Health, Social Care and Early Years Group **Welsh Government** Enhanced Monitoring Maternity and Neonatal Services Swansea Bay University Health Board Ref: SBUHB/MatNeo/04/001	Llywodraeth Cymru Welsh Government

Meeting Notes

26 April 2024

1. Welcome and Introductions

Attendance and apologies were noted and reflected in the table below.

The health board provided a monthly report and slide deck for the meeting in the form of a presentation prior to the meeting.

2. Actions from previous meeting

The note of the previous meeting was agreed and all actions had been completed.

3. Enhanced monitoring framework

Welsh Government confirmed the enhanced monitoring framework formed part of the larger escalation framework for the health board and had been formally signed off at the TI meeting earlier in the week. The health board confirmed they were content with the de-escalation criteria.

4. Progress against agreed metrics

Outcome metrics - maternity and neonat

Following the last meeting, the attached set of performance measures were agreed as the basis for discussion and measuring progress at each meeting. The detailed slide pack outlined the current position against each of the agreed outcomes.

1 EM Slidedeck Apr-24 FINAL.pptx

<u>Measure 1: Workforce</u>

The health board confirmed that they are fully established against the required midwifery compliment for the maternity service – the 2.36 WTE vacancies in community reported on the slide had been recruited to the previous week.

In order to ensure that neonatal services are adequately resourced, the health board is using international recruitment to fill some of the vacancies. There have been 35 applications for jobs. The health board has over recruited to the Band 5 vacancies, and the expectation that existing Band 5 personnel can progress to Band 6.

In terms of BAPM compliance, the health board reported 69.35% shifts covered. It was noted that compliance concerns may be reflective of the skill mix of the staff rather than the number of staff.

Action 01: Health board to ensure that slides include the date the data refers to.

The health board provided an update following the HIW unannounced visit and the one immediate action around staffing. They have agreed that action will be taken to ensure that the midwives working in AAU are protected and not allocated to other areas.

ACTION 02 – Health board to confirm that this has been actioned and whether this is successful.

The health board reported that 82% of shifts were compliant, however this is not calculated in line with intrapartum or ward based Birthrate plus app.

Measure 2: Quality and Safety Management and Governance

The highest number of reported incidents are across maternal adverse events and predominantly relating to unexpected admissions to neonatal unit. Of the incidents, 46 were closed with low or no harm. All incidents are reviewed within 24 hours by a senior member of staff and there is a rapid review process for moderate or severe incidents.

On IPC, an improvement has been seen with three incidents reported since December. All HCAIs go through a MDT scrutiny. The health board confirmed all staff are going through training on how to take swabs.

Action 03: Health board to provide a timeline for data

Measure 3: Outcomes

The health board confirmed all maternal deaths and still births are reviewed against the national standards.

As part of the quality improvement project, the health board has undertaken a staff survey which indicated there is a need for education in terms of identifying what is an SSI.

Action 04: Health board to add neonatal deaths to the slide

Measure 4: Patient experience

HIW had reflected that the health board had good practice with the 'You said, We did' boards. They were also complimentary of the QR codes to help patients record feedback. The health board reported the use of the QR code was increasing. It was also noted the positive social media stories. The HIW patient feedback was positive.

5. Maternity and Neonatal Improvement Plan

The health board provided an update against the maternity and neonatal action plan. 81% of actions are complete. For those actions that are not complete, the health board gave assurance that plans are in place to deliver the outstanding actions.

Outstanding HIW inspection actions – the health board confirmed they have made progress in delivering the requirements from the HIW unannounced inspections. and are on trajectory to deliver the outstanding actions. In terms of the 2019 HIW inspection, there are three actions outstanding related to mandatory training.

Progress is reported to the board on a regular basis.

The health board provided an update on some of the QI initiatives that are in place.

6. Birth Centre and Homebirth Services

The plans and programme of work to re-instatement the community services is being reviewed via the Gateway process. This is being considered by internal processes with expected sign off by the end of May, meaning the pathways can restart following this approval.

The health board confirmed it would start with the Neath Port Talbot birth centre followed by the home birth service.

The Band 7 community managers have been appointed.

Welsh Government requested further clarity on the process and timescales.

Action 05: The health board to confirm the timescales, processes and risks related to the reopening of the Neath Port Talbot birth centre and the home birth service.

7. Governance

MBRRACE data – The national report was not yet available to compare against. However, it was recognised that the MBRRACE data viewer is available for all health boards to benchmark themselves against other comparable sites in the UK. In terms of neonatal death data, it appears the health board's stabilised and adjusted rate is between 5% and 15% lower than comparative NICU for neonatal mortality. The health board were of the view that the methodology used by MBRRACE was only correct on one parameter and did not take into account the boundary change that had happened in 2019.

In response to this the Welsh Government confirmed that the boundary change is accounted for since 2018. Pre-2018 it is recognised that the health board had a significantly more births (5,803 in 2017 compared to 3,585 in 2018) however by reviewing the stabilised and adjusted rate as opposed to the crude rate differences in population such as poverty are taken into account.

External review – the health board advised the Chair had been appointed and the panel had also been appointed. The Terms of Reference were out for comment with a deadline of 10 May 2024.

Board awareness – the health board presented a flow diagram showing the governance arrangements and how the Board received updates.

8. Any other business

The health board reported that they felt that there was improved grip and control within the service.

Welsh Government reiterated that enhanced monitoring is to be seen as supportive.

Date of next meeting: 3 June 2024, 15:30

Action Log			
No.	**Action**	**Owner**	**Update/Deadline**
01	Health board to ensure that slides include the date the data refers to	Health board	
02	Health board to confirm that this has been actioned and whether this is successful	Health board	
03	Health board to provide a timeline for data	Health board	
04	Health board to add neonatal deaths to the slide	Health board	
05	The health board to confirm the timescales, processes and risks related to the reopening of the Neath Port Talbot birth centre and the home birth service.	Health board	

Attendance

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