansea Bay

Welsh Government has been advised that a group of families in the Swansea Bay area are considering announcing their own 'family led' review of Swansea Bay Maternity in the next few days. The correspondence received indicates that a number of families have indicated that they have come together to run their own maternity review. There will not have a Chair and agreed terms of reference. They intend to take factual accounts and records from families, staff and key stakeholders and publish them alongside statistics gathered by various members over several years. By Christmas 2024 they intend to release their report which will make recommendations for the health board and wider Welsh NHS to implement.
This work will not include any clinical review of patient case notes but family voices and experiences will feature heavily and will duplicate the engagement elements with the Independent Review with the potential for duplication and potentially different outcomes.
The families say they have the full backing of Donna Ockenden, Chair of the Independent Review into maternity and neonatal services at Shrewsbury and Telford NHS Trust. They have invited the Welsh Government to support their work.

South Wales Police

There has also been recent media coverage about one of the families asking the South Wales police to undertake a criminal inquiry into the events surrounding the maternity unit. The police have indicated they are undertaking a fact-finding exercise to identify if there are any potential criminal offences to investigate. We understand

the police have been in contact with the health board. The police have also asked for a point of contact within the Welsh Government.

Healthcare Inspectorate Wales (HIW) Inspection report

HIW's inspection of the unit in September 2023 highlighted the need for several improvements, particularly around staffing pressures and the number of interim posts in the leadership team. Due to the significance and number of risks identified in September, an unannounced follow-up inspection of Singleton Hospital Maternity Unit took place in April 2024.

Some years prior to this, the health board's maternity services had been inspected in 2019 (Singleton Maternity Unit reported September 2019, and Neath Port Talbot Birthing Centre reported January 2020). The outcomes from those inspections, alongside similar inspections undertaken at other NHS Wales organisations, informed recommendations raised within a national maternity review report published by HIW in November 2020. The health board had previously agreed improvement plans in response to the two local inspections and an action plan to address the national report recommendations.

There was a complaint to the health board that the interim chief executive had misled the Board in relation to the reporting of progress against the HIW actions, an external investigation has taken place and the interim chief executive apologised to the board in July for an error in one of his previous reports. In addition, the health board took a detailed report to their July Board meeting, a summary of the progress against previous inspections. This highlights that there are outstanding actions. These are being reviewed through the enhanced monitoring meetings.

During the inspection in April 2024 three immediate assurances were raised, two of which were resolved at the time of the visit. The remaining area related to staffing at the Antenatal Assessment Unit (AAU) including non-clinical staff taking information from women and birthing people calling the AAU, some people did not receive their initial assessment in 30 minutes as outlined in national guidance and staff members were unable to confirm escalation procedures. The health board responded appropriately to the inspection findings which HIW has accepted. The final inspection report was published on 31 July 2024.

A total of 17 further areas for improvement were identified, some of which were repeated from the previous inspection. Areas for improvement included insufficient health information in languages other than English, bereavement room issues, documentation of birth plan choices and illegible signatures, escalation processes, backlog of open incidents and low levels of appraisals. The health board's improvement plan containing a comprehensive set of actions and plans was accepted by HIW 12 July 2024.

Welsh Government maintain oversight of the health board's delivery of required improvements through the enhanced monitoring escalation arrangements, which includes any actions identified through HIW inspections.

Temporary closure of the midwifery led birthing unit and home birth services

On the 15 September 2021, the Neath Port Talbot Birth Centre was closed, and the home birth service was suspended on 1 February 2022 - both due to staffing shortages and pressures. Since then, the health board has concentrated available resources on Singleton Hospital to ensure safe care could continue to be provided, in line with professional guidance from the royal colleges. In September 2023, the Board approved £750,000 investment in maternity services including the recruitment of 35 extra staff (21 midwives and 14 maternity care assistants) to support the reopening of a birth centre and the reinstatement of home births in Swansea Bay.

The health board management board approved, on 16 May 2024, the reopening of the NPT birth centre and the home birth service subject to final approval by the Board. This followed a comprehensive review process involving a number of formal ‘gateways,’ staff input and engagement. As a result of issues raised by one of their recognised Unions, there was a delay in bringing the formal proposal for the reopening to the Board.

At a special Board meeting on 10 September the health board approved the reopening of the Neath Port Talbot birthing centre and home birth service reflecting months of careful analysis, engagement with staff, and feedback from service users. The re-opening of the midwife-led birth centre at Neath Port Talbot Hospital will take place on Monday 16 September, as well as the reintroduction of the home birth service from Monday 21 October 2024.They are also reintroducing home labour assessments and antenatal education classes provided by our community midwives.

We were informed today (17 September 2024) that the first baby has been born at the reopened Birth Centre has welcomed its first new arrival, less than 24 hours after the Birth Centre re-opened on 16 September 2024

https://sbuhb.nhs.wales/news/swansea-bay-health-news/worth-the-wait-as-rafaellos-becomes-first-to-be-born-in-reopened-neath-port-talbot-birth-centre/