Swansea Bay University Health Board
Enhanced Monitoring Terms of Reference Maternity and Neonatal Services

Meeting date: 26th April 2024

Establishment and Vacancy Update

Workforce – Establishments and Vacancies

Midwifery – Obstetric Unit

Band	Establishment (WTE)	Vacancy (WTE)
7	12.94	0
6 / 5	73.92	0
4	8.53	0

Midwifery – community

Band	Establishment (WTE)	Vacancy (WTE)
RM	51.64	2.36

Neonatal Nursing

Band	Establishment (WTE)	Vacancy (WTE)
7	11.92	2.32
6	32.09	9.47
5	36.14	Over 8.78
4	4.25	0.8

Obstetric and Gynaecology Medical Staffing- including Gynaecology Oncology

Grade	Establishment (WTE)	Vacancy
Consultant	22.7	1.6
Speciality Registrar	12	2.4

Neonatal Medical Staffing

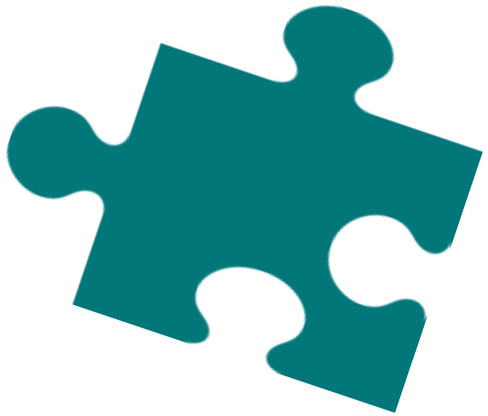
Grade	Establishment (WTE)	Vacancy
Consultant	11	0
Speciality Registrar	15	0
8A Nurse Practitioner	4	0
8B Nurse Practitioner	2	0

Compliance with BR+©
February 2024

82% of all shifts were compliant with BR+© and exceeded the minimum requirement of 14 Registered Midwives per shift.

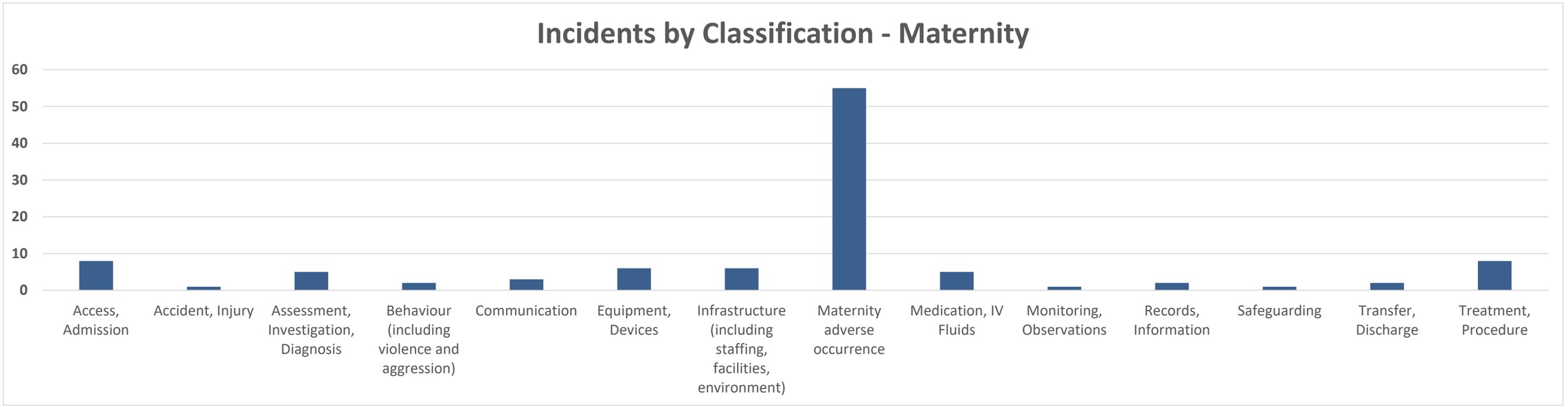
BAPM Standards Compliance (Nursing)

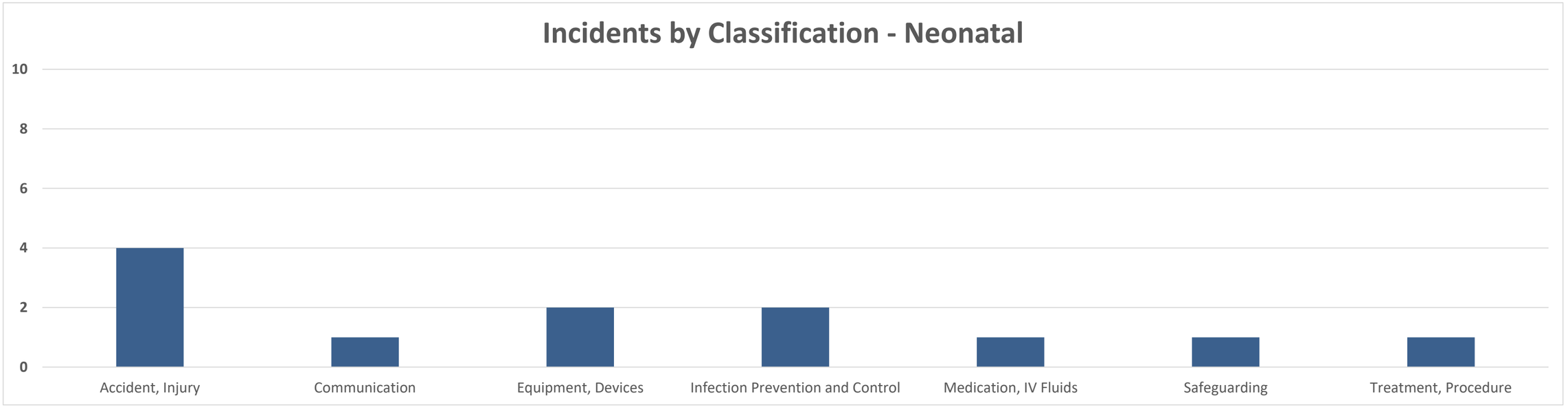
	Unit Level	% Shifts at BAPM	% bank Nursing	Ave Nurse on Shift	Ave Nurse required on Shift	Additional shifts required for BAPM
Singleton NICU	3	63.07	19.3	11.34	11.05	33.8
National Average	3	71.27	10.94	NA	NA	NA



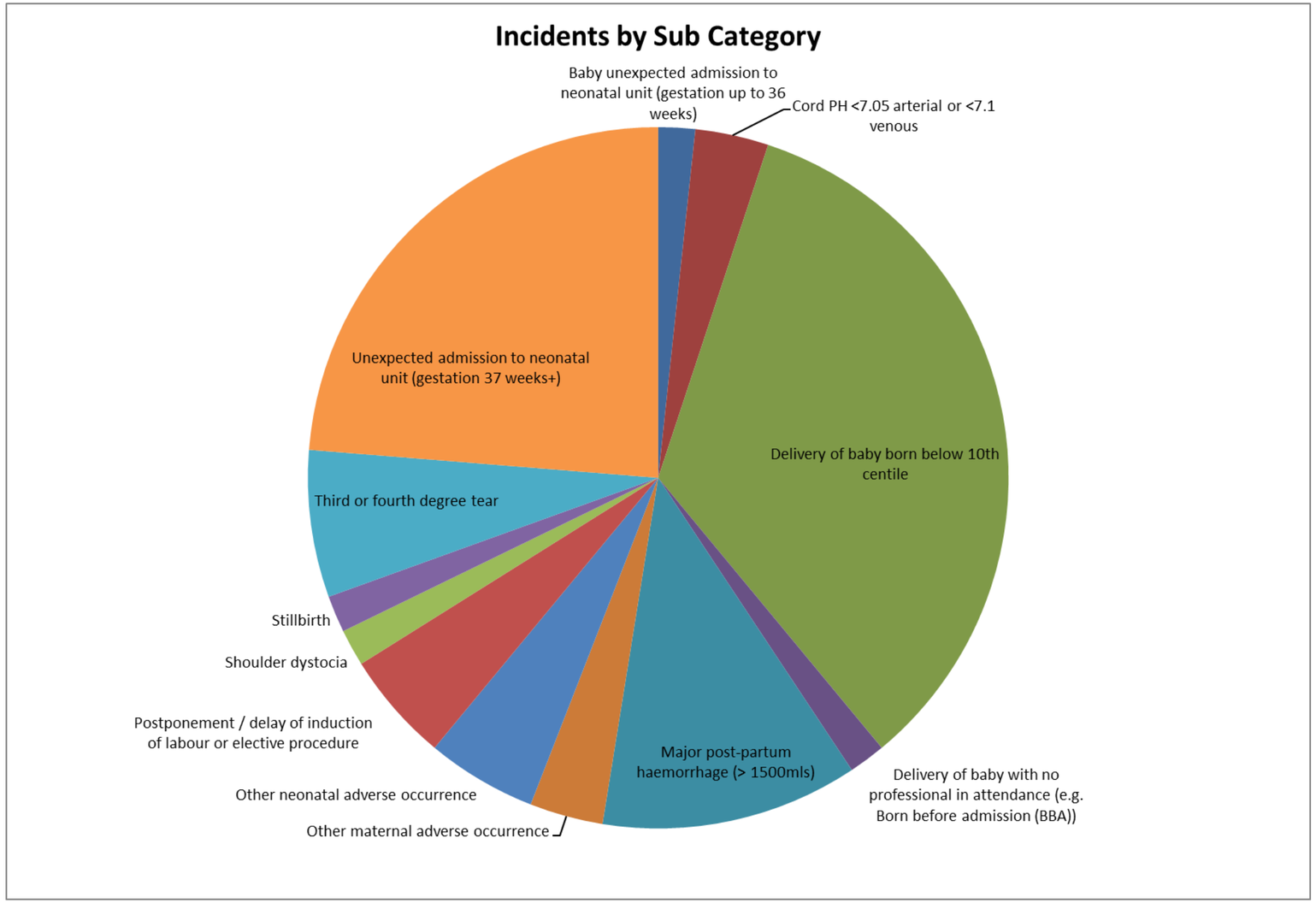
Quality Measures and Outcomes Summary

Incident review - Newly Reported Incidents: 01/02/24 – 29/02/24





Incident review – Adverse Maternity Outcome review: 01/02/24 – 29/02/24



46 Closed incidents all low or no harm

Under investigation – 1 Stillbirth, 3 post Partum Haemorrhage, 1 Cord Ph <7.05, 1 unexpected admission to NICU and 1 medication error.

Infection prevention and control

HCAI rates within maternity and neonatal services to national targets

April 2023 – March 2024

C. difficile NPTSSG

- 0 cases

Staph. aureus Bacteraemia

- SCBU – 9 cases

E. coli Bacteraemia

- SCBU – 1 case
- Ward 20 – 2 cases

Klebsiella spp. Bacteraemia

- SCBU – 1 case

Pseudomonas aeruginosa Bacteraemia

- SCBU – 2 cases

Overview of SSI position and variance

Rates for February were 18.75%
(96 caesarean sections with 18 SSIs)

The results of several wound swabs indicating a growth and "likely colonising flora", or "can not differentiate between colonisation and clinical infection", with these results being included in the overall rate.

Table of the organisms grown

Enterococcus sp	11
Escherichia coli	7
Mixed anaerobes	9
Stapylococcus aureus	3
Klebsiella oxytoca	2
Coliform	3
Klebsiella pneumoniae	1
Acinetobacter lwoffii	1
Citrobacter freundii	1
Enterobacter cloacae	1

Some swab results had one or more organisms

Outcomes & Performance

- Direct Maternal deaths
- Maternal ITU admissions

Indicator	Measure	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Number of women who birthed	Total number of women giving birth	272	265	283	304	274	278	261	292	267	273	267	266	246
Direct Maternal deaths	Direct Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0
Maternal ITU admissions	Maternal ITU admissions	0	0	1	1	0	0	0	0	0	0	1	0	1

- Number of stillbirths, by category of intrapartum and antenatal

Indicator	Measure	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Total Number of births	Total Number of births	277	271	285	307	278	284	262	297	270	277	274	270	249
Number of antepartum stillbirths	Number of antepartum stillbirths	1	3	1	1	0	2	3	1	0	2	2	1	1
Number of intrapartum stillbirths	Number of intrapartum stillbirths	0	0	0	0	0	0	0	0	0	0	0	0	0

Outcomes & Performance

Infants discharged in February 2024

HIE Place of births (Grade 2 and 3)

HIE Grade 2 or 3 requiring cooling - 1 - Inborn

Necrotising Enterocolitis (NEC)

0 cases of NEC

Bronchopulmonary Dysplasia (BPD)

5 cases of BPD

Neonatal Blood Stream Infections

Neonatal Bloodstream Infections = 1 Staph Capitis (possibly contaminant as patient responded despite sensitivities showing on resistant antibiotics. No risk factors

Preterm Brain Injury (IVH 3-4 and/or c-PVL)

2 cases of preterm brain injury (G3/4 IVH or cPVL)

Retinopathy of Prematurity (ROP) rates

0 cases of ROP requiring treatment

Brachial plexus injury

0 cases of Brachial plexus injury

Neonatal Compliance to NIPEC within 72 hours

0 exception to NIPE within 72 hours

Necrotising Enterocolitis (NEC)
Consultant confirmed (and consensus agreed), grade >2 ; radiologically proven, clinical significance requiring treatment with antibiotics and minimum 5 days nil by mouth

Bronchopulmonary Dysplasia (BPD)
At 36 weeks gestation, requiring oxygen or respiratory support

Preterm brain injury
Grade 3 or 4 intraventricular haemorrhage or cystic PVL (periventricular leukomalacia)

Retinopathy of prematurity (ROP)
Requiring treatment

Maternity User Feedback

Maternity Services	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024
No of concerns received	7	5	5	4	2	2	3	10	11
Compliance	43%	0%	20%	25%	0%	0%	0%	60%	TBC

Maternity Feedback February 2024 (Family and Friends)

"I just want to share some positive feedback. Today myself and my son got discharged after an elective c section. I am so grateful for every member of staff at singleton hospital who we came across. Such a stark contrast to my first born in 2021 via cat 1 emergency c section. This time everyone was completely on their game from the surgical team who were so supportive, kind and gentle with me, to recovery staff who calmed me when my baby was literally whisked away from my arms, special care team who saved my baby boys life - the work they do, the hours they do - what amazing people. To the midwives who cared for me and helping me get back and forth to my baby in Special care at all hours of the night, to putting me in a single room because I couldn't bear to hear the cry of the other babies when I couldn't have mine. Even to cleaning staff, porters and food staff. All fantastic. Everyone was completely lovely, kind and helpful. What a healing experience. I think people are quick to complain but not to praise"

"All the individual midwives were incredibly supportive and kind, even under the clear pressures they were facing with the number of patients needing to be dealt with. I never felt like I couldn't ask anything and was always reassured that no question was too big or too small, day or night."

"The staff on the labour and post labour ward and NICU were all so compassionate and caring - nothing was too much for them!"

"The staff are outstanding"

Themes identified maternity concerns:

- Experience during admission and following birth
- Pain management during labour
- Delay in care/ lack of care
- Issues with contacting Community Midwifery Services
- Skin damage due to moist bedding not being changed
- Birth options within SBU including home birth service
- 2 compliments logged via Datix during February 2024

Maternity Feedback February 2024 (Family and Friends)

Results by Ward/Clinic

Ward/Clinic	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know
Total	94.8%	2.6%	115	91	18	3	1	2	0
Antenatal Clinic - Neath Port Talbot	85.7%	14.3%	7	6	0	0	0	1	0
Antenatal Clinic - Singleton	100.0%	0.0%	3	3	0	0	0	0	0
Labour Ward - CDS	100.0%	0.0%	19	18	1	0	0	0	0
Ward 19 (Antenatal)	89.2%	5.4%	37	24	9	2	1	1	0
Ward 20 (Postnatal)	98.0%	0.0%	49	40	8	1	0	0	0

Neonate User Feedback

- 0 concerns received for neonatal services since February 2022
- 8 compliments logged during February 2024

Family and Friends Feedback – Neonates

Results by Ward/Clinic

Ward/Clinic	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know
Total	100.0%	0.0%	14	12	2	0	0	0	0
Neonatal Intensive Care Unit	100.0%	0.0%	14	12	2	0	0	0	0

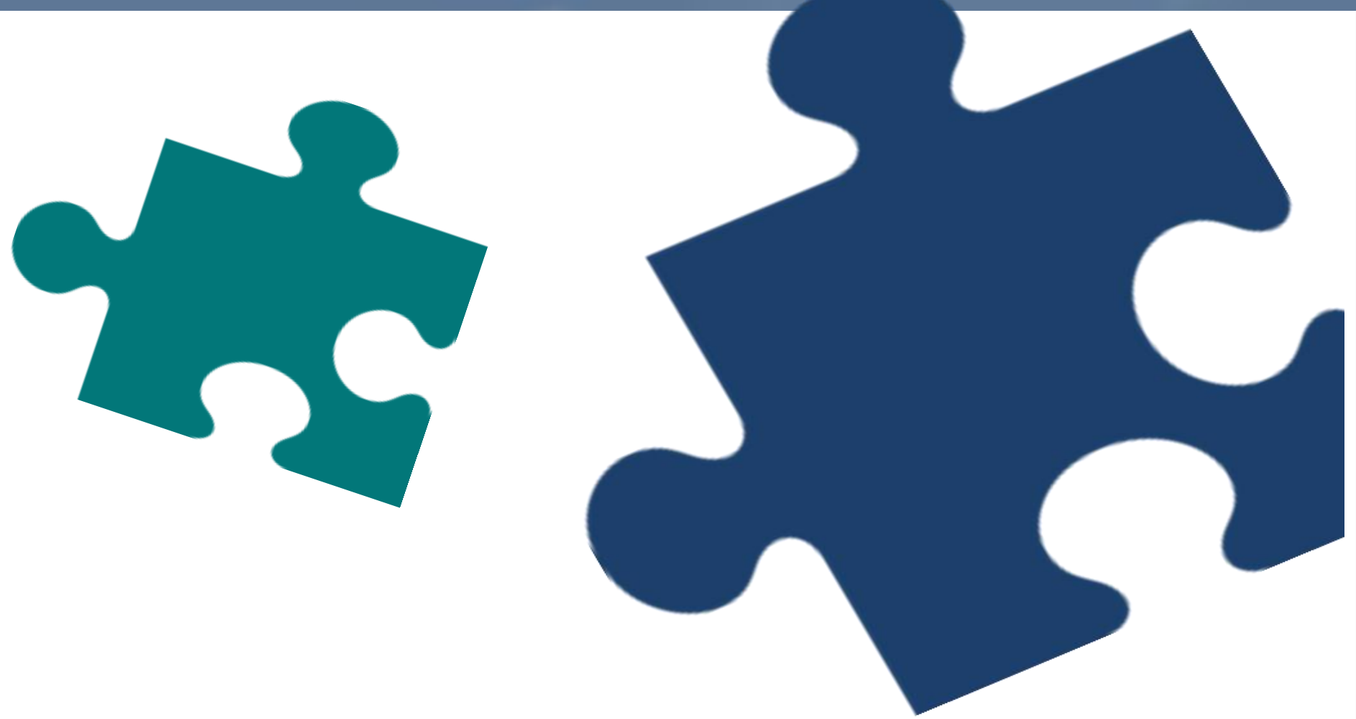
Neonatal Feedback February 2024 (Family and Friends)

"The staff at Singleton Neonatal have been absolutely outstanding during our whole stay! They are very open and honest with you, they always ask your opinion and take on board any comments you make! The care they have provided has been amazing and their fast actions and decisions can't be faulted when he has been poorly during is stay! Many parents may find it difficult to watch certain parts of their babies care more so the medical side to it but I found it very reassuring that the staff, doctors and consultants team had nothing to hide and were possible I was allowed to be by my babies side or near by. The staff have also been very supportive to me as a parent."

"Staff phenomenal. Everything explained and a clear plan of what will happen so no surprises. Super clear information."

"Everyone has been amazing. We have felt safe in the hands of wonderful staff."

"Staff/ everyone so welcoming and reassuring. Med team ask for my opinion which I love. Nothing is too much trouble."



Maternity and Neonatal Improvement Plan

Maternity and Neonatal Services in Wales
Assessment, Assurance and Exception Reporting Tool

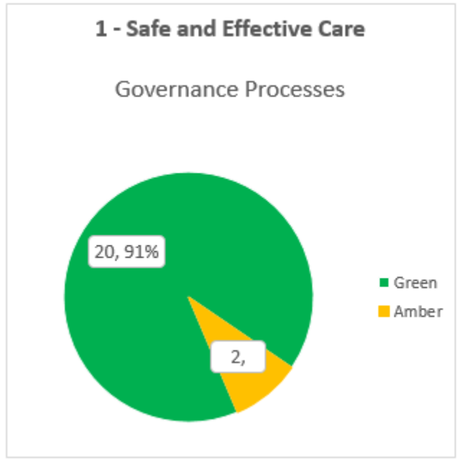
This tool has been developed to support provider health boards to assess their current position against the recommendations made within recently published reviews, reports and audit documents. The tool should be used to assess compliance with the recommendation and exception report and action plan for those recommendations which are **AMBER** and **RED**. It is recommended that an evidence log be created to support the document.

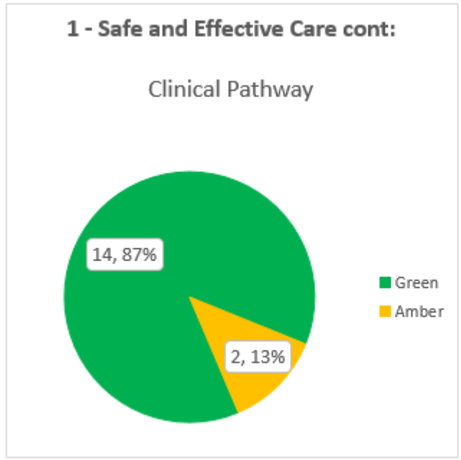
As of May 2022 the following reports and audits have been included. This document can be amended when other reports are published

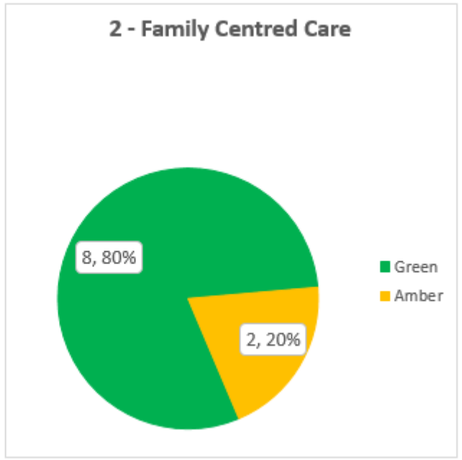
Abbreviation	Author	Report Title
R	RCOG / RCM / IMSOP	Review of Maternity Services at Cwm Taf Health Board / Thematic Maternal Category Report / Thematic Stillbirth Category Report / Review of Neonatal Services at Prince Charles Hospital
O	Ockenden	Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospitals NHS Trust / Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust
H	HIW	Phase 1. National Review of the Quality and Safety of Maternity Services
M-MD	MBBRACE-UK	Saving Lives, Improving mothers' Care: Lessons Learned to Inform Maternity Care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-2018
M-SND	MBRRACE-UK	Perinatal Confidential Enquiry. Stillbirths and Neonatal Deaths in Twin Pregnancies. Recommendations Identified from Existing Guidance Required to Reduce Stillbirth and Neonatal Death in Twin Pregnancy

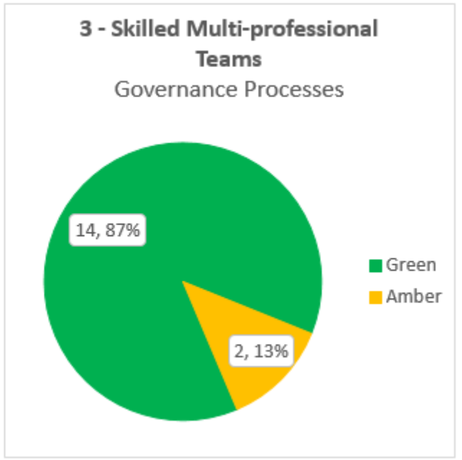
Maternity and neonatal improvement plan

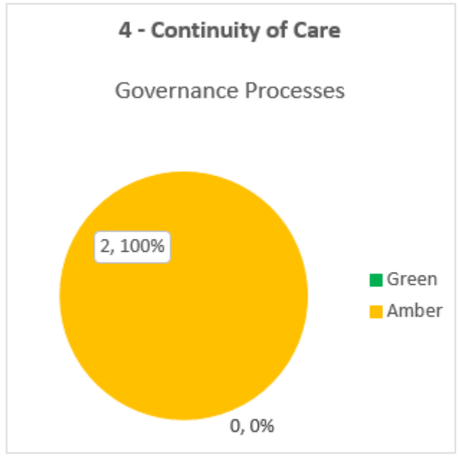
Maternity and Neonatal Services in Wales - Assessment & Assurance

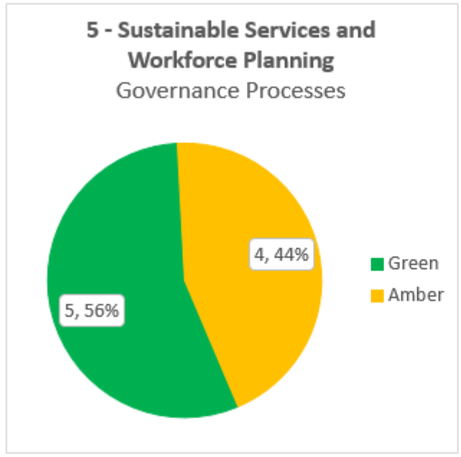


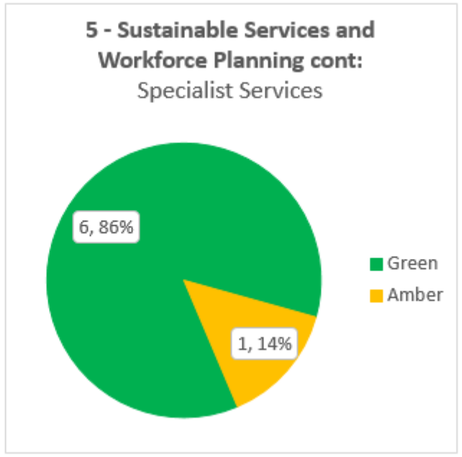












Green – 67 (81.71%)
Amber – 15 (18.29%)

Maternity and Neonatal Services in Wales
Assessment, Assurance and Exception Reporting Tool – Outstanding Actions

Recommendation	Action outstanding	Lead	Timescale	Progress
1.6 Systems must be in place to ensure appropriate management of women with high risk of pre-term birth, including: • **Counselling of parents** • **Appropriate monitoring of pregnancy** • **Mode of delivery** • **Tertiary discussion** • **Continuous audit of In-utero transfers**	Development of a pre term birth clinic with dedicated scanning time	Divisional Service Support Manager	October 2024	BAPM Framework for extreme pre term infants (Peri-Viable) published and presented to MDT. MDT Involvement can be variable. Request for consultation often made on admission to the hospital rather than in the antenatal period This is all now included in Periprem standards Final action is for the establishment of a dedicated clinic with scanning facilities
1.18 External clinical specialist opinion from outside the Health Board, must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. This should include the use of the PMRT where applicable.	Health Board will link with neighbouring Health Board to develop a formal arrangement	HOM to link with HDUHB HOM	May 2024	Specialist opinion from outside Health not yet fully established – HOM & Clinical lead to re-establish links and discussed proposed plan for external scrutiny from neighbouring Health Board. To further progress this the HB will link with neighbouring Health Board, executive support now being sought to ensure this process is formalised. Reviews requiring external opinion sought through the Health Board Legal & Risk Team.
1.28 Complex pregnancy pathways must be in place for • **Preconception advice and management of women with pre-existing conditions** • **Multifetal pregnancies** • **Pre-existing conditions e.g. Diabetes, cardiac, chronic hypertension**	Pre conception advice and management for women with pre-existing conditions required	Divisional Service Support Manager	October 2024	Medical pathways in place with medical antenatal clinics including multi fetal pregnancy clinic and fetal medicine support. Pre conception advice and management for women with pre-existing conditions not fully achieved
1.38 Postnatal care must include systems in place to ensure a consultant review of all readmissions within 14 hours of readmission, including daily review of unwell postnatal women regardless of clinical setting.	Develop a readmission guideline	Matron	March 2024	Draft SOP prepared

Maternity and Neonatal Services in Wales
Assessment, Assurance and Exception Reporting Tool – Outstanding Actions

Recommendation	Action outstanding	Lead	Timescale	Progress
2.2 Service users (ideally through the MVP / MSLC) must be involved in the complaints process, ensuring responses are caring and transparent	**Consider how this can be achieved**	**HOM**	**April 2024**	**Women are involved in review process, MVP – shared themes and actions taken are part of the agenda Governance TOR guidance**
2.4 Improve the ability of birth partners or family members, to be able to support women, in line with a woman's wishes	Undertake further engagement work to establish the wishes	HOM	June 2024	The Service will undertake focused surveys/engagement to fully be assured that women's wishes are being met
3.9 Clinical supervision and consultant oversight of practical procedures must be in place for all staff including specialist midwives and staff doctors	Confirmation audit monitoring processes	Consultant lead for training	April 2024	Review of current procedures underway with record audit.
4.1 Take steps to ensure that women have contact with a consistent group of healthcare professionals, to improve continuity of care	Progress with community continuity review	Community Matron	July 2024	Following implementation of the new team a review of continuity will be undertaken
5.6 A strategy is in place to support a succession planning programme for the maternity workforce and develop future leaders and senior managers. This must include a gap analysis of all leadership and management posts in midwifery and obstetric	Complete the maternity workforce plan including leadership posts	Workforce monitoring group	June 2024	Workforce planning in place, bespoke leadership and mentorship package for new band 7's developed. Nursing and Midwifery leadership academy established with Matron Leadership programme offer to all 8a Nurses and Midwives.
5.12 Ensure the appropriate level of breastfeeding advice, guidance, and support is provided at all times.	Secure funding for fulltime post	Divisional manager	April 2024	Business case developed, current postholder hours increased to support service.

Maternity and Neonatal Services in Wales
Assessment, Assurance and Exception Reporting Tool – Outstanding National Actions

Recommendations	Action outstanding	Lead	Progress
3.2 Midwives responsible for coordinating labour ward must attend a funded and nationally recognised labour ward coordinator education module. This must be a specialist post with an accompanying Job	Require a national steer on the development of a module	HEIW	HEIW – national labour ward Framework for coordinators now developed – newly appointed staff undertaking this and existing staff undertaking aspects of the programme.
3.4 Health Boards must train a core team of midwives to deliver high dependency maternity care, sufficient in numbers to ensure one midwife is available each shift	HEIW developing E-Learning package and looking at specific module.	Labour Ward and Consultant Obstetric anaesthetist	Locally a review of training needs is being undertaken
5.2 Nationally agreed minimum staffing levels based on acuity and complexity of pregnancies, vulnerable families and mandatory training requirements	WG on the development of Birthrate + cymru	WG	
5.4 The feasibility and accuracy of the Birthrate+ tool and it associated methodology must be reviewed nationally	Awaiting national work	WG	

Maternity Services Unannounced HIW Inspection Update

IMMEDIATE IMPROVEMENT PLAN

As at 23rd March 2024, a total of 33 actions have been completed, 7 actions in progress and one action to be completed by July 2024.
(All Actions Due Except One)

Actions due – thematic heading	Number Actions Due	Number Implemented	Number Remaining
Staffing levels	10	10	-
Mandatory training	9	4	5
Equipment	2	2	-
Security (premises/abduction)	9	6	2
Handovers	2	2	-
IPC	5	5	-
Security of Fluids	4	4	-
Actions not yet due	1 (July 2024)	Tbc	Tbc
TOTAL	41		

General improvement plan, the table below summarises the present position showing 78 of the total actions have already been completed, 39 actions to be completed by the end of the year, with the exception of one which will be completed in January 2025.

Target Month Actions Due (by end of month)	Number Actions Due	Number Implemented	Number Remaining
Completed at time of submission	6	6	-
November 2023	10	10	-
December 2023	28	28	-
January 2024	22	21	1
February	13	13	-
March on wards	39	TBC	TCB
TOTAL	118		

Maternity Services HIW 2019 Inspection Update

Current status

Recommendations = 34

Actions = 80

Complete = 76

Not Complete = **3**

Recommendation	Action required	New timescale	Lead	Progress
11 Theatre duties	Increase Prompt training compliance	September 2024	Practice development leads a obstetric medical training lead	Training compliance reported monthly dates booked until September with staff allocated to attend
32 Training compliance	Improved compliance of ELearning compliance	March 2024	Practice development leads obstetric medical lead and midwifery managers	Awaiting compliance figures – nursing & Midwifery staff 89% Medical staff 77%
33 Communication channels	ADAU & AAU criteria on wisdom	February 2024 revised date of completion	Antenatal ward manager	Awaiting approval at next A/N forum

Singleton NICU 2024 QI Priorities

- **Late Onset Sepsis QI Group**

Leads G Davies, K Burke & R Morris

Local governance processes identified rise in Staph Aureus LOS cases Autumn 2023 triggering a local thematic review of 6 cases in October 2023 (no CLABSI's or other correlating factors except 5/6 <1kg). Total 2023 S.A. LOS cases = 9, no related deaths). Await 2023 VON data due to be published June 2024. Several QIP will be undertaken under this umbrella work. MDT set-up with NICU MDT, infection control, pharmacy, microbiology etc.

- **UNIVERS**

Using **N**on **I**nvasive **V**entilation **E**arly in **R**espiratory **S**upport.

Leads L Perkins, S Cannell & J Webb

Reducing BPD QI Group project. Above average BPD rates on NNAP. NNAP 2022 BPD Unit rate 45.9% UK Rate: 39.7% - even if treatment effect applied still positive. Not outliers however and VON more reassuring. BAPM BPD Toolkit identifies DR respiratory management as 2nd of 5 key aspects of BPD prevention. New NNAP measures of NIV only at 1 week for <32 weeks – benchmark below national average. MDT formed. Baseline data collected undertaken & explored problem through QI methodology. Major issue high proportion of babies admitted intubated. SMART Aim: To increase proportion of <32 week infants on NIV at 1 week by 10% in 6 months. 1st PDSA: Providing effective nasal CPAP via shuttle mounted ventilator asap after birth for 25-31 week infants where possible.

- **Optimising Antenatal Steroids**

Lead T Hixson, L Perkins, M Dey and PERIPrem Cymru Swansea perinatal team.

High performing across NNAP Optimal Perinatal Care metric thanks to local perinatal QI group and PERIPrem Cymru programme. BUT challenge remains in delivering optimally timed steroids (reduces mortality in preterm infants by around 30%) partly due to challenges in predicting preterm birth. Locally qfFN business case May 23 – just approved. Roll-out anticipated. In interim focus on evidence-based counselling PDSA.

- **BLISS Baby Charter QI Mapping**

Lead K Burke

Currently mapping wider QI work against BLISS Baby Charter. This crossovers ongoing work re. Maternal Breast Milk (including PERIPrem Cymru 6 hour target) and DR skin to skin. Planned QI re. 'Active Offer' of Welsh Language.

Maps to:

NNAP Complications of Prematurity Composite Measure – published 2023 data due Oct 2024 **VON** – 2023 data due June 2024

MatNeo SSP: Rec: 12.1 Optimise Maternity & Neonatal Outcomes. G. Consider use of established QI process for neonatal infection e.g. Vermont Oxford Network (VON).

BAPM Service and Quality Standards for Provision of Neonatal Care in the UK (2022) 4.1 NSQI 1 Evidence based care

NNAP - new NNAP quality measure 2022: NIV only <32 weeks for 1st week of life (2022 36.4 vs UK 47.1)

BAPM Service and Quality Standards for Provision of Neonatal Care in the UK (2022) 4.1 NSQI 1 Evidence based care

BAPM Toolkit: Reducing the incidence of bronchopulmonary dysplasia A BAPM Quality Improvement Toolkit December 2023

(Inter) National Guidance: NICE (NG124) **Specialist neonatal respiratory care for babies born preterm,** 2019 **European Consensus on RDS 2022.**

NNAP Optimal Perinatal Care composite quality metric – latest data 27.5% (UK 19.1%)

PERIPrem Cymru (Perinatal Excellence to Reduce Injury in Preterm birth, Cymru) – 1 of a 10 intervention bundle being delivered nationally in Wales to reduce severe brain injury and improve survival <34 weeks.

BAPM Service and Quality Standards for Provision of Neonatal Care in the UK (2022) NSQI 2 Team working and communication

BAPM QI Toolkits: Antenatal Optimisation for Preterm Infants less than 34 weeks (2020)

BAPM Service and Quality Standards for Provision of Neonatal Care in the UK (2022) NSQI 3 Parental partnership in care

Mat Neo SSP: 7.4 All Neonatal Units to adhere to Bliss Baby Charter Standards

Re-instatement of Community Pathways - Update

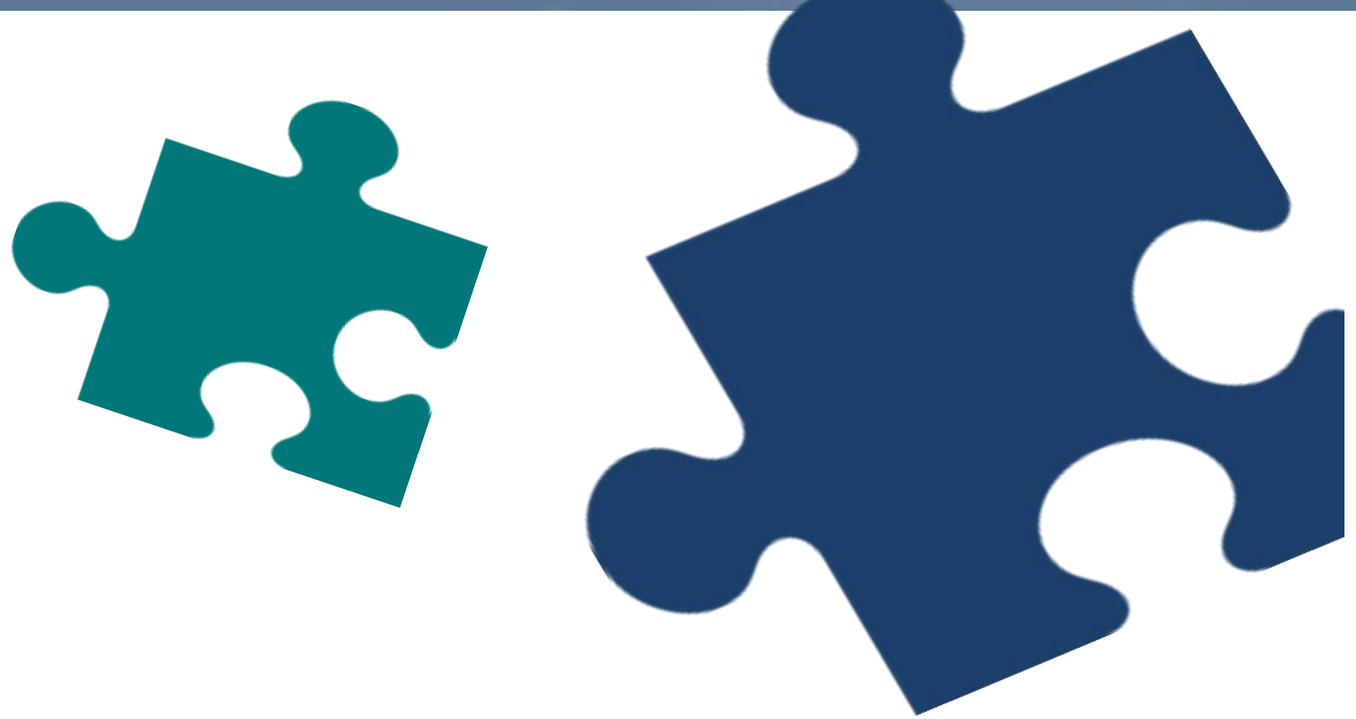
Maternity and Neonatal Birth Centre Update

Re-instatement of community services are being considered via a Gateway Process to ensure safety

Identified Gateways are:

1. Stable clinical establishment (on track)
2. Clinical leadership, appointment of 8 Community Team Managers (band 7) (gateway not yet met)
3. Midwifery proficiency assessment (on track)
4. Environmental and operational assurance (on track)
5. Phased reopening of the FMU, prior to home birth services (on track)
6. A sustainable solution for the managing the obstetric unit at times of high acuity (Managed as part of the Obstetric Unit OCP).

Plan for re-instatement will be taken to Health Board at the end of May 2024 for approval.



Governance: MBRRACE 2022

Analysis of SBUHB report

Swansea Bay MBRRACE report 2022

Perinatal mortality (all deaths)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	13	3.84	3.64	(3.11 to 4.29)	Up to 5% higher or up to 5% lower
Neonatal	3	0.89	1.62	(0.97 to 2.57)	More than 5% and up to 15% lower
Extended perinatal	16	4.73	5.27	(4.55 to 6.52)	Up to 5% higher or up to 5% lower

Perinatal mortality (excluding deaths due to congenital anomalies)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	13	3.84	3.26	(2.92 to 3.69)	Up to 5% higher or up to 5% lower
Neonatal	3	0.89	1.23	(0.74 to 1.93)	Up to 5% higher or up to 5% lower
Extended perinatal	16	4.73	4.48	(3.99 to 5.41)	Up to 5% higher or up to 5% lower

Swansea Bay MBRRACE report 2022

Trends (Neonatal deaths - Crude) 2022 included

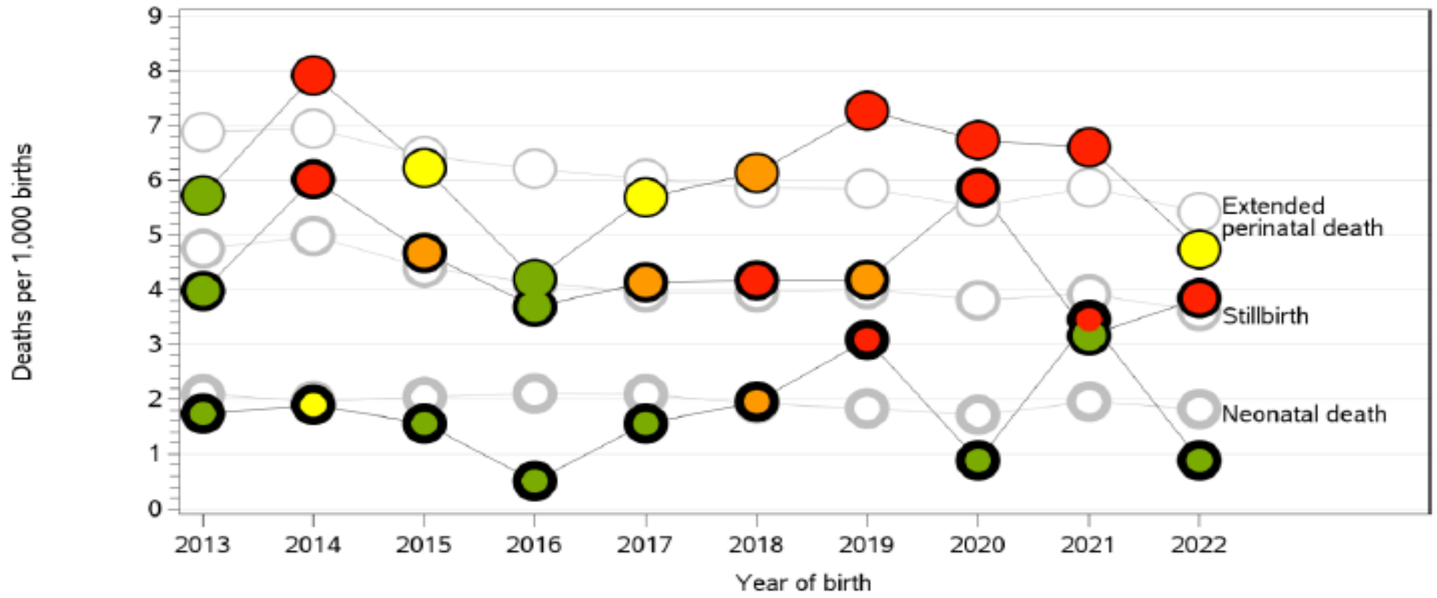
Comparator group is level 3 NICU and not annual births where Swansea Bay is disadvantaged by reduction in low-risk births from HB boundary change – masking improvement

2. Mortality rates over time

Crude mortality by year of birth (all deaths)

Crude mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

Due to updates to the data, these results might differ slightly from those in previous reports.



Interpretation codes:

- more than 15% lower than the average for the group
- more than 5% and up to 15% lower than the average for the group
- up to 5% higher or up to 5% lower than the average for the group
- more than 5% higher than the average for the group

Trusts and Health Boards whose mortality rates are marked ● or ● should carry out an initial investigation of their data quality and possible contributing local factors that might explain the high rate. Irrespective of where they fall in the spectrum of national performance all Trusts and Health Boards should use the national PMRT to review all their stillbirths and neonatal deaths.

Swansea Bay MBRRACE report 2022

Trends (Neonatal deaths - Crude) 2022 included

Apart from 2019 and 2021 SBUHB neonatal mortality has been significantly lower than national average in 6 out of 10 years and the other 2 years at par.

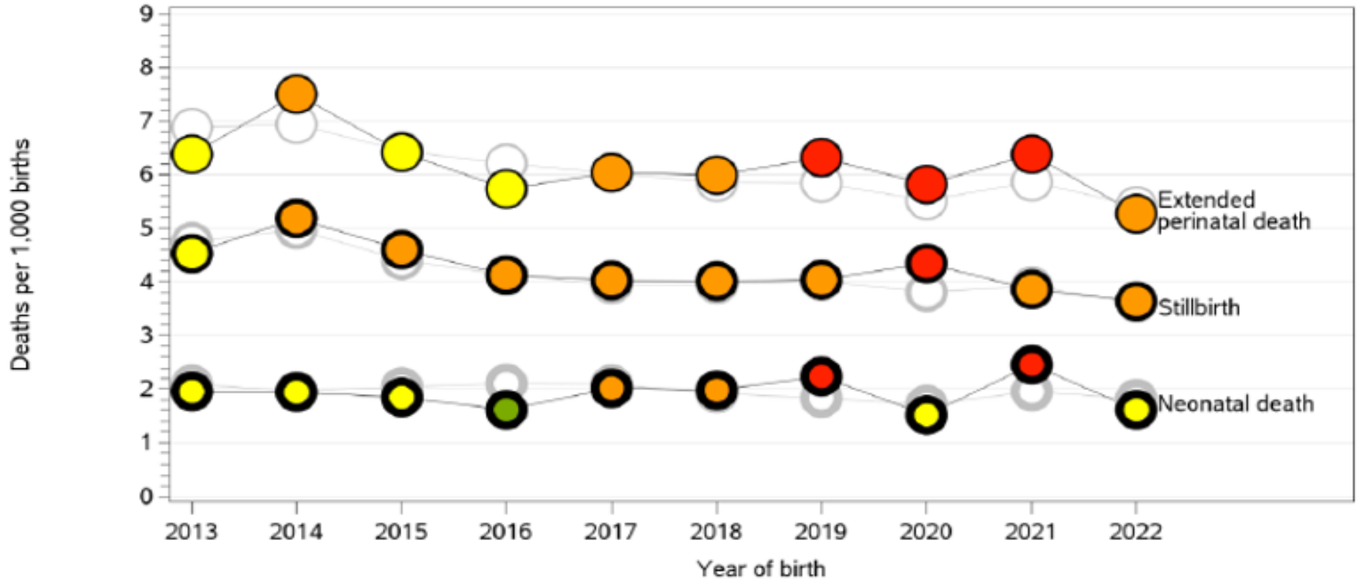
This is despite no adjustment to denominator from 2019 which is likely to have masked improved performance

Mortality rates over time *continued*

Stabilised & adjusted mortality by year of birth (all deaths)

Stabilised & adjusted mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

Due to updates to the data and improvements to the statistical methodology used, these results might differ slightly from those in previous reports.



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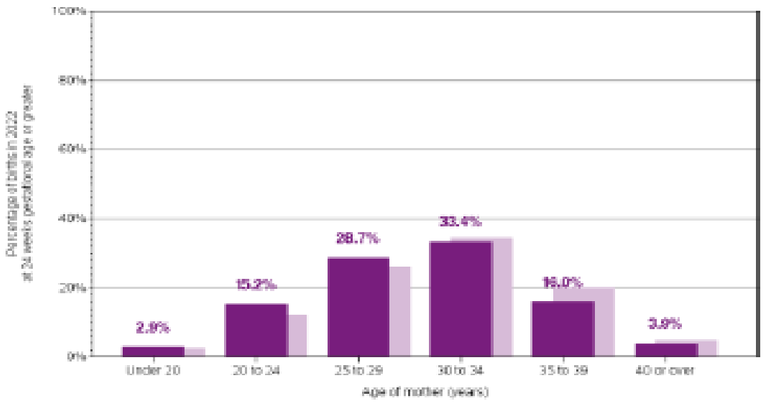
Higher socioeconomic deprivation and younger mothers

4. Your births

Age of mother

The proportion of mothers under 25 years of age was higher than that of the UK as a whole: 18.1% versus 14.5%.

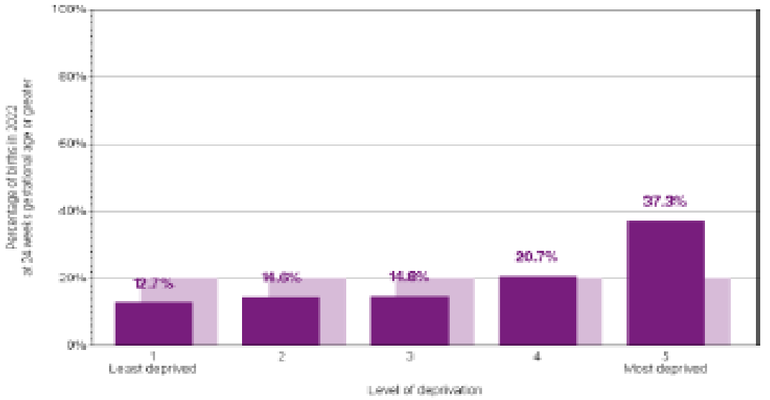
In the national MBRRACE-UK Perinatal Mortality Surveillance Report it was shown that mortality rates were higher for babies born to mothers under 25 and over 34 years of age compared to mothers aged from 25 to 34 years old.



Socio-economic deprivation

This graph shows the distribution of births by level of deprivation, based on the postcode of the mother's residence and using the Children in Low-Income Families Local Measure.

The mothers giving birth in your Health Board were considerably more likely to live in areas of high deprivation than those giving birth across the UK as a whole.

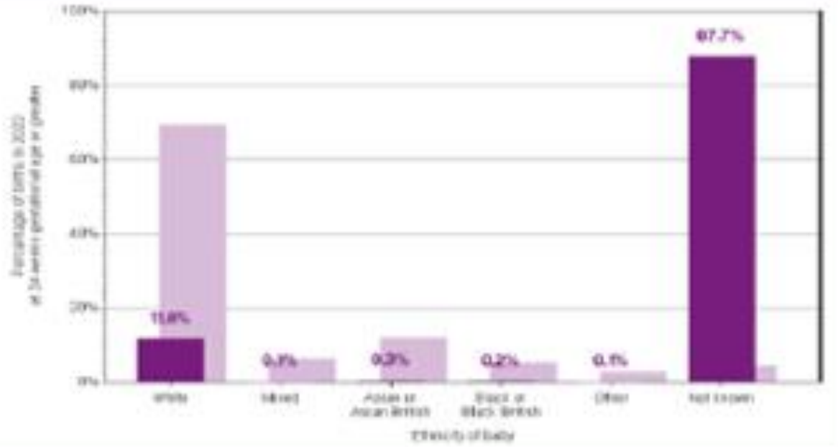


Other issues:

Ethnicity of baby

The proportion of babies of non-White ethnicity was considerably lower than that of the UK as a whole: 0.7% versus 26.2%.

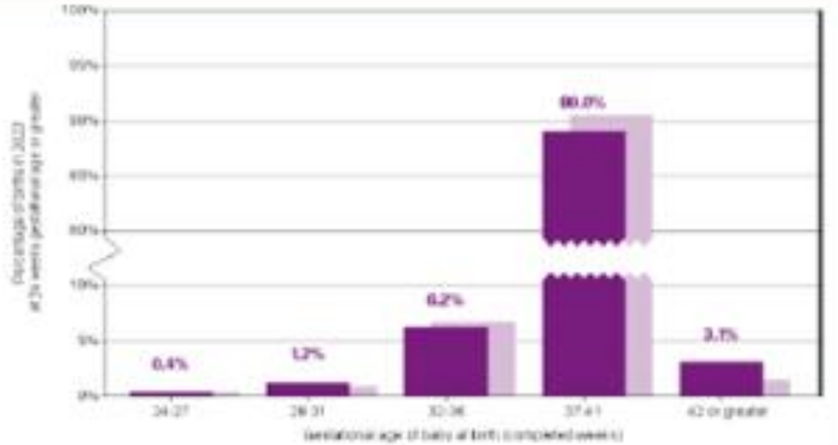
However, for 87.7% of your births the baby's ethnicity was reported as not known. This information is dependent on the accurate coding of babies' ethnicity within the routine reporting of all births.



Gestational age

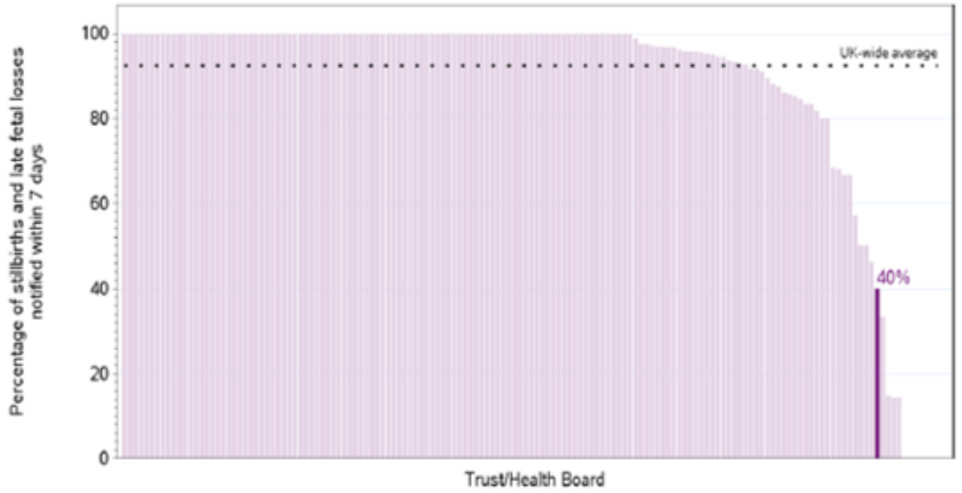
In your Health Board, 13 babies (0.4%) were born at 24 to 27 weeks gestational age, similar to the 0.4% seen in the UK as a whole. However, there was a higher percentage of babies born at 28 to 31 weeks compared with the national average: 1.2% versus 0.8%.

In addition, 105 babies (3.1%) were born post-term (42 weeks or greater), a similar percentage to the UK average of 1.5%.

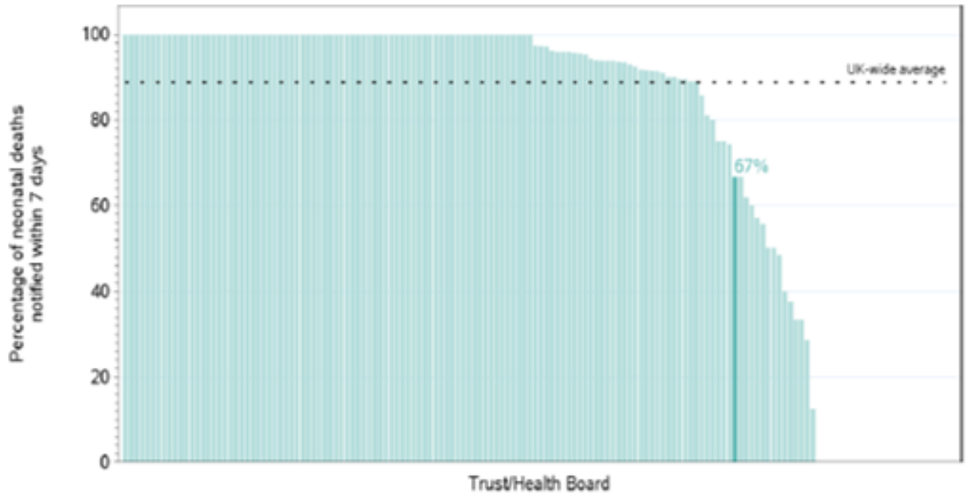


Timely reporting to MBRRACE – improvement required

Still birth notification



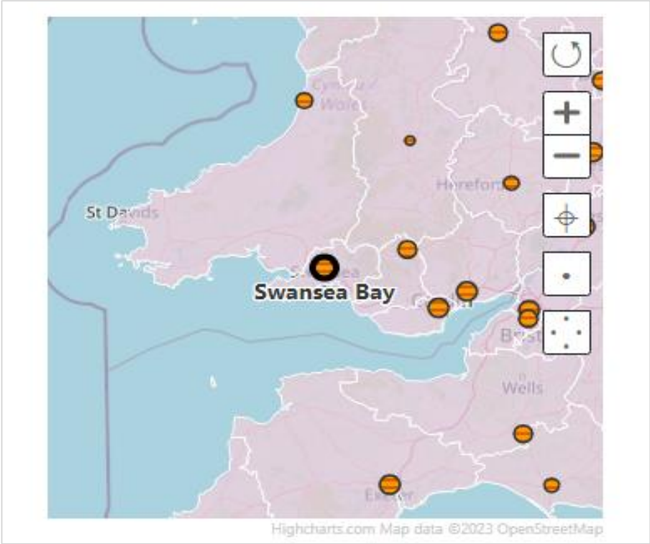
Neonatal death notification

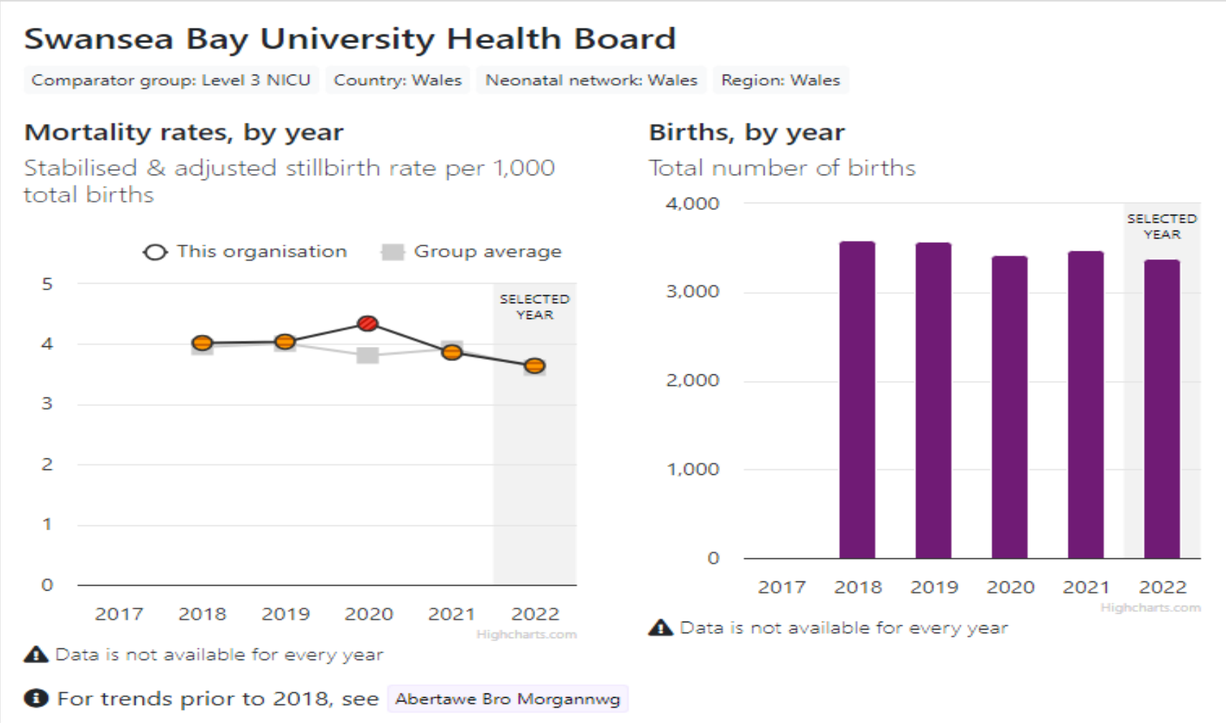


Outdated data – significant improvement – no delay in 2024

Stillbirth Rates in SBUHB

Figure 1 – Geographical averages of stillbirth rate in South Wales (Source MBBRACE)





Cause of Death – Stillbirths 2022

Cause of Death	24 - 27+6	28 - 31+6*	32 - 36+6	37 - 41+6	Total
Infection					0
Placental abruption					0
Congenital abnormality					0
Placental pathology		1	2	1	4
Placental abruption	1	1			2
Twin to twin transfusion	1				1
Eclampsia					0
Unknown		1		4	5
Total	2	4	2	5	12

MBRRACE report recommends use of PMRT in a multidisciplinary meeting to improve the quality of cause of death coding. Swansea Bay use the PMRT for grading of cases. In 2022 MBRRACE report 5 cases were reported death as unknown and 4 cases were reported as placental pathology.

Themes from reviews - Stillbirths

Fetal movements

- Women reported no change in fetal movements – 5
- Women reported first episode of altered fetal movements on day of diagnosis of fetal demise – 5
- Women reported two or more episodes of altered fetal movements - 2 **Total – 12**

Five women attended with their first episode of altered fetal movements and sadly was confirmed an intra-uterine death).

Smoking

Five women reported they were smoking during their booking appointment. All five women were offered smoking cessation support through the Help Me Quit service.
Carbon monoxide monitoring had not been reintroduced in SBUHB in 2022 following the COVID-19 pandemic.

Substance misuse

There were no women who disclosed substance misuse history or in pregnancy.

Mental Health

One woman disclosed mental health at booking to her Community Midwife in a neighbouring Health Board. The woman was prescribed citalopram 40mg pre-pregnancy and continued to take medication. Care was provided by a neighbouring Health Board therefore unable to ascertain mental health support provided to the woman.

Themes from reviews - Stillbirths

Safeguarding concerns

There were no women who were identified as having safeguarding concerns or information to be shared in pregnancy.

Communication

All women except one were British. One was White/Caribbean but chose English as their preferred language.

Raised BMI

The normal BMI for a woman ranges between 18.5 and 24.9 if the body mass index measurement is less than 18.5, the woman is considered underweight. A BMI that is 25 or higher indicates that the person is overweight and anything above 30 is obese.

- **Underweight BMI less than 18.5** – 0 women.
- **Normal BMI 18.8-24.9- 4 women** – BMI was recorded as 20.7, 22.7, 23.6, 23.9.
- **Overweight BMI of 25-30** - **3 women** – BMI was recorded as 25.1, 27.8, 28.5.
- **Obese BMI of greater than 30** - **6 women** – BMI was recorded as 30.1, 31 ,37.6, 39.4, 40

Themes from reviews - Stillbirths

SGA Babies

- <10th centile - 5
- >10th and < 25th centile - 2
- > 25th and <50th centile - 1
- > 50th centile and < 90th centile - 2
- > 90th - 1

Note – one women who birthed twins did not have a calculated birth weight centile due to multiple pregnancy.

Small for gestational ages babies born under 10th centile

- There were five out of twelve women who birthed babies under the 10th centile.
- Out of the five women who birthed babies with a birth weight centile under the 10th, three were having serial scans however sadly an intrauterine death was confirmed on attendance of one woman's first serial ultrasound scan.
- Out of the five women who birthed babies with a birth weight centile under the 10th, three disclosed as smoking at booking (LD, NW and ND). SBUHB at the time only provided serial scans for women who smoked over 11/day therefore two women did not receive ultrasound scans due to smoking.

Grading of Stillbirth cases for 2022

12 cases were graded although 13 stillbirths were reported as one case was a twin pregnancy

PMRT Grading

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

Grade A - The review group concluded that there were no issues with care identified up to the point the baby was confirmed as having died.

Grade B -The review group identified care issues which they considered would have made no difference to the outcome of the baby.

Grade C -The review group identified care issues which they considered may have made a difference to the outcome for the baby.

Grade D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby.

- 7 cases were graded as ‘a’ for care up until the death of the baby
- 4 cases were graded as ‘b’ for care up until the death of the baby
- 1 case was graded as a ‘c’ for care up until the death of the baby
- No cases were graded as a ‘d’ for care up until death of the baby

Grading of Stillbirth cases for 2022

Learning from incidents graded 'b' - ***The review group identified care issues which they considered would have made no difference to the outcome of the baby.***

- Antenatal care must be delivered in line with NICE guidelines as prior to the Covid pandemic.
- All bereavement documentation to be kept as a bundle to reduce the risk of documentation being missed.
- Clinical Risk Midwife and Bereavement Midwife to commence a safety net pathway of checking bloods following an intrauterine death and highlighting any abnormal result for action to the named Consultant.
- Fetal loss bundle created for Midwives to follow to ensure all investigations are completed. This bundle is already in use.
- Community Midwife to give date and time of 16 week appointment on completion of booking appointment.
- Growth scans to be reinstated at 28 weeks following the COVID pandemic completion reducing the risk of missed SFH measurement on Consultant-Led care women.

Grading of Stillbirth cases for 2022

Learning from incidents graded ‘c’ - The review group identified care issues which they considered may have made a difference to the outcome for the baby.

Case 1:

A woman booked care with Maternity services at 12+6 weeks gestation. The woman reported to smoke 6 cigarettes a day at booking. The woman attended her dating ultrasound scan at 15+3 weeks gestation and her anomaly ultrasound scan at 20+3 weeks gestation, which were both, reported as normal. The woman was not booked for serial ultrasound scans as at the time of her pregnancy SBUHB guidance was to perform serial ultrasound scans for women who disclosed smoking 11 or more cigarettes a day.

The woman attended an appointment with her Community Midwife at 24+6 weeks gestation, which was reported as normal. The woman did not attend her 28 week appointment with her Community Midwife and this was subsequently was not followed up. As the woman did not attend her 28-week antenatal appointment, her symphysis fundal height was not measured. The woman attended an appointment with her Community Midwife at 31+6 weeks gestation. At this appointment, the woman disclosed she had ceased smoking and was now vaping. The woman had a home visit with the Community Midwife at 33+2 weeks gestation after self-referring with oedema to her hands and feet and high blood pressure. An antenatal check was performed which reported a blood pressure profile within normal limits and no proteinuria.

Grading of Stillbirth cases for 2022

Learning from incidents graded ‘c’ - The review group identified care issues which they considered may have made a difference to the outcome for the baby.

Case 1 Continued:

The Community Midwife did not perform a symphysis fundal height assessment and a plan was made to revisit the woman for a further blood pressure check the following day. The Community Midwife attended the woman’s home the following day at 33+3 weeks gestation and blood pressure was performed and within normal limits. The symphysis fundal height was not measured at this appointment.

At 35+6 weeks gestation the woman self-referred to the Antenatal Assessment Unit with diminished fetal movements. Sadly, an intrauterine death was confirmed on ultrasound scan.

On review, the woman missed antenatal appointments at 16 weeks and 28 weeks gestation and therefore antenatal care was not provided in accordance with the antenatal schedule recommended by the National Institute of Clinical Excellence (NICE). Symphysis fundal height was only performed during one appointments at 31 weeks gestation. There was a missed opportunity to perform symphysis fundal height at 28 weeks and 33 weeks gestation. As only one symphysis height measurement had been performed and plotted on the GAP Grow chart there was no ability to review linear growth and identify tailing growth

Grading of Stillbirth cases for 2022

Learning from incidents graded ‘c’ - The review group identified care issues which they considered may have made a difference to the outcome for the baby.

Case 1 Continued:
Lessons Learnt

- To provide assurance of Community Midwife is aware that antenatal schedule of care is provided in line with National Institute of Clinical Excellence (NICE) guidance.
- To provide assurance of Community Midwife is aware of guidance for symphysis fundal height measurements in pregnancy.
- The need to ensure all women who disclose smoking at booking are referred for serial growth scans in accordance with recommendations for the Perinatal Institute.

Recommendations

- Community Midwife referred to Clinical Supervisor of Midwives with action plan to provide assurance Midwife is aware and providing care in line with the Antenatal schedule recommended by the National Institute of Clinical Excellence (NICE). Referral requests Midwife to complete audit and to provide personal reflection.
- From 1st January 2023, all women who are booked for maternity care in SBUHB who disclose smoking at booking are referred for serial ultrasound growth scans in pregnancy.

MBRRACE analysed deaths – review and grading n=3

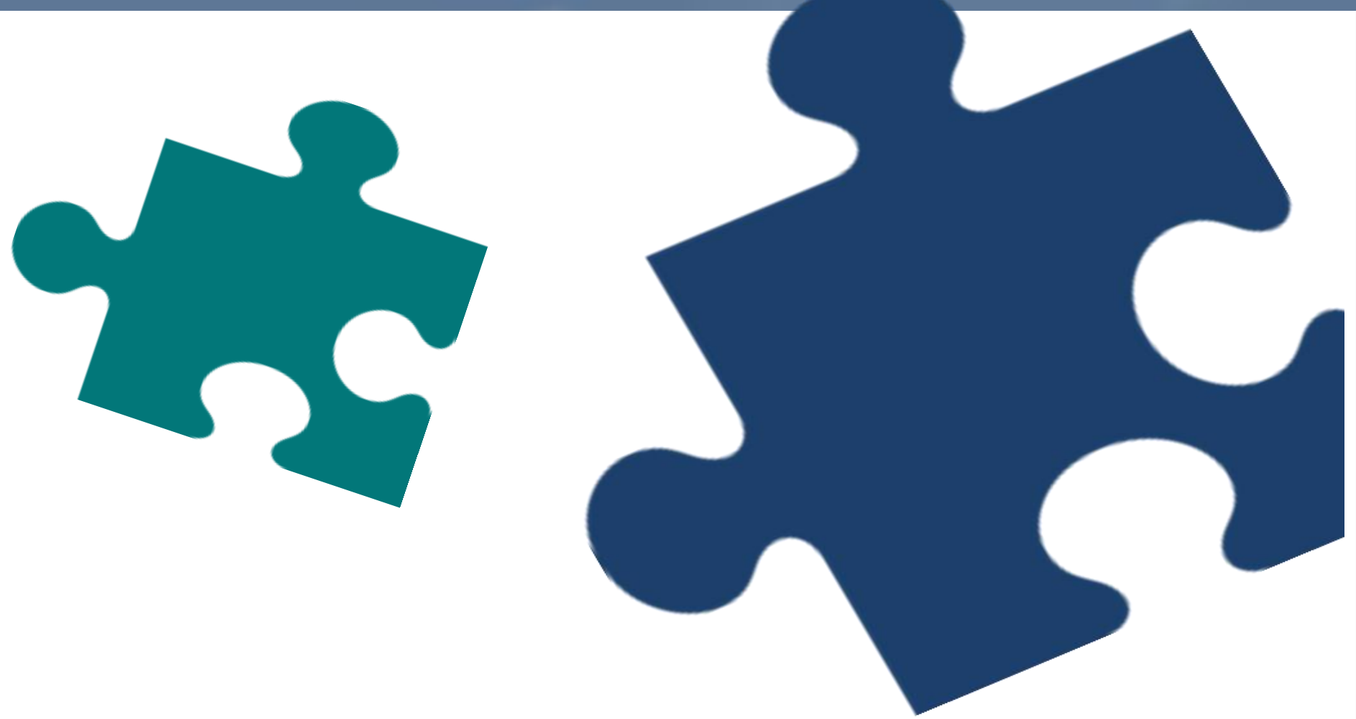
- **Infant 1 –** Twin 1, 24+3 @ 575gms, MCDA, TTTS, laser ablation at 17 weeks, presented at 23 weeks with PROM and confirmed influenza at 23+1 weeks. Precipitous delivery the following week, unprepared but resuscitation and stabilisation managed well. Ongoing difficulties with oxygenation, metabolic acidosis and persistent hypotension. Further significant deterioration at 3 ½ and 5 hours of age. No response to escalation of care so decision for comfort care following decision with parents. Cause of death 1a) Extreme prematurity, 1b)RDS, ELBW 2)MCDA and PPROM. **Grading of care C,** in relation to antibiotics not being administered until 3 ½ hours of life for many competing priorities. Important to note, the team felt that the delay in antibiotic administration was not directly related to the cause of death as there was a probable significant inflammatory cascade of sepsis already in progress from birth. PM offered but declined.
- **Infant 2** – Twin 2, 24+3 @ 550gms, Same history as above, (lack of equipment for second resus, initial respiratory stabilisation on NICU was difficult, Hypotension from birth, receiving boluses and inotropes. Antibiotics prescribed at an hour of age but not given until 4 hours. Further Datix completed for inability to administer iNO (tank empty and other one in use) Bicarb prescribed but not administered for metabolic acidosis, lab reported a processing issue for group and save (twins had same NHS number) so major haemorrhage protocol initiated. Final deterioration at 7 hrs, Saturations dropped to 50's with subsequent bradycardia, unresponsive to intensive care escalation, detailed discussions with parents and decision made for compassionate extubation. Cause of death 1) E.Coli septicaemia, Extreme prematurity, Respiratory distress syndrome, ELBW 500gms, MCDA twin pregnancy and PPROM. **Grading of care C,** as above. PM offered but declined. Network agreed with local review of twins

  Actions following twins delivery –

  - 1) ordering second resus trolley for LW – actioned
  - 2) QIP – Timely administration of antibiotics – new antibiotic stickers
  - 3) RCA for Ecoli positive Blood culture – completed
  - 4) investigation into NHS numbers – IT issue since resolved.

MBRRACE analysed deaths – review and grading n=3 cont.:

- **Infant 3** – Born at 26+1 @ 945grams, had an initial turbulent respiratory course, with a significant pulmonary haemorrhage and pneumothorax, developed a significant unilateral intraventricular haemorrhage with HPI, post pulmonary haemorrhage episode which gradually developed to PHVD. Infant had significant abdominal concerns which later developed evidence of bowel perforation. Joint MDT organised with CHANTS, paediatric surgeons and Neonatologist and parents and overall decision was to redirect care. Infant passed away on day 16 of life following compassionate extubation. Causes of death 1a) intestinal perforation, 1b) gram positive sepsis, prematurity, B/L IVH 2)Placental abruption. Panel felt clinical deterioration was due to NEC and action following review was to update diagnosis on VON. PM was offered but declined by parents. PMRT outstanding bereavement details. **Grading of care B** Network agreed with local review



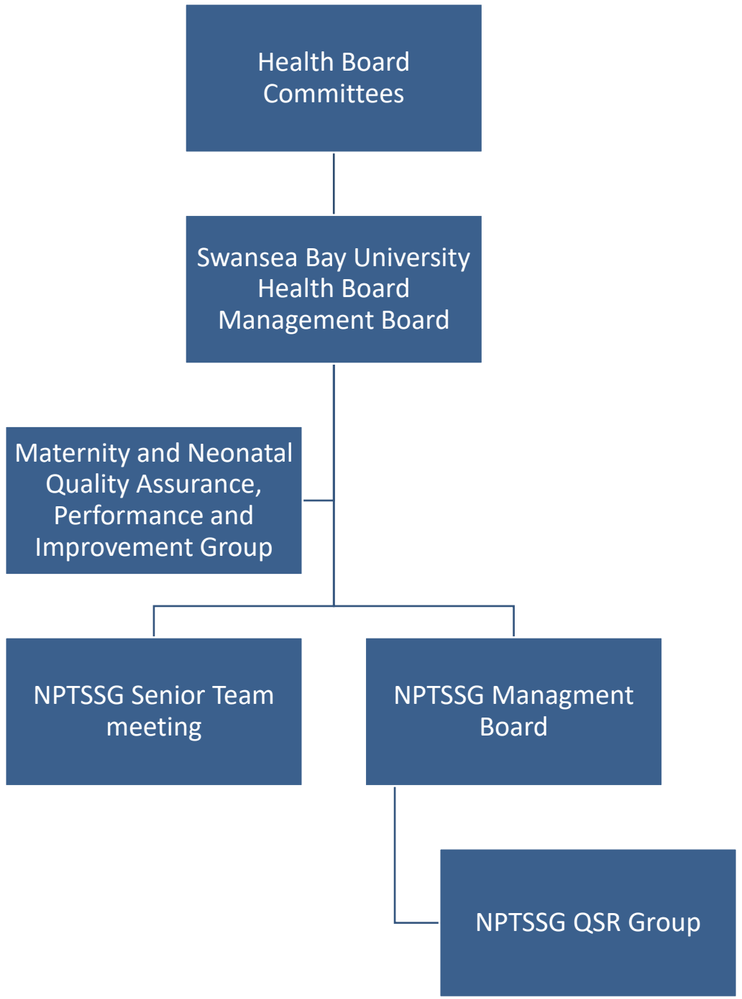
Governance:
External review Update

Maternity and Neonatal - Independent Review

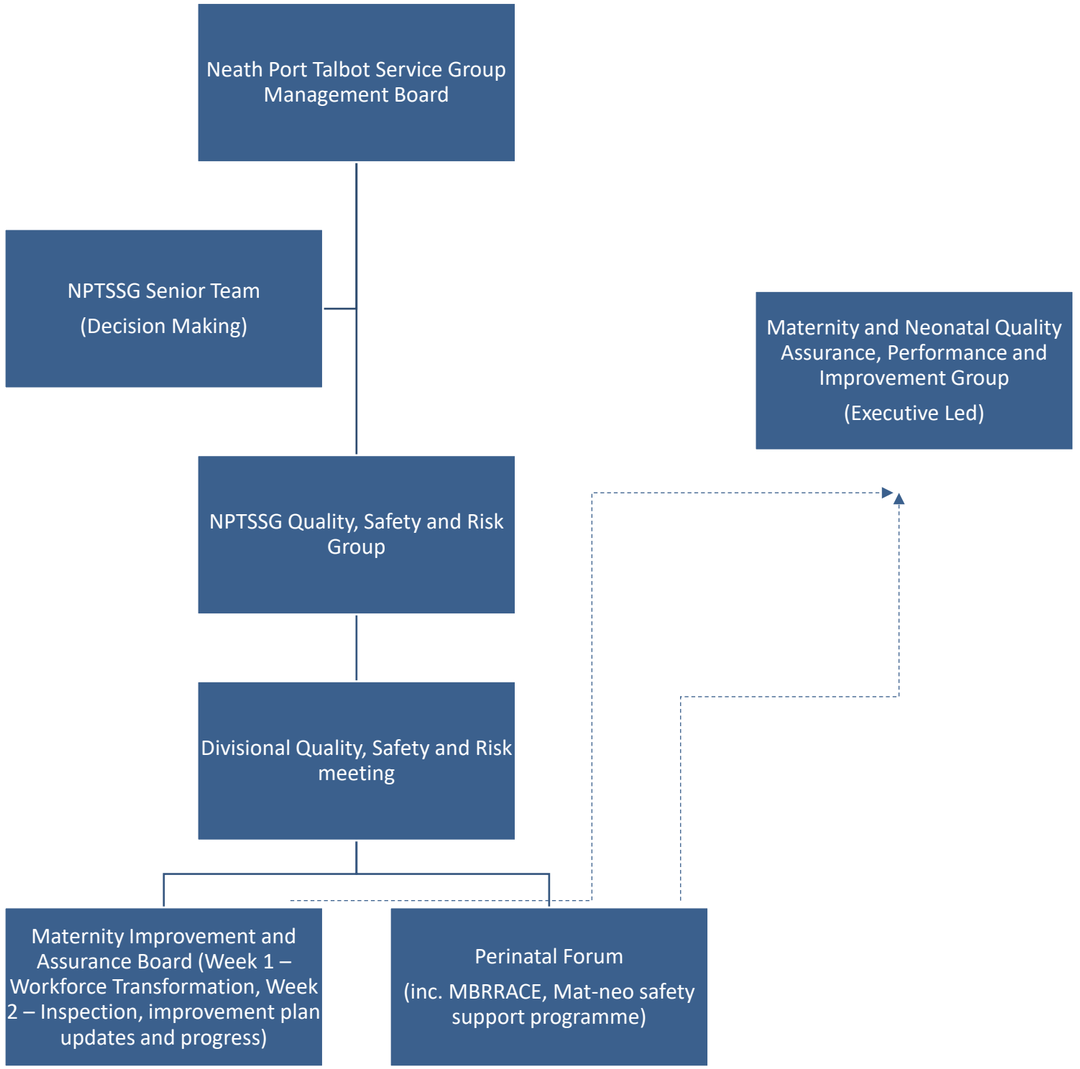
- Chair of the Oversight Panel appointed
- Oversight Panel has been appointed
- Expanded draft Terms of Reference (ToRs) received from the Chair of the Oversight Panel
- Currently out for comments
- Deadline for comments for ToRs - 10th May 2024

Governance:
Board Awareness

Maternity and Neonatal Governance



Maternity and Neonatal Governance



Maternity and Neonatal Governance

Meeting	Chair	Remit	Reporting to
Neath Port Talbot Service Group (NPTSSG) Quality Safety and Risk (QSR) Group	Group Nurse Director / Group Medical Director	Assurance and oversight of Quality, Safety and Risk within the Service Group, reporting to the Group Management Board and Health Board Quality and Safety Group	NPTSSG Management Board
Women's Health and Ophthalmology and Children's and Young People QSR Forum	Clinical Director / Clinical Lead / Head of Nursing CYP / Head of Midwifery	Assurance and oversight of Quality, Safety and Risk within the Service Group, reporting to the Service Group Quality, Safety and Risk Group	NPTSSG QSR Group
Maternity Improvement and Assurance Board **Inc. Midwifery Workforce Transformation Sub-group and Midwifery Improvement Sub-group**	Group Nurse Director	Implementation of the Midwifery workforce transformation programme Implementation and oversight of HIW, Ockenden, MNNN governance review, Safeguarding Improvement plan	• NPTSSG QSR Group • Maternity and Neonatal Quality Assurance, Performance and Improvement Group • NPTSSG Senior Management Team Meeting
Peri-Natal Forum (inc MBRRACE and Matneo Safety Support Programme)	Clinical Director Neonatal Services		• CYP QSR forum • Maternity and Neonatal Quality Assurance, Performance and Improvement Group

Thank you
Any Questions