Health, Social Care and Early Years Group **Welsh Government** Enhanced Monitoring Maternity and Neonatal Services Swansea Bay University Health Board Ref: SBUHB/MatNeo/04/002	Llywodraeth Cymru Welsh Government

Meeting Notes

3 June 2024

1. Welcome and Introductions

Attendance and apologies were noted.

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 apart from action 04: Health board to add neonatal deaths to the slide been completed. Health board agreed to action this for future meetings

3. Highlight report against key metrics

The health board provided an update against the key metrics. Increase in staffing in both neo natal and midwifery specialisms have increased across all bands and is now over-established. The health board confirmed that 17 students have been appointed and are due to commence as qualified midwives in September.

The health board confirmed there are 14 or more midwifes per shift, which is compliant with the BR+© calculation.

Welsh Government questioned whether these staffing levels account for acuity, the health board agreed to confirm

Action: Health board to confirm whether these staffing levels account for acuity.

The health board confirmed approximately 91% of its shifts were BAPM compliant and the health board was asked when presenting its data, to present longitudinal data to allow trends in performance to be noted.

Action: Health board will include longitudinal data for KPIs to ensure trends can be easily identified in future papers.

A consultant locum is currently being advertised for to cover a shortfall of 5 hours.

Incident review – NRI 01/03/24 – 31/3/24

The health board confirmed it has reviewed the number of adverse occurrences to identify themes and the incidents of moderate/high severe harm are under investigation. The health board was asked to confirm the numbers of undiagnosed under 10th centile data and agreed to provide this before the next meeting.

Action: The health board will provide an analysis of its undiagnosed babies born under 10th centile before the next meeting.

Current data shows there was a spike in moderate neonatal incidents reported in 2023 which may be linked to the changes in duty of candour and NRI reporting. The vast majority of incidents are low harm, and the moderate, severe and catastrophic incidents are reviewed and go through the MDT process and inform learning.

It was agreed that the health board would provide a breakdown of how many investigations are open, how long they take to close and the procedures around Never Events and the improvement work that is being undertaken, specifically to retained swabs.

Action: The health board will provide a breakdown of investigations and the improvement work relating to Never Events and retained swabs prior to the next meeting.

Investigations and learning has been undertaken for each NRI and learning shared across the health board. No NRIs have been reported in 2024. There have been three “must reports”. The health board was asked to carry out spot checks of its data to provide assurance that the assessments of levels of potential harm reported are correct, which will aid learning across the organisation.

Action: The health board will carry out ‘spot checks’ of its own assessments of cases of reported potential harm to provide assurance and share the findings.

Infection prevention and control

There has been one case of Klebsiella on neonates in April. The investigation found this was unavoidable. The CSSSI data for 2024 will be shared once available. A training package has been implemented to ensure incidents are accurately recorded and avoid over-reporting.

Outcomes and Performance

The slide was presented, and it was agreed the health board would include neo natal deaths in future reporting.

Actions: The health board to include numbers of neo-natal deaths in future reporting. (outstanding from previous actions)

Patient Experience

Neonate user feedback

Neonate patient experience is positive, and few complaints are received.

Action: The health board will provide a breakdown of the numbers accessing the service in relation to the feedback received.

Maternity user feedback

Maternity user feedback was generally positive, although themes have been identified concerning the waiting times, delays in induction and pain management. Improvement work has been undertaken across these areas and satisfaction scores have improved.

Staff feedback

From June onwards, a schedule to assess staff wellbeing and engagement events will be undertaken across maternity and neonatal teams.

PROMPT

Audits were conducted in 2022 and March 2024 and feedback from this year's audit was positive to previously seen. There were areas of excellent areas of practice and recommendations were made which will be reviewed.

4. HIW Inspections - Update and current position against all actions from 2019, 2023 and the IA from 2024 including evidence to demonstrate completion.

The slide pack provided a detailed breakdown of the actions the health board has undertaken against the HIW inspections carried out as referenced above. It was noted that a number of actions were outstanding and that the health board would confirm the expected completion date.

Action: The health board will provide timescales for the completion of outstanding actions from previous HIW inspections

HIW unannounced visit in April 2024

The formal report has not yet been received. There were three immediate assurances noted, two of which were resolved immediately. The outstanding one related to staffing in the assessment unit and the health board has implemented temporary measures until it conducts a full review and implemented its recommendations. The health board was in the process of reviewing its AU workforce re-design prior to this inspection and a second midwife is now in place. The health board was asked to confirm when the BSOTs workforce work will be implemented.

Action: the health board to confirm when it expects to fully implement the BSOTs workforce plan.

HIW visit to Obstetric Unit in September 2023

The mandatory training has been revised at the end of March 2023, but this remains outstanding and SALTO security system is due to be implemented.

Action: Health board to confirm the date when the SALTO security system will be fully implemented.

The general improvement plan is being worked through and is on track although improvements to the estate is taking longer than anticipated.

HIW inspection in 2019

There are two actions outstanding which link into the 2023 inspection regarding mandatory training. The health board is working to closing these actions as part of its improvement plans.

HIW national review of maternity services in 2020

There are six actions that remain outstanding, and these are being monitored through the improvement and assurance board. The health board is working on closing several actions by September 2024.

Concern was expressed regarding the number of outstanding actions and the assurance mechanism and process that are in place to enable the health board to capture the evidence against the relevant actions. The health board confirmed all actions are monitored through the Improvement and Assurance Board and a senior midwife supports this work but agreed to raise these concerns.

5. Birth Centre and Homebirth Services

The safety gateways were agreed to provide assurance of the safe reinstatement of services. The plans to re-instate the service require approval from the Board. The proposal to reopen was approved by the executive team and the health board are in discussion with the Unions to clarify a number of points. Once agreed that paper will be presented to the Board to agree the re-opening date.

The health board confirmed it is fully recruited with its Band 7 clinical establishment. A new birth pool has been installed. The health board was asked to provide details of the staff model it has used in the birth centre in NPT.

Action: The health board will provide details of its staff modelling used in the birth centre in NPT.

6. Independent Review - Health board support team work programme for the clinical review programme

Welsh Government offered to meet with the health board to highlight previous experience having worked on a previous inquiry into maternity services. A lesson learnt report from this enquiry would be shared with the health board.

Action: A lesson learnt report from this enquiry would be shared with the health board.

Date of next meeting: 11 July 2024

Action Log		
Action	**Owner**	**Update/Deadline**
Key metrics: Health board to confirm whether presented staffing levels account for acuity.		
Key metrics: Health board will include longitudinal data for KPIs to ensure trends can be easily identified in future papers.	Health board	July 2024
Key metrics: Health board will provide an analysis of its undiagnosed babies born under 10th centile before the next meeting in July	Health Board	July 2024
Key metrics: Health board will provide a breakdown of investigations and the improvement work relating to Never Events and retained swabs before next meeting in July.	Health Board	July 204
Key metrics: The health board will carry out 'spot checks' of its own assessments of cases reported of potential harm to provide assurance share the findings for meeting in July.	Health Board	July 2024
Key metrics: The health board will include the numbers of neo-natal deaths alongside stillbirths, maternal deaths and ITU admissions in future reporting.	Health Board	ongoing
Patient Experience: The health board will provide a breakdown of the numbers accessing the service in relation to the feedback received.	Health Board	July 2024
HIW inspections: April 2024 – health board to confirm when it expects to fully implement its BSOTs workforce plan	Health Board	July 2024
HIW inspections: Sept 2023 – Health board to confirm the date when the SALTO security system will be fully implemented	Health Board	July 2024

HIW inspections: The health board will provide timescales for the completion of outstanding actions from previous HIW inspections	Health board	July 2024
Birth Centre and homebirth services: The health board will provide the staff modelling it has used for the NPT birth centre.	Health Board	July 2024
Independent Review: A lesson learnt report from the previous review would be shared with the health board.	WG	July 2024

Note post meeting

As noted in the meeting as the papers/slides were sent just before the meeting it was difficult to scrutinise them effectively and this impacts on the robustness of the enhanced monitoring meeting.

Listed below are a number of areas that require clarification:

Appendix 1 – Master draft

1. Slide 5 – how many SI/NRI are open and from when?
2. Slide 8 – INC 51121, is this a joint maternity and neonatal investigation?
   INC 53001, no mention of make safes.
3. Slide 10 – risk register in this format does not give is the information we need. What mitigations are in place and what score does this bring it down to? Would be easier to see the full risk register.
   - ID 2788, Critical staffing levels for midwifery remain on register and not sure why as they are at full complement and 17 wte midwives commencing in Sept/Oct
   - ID 3360, unable to provide antenatal education because of staffing levels – as above we are not clear why if there are no vacancies.
4. Slide 18 – NLS training for Tier 2 is 90.9%, what are the plans to improve this?
5. Slide 22 – The information provided would be easier to understand broken down into staff groups not place of work as there is no narrative attached to it.
6. Slide 27 – can we have the number/% of undiagnosed babies born below the 10th centile
   - Appears to be quite a jump in babies born with an Apgar score below 7 at 5 minutes, have you looked into this and harm caused?
7. Slide 30 – can neonatal deaths be added to the main stillbirth slides in the slide deck used for the meeting and to slide 35 in this slide deck
8. Slide 32 - what we want to know ultimately is the numbers of babies cared for on the neonatal unit that could have been cared for on transitional care please
9. Slide 34 – is this “non-compliance” with NIPEC?
10. Slide 35 – ITU admission in February, mindful that the ITU pathway is under review (mentioned in HIW self-assessment), was the pathway contributory?
11. Slide 36 – we are not sure we understand this

Appendix 2 – HIW self-assessment

1. Page 2 – revised target date as the end of March 2024 but already in June
2. Page 3 – January – has the signage now been ordered?
   March – when do we expect this training to be delivered

Is the asset list complete as revised date May 2024?

3. Page 4 – has the action plan had been approved?

Appendix 3

1. Page 6 – action on signage states complete however if you see above on self-assessment page 3 it is not

Attendance

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