Swansea Bay University Health Board – Independent Maternity Review

In November 2023, Swansea Bay University Health Board agreed to commission an external review of maternity and neonatal services to provide: assurance to the Health Board; reassurance to families, in respect of services delivered, and to identify opportunities for service improvement. The Board also agreed to the establishment of an Oversight Panel reporting directly to Board.

Points to note

1. There has been no further communications/update from the family led review
2. The Chair wrote to you last month stating that two reports would be presented to the next Board meeting – one on governance and one on engagement. This is now not the case as they are of the view that presentations and updates should now be given and the entire report issued in June.
3. The clinical review team have reviewed 19% of the eligible cases and fed back to the health board team. Whilst there are many serious points in this feedback, there is nothing that the health board were not aware of and all issues are being addressed. Welsh Government have not been involved in this feedback process, we would only be engaged if serious issues that were new were escalated.
4. The governance strand of the review have submitted an interim report to the health board (this has not been shared) titled: “How safe are you know” and reviews the health board against 5 themes. One theme had a limited assurance rating related to the resolution of incident reporting and the backlog of incidents. We are monitoring this monthly and it is improving.
5. The Board will discuss in its “private” session its plans to appoint a permanent Chair if the Review
6. Last Friday Welsh Government were made aware of 2 incidents which have occurred Thursday/Friday. These have not been made public, but there is also a risk that details are made public.
    - Home Birth (out of Guidance)
        - Baby (5kg) resuscitated successfully but no brain activity noted so care is likely to be withdrawn. Mum now stable condition in hospital. Health board have assigned a family contact and external review is being requested. Last risk assessment undertaken 18 Nov
    - Maternal Death at Singleton
        - During the resuscitation attempt for the mother a peri-mortem caesarean section was performed and the baby was stillborn.
        - Health board have assigned a family contact and external review is being requested
    - The heath board have clinical psychology attending unit today for staff debrief and EMERTS debrief has also occurred
    - Risk assessment and out of guidance cases update to be sent to CNO

7. It must be noted that the health board have responded quickly to these incidents and engaged Welsh Government in an open, transparent and mature manner.

Review Timeline

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

These are indicative timescales and may vary depending on the self-referrals.

- **June to November 2024 - Setting up safe and controlled fieldwork**
  - 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 June 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)

Engagement

The Oversight Panel Chair has made a **new appointment to the Oversight Panel**, Ken Sutton, to provide additional oversight of the family engagement work. Ken has a long and distinguished track record in policy and operational delivery rising to become a Senior Director at the Home Office. After a period on secondment to Marie Curie Cancer Care, Ken specialised in engaging bereaved and other families affected by public tragedy and in independent investigations. He established the Hillsborough Independent Panel and worked closely with its chair Bishop James Jones on that inquiry and their follow up Report, " The Patronising Disposition of Unaccountable Power ". Ken was Secretary to the independent investigation into Maternity and Neonatal Services at East Kent and is currently working to secure improvements in maternity care in England.

The family engagement team is being supported by a communication company (Pinch Point) who are supporting the family engagement plan and the reach of the review via a range of communication routes to families using the maternity and neonatal services.

In October 2024 the family engagement team had contact with around 250 service users, following presence at shopping centres in the Swansea Bay area. This work has been undertaken in parallel with the work of Llais.

Llais has also independently engaged with families via a variety of means leading to 465 contacts. Llais will now collate its findings as part of its own work, "Having a Baby Project" which ran in the summer and the outcomes will also be shared with the Independent Review via a consolidated report.

The **Family and Voices Steering Group (FCVSG)** has been set up to oversee the engagement plan and continuous discussion at the meetings, providing assurance that it reflects what families want. The FCVSG is a co-production group that discusses engagement options, how to connect with families and encourage them to make a difference to make sure their voices are heard.

Posters for co-chairs/representatives have been put on the website and sent to Directorate of Insight, Communications and Engagement (DICE) team at Health Board. DICE have circulated this to all their contacts e.g. community groups, places/groups where families, mums and babies meet to support community engagement. This has resulted in family members coming forward who are planning to attend the next meeting planned for end of November. The FCVSG will discuss and consider whether to send text message to families that have used Swansea maternity and neonatal services and the approach to be taken.

The family engagement team are currently planning three webinars scheduled to take place on 27/11. The webinar will explain the review process, discuss how their input can help shape the future of maternity and neonatal care and answer questions. The webinar details will be published by Pinch Point and Maternity Voices Partnership Chair has agreed to circulate the poster advertising the webinar on their social media and other platforms they use.

Short videos providing information on the review and how to find out more and engage are being added to the review website and will be promoted through posters/videos via contacts on social media, including schools, GP practices and community groups.

The Family Engagement team will be exploring options to reach out to seldom heard groups and have already reached out to: Sketty Mosque and Muslim Community Centre; the African Community Centre and playgroups in the area.

Clinical Review Team – Issuing of Letters

All review letters have been sent to individuals and families involved in 2022, 2021 and 2020 cases. The letters were written sensitively with a covering letter explaining why they were being contacted with a separate letter included within a separate sealed envelope. The covering letter acknowledged that it might be upsetting to be contacted and suggested that individuals only open the second, sealed envelope when they felt

ready and able to. The second letter outlined in detail the process and made it clear how to contact the review should they need any form of support. At present, 25% of the clinical case reviews have been completed and it is anticipated that approximately 40% of the clinical case reviews will be completed by the end of January 2025.

Psychological Support

In terms of bereavement and emotional / psychological support, this is available to families who would like to access this support through Ty Elis Counselling Services which is a confidential service, independent of the Health Board and can be accessed directly by families via:

Self referral

The review self-referral has been widened to make it more inclusive to service users to support the review being inclusive rather than exclusive_There is no timespan for self-referral to give individuals an opportunity to revisit their care when they feel it necessary and appropriate.

Governance
A presentation setting out the current position of the Current Controls, which includes current leadership and governance, will be provided to the Board meeting.

Costs
In terms of the expected cost of the independent review, this is difficult to predict with any certainty as it will depend on the number of case reviews and how many service users self-refer for a review of their experience of care. A sum of £700,000 has been set aside for 2024/25 which will include costs for:

- Oversight Panel members;
- Clinical Reviews;
- Engagement with service users and staff;
- Governance and leadership;
- Wellbeing / psychological support for families;
- Legal advice;
- Resource within the health board to support the request for information for the review teams.

The current spend totals £427,967.