

Swansea Bay University Health Board

Integrated Quality, Planning and Delivery Meeting

17th June 2024

<Redacted>

Maternity and Neonatal

Workforce – Establishments and Vacancies Data (April 2024)

Midwifery – Obstetric Unit

Band	Establishment (WTE)	Vacancy (WTE)
7	14.88	0
6 / 5	86.06	0
4	9.28	0

Midwifery – community

Band	Establishment (WTE)	Vacancy (WTE)
RM	52.79	0

Neonatal Nursing

Band	Establishment (WTE)	Vacancy (WTE)
7	11.92	2.06
6	32.09	7.75
5	36.14	Over 12.70
4	4.25	0

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	91.67	3.03	11.55	9.65	1.7
National Average	3	74.51	8.61	NA	NA	NA

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+© March 2024

81% of all shifts were compliant with BR+© and exceeded the minimum requirement of 14 Registered Midwives per shift.

Workforce – Unavailability & Temporary Staffing Usage

🕒 Analysis of monthly staffing levels - unfilled shifts, vacancy rates, rota gaps and shift compliance to service standards

Unavailability Data

Area	Total Unavailability	Parenting	Annual Leave	Sickness	Study Leave
Midwifery	29.42	5.24	6.7	14.12	3.36
NICU Nursing	31.7	10.6	12.6	4.2	4.6
Neonatal Medical Staff (Consultants)	7.4	0	1.2	6.2	0
Junior Doctors	24.4	0	15.3	6.1	3.0

Data Source – Allocate Optima

Roster Period 07/04/24 – 04/05/24

Temporary Staffing Usage

Area	Total Bank / Agency use	Agency Usage	Agency % of temp staffing
NICU Nursing	9.6%	0.7%	7.5%
Labour Ward	12.1%	7.6%	62.5%

Data Source – Roster Perform

Roster Period 07/04/24 – 04/05/24

Note: all midwifery temporary staffing for the obstetric unit is booked to Labour Ward, staff are re-deployed to appropriate ward area from there. Antenatal and Postnatal Ward have no temporary staffing booked against the rosters.

Workforce – Training Compliance

Statutory and Mandatory Training		Apr-24	May-24
* Welsh Government Target		85%	
Medical Staff	Obstetric	74.7%	78.1%
	Neonatal	86.0%	81.6%
Additional Clinical Services	Maternity	85.8%	81.2%
	Neonatal	98.7%	72.5%
Nursing and Midwifery	Maternity	92.6%	94.1%
	Neonatal	93.3%	93.8%

Maternity Training		Apr-24
Prompt	Obstetric Medical Staff	97.5%
	Neonatal	94.0%

Fetal Surveillance	97.0%
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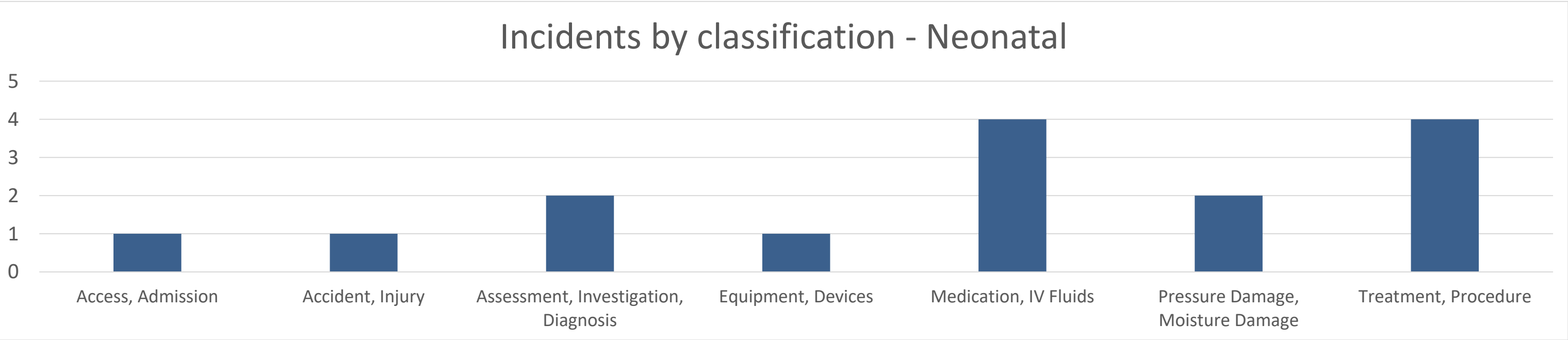
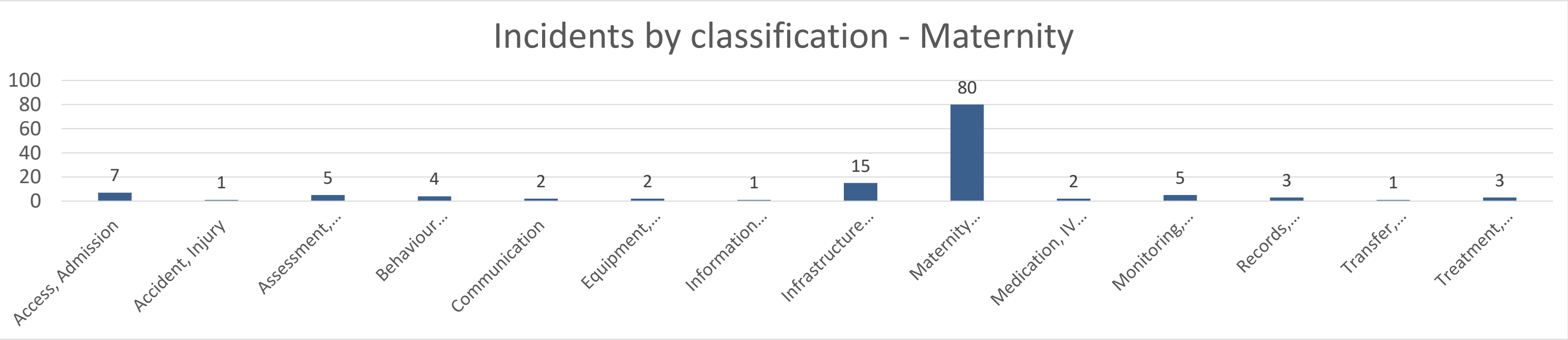
NLS	93.0%
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Gap Grow	Obstetric	88.0%
	Midwives	85.0%

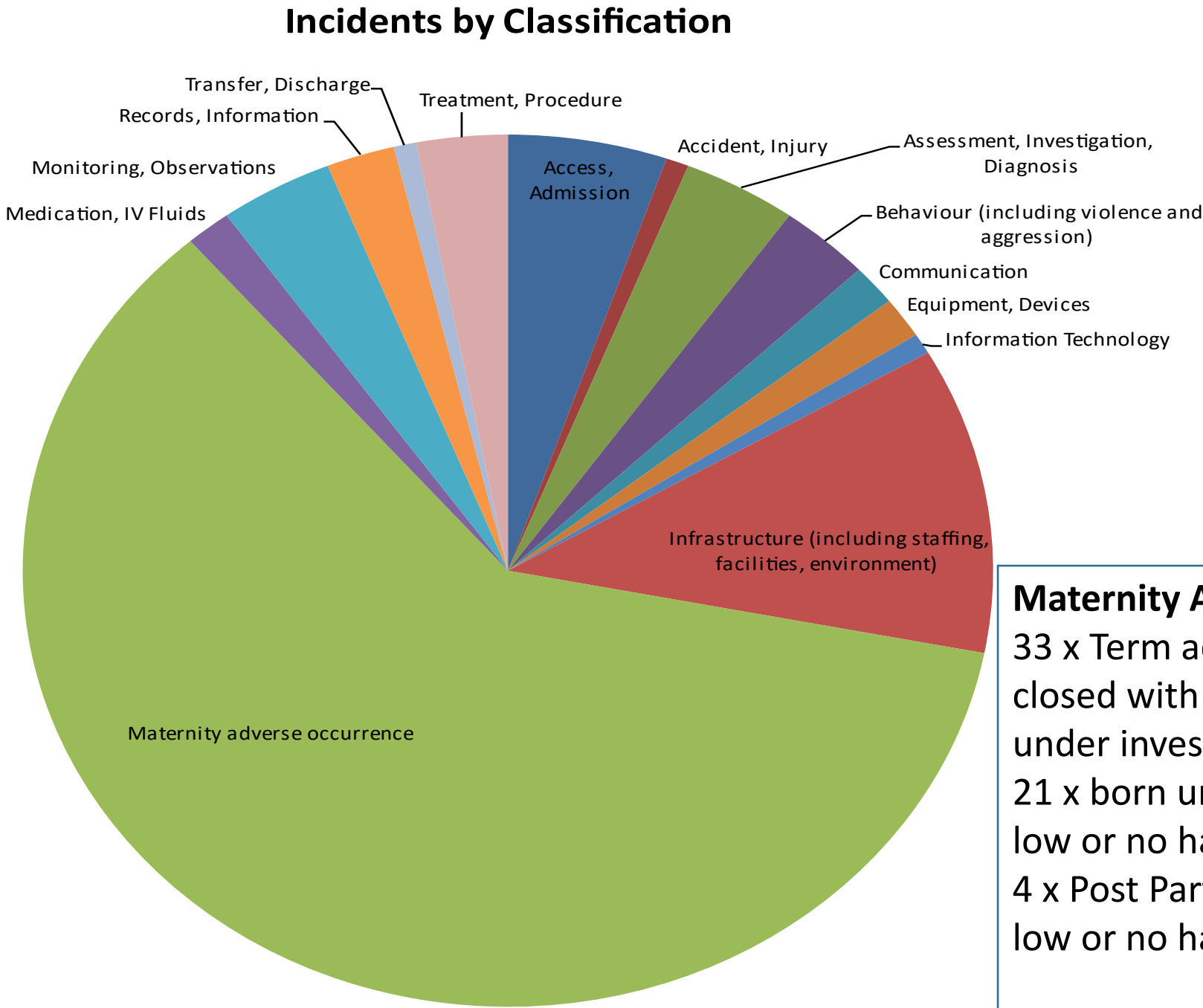
Neonatal Training		Apr-24
NLS	Nursing	95.0%
	Consultants	100.0%
	Juniors - Tier 1	100.0%
	Juniors - Tier 2	90.9%

Nurses Qualified in Speciality		Apr-24
Module 1		56.0%
Module 2		53.0%

Incident review - Newly Reported Incidents: 01/03/2024 – 31/03/2024



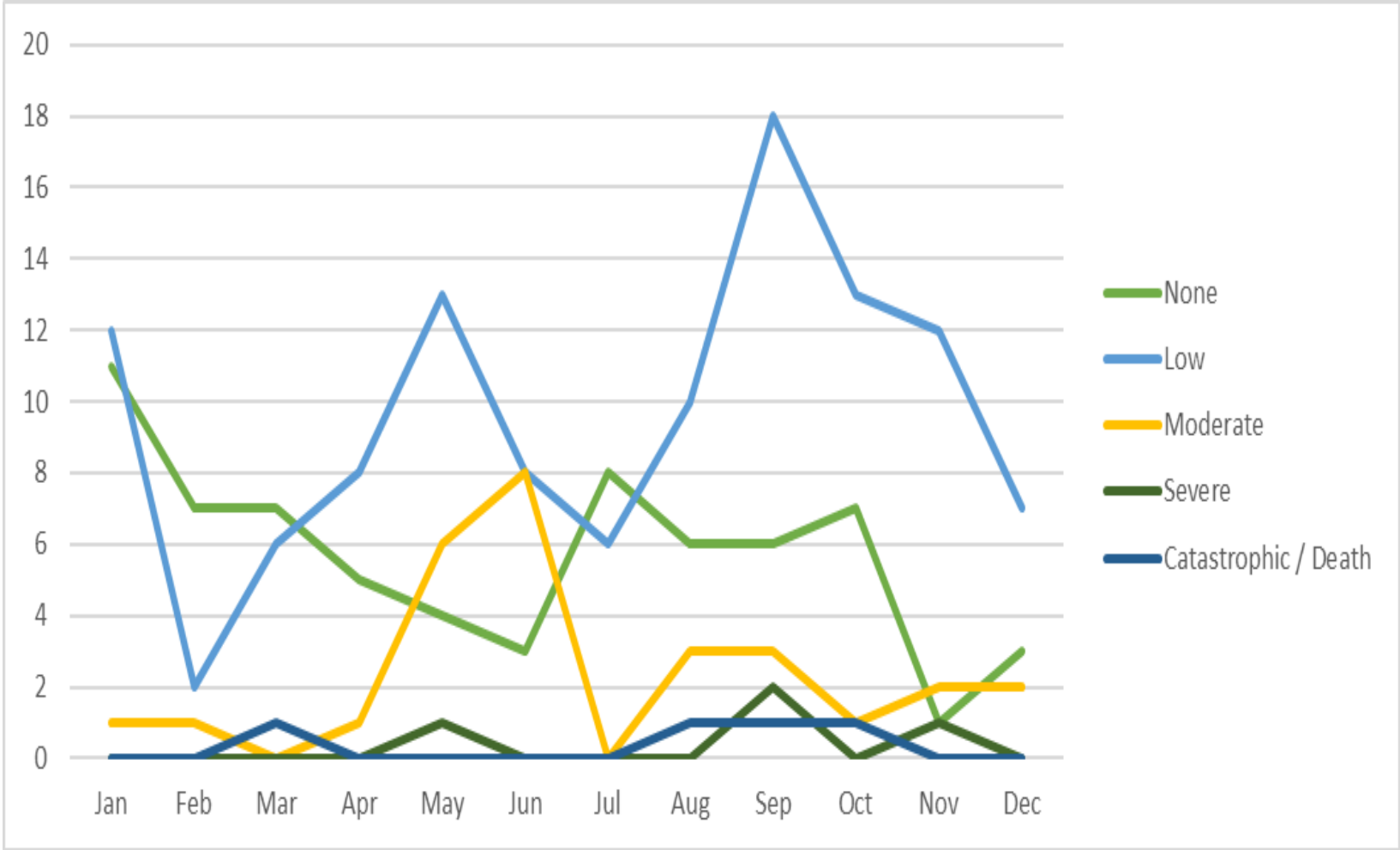
Incident review - Newly Reported Incidents: 01/03/2024 – 31/03/2024



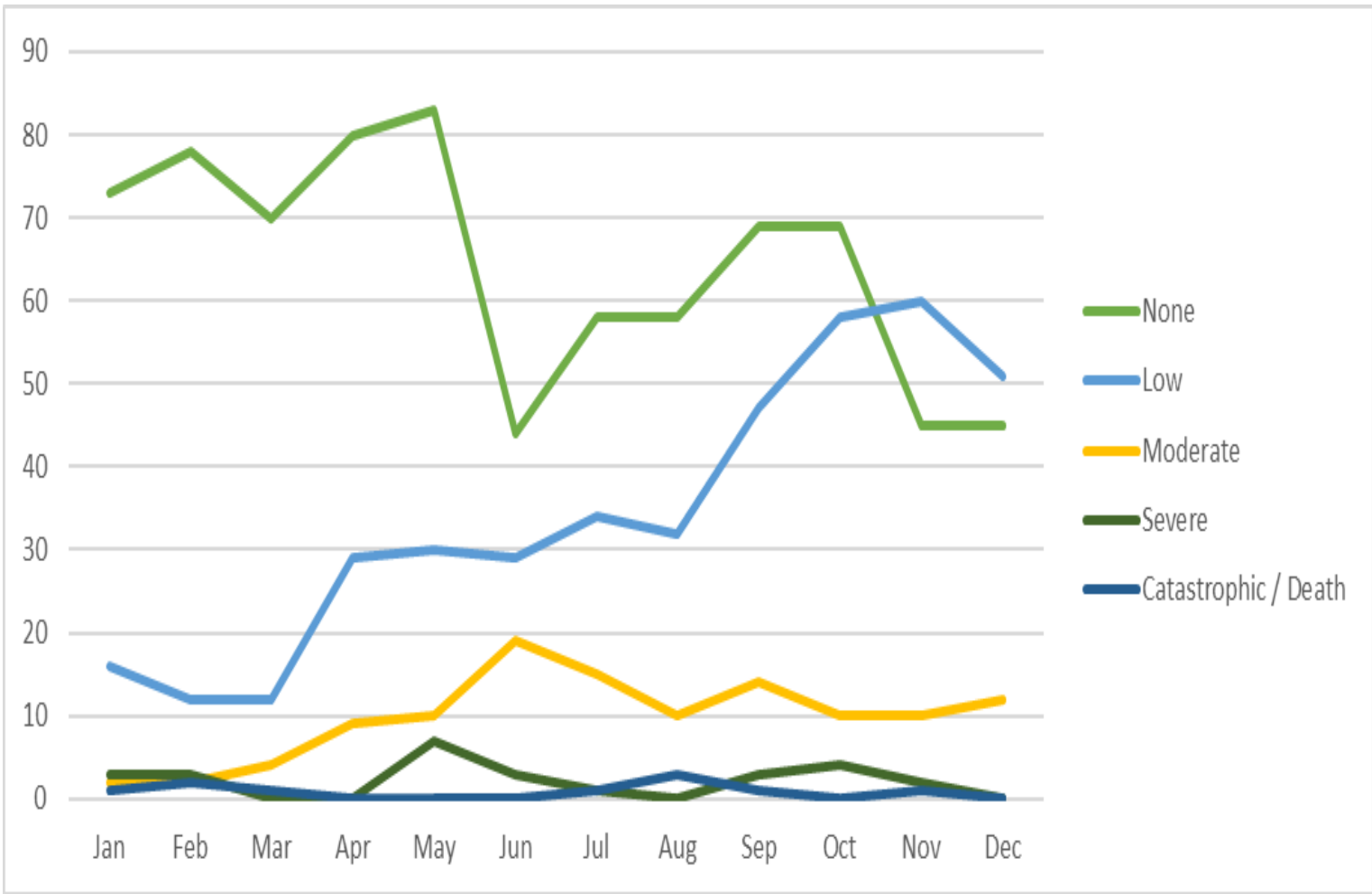
Maternity Adverse Occurrence:
33 x Term admissions to NICU (26 closed with low or no harm, 7 under investigation)
21 x born under 10th centile – all low or no harm
4 x Post Partum haemorrhage – low or no harm

Incident review – Incident reporting trends 2023

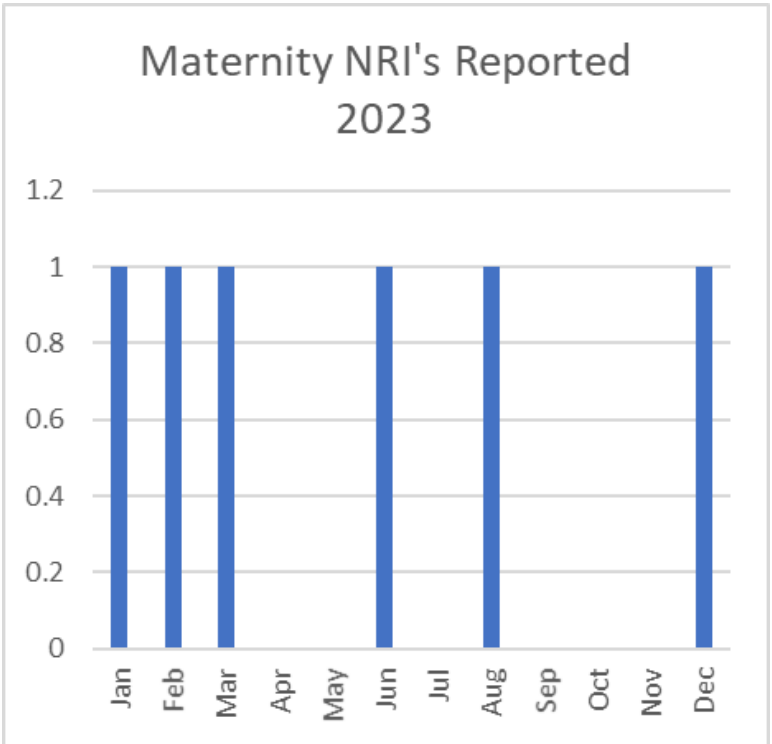
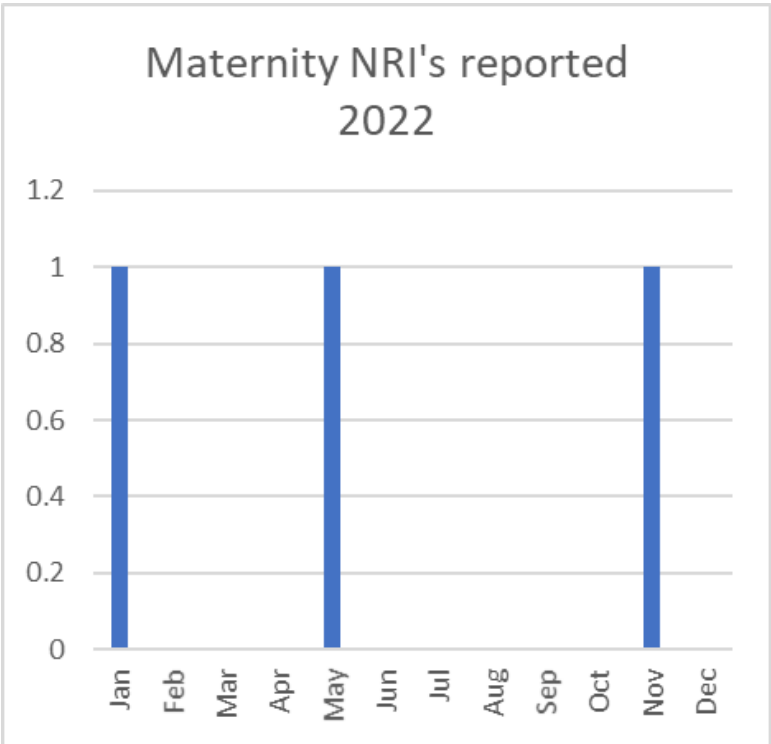
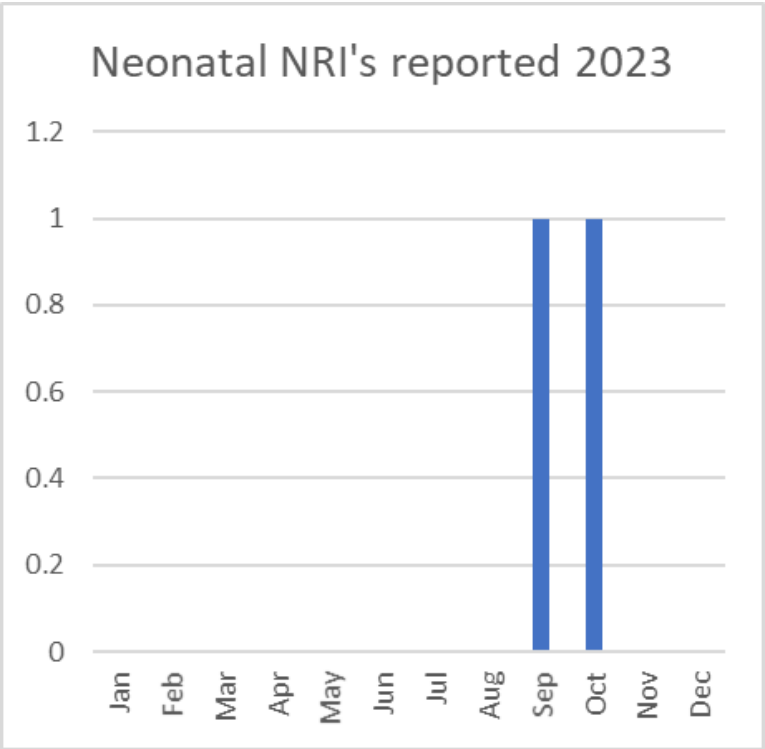
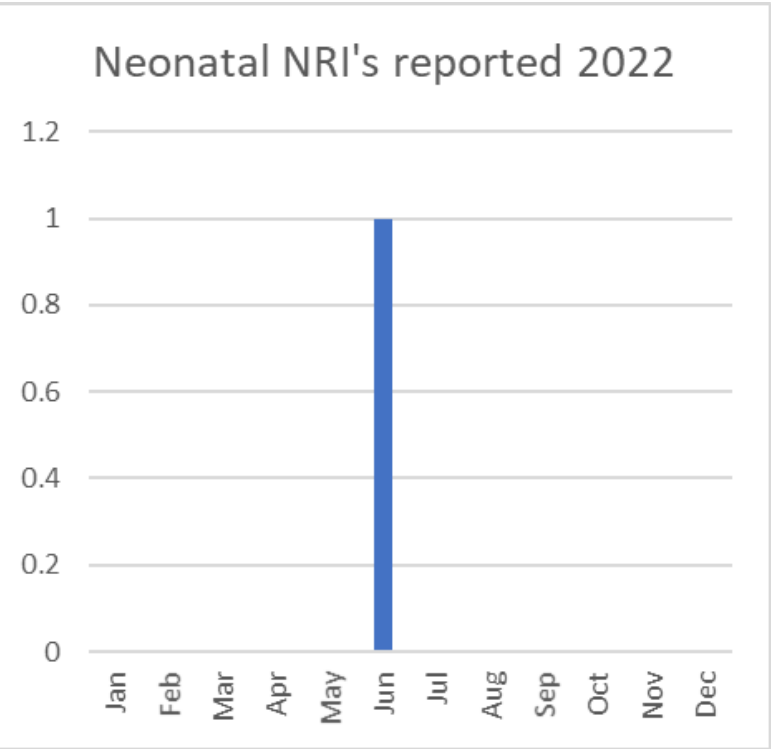
Neonatal Incidents in 2023 sorted by level of harm by reporter – all incidents closed



Maternity Incidents in 2023 sorted by level of harm by reporter – 51 incidents still under investigation



Incident review – Nationally reported incidents 2022 – 2023



2023 Maternity Incident details:

- Jan 2023 - ID 19684 - NRI due to a baby sustaining a burn to their foot using a foot heat pad during a blood test. Rapid review identified the heat pads used were not suitable for use for neonates or for directly on the skin. Reported as NRI due to unsure long term harm. Baby discharged from plastics at four months old with fit for discharge and no further follow up. Closed as moderate incident.
- Feb 2023 - ID 21507 - Never Event - retained swab following suturing of perineal tear.
- March 2023 - ID 24706 - Stillbirth. Reported as NRI as following rapid review identified advice given over phone from AAU was inadequate and below standard therefore care could have contributed to outcome.
- June 2023 - ID 30705 - Stillbirth. Reported as NRI as rapid review identified care fell below standard on review of the CTG and delivery should have been indicated which may have contributed to the outcome.
- August 2023 - ID 35034 - Stillbirth. Reported as NRI as rapid review identified care fell below standard for review of an antenatal CTG (classified as normal when abnormal) and diabetes care. Could have contributed to outcome.
- December 2023 - ID 43884 - Not NRI but a 'must report' from NHS exec as MBRRACE reportable. All stillbirths require a NRI notification and closure form even if determined as no care failings. No care failings identified as woman refused midwifery care and intervention. Presented with stillbirth at 44 weeks gestation following declining induction and monitoring. Graded as green no harm incident

Patient Safety and Risk

Incidents upgraded to Moderate following

Nothing to report – No incidents upgraded to moderate following initial investigation for with Maternity or Neonates

2024:

3 NRI's "must reports" due to NHS Exec and MBRRACE reporting requirements

No other Nationally Reportable Incidents to date

Outcomes & Performance – Apr 23 to Apr 24

- 🕒 Direct Maternal deaths
- 🕒 Maternal ITU admissions
- 🕒 Neonatal Deaths

Indicator	Measure	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
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	1	1	0	0	0	0	0	0	1	0	1	0	0

🕒 Number of stillbirths, by category of intrapartum and antenatal

Indicator	Measure	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Number of antepartum stillbirths	Number of antepartum stillbirths	1	1	0	2	3	1	0	2	2	0	1	0	2
Stillbirths / IUD (Intrapartum)	Stillbirths / IUD (Intrapartum)	0	0	0	0	0	0	0	0	0	0	0	0	0

🕒 Neonatal Deaths

Neonatal deaths less than 7 days			
Jan-24	Feb-24	Mar-24	Apr-24
1	0	0	1

Neonatal deaths 7-28 days			
Jan-24	Feb-24	Mar-24	Apr-24
0	0	0	0

Readmissions within 7 days of discharge			
Jan-24	Feb-24	Mar-24	Apr-24
0	1	1	0



Infection prevention and control

🕒 HCAI rates within maternity and neonatal services to national targets

🕒 **C. difficile NPTSSG**

🕒 NICU - 0 cases

🕒 **E. coli Bacteraemia**

🕒 NICU – 0 case

🕒 **Staph. aureus Bacteraemia**

🕒 NICU – 0 cases

🕒 **Pseudomonas aeruginosa Bacteraemia**

🕒 NICU – 0 cases

🕒 **Overview of SSI position and variance**

🕒 January 2024 - 101 caesareans 7SSI's 6.9%

🕒 February 2024 - 96 caesareans 18SSI's 18.75%

🕒 March 2024 - data not fully completed but 102 caesareans overall SSI rate 5.8%

Neonate User Feedback -1

supportive
helping
empathy
kind
supportive
"so patient"

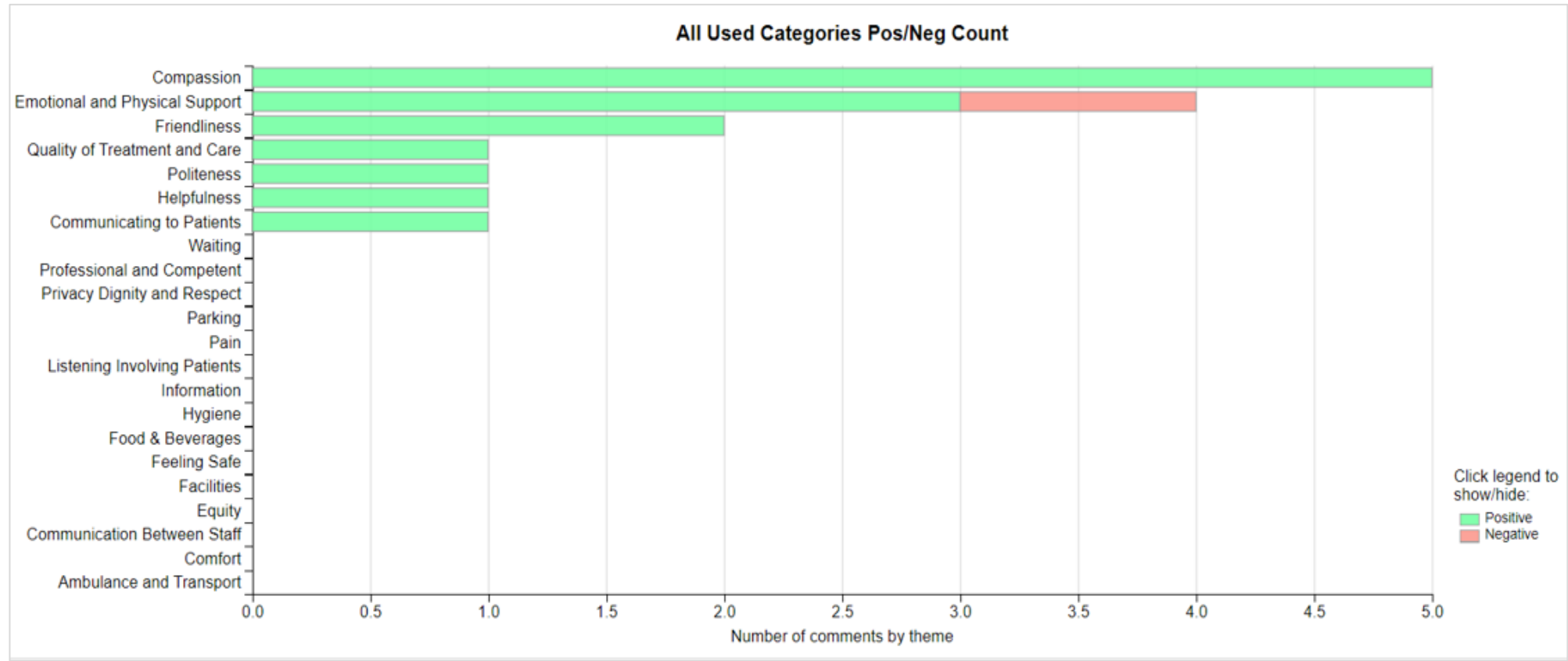
🕒 For the month of April there were 15 Friends and Family survey returns with an overall score of 100%

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%	15	15	0	0	0	0	0
Neonatal Intensive Care Unit	100.0%	0.0%	15	15	0	0	0	0	0

Here are some positive comments we received:

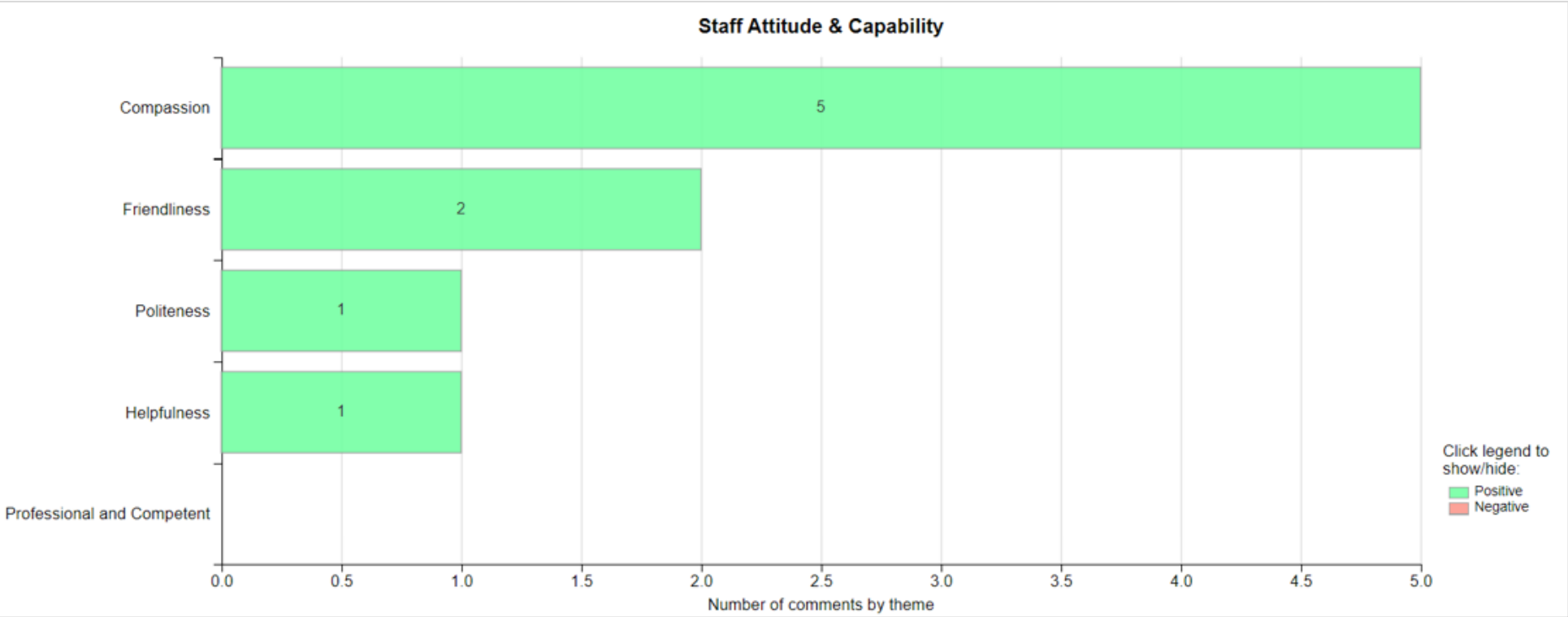
- The whole team have been superb. They feel more like friends and family and that is such a good feeling when you know that your baby is in their hands.
- Everyone has been amazing. Midwives were wonderful. Midwives mentally saved me that first day as I was really struggling. She wheeled me to see my baby because I was so upset and the midwives would feed me sips of water, huge empathy from everyone. Staff are incredible. Its not just the physical support that patients need but the mental and emotional support is sometimes even more important. I was shown a kindness and empathy that will stay with me forever. It was what I needed, when i was going through the worst of times.
- Honestly we could not be more grateful. The care we have had has restored my faith in the NHS. Everyone is so personable. We had a couple of issues initially they were resolved immediately and without fuss. No defensiveness - just action. Also our religion was very much respected, especially when we were fasting. Incredible staff and super positive experience. We are being transferred to Bridgend, but wish we could stay here.



Neonate User Feedback - 2

🕒 For the month of April there were 15 Friends and Family survey returns with an overall score of 100%

supportive
helping

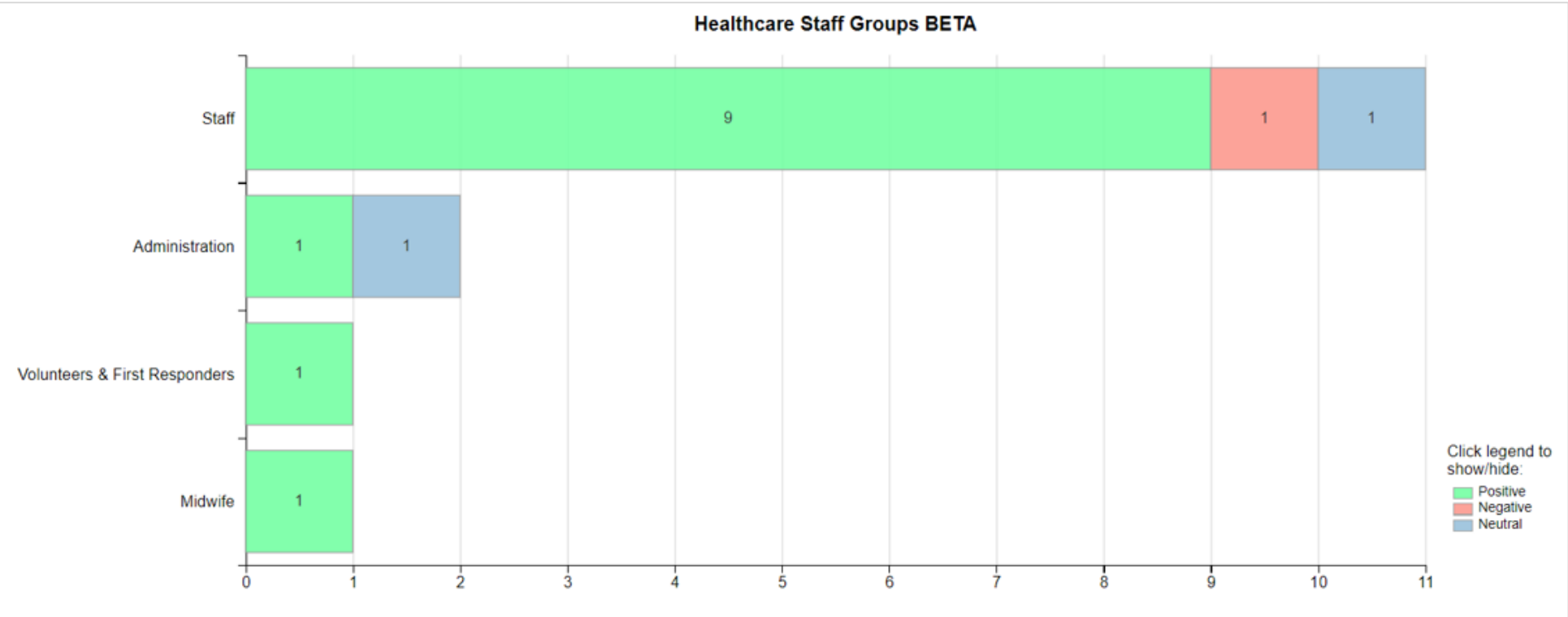


Here are some positive comments we received cont:

- Staff are so kind and supportive I especially love the updates at night via the app. it really does make all the difference and I sleep easier.

Here are some negative comments we received:

I feel neonatal volunteers are overly familiar. I didn't give my consent or indicate in any way that I wished to speak with them. Its like they are coming in to my babies bedroom with out being invited. There should be a step in-between where I am asked if I want to talk to them, because I don't , but I'm too polite to say.



empathy
kind
supportive
"so patient"

Maternity User Feedback -1

🕒 For the month of April there were 243 Friends and Family survey returns with an overall score of 94%

Results by Ward/Clinic

Ward/Clinic	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know
Total	95.1%	2.1%	243	199	32	6	2	3	1
Antenatal Assessment Unit	100.0%	0.0%	16	13	3	0	0	0	0
Antenatal Clinic - Neath Port Talbot	98.7%	0.0%	78	72	5	1	0	0	0
Antenatal Clinic - Singleton	87.0%	4.3%	23	13	7	2	0	1	0
Labour Ward - CDS	100.0%	0.0%	34	31	3	0	0	0	0
Midwife Led Unit	100.0%	0.0%	5	4	1	0	0	0	0
Transitional Care Unit	83.3%	16.7%	6	5	0	0	0	1	0
Ward 19 (Antenatal)	92.0%	0.0%	25	20	3	1	0	0	1
Ward 20 (Postnatal)	91.1%	5.4%	56	41	10	2	2	1	0

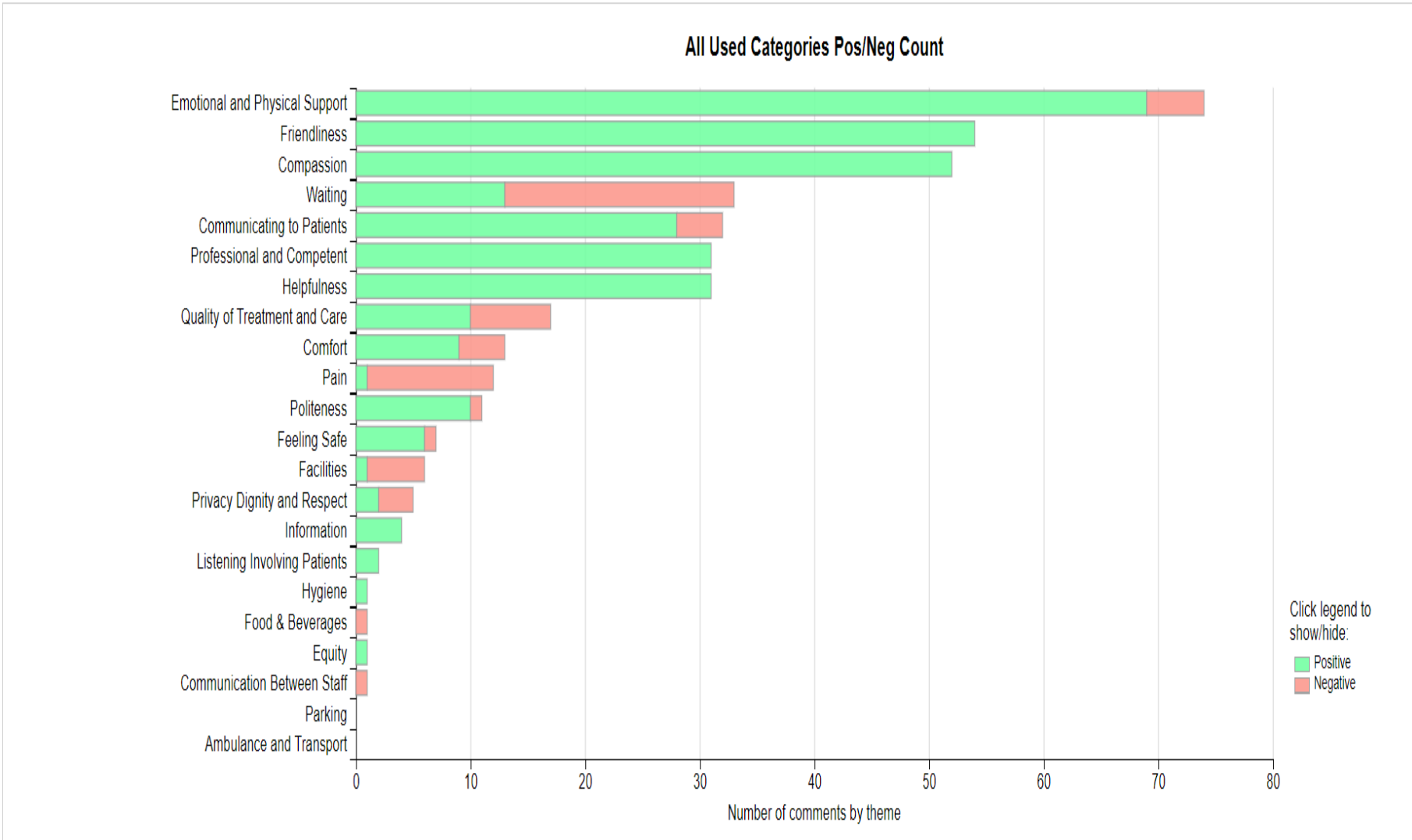


Some positive comments received:

- *My experience on Singleton Labour Ward was the best I could've hoped for. I was anxious about the induction (maternal age) process and the midwives explained everything clearly and reassured me throughout. I would love to say a special thank you to who all took great care of me!*
- *My baby was 3 days old and the staff went above and beyond to ensure we were safe and kept away from the general public as she was so new with very little immunity to germs, they all were amazing!*
- *The hardworking midwives on Ward 19, 20 and the labour ward at Singleton Hospital. There is no where near enough staff on any of these wards but each and every one of them are trying their best with the resources they have.*
- *The two midwife sonographers were amazing. They made the whole experience fun and memorable. What lovely ladies!*
- *Flawless experience. Midwives are phenomenal. They navigated and communicated throughout and kept us fully informed. As first time parent can honestly say we had the best experience ever.*
- *So grateful to the staff they were all amazing and my first time experience as a new mum has been even better than I could have hoped for. Please don't change a thing. it could not have been a better experience for myself or my partner.*

Maternity User Feedback -2

🕒 For the month of April there were 243 Friends and Family survey returns with an overall score of 94%



relaxed
friendly
welcoming
warm
pleasant

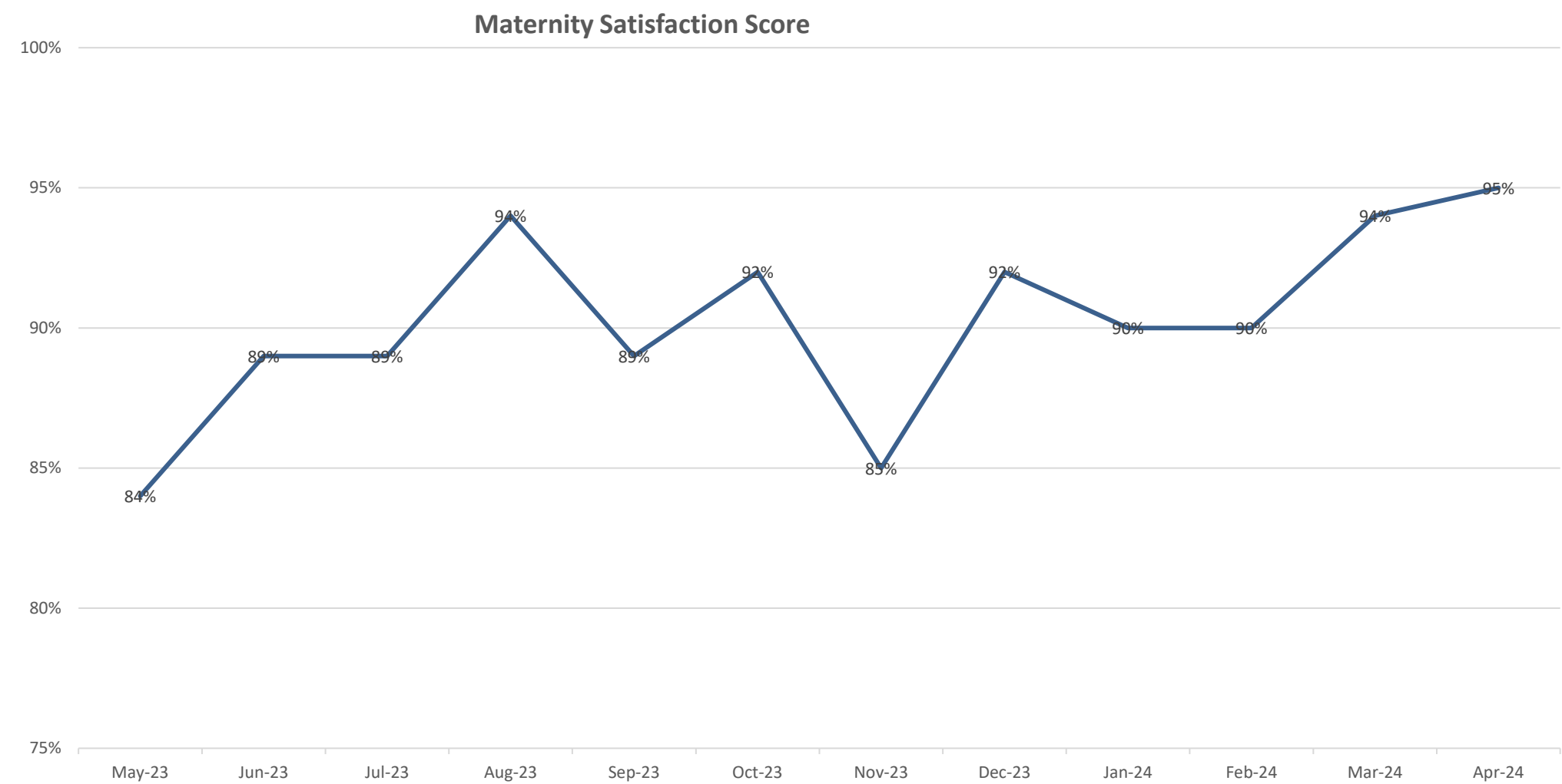
accommodating
willing
helpful
attentive
helping

"wasnt seen"
"almost an hour"
waited
eventually
"for 36 hrs" waiting
"put off"
chase
delay
"left waiting for 36 hrs"
postponed
chased ages
"took a long"
delayed

"understanding of the concerns"
"care and support"
helped
"good support"
"very understanding"
"spent time"
supportive
"great support"
helpful
"ease nerves"
"so understanding"
"put at ease"
reassuring
supported
helping
reassured
"put me at ease"

"asked multiple times for pain"
"in pain"
"asking for pain"
"beg for"
"begged for"
"of pain"
"have pain"
"pain relief was not"

Maternity Satisfaction Score – Trend Graph (April 2024)



Patient experience improvement work

Assessment for Self Administration has been added to the bundle booking completed on admission

Regular “medication rounds” introduced to ensure regular analgesia is offered

Delays in inductions escalated to senior team for review and Datix incident completed

Health Inspectorate Wales - Singleton Hospital Ward 18,19, Labour Ward and Midwifery led Unit 22nd – 23rd April 2024

HIW undertook an unannounced inspection within the Maternity Unit at Singleton hospital in April 2024

One immediate improvement was identified with an immediate improvement plan completed.

The improvement related to the Antenatal Assessment Unit staffing and triage

Immediate actions were taken at the time, and the improvement plan as submitted and accepted by HIW on the 14th May 2024

The Health Board are awaiting the draft report and general improvement plan

Health Inspectorate Wales - Singleton Hospital Ward 18,19, Labour Ward and Midwifery led Unit September 2023

Healthcare Inspectorate Wales Immediate Improvement Plan

As at 23rd March 2024, a total of 35 actions have been completed, 5 actions in progress and one action to be completed by July 2024.

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

Mandatory training:

- 3 actions relate to demonstrating improved outcomes (through achievement of target compliance levels;) Revised date the end of March 2024.
- 1 related to ward managers having access to ESR.

Security:

- SALTO System to be implemented.

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	17	15	2
April	11	5	4
May onwards	11	TBC	TBC
TOTAL	118		

January

- External signage reviews complete, signage to be ordered.

March

- To provide cultural training and support for maternity service, task and finish group developed and development of ongoing engagement plans underway.
- Management of medical devices, awaiting updated assets lists revised date May 2024.

April

- Delay in induction of labour

1. Reopening of NPTBC

Antenatal Assessment Unit

1. AAU staffing establishment

- ITU

1. Health Board to undertake a review of ITU care- revised date October 2024.

- Language translation app- revised date June 2024.

Health Inspectorate Wales - Singleton Hospital Ward 18,19, Labour Ward and Midwifery led Unit 2019

34 Recommendations with 80 individual actions

78 completed, 2 outstanding

Improvement Required	Standard	Service Action	Responsible Officer	Timescale
Any staff performing duties in theatres and recovery are appropriately trained and competent to perform this role.	2.1 Managing risk and promoting health and safety	PROMPT training provided for all maternity staff annually- 1 st year reporting in January 2020. Training attendance currently on target to achieve >90%	Professional Development midwife	September 2024
Ensure training compliance is improved and maintained	7.1 Workforce	Improved compliance of E-Learning compliance	Practice development leads obstetric medical lead and midwifery managers	Update Midwives – 94.13% Additional Clinical Services – 81.22% Medical for Obstetrics – 78.13% Total compliance 84.49 – April 2024 data

Health Inspectorate Wales –HIW National review of Maternity Services 2020

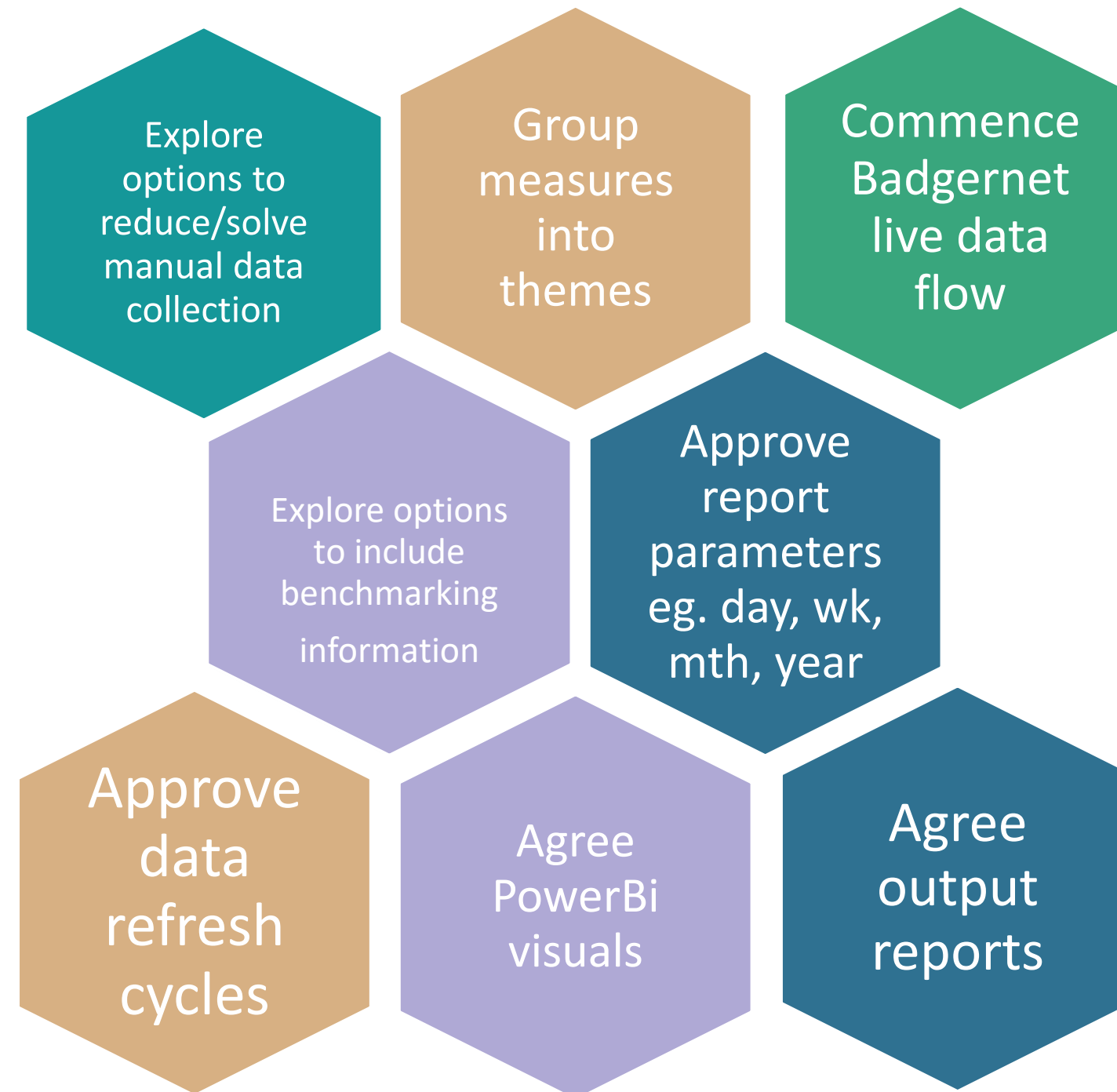
Recommendations = 33, Actions = 99

Completed = 93, outstanding = 6

Improvement Required	Service Action	Responsible Officer	Update
Develop a directory for staff of all available maternity related leaflets in different languages to provide to women or signpost to an on-line service	Directory of information leaflets to be compiled including what languages are available	Digital Midwife and Public Health Midwife	Sharepoint page currently under development Action completion overdue March 2024
Review of Obstetric antenatal clinic provision commenced in July 2020- delayed due to Covid pandemic. Group reconvened February 2021. Continuity of obstetric team to be included within the parameter of the review.	Obstetric and community Organisation Change now completed, work reconvened.	Head of Midwifery, Clinical Lead, Service Group Manager	Draft Terms of reference completed Working Group to be established Action completion: September 2024
Make the following improvement to the current perinatal mental health clinics: A dedicated multi-professional team of obstetrician, midwife and mental health professional Continuity of carers Links with the Swansea Bay UHB mental health teams and primary care Links with third sector services for referral and support e.g.(NSPCC/MIND)	Meetings in diaries to take this work forward Transformation work in line with Antenatal Clinic review National pathway for perinatal mental health implemented in HB – inc. screening tools. Referral process for provides support/upskilling sessions for midwives to discuss individual women with named perinatal mental health midwife, which includes opportunities to use the services of the 3 rd sector Further work to develop a more dedicated multi-professional team is required – SBAR completed and options appraisal developed.	Clinical lead / Head of Midwifery / PRAMS / Perinatal mental health midwife	In progress to form part of the antenatal clinic service review
All health professionals in maternity to undergo annual PROMPT training and report 100% compliance of mandated available staff to Welsh Risk Pool	Revised Action: Service to ensure improved uptake of PROMPT training by relevant health professionals in order to achieve the national 95% target.	SBUHB PROMPT	Due September 2024
Ensure a 100% of available staff are compliant in the following mandatory training: <ul style="list-style-type: none">Fire safetyManual handling	Revised action: Service to ensure improved uptake of fire safety training by all Health Care Professionals in order to achieve national target.	Practice Development lead Midwives All Staff	
Ensure a 100% of available staff are compliant in the following mandatory training: Level 2 Infection prevention and Control	Compliance low in staffing groups- action plan developed by Matron and area leads, to improve compliance.	Matrons / Area Leads / PDM	

Maternity & Neonatal Dashboard Development

- Work is ongoing to establish a comprehensive list of measures and verify the data source
- Working through agreed measures to gain assurance of formulas used
- Progressed to building the dashboard with signed off measures
- Agreed a dashboard view with drill down to SPC sortable by day, week, month and location as well as a target overview green red display
- Badgernet live feed up and running



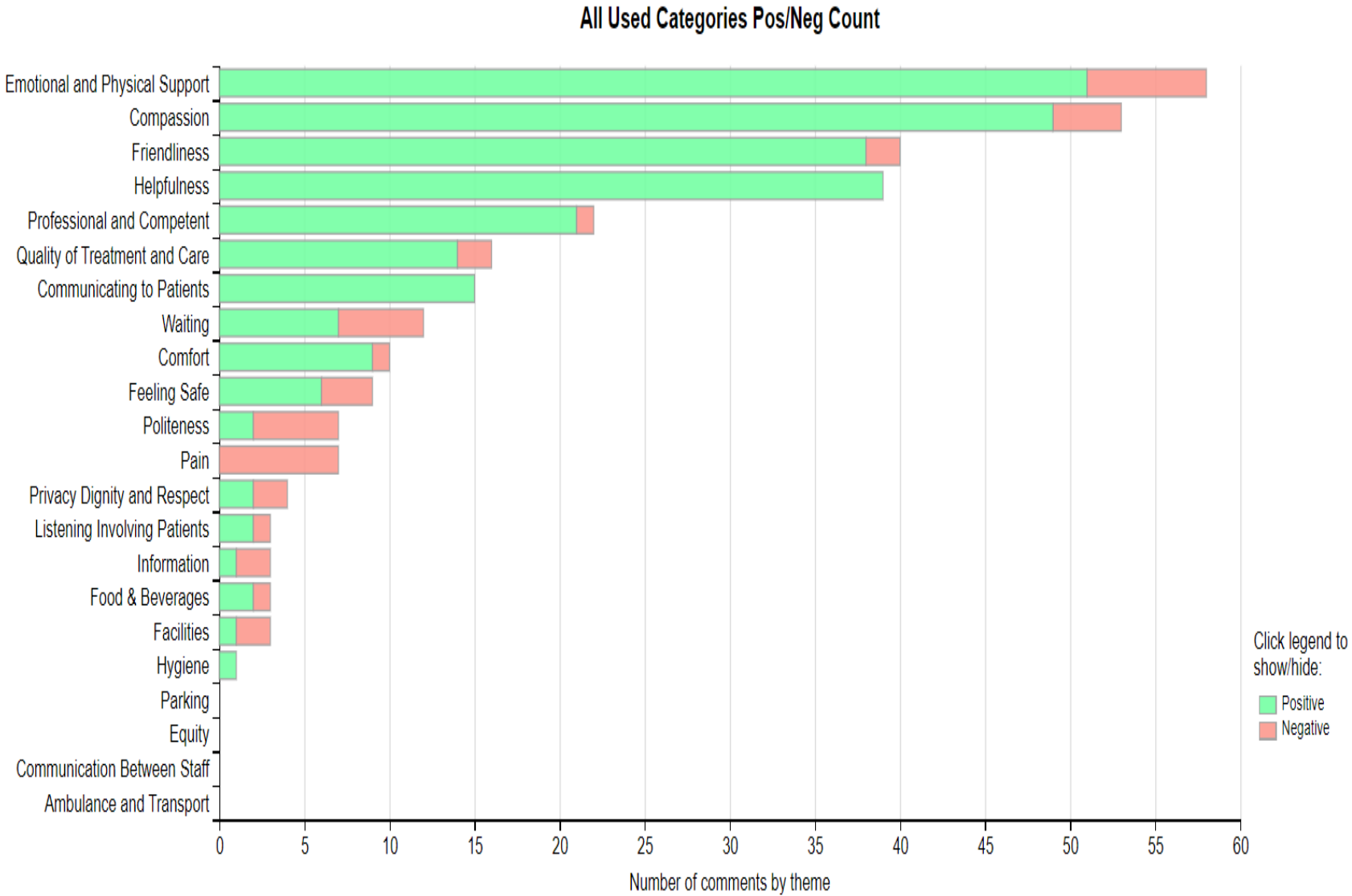
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Patient Experience

May Overview

- Overall score – 93%
- Total number of feedback responses – 5,342
- Main theme ‘Waiting & Emotional and Physical Support’
- Overall Maternity score - 93% 187 Responses
- Calls answered by our department - 4 feedback passed on

NB Not all parts highlighted in red on the chart are negative. Civica may see words like "pain" and "wait" as negative, even if they're meant positively. Sometimes, the system may not get the context right. Also, a patient might give a positive score like 'Good/Very good' but use words like 'I'm out of pain,' which Civica might label as negative in the comment analysis. However, the 'Good/Very good' rating will have a positive effect on the satisfaction scores.



Quality and Safety

Other recent inspections of note:

HIW inspection at Singleton Hospital Maternity Unit (April 2024)

Following the September 2023 inspection of the above service, a further HIW inspection took place in April 2024. The health board has already agreed an Immediate Improvement Plan with HIW to address matters arising within the Ante Natal Assessment Unit. A draft report has now been received with further improvement areas for attention, the response to which is currently subject to consideration.

HFEA inspection of Wales Fertility Institute at Neath (May 2024)

The HFEA conducted interim inspection at WFI Neath Unit in May 2024. A draft report is awaited – no critical findings were highlighted during immediate feedback provided.

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