Health, Social Care and Early Years Group Enhanced Monitoring Maternity and Neonatal Services Swansea Bay University Health Board	Llywodraeth Cymru Welsh Government

Meeting Notes

26 November 2024

1. Welcome and Introductions

Attendance and apologies were noted and reflected in the table below. Please note that the meeting was rescheduled from the previous meeting and therefore attendance was restricted due to diary commitments.

Welsh Government have raised the following queries after the meeting:

- Slide 3 – What was the nature of the Severe Incident noted for neonates. Where there any make safes?
- Slide 5 – is OASI bundle used? Degree of harm caused, any PTR?
- Slide 8 – Open neonatal Incidents appear to be increasing (more opening than closed). Has this continued since September? What plans are in place to manage this?
- Slide 13 - There is a need to ensure an all-Wales approach to definition as we should be able to compare
- Slide 26 – Are there any QI plans to increase the number of women booked by 10 weeks?
- Slide 33 – There was a QI project earlier this year on decision to section time for Category 1 – rates do not appear to be improving? Please could we have an update with that project?
- Slide 34 – note a significant increase in induction delays plus an increase in low cord ph, have these been reviewed and any harm?
- Slide 40 – why are PMRT reports open from 2020(1), 2021(3), 2022(3)?
- Slide 54 – Why is MONET a higher risk than Staffing levels for neonatal services? Staffing concerns seem to be the focus of not being able to implement MONET.

A response to these points is requested by 9 December 2024 to **performanceandescalation@gov.wales**

2. Actions from previous meeting

The notes of the previous meeting were agreed, all actions were addressed in the information sent in advance of the meeting.

3. Health board position against the agreed metrics

A detailed information pack plus a slide deck was presented in advance of the meeting. It was noted that good progress was being made. The discussion focused on the following areas:

Workforce

- To ensure that the health board had sufficient band 5 and 6 staffing levels within the neonatal unit, work was being undertaken in line with succession planning as part of the workforce strategy using the agreed toolkit. This has enabled the health board to map out what the workforce profile will look like over the next three-five years and ensure that it can plan accordingly.
- The neonatal workforce is over established, comprising of a younger workforce, which results is leave related to maternity and parental. Ten new streamliners were due to commence within the team later this year
- There are a number of student midwives who were due to finish their training and would be ready for permanent posts.

Bloodstream Infections

- The health board confirmed that there had been one neonatal death which was associated with klebsiella. A working group had been established to try and reduce any late onset sepsis.
- To note, no s. aureus infections had been reported to date for 2024. Other infections had been isolated to the extreme preterm group.

Action: Health board agreed to forward a copy of the updated neonatal bloodstream infections action plan to the performanceandescalation@gov.wales mailbox.

Welsh Government have asked the NHS Executive team to undertake an assurance review on the work undertaken as part of enhanced monitoring. Visits to clinical areas have taken place as part of this assurance review.

4. Risk Register

The process by which the maternity and neonatal risks were managed was discussed including the challenges from the senior management and midwifery team. The key risks were discussed:

Maternity Risks

- Birthrate Plus Compliance is at 16 – streamlining of 17 newly qualified midwives all aimed to be in post by December 2024. Implementation of BSOTS in November 2024. The health board will review Birthrate plus compliance with introduction of BSOTS.
- Screening for Fetal Growth Assessment in line with Gap-Grow has reduced from 20 to 12 due to the successful introduction of three weekly serial scans implemented across sites. This follows on from the implementation of serial scanning for all women who disclose smoking and women who have a low PAPP-A. The service will continue the risk until January 2025 where it will be reviewed. If three weekly serial scans are achieved and maintained the service group will close the risk.
- High quality birth choices – this risk was opened due to the suspension of homebirths and births in the freestanding midwife led unit. The freestanding midwife led unit reopened in September and homebirths recommenced in October 2024. The service group will continue the risk until January 2025 and if able to maintain choices for birth in all areas will close the risk. The birth rate plus compliance risk rating will be reviewed shortly following the completion of the work undertaken in this area.
- Maternity Services do not fund a second theatre and has a score of 16. A standing operating procedure has been introduced for opening a second theatre

– developed and implemented in collaboration with the Theatre team - implemented in July 2024. Team monitoring incidents reported following 6 months of implementation of SOP and to consider reducing risk score.

- Induction of labour – delay in induction and augmentation of labour has a score of 16. All induction delays in induction of labour (waiting over 24 hours for transfer to artificial rupture of membranes) or augmentation of labour (waiting over 24 hours to commence Syntocinon augmentation) are Datix reported and reviewed as to whether delay contributed to any adverse outcome or harm. Induction of labour T+F group to commence in January 2025 following implementation of BSOTS to review criteria for IOL and patient flow.
- Staffing levels – Midwifery - current score of 16 – on boarding of 17 midwives through streamlining. To monitor use of agency and bank cover for short term absences and to review risk scoring in 3 months. Staffing was listed as 25 for a prolonged period of time, this has now changed since the third pathway had been opened. Staffing was monitored across the three pathways continuously especially the community pathways.
- Unavailability of cCTG monitoring - current score increased from 16 to 20. Business case completed and awaiting quote for installation of cCTG on K2 system. (Clarified that this was related to antenatal CTG's only and no woman had not had access to cCTG monitoring when required ad machine shad been moved to accommodate this.)
- Obstetric theatre lights require replacing - current score 20 – shared risk with theatres. Work planned to replace in December 2024. Once replaced risk to be closed.

<u>Neonatal Risks</u>

- Replacement/additional shuttle - Current score of 20. Opened 01/05/2024
- 2 shuttles are awaiting delivery, additional equipment needs to be purchased to go into the new shuttle systems but currently one of the existing shuttles has a failed battery therefore equipment will be transferred over to new shuttle upon arrival and an additional shuttle will need to be purchased.
- Medical workforce - current score of 20. Opened 4/10/2022. Not BAPM compliant for consultant cover 12 hours a day 7 days a week, backfill maternity 0.8WTE going through VCF process.
- Replacement of phototherapy units - current score of 20. Opened 25/03/2023
- Funding approved this month, procurement process underway and when purchase risk will be reviewed and closed.
- Lack of permanent 24-hour transport service – current score of 16. Opened 06/05/2014. This service requirement is under review by JCC as part of review of demand and capacity of neonatal services across Wales.

5. Independent Review

The clinical review team have reviewed 19% of the eligible cases and fed back to the health board team. Whilst there are many serious points in this feedback, there is nothing that the health board were not aware of and all issues are being addressed. Welsh Government have not been involved in this feedback process; we would only be engaged if serious issues that were new were escalated.

The governance strand of the review has submitted an interim report to the health board (this has not been shared) titled: “How safe are you now” and reviews the health board against five themes. The report looked into five areas and the following points were noted:

- ‘Staffing and service delivery’ assessed as reasonable assurance.
- ‘Management of change’ assessed as reasonable.
- ‘Analysis and learning’ assessed as limited related to the poor resolution of incident reporting and the backlog of incidents with a recommendation that an urgent action be taken forward to clear the backlog.
- ‘Engaging with women and families’ assessed as reasonable
- ‘Clinical governance and adherence to protocols’ assessed as reasonable.

The Board will discuss in its “private” session its plans to appoint a permanent Chair of the review.

The health board gave an update on the ‘How safe are you now’ report which would need to remain confidential until it was fact checked and shared with the service groups.

Action Log			
No.	**Action**	**Owner**	**Update/Deadline**
1	Heath board to respond to the queries on the slide deck to **performanceandescalation@gov.wales**	SBUHB	9 December 2024
2	Health board agreed to forward a copy of the updated blood stream infection action plan to the performanceandescalation@gov.wales mailbox.	SBUHB	9 December 2024

Attendance

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