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.

Key

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

1. Safe and Effective Care

Maternity care provision has seen growing levels of complexity over the last decade with rising rates of obesity and chronic medical conditions. To ensure that services are sustainable and provide the best care it is imperative that women and families are cared for within the most appropriate pathways and by the professionals who best meet their needs.

Governance Processes			
Abbrev.	**No.**	**Recommendation**	**RAG Rating**
O	1.1	Patient safety specialist should be in post at each health board.	
O, R	1.2	Any clinician with the responsibility for clinical governance must have sufficient time within their job plan to deliver their duties. They should also receive training in human factors, causal analysis and family engagement. Have appropriate clinical risk and governance processes and training in place, including a consultant lead. A governance framework from ward to board must be evident ensuring joint ownership form maternity and neonates.	
O	1.3	Regular progress reports presented at Board level to review progress against improvement plans.	
R, O	1.4	Processes are in place for data collection and accuracy checking, clinical validation and monitoring of clinical practice and outcomes. Clinical change where required must be embedded across health boards with regional clinical oversight in a timely way. Health boards must be able to provide evidence of this through structured reporting mechanisms.	
R, H, M-SND	1.5	Identify named midwife/obstetrician to lead on updating policies and procedures, ensuring staff are aware of updates to maintain the delivery of safe and effective care.	
O	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	
R, O	1.7	Midwifery, neonatal and obstetric co-leads identified for audit, clinical guidelines, mortality and morbidity.	
O	1.8	Processes are in place to provide assurance that adherence to guidance is being achieved. Where guidance is not being followed evidence should be available to outline the reasons why	
R	1.9	Support a full program of clinical audit.	

R, H, M-MD	1.10	Ensure appropriate staff training is available, including CTG, emergencies, NLS and Develop an effective department wide multi-disciplinary teaching program. This must include clinical governance, skills and drills for obstetric emergencies, CTG interpretation, human factor training, NLS and psychological safety; incorporating learning from audits. Ensure that staff have timely access to the training that is required for them to carry out their roles. Compliance should be monitored.	
O	1.11	Health Boards should appoint a dedicated Lead Midwife and Lead Obstetrician for fetal surveillance who will run regular fetal surveillance meetings, cascade training and lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	
O	1.12	Clinicians working on labour ward or delivering intrapartum care must be trained in CTG and emergency skills. This must be mandated	
O	1.13	Local guidelines should be in place for: • When Consultant Obstetrician presence is mandatory • When Consultant Obstetrician and Mangers need to be informed of situations • Escalation to a tertiary unit is required	
H	1.14	Ensure medicines management policies in place which include safe storage of medicines and the prescription and administration of medication for the induction of Labour	
R	1.15	Have process in place to facilitate MDT debrief after an unexpected outcome	
R, O, H	1.16	Health Boards must work collaboratively to ensure that local investigations into National Reportable Incidents (NRIs) are reported as per Welsh Government Framework. All significant learning should be shared across Wales. Lessons from clinical incidents must inform local multi-disciplinary training	
R, H	1.17	Ensure that steps are taken to encourage staff to speak up and report incidents without fear of reprisal or repercussion.	
R, O, H, M-SND	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.	
R, O, M-SND	1.19	Ensure learning and service improvement actions are implemented following incidents, concerns or audit, is effectively shared with staff across all sites. Mechanisms will be in place to capture this information to close the loop.	
O	1.20	There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	
H	1.21	Ensure that a high standard of documentation is maintained, in particular ensuring that the standard of patient records is improved and prescribing.	
H	1.22	Ensure the ongoing monitoring in line with health board policy of neonatal resuscitaires and emergency medical equipment.	

Clinical Pathway			
Abbrev.	**No.**	**Recommendation**	**RAG Rating**
O, M-MD	1.23	Development for high-risk pregnancies including rapid referral for neurology review, an epilepsy team, rapid specialist stroke care, specialist multidisciplinary care for pregnant women who have had bariatric surgery	
O, M-MD	1.24	Regional integration of maternal mental health services should be considered	
O	1.25	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional and must include ongoing review of the intended place of birth	
O, M-MD	1.26	Ensure early senior involvement in the care of women with extremely preterm prelabour rupture of membranes and a full explanation of the risks and benefits of continuing the pregnancy. This should include discussion of termination of pregnancy.	
O	1.27	Robust pathways of care in place between hospital and community setting	
O	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	
O	1.29	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	
O	1.31	During labour and birth women must receive a full clinical assessment on presentation, including a review of risk factors. Women who choose to birth outside of a hospital setting must receive documented information on transfer times to an obstetric unit.	
O	1.32	Pathways must be in place for induction of labour, that includes the management of delays	
O, M-MD	1.33	Centralised CTG monitoring must be mandated	
O	1.34	There must be clear pathways of care for the provision of neonatal care. Activity outside of the agreed pathways must be supported by NICU advice on resuscitation and management, with all cases outside of pathway exception reported.	
O	1.35	Neonatal staff should have the opportunity for secondment to other units to maintain clinical expertise. Units should maintain Network contacts to share best practice, learning and education	

R, O	1.36	Bereavement care must be available on a daily basis to ensure compassionate, individualised, high quality bereavement care is consistently offered to all families experiencing perinatal loss. This should be included as part of regular training updates.	
O	1.37	Obstetric Anaesthetic assessments must be robustly documented in line with Good Medical Practice GMC recommendations. Follow up care should include but not be limited to: postural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia. Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.	
O	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.	

2. Family Centred Care

Respect and compassion are core values underpinning the care women and their families receive. Respectful family-centred care enables women to have control over their behaviour, surroundings and the treatment they receive. This supports meaningful discussions and shared decision making about their pregnancy, Labour, birth and postnatal care. Maternity services also have a key role in promoting the health and wellbeing of the mother and her family, and in preparing families for parenthood.

Abbrev.	No.	Recommendation	RAG Rating
R	2.1	Maternity and neonatal services must ensure that women and their families are listened to with their voices heard.	
O	2.2	Service users (ideally through the MVP / MSLC) must be involved in the complaints process, ensuring responses are caring and transparent	
R	2.3	Develop and strengthen the role and capacity of the MSLC/MVP to act as a hub for service user views and involvement of women and families to improve maternity care:	
H	2.4	Improve the ability of birth partners or family members, to be able to support women, in line with a woman's wishes	
O	2.5	All Health Boards will have pathways in place to provide timely emotional and specialist psychological support	
O	2.6	Psychological support for the most complex levels of need, should be delivered by psychological practitioners, who have specialist expertise in maternity care	
O	2.7	A framework for Family Integrated Care should be implemented and its impact evidenced.	

O	2.8	Peer support networks should be developed for families when using and after discharge from the neonatal services.	
H	2.9	All Health Boards must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care. Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care. Women's choices following a shared and informed decision-making process must be respected.	
H	2.10	Ensure that women are aware of how they can request information or support in their language of choice	

3. Skilled Multi-professional Teams

Professional groups who work together must develop strong inter-professional working skills to ensure that they share clear aims, language and culture in order to deliver safe and effective care. Multi-professional training should be a standard part of professionals' continuous professional development, both in routine and emergency situations

Governance Processes

Abbrev.	No.	Recommendation	RAG Rating
O	3.1	Health Boards must implement a robust preceptorship programme for newly qualified midwifes	
O	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 Description	
O	3.3	Health Boards must ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs.	
O	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	
O	3.5	Competing workloads in obstetric staffing must be risk assessed and discussed at Board (where no separate rota is in place)	
R, O	3.6	Ensure the Medical Director has effective oversight and management of the consultant body by: making sure they are available and responsive to the needs of the service, urgently reviewing and agreeing job plans to ensure the service needs are met, clarifying what is to be covered as part of SPA activity (audit, governance, teaching, guidelines, data	

		assurance, train more consultant obstetricians as appraisers), ensuring the most unwell women are seen initially by a consultant and all women are seen by a consultant within 12 hour NCEPOD recommendation4 (national standard).	
R	3.7	Ensure obstetric consultant cover is achieved in all clinical areas when required by: • reviewing the clinical timetables to ensure that 12-hour cover per day on Labour ward is achieved, • undertake a series of visits to units where extended consultant Labour ward presence has been implemented • Ensure the consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period of call. This must involve the antenatal ward round being performed by the consultant.	
R	3.8	Neonatal consultant of the week 09:00-17:00 with a minimum of 4 weeks service per year.	
R, O	3.9	Clinical supervision and consultant oversight of practical procedures must be in place for all staff including specialist midwives and staff doctors.	
R, O	3.10	Support training in clinical leadership. The Health Board must allow adequate time and support for clinical leadership to function. Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	
R, H	3.11	Review their workforce plans to ensure appropriate actions are being taken to address the impact of staff working excessive hours, and any shortfall across staff groups.	
H	3.12	Consider implementation of positive initiatives to recognise the good work carried out by staff within the midwifery and medical teams.	
H	3.13	Ensure all midwives complete appropriate training before being required to assist in theatre	
O	3.14	Bereavement training must be offered to all staff	
O	3.15	Rotation of neonatal staff into exemplar units to ensure competence in key clinical skills and decision making.	
R, O	3.16	Investment in neonatal nursing staff, part matron part improvement. Nurse in charge to be supernumerary, ANNP should be expanded to ensure career progression. Nurse consultant roles to be explored. AHP in line with national recommendations including an expansion of pharmacy services.	

4. Continuity of Carer

Continuity of carer affords women and Midwives / Obstetricians the opportunity to build a trusting relationship over the pregnancy journey and into parenthood. It is acknowledged that women often have very individualised journeys through pregnancy from straight forward to complex and requiring multiple specialist inputs

Governance Processes

Abbrev.	No.	Recommendation	RAG Rating
H	4.1	Take steps to ensure that women have contact with a consistent group of healthcare professionals, to improve continuity of care.	

5. Sustainable Services and Workforce Planning

Maternity services in Wales should provide equity across health boards to ensure all women and families have individualised care appropriate to their needs. This will require key resources to ensure sustainable future delivery of services.

Staffing

Abbrev.	No.	Recommendation	RAG Rating
H	5.1	Multiyear workforce planning process in place, incorporating the whole perinatal team	
H	5.2	Nationally agreed minimum staffing levels based on acuity and complexity of pregnancies, vulnerable families and mandatory training requirements	
H	5.3	When staffing levels cannot be achieved a process of escalation to the highest level of senior management in the organisation	
H	5.4	Staffing uplift to be representative of the previous 3 years data on sickness, maternity leave, mandatory training and annual leave	
H	5.5	The feasibility and accuracy of the Birthrate+ tool and it associated methodology must be reviewed nationally	
H	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	

H	5.7	Obstetric anaesthesia staffing guidance to include: • The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave. • The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity. • The competency required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments. • Participation by anaesthetists in the maternity multidisciplinary ward rounds	
O	5.8	RCOG guidance on locum management is to be followed	
R, H	5.9	Neonatal units must be staffed according to BAPM guidelines.	
Specialist Services			
Abbrev.	**No.**	**Recommendation**	**RAG Rating**
R, H	5.10	Consider the introduction of smoking cessation leads to strengthen their approach.	
H	5.11	Consider working with Public Health Wales to further promote healthier living and lifestyles.	
R, H	5.12	Ensure the appropriate level of breastfeeding advice, guidance, and support is provided at all times.	
O, H	5.13	Review the adequacy and availability of perinatal and postnatal mental health support for women.	
O, H	5.14	Ensure effective and timely access to dedicated perinatal mental health service is available to all women who require it.	
H	5.15	Consider how water birth options can be made available across all units.	
H	5.16	Consider the implementation of champion midwives to support further innovation and research.	

Exception Reporting Tool

Recommendation Number	1.3 Regular progress reports presented at Board level to review progress against improvement plans.
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	Maternity services have a maternity and strategy group who meet monthly to review all issues related to maternity services including a review of improvement plans. Exceptions to the improvement plan are reported into the maternity services' Quality, Safety & Risk Group. Further escalation in response to exceptions for improvement plans is through the Women's Health and Ophthalmology Division (WH&O), the Neath Port TalbotSingleton Service Group and to Board. The maternity service provides exception reports to the Quality, Safety & Governance Group (QSSG). However improvement plan updates are not reported through this avenue.
How will we evidence that we are meeting this recommendation?	The inclusion of quarterly updates for improvement plans can be included in the QSSG exception report. It is envisaged going forward to hold one overarching action plan in line with the maternity and neonatal network assurance framework as it evolves.
How do we know that these are effective?	The board are assured and fully cited on maternity service improvement plans.
What further action do we need to take?	Discuss considered reporting structure for improvement plans in next QSSG meeting for acceptance to standing agenda on a quarterly basis. Improvement plan to be standing agenda item in maternity, quality and safety group on a quarterly basis rather than by exception.
Who and by when?	Head of Midwifery July 2022
What resource or support do we need?	
How will we mitigate risk in the short-term?	Reporting updates for improvement plans can be resolved easily through an agreed update of the reporting template to QSSG to ensure quarterly reporting

Exception Reporting Tool

Recommendation Number	1.4 Processes are in place for data collection and accuracy checking, clinical validation and monitoring of clinical practice and outcomes. Clinical change where required must be embedded across health boards with regional clinical oversight in a timely way. Health boards must be able to provide evidence of this through structured reporting mechanisms
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	SBUHB has an identified member of the maternity services management team who populates a maternity and neonates dashboard that is accessible to all staff to review performance. The data is drawn from the Welsh Patient Administration System (WPAS). The performance board each year collates data from this system which has been found inaccurate for certain data requirements. We are awaiting a national maternity digital system and are fully engaged with Maternity Digital Cymru.
How will we evidence that we are meeting this recommendation?	The maternity dashboard is updated monthly using the available digital data on WPAS. This does not provide for regional clinical oversight at this time.
How do we know that these are effective?	As the local maternity dashboard is available and reported and reviewed monthly in the maternity, quality and safety group there is oversight of reported digital data – national response necessary.
What further action do we need to take?	The data provided does not enable us to benchmark our position against other health boards. SBUHB await the Maternity Digital Cymru project completion towards standardised data collection and publication across Wales.
Who and by when?	Welsh Government 2023
What resource or support do we need?	SBUHB will require resource to purchase a Welsh Government recommended digital system. A project board will need to be set up for implementation and training.
How will we mitigate risk in the short-term?	SBUHB will continue to produce the local maternity dashboard on a monthly basis with publication in the shared drive for all staff.

Exception Reporting Tool

Recommendation Number	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
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	BAPM Framework for extreme pre term infants (Peri-Viable) published and presented to MDT. MDT Involvement can be variable. Request for consultation from neonatal colleagues is often made on admission to the hospital rather than in the antenatal period. Work stream to set up to develop pre-term antenatal clinic in line with MBRRACE recommendations supported by the multi-professional team. We have identified an obstetrician who is keen to lead on this work.
How will we evidence that we are meeting this recommendation?	Once the pre-term birth clinic has been developed there will be presence of an obstetric consultant, midwife and neonatal consultant. To provide a “one stop” service for women who are at risk for pre-term birth meeting the BAPM framework for extreme pre-term infants.
How do we know that these are effective?	Once developed patient experience surveys will be undertaken for satisfaction scores. Women at risk of pre-term birth will be fully informed of their care pathway. We anticipate improved communication across the MDT who provide care for women with high risk of pre-term birth.
What further action do we need to take?	A business case will be prepared and presented to Neath Port Talbot Singleton Service Group. This has not yet been agreed and will require additional sessions in order to provide this service post.
Who and by when?	Maternity Service Manager March 2023.
What resource or support do we need?	Consultant job planning for obstetrics and neonatal MDT presence. This would require additional workforce and could not be accommodated within existing roles. A business case required. Availability of ultra sound scan machine with appropriate equipment. Room availability in Singleton Hospital. Administrative support. Midwifery support.

How will we mitigate risk in the short-term?	Women who are at risk of pre-term birth are currently cared for within obstetric led clinics on admission in suspected labour. If fetal medicine are involved in care, a neonatal referral is undertaken in the antenatal period for neonatal support.

Exception Reporting Tool

Recommendation Number	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.
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	The maternity service governance process continues to evolve. The governance team present at the maternity and neonatal network review meetings gaining external specialist opinion. The health board are fully compliant with reporting to PMRT. The maternity service has two clinic governance multi-professional forums: Obstetric clinical review of incidents meeting (OCRIM) and the ATTAIN meeting held on a monthly basis with no external panel member. Contact has been made with a neighbouring health board with a view to secure presence from a senior clinician at these meetings. It is considered additional support is required to secure the resource for external review at the necessary groups.
How will we evidence that we are meeting this recommendation?	There is partial meeting of this recommendation through the maternity and neonatal network review meetings. However all reviews are not taken through this route. Discussions will continue with our neighbouring health board while we await a more strategic approach for incident reviews.
How do we know that these are effective?	The cases presented at national level are well received. Learning from the events is cascaded back to the health board and shared with relevant professionals through email, newsletters and safety briefs.
What further action do we need to take?	To continue to discuss options for external review with neighbouring health board.
Who and by when?	Clinical Lead December 2022
What resource or support do we need?	The resource for two external clinical specialists' sessions per month.
How will we mitigate risk in the short-term?	SBUHB will continue to provide robust review of all significant incidents and report externally where possible. Through ongoing development the health board has presented its process as an exemplar for reviews to the maternity and neonatal network.

Exception Reporting Tool

Recommendation Number	1.23 Development for high-risk pregnancies including rapid referral for neurology review, an epilepsy team, rapid specialist stroke care, specialist multidisciplinary care for pregnant women who have had bariatric surgery
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	The antenatal outpatient review is considering all recommendations from national reports when developing its new clinic template. We currently provide a clinic for women with epilepsy supported by the MDT and including specialist epilepsy nurses. An obstetric consultant clinic is provided for women with a BMI >40. However this does not automatically capture women who have undergone bariatric surgery. It is rare to require specialist stroke care however we provide maternal medicine clinics to all women as appropriate.
How will we evidence that we are meeting this recommendation?	Need to complete the antenatal outpatient review including the criteria for all specialist maternal medicine clinics to include stroke care and bariatric surgery. These clinics will be set up for the multi-professional team including specific referral care pathways.
How do we know that these are effective?	Women's feedback will be sought once the clinics have been developed. Women will receive appropriate care and will be prepared for birth and the postnatal period.
What further action do we need to take?	Need to have clear pathways for maternal medicine clinics to include above risks.
Who and by when?	Clinical Lead Head of Midwifery December 2022
What resource or support do we need?	Clinic room availability. Clinical expertise to develop care pathways. Administration and midwifery support.
How will we mitigate risk in the short-term?	All women with the above risks are currently managed through the obstetric led care pathways via maternal medicine clinics.

Exception Reporting Tool

Recommendation Number	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
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	Preconception advice is provided via specific specialised services including maternal medicine (diabetes and epilepsy) and with referrals from the fertility clinic. There is no formal pathway from the GPs however some GPs may contact individual obstetricians where advice is required. Some women receive pre counselling within a general gynaecology clinic. The service is compliant with the NICE care pathway guidance for multiple pregnancy. However there is no specialised clinic for women with multiple pregnancy.
How will we evidence that we are meeting this recommendation?	Need to evidence pre conception care advice provided through appointments on separate clinic codes. Need to create pre conception care pathways as stated above.
How do we know that these are effective?	Will capture women's feedback. SBUHB will see an increase in pre conception consultations. GPs will feel supported having access to specialist advice pre pregnancy.
What further action do we need to take?	Set up project board for antenatal outpatient review to: Develop a multiple pregnancy specialised clinic; Assess the capacity requirement for pre conception advice clinics; Set up pre conception appointment codes within the maternal medicine clinics; Develop a pathway for pre conception care and circulate to GPs.
Who and by when?	Clinical Lead Maternity Service Manager Head of Midwifery December 2022
What resource or support do we need?	Clinic space within Singleton Hospital. Obstetric consultant sessions.

How will we mitigate risk in the short-term?	SBUHB will continue to offer pre conception advice within maternal medicine clinics as requested.

Exception Reporting Tool

Recommendation Number	1.29 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
Area assessed as amber / red	AMBER **– duplicate**
What is currently in place to meet this recommendation?	
How will we evidence that we are meeting this recommendation?	
How do we know that these are effective?	
What further action do we need to take?	
Who and by when?	
What resource or support do we need?	
How will we mitigate risk in the short-term?	

Exception Reporting Tool

Recommendation Number	1.33 Centralised CTG monitoring must be mandated
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	Centralised CTG monitoring system has been purchased in March 2022. A project board has been set up towards full implementation in 2022/23.
How will we evidence that we are meeting this recommendation?	Centralised CTG monitoring system will be fully implemented within the current financial year.
How do we know that these are effective?	Centralised CTG monitoring system will be fully implemented within the current financial year.
What further action do we need to take?	Complete installation and project plan including training of all staff.
Who and by when?	Maternity Service Project Board March 2023
What resource or support do we need?	Time for staff training. Installation costs already realised.
How will we mitigate risk in the short-term?	SBUHB will continue to utilise paper based CTG. Paper recordings will be maintained in specialist envelopes.

Exception Reporting Tool

Recommendation Number	1.37 Obstetric Anaesthetic assessments must be robustly documented in line with Good Medical Practice GMC recommendations. Follow up care should include but not be limited to: postural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia. Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	Local obstetric anaesthetic documentation is considered to be of good quality. We currently have standardised Remifentanil, Epidural, Obstetric Anaesthetic, PDPH and follow up charts. The Obstetric anaesthetic chart and epidural chart are currently being updated to help improve documentation. In patient follow-up of complications is done well. However, no outpatient follow-up clinics are currently available for the above conditions to be seen. Patients are currently seen on ad hoc basis in antenatal anaesthetic obstetrics clinics or by telephone follow-up by the anaesthetist on labour ward.
How will we evidence that we are meeting this recommendation?	Audit of obstetric anaesthetic documentation. Updated charts. Availability and use of follow-up clinics. Difficult to evidence number of complications currently as data reporting system is too poor to be able to facilitate this – need updated obstetric anaesthetic database that more effectively allows tracking of complications.
How do we know that these are effective?	Improved documentation will clearly be effective. More clarity of charts will help improve documentations. Having availability to follow-up clinic will mean patient satisfaction is improved and improve communication with community teams. Improved data reporting system will ensure no patients are lost to follow up.
What further action do we need to take?	Business case for post-natal follow up clinic with appropriate access to other specialties i.e. psychology/psychiatry services. Maternity Data Cymru work needs to include Obs anaesthetic database that links into other systems.

Who and by when?	Maternity Services Team December 2022
What resource or support do we need?	Financial support for new clinic Digital support for new database
How will we mitigate risk in the short-term?	Continue to use current charts, follow up methods and database. Encourage better documentation

Exception Reporting Tool

Recommendation Number	2.2 Service users (ideally through the MVP / MSLC) must be involved in the complaints process, ensuring responses are caring and transparent
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	The health board is currently developing its MVP. We currently have a MVP Chair and Vice Chair appointed. The MVP Group is in recruitment. A Facebook page has been developed. A work plan will include monitoring feedback, digital stories and 15 steps. There is MVP representation at clinical forums and at the maternity services Quality, Safety & Risk Group, where action plans from complaints and incidents are reviewed. Themes and trends will be monitored and reported to the service. Concern raised regarding involvement with individual complaints due to confidentiality.
How will we evidence that we are meeting this recommendation?	Excellent partnership working between maternity service and MVP.
How do we know that these are effective?	MVP evaluation will include all aspects of their work plan and involvement in maternity service forums/groups.
What further action do we need to take?	As this is a new initiative the MVP will evolve over time. It is anticipated the MVP will produce an annual report supported by the maternity service team. Phase 2 of the MVP will include a patient experience midwife who will act as the liaison between the MVP and service. This role is currently fulfilled by the consultant midwife.
Who and by when?	Consultant Midwife MVP May 2023 (annual report)
What resource or support do we need?	Patient experience midwife will be an additional resource. A commitment for ongoing funding for MVP officers.
How will we mitigate risk in the short-term?	SBUHB continue to promote friends and family feedback. All ward managers are sent their feedback on a monthly basis with the expectation of You Said We Did action. The MVP will continue to attend clinic forums and quality and safety providing update reports and work on behalf of service users for service initiatives.

Exception Reporting Tool

Recommendation Number	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 Description
Area assessed as amber / red	RED
What is currently in place to meet this recommendation?	Band 7 labour ward co-ordinator roles are advertised as vacancies arise. A generic induction program is provided. Newly appointed labour ward co-ordinators are supported by their peer group and line manager into the role. We do not have a specific job description for labour ward co-ordinators. As vacancies are infrequent we would require access to a regional course.
How will we evidence that we are meeting this recommendation?	A specific job description using a national profile will be adopted.
How do we know that these are effective?	Labour ward co-ordinators will be clear on their roles and responsibilities through a specific job description.
What further action do we need to take?	To work within an All Wales group including HEIW for development of this specialist role.
Who and by when?	Head of Midwifery March 2023
What resource or support do we need?	Require an increased number of labour ward co-ordinators to ensure the required uplift to secure development opportunities and access to training courses.
How will we mitigate risk in the short-term?	SBUHB will continue to provide peer and line manager support for newly appointed labour ward co-ordinators into their role.

Exception Reporting Tool

Recommendation Number	3.3 Health Boards must ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs.
Area assessed as amber / red	RED
What is currently in place to meet this recommendation?	Band 7 labour ward co-ordinator roles are advertised as vacancies arise. A generic induction program is provided. Newly appointed labour ward co-ordinators are supported by their peer group and line manager into the role.
How will we evidence that we are meeting this recommendation?	Newly appointed labour ward co-ordinators will attend a nationally recognised labour ward co-ordinator education module.
How do we know that these are effective?	Labour ward co-ordinators will receive an effective induction into the role and will develop skills through a national recognised program. They will be clear on their roles and responsibilities through a specific job description.
What further action do we need to take?	To work within an All Wales group including HEIW for development of an orientation package specific to this specialist role.
Who and by when?	Head of Midwifery March 2023
What resource or support do we need?	Require an increased number of labour ward co-ordinators to ensure the required uplift to secure development opportunities for individual need specific to the specialist role.
How will we mitigate risk in the short-term?	SBUHB will continue to provide peer and line manager support for newly appointed labour ward co-ordinators into their role.

Exception Reporting Tool

Recommendation Number	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
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	The maternity service does not currently have access to critical care modules for midwives. All obstetric core midwives attend PROMPT annually which includes care of deteriorating women.
How will we evidence that we are meeting this recommendation?	Access is required for midwives to attend an accredited critical care course.
How do we know that these are effective?	Women will receive excellent critical care as required within the maternity service.
What further action do we need to take?	SBUHB need to identify an accredited course for midwives to develop high quality skills in critical care provision. It is recommended that two Band 7 midwives are on shift at any time for high quality care. One being the labour ward co-ordinator who is supernumerary and the second highly skilled Band 7 for critical care service provision.
Who and by when?	Head of Midwifery March 2023
What resource or support do we need?	Require an increased number of Band 7 clinical leaders in the obstetric unit to enable adequate time for training.
How will we mitigate risk in the short-term?	SBUHB have an excellent team of senior clinical midwives who have extensive experience of co-ordinating labour ward and providing critical care without formal accredited training.

Exception Reporting Tool

Recommendation Number	3.10 Support training in clinical leadership. The Health Board must allow adequate time and support for clinical leadership to function. Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	There is currently a narrow structure for midwifery management that does not allow adequate time and support for the clinical leadership to function effectively. Throughout the pandemic all team leaders have provided clinical care. The health board provides development opportunities including Bridges, IQT training and coaching. All new managers undergo an induction program. There is no formal appointment of a mentor role. There are no obstacles to development opportunities for obstetricians
How will we evidence that we are meeting this recommendation?	There is currently a review of the midwifery workforce which will include management and specialist roles. The recommendation is to strengthen the midwifery management team to include a director of midwifery and non-clinical team leaders to strengthen midwifery leadership across maternity services in line with the RCM recommendations.
How do we know that these are effective?	There will be effective strategic and operational management and clinical structures of the service that gives assurance to the board.
What further action do we need to take?	SBUHB need to complete the workforce paper and gain support to redesign and develop the management and clinical structures.
Who and by when?	Service Group Leadership Head of Midwifery March 2023
What resource or support do we need?	Director of midwifery will be an additional role. Removing the team leaders from the clinical SIP will lead to requirement for clinical backfill.
How will we mitigate risk in the short-term?	The midwifery leadership are working with the service group to ensure the critical function of the management team is maintained.

Exception Reporting Tool

Recommendation Number	3.11 Review their workforce plans to ensure appropriate actions are being taken to address the impact of staff working excessive hours, and any shortfall across staff groups
Area assessed as amber / red	RED
What is currently in place to meet this recommendation?	A review of the midwifery workforce is currently taking place. The maternity service employs the commissioned number of graduate midwives annually. There is no budget for graduate midwives. Vacancy and recruitment for experienced Band 6 midwives mid-year has limited success due to a national shortage of midwives. Daily acuity is monitored and midwives redeployed as appropriate to maintain safe service. A record is maintained of all additional hours worked by community midwifery staff during on-call. Midwifery management team attend monthly roster scrutiny panels. The midwifery team are working with the Birthrate+ Cymru project for presentation to Welsh Government for future workforce needs. Representation confirmed for the planned meeting on 30 May 2022 regarding midwifery workforce. The obstetric workforce is above the minimum RCOG recommendations. Locums are employed for service need. Locums are known to the service. An induction program is in place should the need arise for a locum unknown to the service. The neonatal medical workforce is currently below recommended BAPM levels, with a shortfall of consultant level on site support at weekends. A business plan is in the preparation phase in order to appoint an additional consultant. Medical staff on their tier 1 and 2 rotas do not work excessive hours and they work compliment rotas. Neonatal nursing workforce are severely understaffed with many shifts staffed below BAPM recommendations.
How will we evidence that we are meeting this recommendation?	The midwifery workforce will not work excessive hours. All clinical areas will be appropriately staffed.
How do we know that these are effective?	Staff surveys reduced sickness absence.
What further action do we need to take?	Complete Birthrate+ Cymru assessment. Present workforce paper to board to support future model of midwifery care.

	Neonatal nursing recruitment – overseas and through streamlining – is added to the workforce and is being supported by the SBUHB executive team.
Who and by when?	Head of Midwifery March 2023
What resource or support do we need?	As the workforce paper is developed it will highlight gaps in midwifery staffing. A business case will be prepared for board. Funding for an additional neonatal consultant and further support for neonatal nursing recruitment will be required.
How will we mitigate risk in the short-term?	Daily acuity is monitored and midwives redeployed as appropriate to maintain safe service. Clinical areas must contact the midwifery manager on-call prior to deployment of community midwives. Use of agency neonatal nurses and DATIX reporting of understaffing with investigation and support from management.

Exception Reporting Tool

Recommendation Number	3.12 Consider implementation of positive initiatives to recognise the good work carried out by staff within the midwifery and medical teams.
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	The midwifery teams have clinical supervisors for midwives (CSfM) and RCM workplace representatives who provide support through initiatives such as “Caring for You”, random acts of kindness and fundraising. The International Day of the Midwife was a positive experience. Midwives are asked to provide vignettes of their experience of being a midwife which is shared across the teams. The midwifery management team take opportunities to join team meetings for team building. Staff engagement events are offered. Compliments are recorded via DATIX reporting system. The governance team provide positive feedback to all staff following involvement in incidents with the opportunity for team or individual debrief. The obstetric team consider further work can be undertaken including taking the opportunity for planned away days for team building.
How will we evidence that we are meeting this recommendation?	Excellent multi-professional team working relationships that provide excellent, high quality care.
How do we know that these are effective?	Staff surveys. Effective team working. Reduced staff attrition.
What further action do we need to take?	Link in with health board education and development team to plan away days. Introduce a quarterly “good news” newsletter.
Who and by when?	Governance Team October 2022
What resource or support do we need?	Backfill to support obstetric away day. Governance resource to plan and publish “good news” letter.
How will we mitigate risk in the short-term?	SBUHB will continue with current good practice within midwifery. Training such as PROMPT, M&S bring the multi-professional team together for shared learning and team building.

Exception Reporting Tool

Recommendation Number	4.1 Take steps to ensure that women have contact with a consistent group of healthcare professionals, to improve continuity of care
Area assessed as amber / red	RED
What is currently in place to meet this recommendation?	Due to critical midwifery staffing, services have been centralised into Singleton Hospital. Attempts have been made by community midwives to maintain a level of continuity as possible. A community service review is in train to review workforce and models of care toward a sustainable service for the provision of continuity of care. Obstetric led antenatal outpatients provide a level of continuity. The antenatal service review will improve continuity going forward with booking appointment clinic cancellations when an obstetrician is unavailable.
How will we evidence that we are meeting this recommendation?	The community midwifery provision is audited annually to review continuity of care. The results are published for individual midwives and teams (this has not taken place during the pandemic). The consultant midwife plans to reinstate this activity as community midwifery staffing improves as we move away from centralised service.
How do we know that these are effective?	SBUHB will be providing care in line with the Welsh Government maternity vision for continuity. The midwifery workforce will be in line with Birthrate+ Cymru.
What further action do we need to take?	We need to complete the community service review and workforce paper to present to service group and management board. Complete Birthrate+ Cymru assessment.
Who and by when?	Head of Midwifery September 2022
What resource or support do we need?	Resource required will be identified on completion of the above work streams.
How will we mitigate risk in the short-term?	SBUHB are maintaining a centralised service model where midwifery staff are deployed to clinical areas to maintain safe staffing.

Exception Reporting Tool

Recommendation Number	5.2 Nationally agreed minimum staffing levels based on acuity and complexity of pregnancies, vulnerable families and mandatory training requirements
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	This is a national standard. Locally SBUHB employ specialist midwives to lead the clinical workforce for women with complex pregnancy and/or vulnerable families. The specialist midwives provide advice, support and training for all staff members within the MDT. Obstetric clinics are provided for women with complex pregnancy and vulnerable families including substance misuse, perinatal mental health and maternal medicine clinics. SBUHB are a pilot site for Born Into Care recommendations. A joint working board has been created between maternity services and local authorities (Swansea and Neath Port Talbot) to work in partnership considering the recommendations of the report. Local authorities provide additional service, midwives are employed by JIG-SO in Swansea and Flying Start in Neath Port Talbot to support vulnerable families. The training and education forum meet monthly to plan the annual mandatory training agenda including PROMPT, fetal surveillance and midwifery professional update day. They also co-ordinate training such as NALS, NIPE and GAP Specialist midwives provide training via TEAMS for staff to attend as available. Registers are maintained for all attended. The forum are currently focussed on e-learning to ensure compliance in line with Welsh Government targets. The pandemic has impacted on the service ability to achieve full compliance for mandated training.
How will we evidence that we are meeting this recommendation?	Compliance with mandated training across all staff groups. Feedback from women and families of experience of service. Women receive high quality effective individualised care.
How do we know that these are effective?	Highly trained and skilled multi-professional workforce. Feedback from women and families of experience of service.

What further action do we need to take?	Awaiting national steer for midwifery staffing levels using Birthrate+ Cymru assessment. Complete our review of antenatal outpatients to make recommendations to change, to ensure we meet the needs of complex and/or vulnerable families.
Who and by when?	National Action December 2022
What resource or support do we need?	To ensure adequate staffing for care to women with complex pregnancy and vulnerable families. This will be included in the workforce plan for midwifery. To ensure adequate staffing to deliver all mandated training within working hours of all staff.
How will we mitigate risk in the short-term?	Midwifery staffing is monitored through twice weekly scrutiny panel and daily acuity reporting and staff redeployed to maintain safety within the clinical areas. Key specialists midwives including safeguarding lead midwife, perinatal mental health midwife, substance misuse midwife and JIG-SO team leader are working jointly to ensure women with complexity or are vulnerable receive appropriate individualised care. The training and education forum monitor training compliance through a database and exception report to maternity quality and safety group concerns regarding compliance.

Exception Reporting Tool

Recommendation Number	5.4 Staffing uplift to be representative of the previous 3 years data on sickness, maternity leave, mandatory training and annual leave
Area assessed as amber / red	RED
What is currently in place to meet this recommendation?	There is currently a 22% uplift for the midwifery staffing budget. Sickness, mandatory training and annual leave is included within the 22%.
How will we evidence that we are meeting this recommendation?	This is a national decision and not a local issue.
How do we know that these are effective?	This is a national decision and not a local issue.
What further action do we need to take?	This is a national decision and not a local issue.
Who and by when?	This is a national decision and not a local issue.
What resource or support do we need?	This is a national decision and not a local issue.
How will we mitigate risk in the short-term?	This is a national decision and not a local issue.

Exception Reporting Tool

Recommendation Number	5.5 The feasibility and accuracy of the Birthrate+ tool and it associated methodology must be reviewed nationally
Area assessed as amber / red	RED
What is currently in place to meet this recommendation?	This is a national decision and not a local issue.
How will we evidence that we are meeting this recommendation?	This is a national decision and not a local issue.
How do we know that these are effective?	This is a national decision and not a local issue.
What further action do we need to take?	This is a national decision and not a local issue.
Who and by when?	This is a national decision and not a local issue.
What resource or support do we need?	This is a national decision and not a local issue.
How will we mitigate risk in the short-term?	This is a national decision and not a local issue.

Exception Reporting Tool

Recommendation Number	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
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	Currently there is no formal succession planning programme for the multi-professional maternity workforce to develop future leaders.
How will we evidence that we are meeting this recommendation?	SBUHB will evidence meeting this requirement through identifying future leaders through the PADR process and appraisal process that opportunities are available for further education and training, shadowing opportunities. Midwives will be exposed to all areas of the maternity service and external opportunities to network across health boards.
How do we know that these are effective?	SBUHB will identify and invest in future leaders who are prepared to step into senior roles as they become available.
What further action do we need to take?	The midwifery management team is working with the Singleton Neath Port Talbot Service Group management team to review midwifery workforce requirements to ensure adequate resource to support succession planning.
Who and by when?	Head of Midwifery Service Group Leadership March 2023
What resource or support do we need?	Ensure adequate uplift to backfill members of the multi-professional team to gain experience in all areas of the service including external opportunities.
How will we mitigate risk in the short-term?	By ensuring adequate internal opportunities for development and shadowing.

Exception Reporting Tool

Recommendation Number	5.7 Obstetric anaesthesia staffing guidance to include: • The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave. • The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity. • The competency required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments. Participation by anaesthetists in the maternity multidisciplinary ward rounds
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	National guidance from RCOA states "As a basic minimum for any obstetric unit, a consultant or other autonomously practising anaesthetist should be allocated to ensure senior cover for the full daytime working week; that is, ensuring that Monday to Friday morning and afternoon sessions are staffed. This cover is to provide urgent and emergency care, not to undertake elective work." Locally SBUHB currently offer Monday to Friday, morning and afternoon consultant cover on labour ward. However, these consultants may be providing both emergency AND elective work. Internal cover is provided for staff annual leave. However, current levels of staffing mean that short term absences i.e. sickness and COVID isolation can cause difficulty covering the unit out of hours. Again this is covered internally but can mean a significant on-call workload for a small number of anaesthetists. Although the obstetric anaesthetist on labour ward might not have had their Initial assessment of competence on Obstetric Anaesthesia (IACOA) signed off, an autonomously practising anaesthetist is available on site 24 hours a day, 7 days a week (second on call). However, they provide INDIRECT cover, not DIRECT as stipulated by the RCOA GPAS document. SBUHB do not have a document defining our local safe staffing levels or roles of the anaesthetists. Elective caesarean sections lists are covered by consultants or very senior trainees, nearing their CCT. Antenatal obstetric anaesthetic clinics are covered by consultants.

	PROMPT is attended by all obstetric anaesthetic consultants, middle grades and a large number of trainees. We have twice yearly obstetric and anaesthetic joint audits. Labour ward forum is attended by a consultant anaesthetist as is the Obstetric clinical risk meeting. No consultants cover obstetrics out of hours without regular labour ward sessions. Currently attendance at labour ward multi-disciplinary handover is excellent but attendance of the ward round is not.
How will we evidence that we are meeting this recommendation?	Document on safe obstetric anaesthesia staffing and roles will need to be written. Continued consultant presence at multi-professional meetings i.e. governance, audit, labour ward forum, PROMPT Low levels of external locums
How do we know that these are effective?	RCOA GPAS document
What further action do we need to take?	Consideration needs to be given as to whether it is viable to staff labour ward until 8pm with consultants to ensure DIRECT cover is provided for obstetric novice trainees (those without their IACOA) with current levels of consultant staffing. Appropriate action needs to be taken to increase the number of consultants that cover labour ward to ensure there is no possibility of on calls gaps occurring or current staffing becoming burnt out. A review of the size of Consultant Obstetric Anaesthetic group needs to be undertaken and a document produced 'Local safe staffing levels' by end of year. Local consideration of how we provide a multi-professional solution to the mixed elective and emergency streams i.e. whether a completely separate elective service is possible. If it is not, then a clear justification will need to be provided as why not.
Who and by when?	Consultant Anaesthetic lead December 2022
What resource or support do we need?	Hoping to recruit 2 new consultants this year (posts to be advertised this/next month). Decision on whether to cover till 8pm by end of year. Within a year need a plan on whether we will be able to separate our elective and emergency work streams.

	Anaesthetic duty doctor to attend labour ward round immediately (unless otherwise busy on labour ward).Business case for staffing with consultants until 8pm. Funding for an increase in consultant on call group (2 posts are soon to be advertised) and ensure that any gaps created by retirements / resignations are proactively filled. Significant financial support if we are to consider completely separating our elective and emergency streams.
How will we mitigate risk in the short-term?	Ongoing internal cover of any on call gaps. If this becomes too onerous on this work group it may be that obstetric anaesthetist cover has to be prioritised over other general anaesthetic duties, with either anaesthetists from the rest of the department picking up these lists or these lists being cancelled. Presence of “second on call” anaesthetist wherever possible allows some cover for novice obstetric anaesthetists. 6 patients a week are done on elective CS lists. There is no way to mitigate currently for our increasing elective work stream which is mixed with emergency work.

Exception Reporting Tool

Recommendation Number	5.10 Consider the introduction of smoking cessation leads to strengthen their approach.
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	All women are offered CO monitoring in pregnancy. All community midwives and antenatal outpatient staff have access to CO monitors. Automatic referrals are generated to Help Me Quit service at booking from WPAS. The public health midwife has worked with the clinical teams toward the offer of NRT for women who smoke. The public health midwife has worked with public health to prepare a business case to be submitted to service group operational management meeting for consideration of MAMMS project. This business case is in competition with many other submissions for public health funding.
How will we evidence that we are meeting this recommendation?	Monitoring of CO recordings is undertaken by documentation audit annually. Referral and uptake rates to Help Me Quit are monitored by the public health midwife.
How do we know that these are effective?	SBUHB will see an increase in smoking cessation rates.
What further action do we need to take?	SBUHB need improved data capture regarding quit rates. Support is required for the business case for MAMMS project.
Who and by when?	Public Health Midwife Deputy Head of Midwifery July 2022
What resource or support do we need?	Public health agreement to fund MAMMS project.
How will we mitigate risk in the short-term?	SBUHB will continue with current smoking cessation strategy supporting women as described above.

Exception Reporting Tool

Recommendation Number	5.11 Consider working with Public Health Wales to further promote healthier living and lifestyles.
Area assessed as amber / red	AMBER
What is currently in place to meet this recommendation?	SBUHB employ a public health midwife who leads on public health initiatives including smoking cessation, diet and lifestyle, vaccination. The public health midwife has developed a wide network of partners including Public Health Wales. Also developed a work plan for public health initiatives. The public health midwife work plan is robust however, consider further involvement of Public Health Wales would be of benefit.
How will we evidence that we are meeting this recommendation?	SBUHB will see an increase in smoking cessation. Women will make healthy choices in relation to diet and exercise. SBUHB will report high levels of vaccination for flu, pertussis and COVID.
How do we know that these are effective?	SBUHB will see an increase in smoking cessation. Women will make healthy choices in relation to diet and exercise. SBUHB will report high levels of vaccination for flu, pertussis and COVID.
What further action do we need to take?	SBUHB require greater engagement from Public Health Wales for promotion of healthier lives.
Who and by when?	Public Health Midwife Deputy Head of Midwifery Public Health Wales March 2023
What resource or support do we need?	Support from Public Health Wales to take forward initiatives planned and proposed by public health midwife.
How will we mitigate risk in the short-term?	The public health midwife has a robust work plan toward achievement of key goals. The public health midwife will continue to audit the effectiveness of her plan and report into maternity strategy forum and exception report to maternity quality and safety group.