Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Our ref: WQ89808, WQ89827, WQ89828, WQ89829, WQ89843, WQ89844, WQ89845, WQ89912, WQ89913

Andrew R.T. Davies MS
Senedd Regional Member for South Wales Central

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20 December 2023

Dear Andrew,

Thank you for your recent Written Questions asking me:

- When was the Minister first made aware that Welsh Government officials had told families who had experienced serious failings that a review of Swansea Bay University Health Board's maternity services had taken place in December 2022 and yielded no immediate concerns, when in fact no such review had taken place? (WQ89808)
- Which review were Welsh Government officials referring to in communication with the Channon family when they said that a December 2022 review raised no immediate concerns? (WQ89827)
- When was the Minister made aware that the December 2022 Swansea Bay maternity services review had not been conducted? (WQ89828)
- Will the Minister confirm when she was made aware of communications with the Channon family regarding a December 2022 Swansea Bay maternity services review? (WQ89829)
- Will the Minister consider calls from affected families for a full independent review into the maternity services at Swansea Bay University Health Board? (WQ89843)
- When did the Minister last visit a Swansea Bay University Health Board maternity unit? (WQ89844)
- Has the Minister ever personally requested a Swansea Bay University Health Board maternity services review and if so, when? (WQ89845)
- When did the assurance process covering Swansea Bay University Health Board maternity services conclude, and what time period did this assurance process cover? (WQ89912)
- Will the Minister clarify the differences between an assurance process and an inquiry process as regards to maternity service reviews? (WQ89913)

Please accept my apology for the delay in responding. Given the number of questions you have raised, I felt it would be helpful to provide a collective response.

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Since becoming Minister for Health and Social Services, I have not been invited to visit, nor have I visited a Swansea Bay University Health Board maternity unit.

I can confirm that a review exercise did take place in December 2022. In November 2022 Welsh Government officials asked the NHS Wales Delivery Unit to undertake a review of the quality indicator data they held such as complaints, National Reportable Incidents and Ombudsman reports regarding Swansea Bay University Health Board's maternity and neonatal services. The aim of this work was to explore incident themes and contributory factors, and to gain assurance about the rates and nature of incident reporting when compared to other health boards in Wales.

The request made to the Delivery Unit constituted an evidence review requested by officials, rather than a Ministerially commissioned service review or investigation. The Delivery Unit submitted this to officials in early December 2022. A discussion took place between officials and the Delivery Unit on 15 December, during which officials reiterated the request for the health board's nationally reported incidents, complaints and Ombudsman reports to be considered. The Delivery Unit shared a further response with officials on 23 December inclusive of nationally reported incident data. The data covered the period from 14 June 2021 to 18 November 2022 to reflect changes in national incident reporting arrangements. In the interests of transparency, I have attached a copy of the information provided by the Delivery Unit. Given its potentially identifiable nature, I hope you can appreciate it has been necessary to redact some of the contents.

The Welsh Government's clinical professional leads assessed the information provided from the Delivery Unit, together with other available data and intelligence and concluded in early 2023 that the evidence, at that time, did not highlight any immediate concerns warranting specific action or assurance outside of existing arrangements. It was agreed that quality and safety at Swansea Bay University Health Board's maternity and neonatal services would continue to be monitored through routine national oversight and assurance mechanisms, which includes triangulation with intelligence from other public bodies and regulators.

There are well established national mechanisms for monitoring the quality, safety and effectiveness of services provided by health boards across Wales. Assurance is sought and challenge provided on a regular basis regarding emerging and ongoing operational issues, through mechanisms including the integrated quality, planning and delivery (IQPD) arrangements which are held monthly. Information from a range of processes and partner organisations, including the review conducted by the Delivery Unit, have and continue to feed into these assurance mechanisms.

Under the NHS Wales Escalation and Intervention Arrangements, Welsh Government officials also meet with Audit Wales and Healthcare Inspectorate Wales to discuss each health board, NHS Trust and Special Health Authority in respect of quality, governance, service performance, financial management and other issues as appropriate. The intelligence obtained from these tripartite meetings alongside a wide range of information and intelligence is considered by the Welsh Government before making recommendations to me on the escalation status of NHS Wales bodies.

In addition to regular assurance activities undertaken or coordinated by officials, Welsh Ministers have legal powers to establish a public inquiry or review into matters within their remit. This would typically require significant concerns of an institutional or systemic nature.

I am aware of the request for an independent review of Swansea Bay University Health Board's maternity services. The health board confirmed on 12 December that it has commissioned an independent review of maternity and neonatal services. I welcome this announcement; this is the correct approach for the health board to provide assurance about its services, and we will work closely with the health board over the coming months to

ensure any identified learning is taken forward and immediate actions are escalated as needed.

You will be aware I have confirmed my decision to escalate the health board's maternity and neonatal services to enhanced monitoring. This will ensure the health board has the comprehensive support it needs to deliver the improvement plans it has developed and will ensure officials are well placed to assess progress. The health board has welcomed this escalation.

Yours sincerely,

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Swansea Bay UHB Assurance – November 2022

Overview

Swansea Bay UHB have monthly quality committee meetings with each service board taking it in turns to present a highlight report. The report in November 2022 was from Singleton/NPT (previous in July) and so focused on women and children services. Assurance updates on Maternity services also feature consistently, reporting the significant staffing challenges and resulting service changes and the self-assessment following the Ockenden report.

There were overall positive comments about Health Board governance at the HIW Summit in November 2022.

Swansea Bay UHB were an early adopter of the Civica system for patient experience and %age scores on patient satisfaction are shared at Committee meetings.

Swansea Bay UHB have clearly identified quality priorities such as infection control and falls and the Committee is regularly updated on progress and challenges in achieving these priorities.

In October 2022 **80% of complaints** met the 30 day PTR target.

Incidents June 2021 - November 2022

3 maternal related – [redacted]

Reports shared at Quality Committee and Board for Maternity and Children Services

These reports were reviewed as the index complaint concerns quality of care and communication with the family from both these services.

Maternity Concerns (Meeting 22nd November 2022)

Report to Committee following the Wales Maternity and Neonatal Network (WMNN) external review of the Health Board's Maternity Service Governance process following a serious complaint. The review team consisted of the WMNN Clinical Lead Obstetrician, Lead Midwife and Network Manager. They attended in August 2022 over two days, which included visits to the clinical areas to engage in conversation with staff members.

The panel concluded:

- Evidence of a Health Board that delivers a culture of patient safety and prioritises opportunities for improvement through reflecting on data and lessons learned through adverse events.
- The panel was assured that the Health Board is committed to ensuring that the voice of the service user is heard.
- The panel highlighted exemplar initiatives and commended the Health Board on the development of a Hypoxic Ischaemic Encephalopathy (HIE) review tool incorporating parents' voices.

The panel recommended

- The Health Board seriously consider the appointment of a Patient Experience Midwife.
- The family engagement framework to be re-invigorated to continue the work already completed.
- Extension of the maternity performance dashboard to include patient experience information to be completed by December 2022.
- The inclusion of data regarding patient experience, complaints, concerns, complaints as well as Datix figures and staff experience within the Maternity Performance Dashboard.

The Divisional Children Community Nursing Service

The Executive team commissioned an external review of the Children's Community Nursing Team Service in 2020. The review was commissioned in response to concerns raised by families who used the service. The review was undertaken by two external reviewers who were commissioned for their experience in providing social care services for families with children and long term commissioning. The review focused in detail on:

- The culture of care, particularly focussing on family involvement;
- Direct experience of children and families using the service;
- Direct engagement with staff within the service; and
- How professional nursing standards are delivered.

The review found that limitations were identified that prevented families from receiving the standard of service that would have been expected or which fully represented the HB values.

a) Governance arrangements for the CCN Service were ambiguous and lacked clarity.
b) Concerns appeared to be managed internally with no robust consistent processes in place for reporting, or monitoring them. 90% of the families the reviewers spoke to had concerns that had not been addressed to their satisfaction.
c) The Service Model implemented provided services for three distinct categories of children but Continuing Care was the primary focus and formed the basis of the funded establishment for the whole Service.
d) No performance or trend data was collected for two of the three cohorts of children receiving support. The accepted practice at that time of not reporting concerns via the Datix process also served to conceal the emerging trends from the wider HB.
e) Partnership working with parents including a co-production approach to determine the type, frequency, and level of care families felt they needed was not evident. There was little evidence of the families being seen as partners in the delivery of care for children who require clinical care delivery and/or health monitoring 24 hours a day in the community
f) The culture of care within the team was complex, the leadership style appeared inflexible with innovative ideas neither encouraged nor taken forward

The Improvement Plan is shared monthly with Service Group leadership on the progress made against the recommendations, with an escalation process in place for delays of progress. Initially overseen by the Board, updates were shared at QC 23rd August 2022 with a further update to QC on 22nd November which reported that the fragility of the service remains a high risk and a challenge to progress actions within the improvement plan without key resources available.

Other Inspections

Healthcare Inspectorate Wales completed unscheduled regulatory inspections in Singleton Obstetric Services 24th – 26th June 2019 and Neath Port Talbot Freestanding Birth Centre 22nd and 23rd October 2019, and found no immediate assurance requirements for the governance of the maternity service. However, these were pre-pandemic and the resulting staff challenges.

Audit Wales report August 2022

The Health Board's corporate quality governance arrangements demonstrate a number of strengths, but there are significant weaknesses in arrangements both corporately and within operational teams, which limits the Health Board's ability to know whether the services it provides are safe and effective.

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Swansea Bay UHB
Maternity & Neonatal NRI Data
14 June 2021 – 18 November 2022

Quality & Safety Team

Maternity & Neonatal NRIs

- **NRIs**:
  - reported by SBU to DU between 14 June 2021 and 18 November 2022
  - coded as 'maternal' related
  - total = **3**

- Never events = 0
- [redacted]

NRIs reported

- [redacted]
  - **Key contributory factors**
    - [redacted]

      - the review identified there was no documentation of attempted successful/unsuccessful telephone contacts with patient in the antenatal notes section on the Wels[redacted]ministration service (WPAS) record for patient. There was evidence of attempted contact with patie[redacted]nning [redacted]ented in the [redacted] shared drive in Maternity services. Therefore, the review group do not feel this is contributory to [redacted]
- [redacted]
  - **Key contributory factors**
    - unclear guidelines, policies and procedures relating to the management of altered fetal movements.
    - There were two guidelines available on WISDOM* - the Maternity Network Wales 'All Wales Fetal Movements in Pregnancy' guideline and SBUHB Management of Altered Fetal Movements Guideline. Although the SBUHB guideline states it is a supplement to the All Wales Fetal Movements in Pregnancy Guideline the learning event highlighted that having two guidelines caused ambiguity for clinicians as to which guideline to adhere to. Although the review confirmed neither guideline was strictly followed.
    - The supplemented SBUHB guideline highlights 'if a woman is unsure about a change in fetal movements it is appropriate to ask her to lie down for an hour with a cold drink and something to eat, and to ring back if still concerned after that'. Furthermore, the guideline states 'between 28 and 37 weeks gestation onwards if a woman reports a change in fetal movements for the first time then she should be seen in AAU as soon as possible for an antenatal assessment.' The emphasis is on whether a woman is 'sure' allows for human error.
- Incident 3 – maternity/neonate – [redacted] confirmed and woman transferred to labour ward for [redacted] point of care test was [redacted] abnormal, identifyi[redacted]r an [redacted] During the caesarean [redacted]
  - **Outcomes form not yet received for this incident**