Health, Social Care and Early Years Group

Enhanced Monitoring
Maternity and Neonatal Services
Swansea Bay University Health Board

Llywodraeth Cymru
Welsh Government

Meeting Notes

20 February 2025

1. Welcome and Introductions

Attendance and apologies were noted and reflected in the table below. A detailed slide deck was provided to support the meeting.

EM Mat Neo February 2025 FINAL.

2. Structure of future meetings

A discussion took place related to the structure and topics of future meetings. It was agreed that each meeting would include a detailed theme for review supported by a discussion and review against the agreed metrics and the de-escalation criteria to gain assurance that the service remains safe and delivers high quality care.

Amendments were made to the suggested topics for future meetings and it was agreed that mortality and morbidity would be reviewed in March.

Enhanced monitoring meeting are not scheduled for April or August as maternity/neonatal is covered in the IQPD.

The health board agree to issue a revised forward look

ACTION: Focus of the next meeting in March will be on mortality and morbidity.

ACTION: Health Board to issue a revised forward look.

3. Quality and Outcomes

The health board presented the perinatal services quality framework and demonstrated how they are applying and monitoring it within their services. They provided an update on their quality planning related to incidents and governance. Through monitoring the number of incidents and the number of closures each month the health board has assurance that the local reporting rates are in line with expectations and can assess whether there is sufficient resource to manage the volumes required in a timely manner.

It was agreed that the health board would include some additional quality improvement metrics relating to the outcomes of investigations such as the number of investigations which are being reopened. The health board are working on strengthening their reporting and ensuring staff are clear on what needs to be reported and how to report it.

The health board has an early warning system around the harm incidents and incidents that trigger the duty of candour. They ensure that any admission to critical care and babies undergoing any active cooling for HIE are reportable as duty of candour incidents.

The health board reviews HIE, which includes an early review within 72 hours of the incident and is in the process of undertaking a thematic analysis of HIE and will consider the risk factors for both the mother and baby.

The health board confirmed that they are looking at real time data monitoring of MBRRACE and will present a detailed analysis of the 2023 MBRRACE data at the next meeting.

The health board are reviewing neonatal incidents over time in terms of the average number of incidents that are being reported month on month, trends around capacity to manage and confidence they have the resources to respond in a timely way. The health board highlighted a particular incident where a detailed review was done and there was some learning, which was disseminated with the team, there was also extensive liaison with other teams.

ACTION: Health board to consider additional quality metrics such as quality improvement metrics relating to the outcomes of investigations such as the number of investigations which are being reopened.

ACTION: Health board to present detailed analysis of the 2023 MBRRACE data at the next meeting,

4. Workforce

The health board presented their current workforce establishments, vacancies and compliance with managing the rotas to both birth rate plus and BAPM standards. The health board confirmed that staff which moved when Princess of Wales were closed were not included within the health board roster management system and then have now all returned to Cwm Taf Morgannwg UHB. They also outlined their current training compliance and highlighted the drop in the gap and grow compliance which when they reviewed seems to relate to it not being recorded on the ESR. They are reminding staff that this must be updated in a timely manner.

The health board have looked at their data in relation to the protected characteristics of those accessing maternity and neonatal services and plan to review this data on a six monthly basis moving forward to help inform service planning and recruitment.

5. Improvement Projects

The health board has created a team to help implementation and plan to launch NEWTTS2 from 3 March. They have developed materials and a training package with 85% of staff trained. The team are going to do monthly audits to check compliance. In relation to MEWS, there is more training needed so the implementation of this will follow once NEWTTS2 is in place.

The work undertaken on surgical site infections following caesarean sections, is now starting to influence some national work in this area. Women with SSI often have a

poor experience and are more likely to be readmitted, struggle with bonding with their baby and is commonly associated with complaints. The health board has chosen to report SSIs up to 28 days as the women are still within their care at 28 days and they want to be looking at what they can improve and what the themes are. As part of the quality improvement project, they have created a patient information leaflet and education package for all community midwifery teams and obstetric teams during their new rotation to ensure staff have relevant and up to date knowledge on how to take a swab and identify and manage an SSI and ensure accurate data collection.

In relation to the implementation of PeriPrem Cymru, when reviewing the baseline 2022 data the health board has the highest level of compliance with all interventions. The health board identified four areas to prioritise and focus improvement on which were early expressed breast milk, antenatal steroids, antepartum antibiotics and probiotics. The health board worked collaboratively as a perinatal team and worked collaboratively with multi-disciplinary colleagues with intervention focus awareness and teaching sessions. In relation to early expressed breast milk the baseline data was around 46% and saw an improvement to 71%. The health board are working with Improvement Cymru on a national project to improve the optimal timing of antenatal steroids and design standardised pathways and training for obstetric staff. The 2023-24 data shows the health board compliance with all interventions has increased to 14%.

6. Other

It was noted that there had been an unannounced inspection at the Birthing Centre and the health board are awaiting the draft report.

Date of next meeting: 20 March 2025.

Action Log			
No.	**Action**	**Owner**	**Update/Deadline**
1	• Agreed the focus of next meeting would be on mortality and morbidity including the MBRRACE perinatal mortality data for 2023.	SBUHB	20 March
2	• Circulate revised forward look of themes for future meetings	SBUHB	20 March
3	• Consider additional quality metrics such as quality improvement metrics relating to the outcomes of investigations such as the number of investigations which are being reopened	SBUHB	20 March
4	• Present detailed analysis of the 2023 MBRRACE data at the next meeting	SBUHB	20 March

Attendance

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