Health and Social Services Group **Welsh Government** Enhanced Monitoring Maternity & Neonatal Swansea Bay University Health Board Ref: SBUHB/MatNeo/02/001	Llywodraeth Cymru Welsh Government

Meeting Notes

28 February 2024

1. Welcome and Introductions

This was the first meeting for the enhanced monitoring intervention for Swansea Bay University Health Board maternity and neonatal services following the escalation of the service. Inception and scoping meetings had taken place prior to this first formal meeting.

Attendance and apologies are highlighted in the table below.

The health board provided a very comprehensive data pack in the form of a presentation prior to the meeting. It was agreed that this was very helpful and subject to a few additional points then this would be used as the basis of the monthly report requested as part of the enhanced monitoring intervention.

A couple of issues were not covered in the slide pack and these were discussed separately and the health board agreed to consider whether these could be included, but if not they would be covered as part of the meeting discussion. These include digital dashboard, progress of the independent review, and specific updates regarding the improvement plan.

2. Agree terms of reference

The proposed terms of reference were circulated and the health board would feed back any concerns by the 2 April 2024. A meeting between OS and GH was agreed to discuss the terms of reference further.

Action01 Health board to feedback on the terms of reference by 2 April 2024.

3. Reporting and Governance

<u>Governance structure and board oversight</u>
The health board presented the governance structure and reporting arrangements that they have put in place to monitor and improve maternity services and to ensure that the Board has direct oversight of enhanced monitoring.

Core groups include the MatNeo Improvement group, MatNeo operational group, and the MatNeo quality and safety group.

The health board was asked to provide more details on how the system operates and how effectiveness is being measured. Colleagues questioned if further details could be added to the structure flow chart to illustrate what/who feeds into the

improvement groups and management board and where the escalation framework will feed in. It was agreed that more detail will be shared in advance of the next meeting.

Action02 The health board to provide further details on governance and reporting before the next meeting

SBUHB confirmed that there had been a Board update on both the quality improvement work and the independent review. The Board has also sighted on the escalation framework for the service.

Dashboards

The health board has agreed a number of maternity and neonatal metrics that are being used to manage and run the service. At present these are not integrated into one holistic dashboard. However, they are being used on a daily basis to support the service.

The long term intention is to develop an integrated dashboard for maternity and neonatal services that everyone can access digitally. Work is underway to scope out the requirements based on best practice elsewhere. Whilst this is in development the existing systems will be used.

Action03 The health board to provide an update on the expected timeline for this work.

Action04 The health board to present at the next meeting the indicators being used to measure outcomes.

The chair and panel have been appointed to the independent review and the clinical review team have been identified. The review is expected to start in April 2024 and the panel will provide monthly updates and escalate any identified issues. The health board noted that the terms of reference for the review are still subject to change.

4. Quality Management Systems

The health board presented the most up to date risk register for maternity and neonatal services. There are currently 6 risks listed with a score of 20. Mitigations for these risks were discussed.

A discussion took place concerning the risk rating allocated to midwifery staffing, which seemed slightly out of line with the slide pack that demonstrated that there were no current vacancies within the service. The health board explained this was due to the skill-mix of the staff and closure of community pathways and the birth centre. The health board is keeping the risk at a 20 score until it has safely assessed and reopened these pathways.

Information concerning risk mitigations in place against the high scoring risk was requested for future meetings.

Postmortem delays were discussed with some cases experiencing delays of up to 9 months and Welsh Government to seek clarification of the current position from WHSSC as commissioners of the service.

The project plan for the reopening of the birth centre is undergoing a gateway review and an update will be given at the next meeting.

Action05 The health board to provide risk mitigations for the risks over 20

Action06 Welsh Government to discuss post-mortem waiting times with WHSSC

5. Workforce and Staffing

The health board confirmed their workforce training compliance, staff turnover, sickness and vacancies, and staff wellbeing.

In regard to training compliance, the health board noted that training targets for staff have been met, with the exception of foetal monitoring training for midwives (88.2%). Additional data and information on NLS training compliance data to be provided for all staff/grades, not just consultants.

Action07 Health board to update slides in relation to NLS training compliance.

Welsh Government colleagues said that the perinatal workforce plan being developed by HEIW is also looking at the MDT around maternity and neonatal care.

HR support line managers with staff sickness management through a service of audits, policy training, coaching, and listening sessions. The staff psychology team are in the development of a bespoke wellbeing pack for staff. The health board are currently considering if further support can be through Trauma Risk Management (TRiM), Group Traumatic Episode Protocol (G-TEP), and others.

Regarding clinical leadership, the health board noted that the Clinical Director post has now gone out to advert and the Director of Midwifery post should follow soon.

Further details were requested on HIE data to be included in outcome measure information.

Action08 Health board to provide HIE data to be included in outcome measure information.

6. Engagement, Patient and Family Feedback

There have been 2 complaints logged for neonatal services and 9 for maternity services in January.

Maternity concerns themes identified from service feedback:

- Post birth complications (retained placenta)
- Extended delays in treatment during birth
- Administration of medication, delays in cannulation
- Information Governance breach – sharing information without consent

An update was given on the Perinatal Mortality Review Tool (PMRT) process and family engagement. There are currently 39 open reviews within PMRT, this is a high number and is concerning. The health board confirmed that many reviews remain outstanding due to issues of postmortem reports being significantly delayed as discussed earlier in the meeting.

In regard to patient feedback, Welsh Government requested that more information be provided at future meetings such as feedback sample size and the balance between negative and positive responses, as well as how the feedback is being used to inform service design and improvements.

Action09 Health board to provide a more detailed analysis of patient feedback, including how this informs service improvements.

7. Any other business

It was agreed that the information slide pack provided would make up the contents of a monthly MatNeo health board report.

It was suggested that clinical outcome data be presented at future meetings as run charts to show trends and variations over time.

Action Log			
No.	**Action**	**Owner**	**Update/Deadline**
01	Health board to feedback on the terms of reference by 2 April 2024.	redacted	Completed
02	Health board to provide further details on governance and reporting before the next meeting.	redacted	
03	The health board to provide an update on the expected timeline for this work.	redacted	
04	The health board to present at the next meeting the indicators being used to measure outcomes.	redacted	
05	The health board to provide risk mitigations for the risks over 20.	redacted	
06	Welsh Government to discuss post-mortem waiting times with WHSSC	redacted	Completed
07	Health board to update slides in relation to NLS training compliance.	redacted	
08	Health board to provide HIE data to be included in outcome measure information.	redacted	

09	Health board to provide a more detailed analysis of patient feedback, including how this informs service improvements.	redacted	

Attendance

Attendance and apologies		
Health Board	**NHS Executive**	**Welsh Government**
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redacted		redacted
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Apologies		