Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Quality and Patient Safety Academy		
Date	26.07.23	Agenda item	QA.7.23.10.1

MATERNITY AND NEONATAL (PERINATAL) SERVICES UPDATE – JUNE 2023

Presented by	Sara Hollins, Director of Midwifery	
Author	Sara Hollins, Director of Midwifery	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To provide the Quality and Patient Safety Academy and Trust Board with a monthly update on progress with the Maternity Improvement Plan, including CQC Action Plan, monthly stillbirth position and continuity of carer. Ensures that key elements of the Perinatal Quality Surveillance Model are visible and transparent at Trust Board level.	
Key control	Identify if the paper is a key control for the Board Assurance Framework	
Action required	For assurance	
Previously discussed at/ informed by		
Previously approved at:	**Academy/Group**	**Date**

Key Options, Issues and Risks

The December 2020, NHS publication ' Implementing a revised perinatal quality surveillance model' set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety.

The requirements to strengthen and optimise Board oversight for maternity and neonatal safety includes:

- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.
- That all maternity Serious Incidents (SIs) are shared with Trust Boards and the Local Maternity System (LMS), in addition to reporting as required to Healthcare Safety Investigation Branch (HSIB).
- To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at Board meetings.

This paper is prepared on a monthly basis and presented to Quality and Patient Safety Academy as a Committee of the Board, holding delegated authority to interrogate, challenge and approve/agree maternity and neonatal information and recommendations, including papers and reports prepared to demonstrate compliance with the NHS Resolution Maternity Incentive Scheme (MIS). A separate summary paper is presented to Trust Board providing assurance that Quality and Patient Safety Academy has executed its delegated authority.

The monthly maternity and neonatal services report presented to Quality and Patient Safety Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Academy on behalf of Board has an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services.

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The format of this report supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible and transparent at Trust Board level.

The monthly paper also serves as the main mechanism for Quality and Patient Safety Academy on behalf of Trust Board to have oversight of key elements of the NHS Resolution Maternity Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool reports, quarterly Avoiding Term Admissions Into Neonatal Units (ATAIN) reports, and monthly midwifery and obstetric staffing updates.

This paper is shared with the Maternity Leads at Bradford District and Craven, Health Care Partnership and feeds into the West Yorkshire and Harrogate (WY&H) Local Maternity and Neonatal System (LMNS) perinatal quality oversight groups.

Analysis

This paper provides Quality and Patient Safety Academy on behalf of Trust Board with information and data regarding perinatal quality and safety, enabling Academy members to rapidly identify any emerging concerns, trends or issues.

It is open and transparent and provides information and evidence of compliance with national maternity reports and schemes.

The overarching maternity improvement plan has been updated to include the Ockenden Assurance action plan and a sustainable Care Quality Commission (CQC) action plan.

The service presented proposed transformation plans to Board of Directors in May 2020, focusing on key areas of improvement identified as necessary to reduce the stillbirth rate. The Outstanding Maternity Services Programme is now the key driver for transformation within the service and is well embedded within the culture of the unit.

Monitoring of the monthly stillbirth rate continues, with every case subject to a 72 hour review and discussion with the Executive, Non-Executive and Trust level Maternity Safety Champions. This process is well embedded, including the rapid identification and escalation of in-month ‘spikes’ in the stillbirth rate which are subject to thematic reviews and reporting of any findings and subsequent learning to Trust Board.

Recommendation

- Quality and Patient Safety Academy is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, June 2023.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 2, including the description of incidents and any immediate actions/lessons

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learned.

- Review of Yorkshire and Humber regional data for cases of Hypoxic Ischaemic Encephalopathy (HIE) occurring in 2022/23, suggests that BTHFT is an outlier. Academy is asked to note that multidisciplinary team 'deep dive' will take place in July and the findings shared with September Academy.
- There are 8 ongoing maternity SIs/Level 1 investigations, 4 HSIB and 4 Trust level.
- Appendices 1a and 1b are copies of a completed level 1 investigation and completed HSIB investigation including recommendations for Quality and Patient Safety Academy's information.
- Quality and Patient Safety Academy is asked to note that there was 1 HSIB reportable Serious Incidents (SI) declared in June.
- Academy is asked to note appendix 2, Perinatal Mortality Review Tool, Quarterly report, including learning. This is required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme, Year 5. Academy is asked to note that the service has either met, or is within timeframe to meet the standard.
- Quality and Patient Safety Academy is asked to note appendix 5, Maternity Training compliance report including the improvement actions for the 8 areas falling below 80%.
- Academy is also informed that the CSU has an emerging concern regarding the Core Competency Framework training requirements and the significant increase required for each midwife to meet compliance. This is to be discussed with the Chief Nurse regarding next steps.

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for our patients, delivered with kindness			g			
To deliver our financial plan and key performance targets			g			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					

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Explanation of variance from Board of Directors Agreed General risk appetite (G)	

Benchmarking implications (see section 4 for details)	**Yes**	**No**	**N/A**
Is there Model Hospital data relevant to the content of this paper?	☒	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☒	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☒	☐	☐

Risk Implications (see section 5 for details)	**Yes**	**No**
High Level Risk Register and / or Board Assurance Framework Amendments	☐	☐
Quality implications	☒	☐
Resource implications	☐	☒
Legal/regulatory implications	☐	☒
Equality Diversity and Inclusion implications	☒	☐
Performance Implications	☐	☒

Regulation, Legislation and Compliance relevance
NHS England: (please tick those that are relevant) ☒Risk Assessment Framework ☒Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: Choose an item.
Care Quality Commission Fundamental Standard: Choose an item.
NHS England Effective Use of Resources: Choose an item.
Other (please state):

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality &Patient Safety	Finance & Performance	Other (please state)
☐	☒	☐	☐

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1 PURPOSE/ AIM

The purpose of this paper is to provide a monthly update on progress with the Maternity Improvement Plan, including the Care Quality Committee (CQC) Action Plan, the monthly stillbirth position and continuity of carer. It also provides an update on the Outstanding Maternity Service quality improvement/transformation programme, intended to improve key areas of the service and support the journey towards being outstanding.

The December 2020, NHS publication 'Implementing a revised perinatal quality surveillance model' set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety.

The requirements to strengthen and optimise Board oversight for maternity and neonatal safety include:

- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.
- That all maternity Serious Incidents (SIs) are shared with the Trust Board and the LMS, in addition to reporting as required to HSIB.
- To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at Board meetings.

This paper is prepared on a monthly basis and presented to Quality and Patient Safety Academy as a Committee of the Board, holding delegated authority to interrogate, challenge and approve/agree maternity and neonatal information and recommendations, including papers and reports prepared to demonstrate compliance with the NHS Resolution Maternity Incentive Scheme (MIS). A separate summary paper is presented to Trust Board providing assurance that Quality and Patient Safety Academy has executed its delegated authority.

The monthly maternity and neonatal services report presented to Quality and Patient Safety Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Academy on behalf of Board has an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services.

The format of this report supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible and transparent at Trust Board level.

The monthly paper also serves as the main mechanism for Quality and Patient Safety Academy on behalf of Trust Board to have oversight of key elements of the NHS Resolution Maternity Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool reports, quarterly Avoiding Term

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Admissions Into Neonatal Units (ATAIN) reports, and monthly midwifery and obstetric staffing updates.

This paper is shared with the Maternity Leads at Bradford District and Craven, Health Care Partnership and feeds into the West Yorkshire and Harrogate (WY&H) Local Maternity and Neonatal System (LMNS) perinatal quality oversight groups.

2 BACKGROUND/CONTEXT

Ockenden Report of Maternity Services at Shrewsbury and Telford NHS Trust, Ockenden Assurance Plan and East Kent Report

The Ockenden report of Maternity Services at Shrewsbury and Telford NHS Trust was published on 10 December 2020 followed by the 2nd Report on 30 March 2022. The reports looked at maternal and neonatal harms occurring between 2000-2019 at Shrewsbury and Telford Hospital and resulted in 27 recommendations for the named Trust with a further 7 early recommendations, referred to as immediate and essential actions (IAE's) to be implemented by all NHS Maternity services. A further 15 IAE's were included in the 2nd report.

The service had its Regional Maternity Team assurance visit on 29 June 2022. The full report was received in August 2022 and reflects the initial feedback presentation shared with Board in the July 2022 update paper. An Ockenden Assurance Action Plan update is to be shared with West Yorkshire and Harrogate (WY&H) Local Maternity and Neonatal System (LMNS) in January.

The services outstanding compliance action is regarding the lack of ability to audit of the use of the Personalised Care Plan (PCP).

The PCP is currently offered in paper format only and is held by the woman and not the service; this makes it impossible to robustly audit. The service is working towards the use of the Patient Portal, which will give women access to complete their individual PCP on line, and will be accessible to midwives and obstetricians to view and input as required. The service and IT colleagues are working closely to resolve the situation and are exploring the available options, none of which appear to meet the full PCP requirement. A solution continues to be sought by the service and IT colleagues. There are no updates on progress to share during June. However, this was escalated to Trust Board in May 2023 following review of the recently published Three Year plan and the potential compliance risks associated with digital capability. The recommendation was for a position paper to be presented to Executive Team Meeting (ETM) in June, outlining the options available. This was completed and the plan is for the service to see a demonstration of the 'Zesty' option before potentially proceeding with this solution.

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East Kent Report:

The Kirkup Report, 'Reading the signals: Maternity and neonatal services in East Kent- the Report of the Independent Investigation' was published on 19 0ctober 2022 examining failings in maternity and neonatal services at The Queen The Queen Mother Hospital (QEQM) and the William Harvey Hospital (WHH), part of East Kent Hospitals University NHS Foundation Trust, between 2009 and 2020.

A precis of the report and actions for the maternity service and Trust Board was presented to November 2022 Board. There have been no Regional or National updates or requests for information/local action since the report was published.

NHS England published the 'Three year delivery plan for maternity and neonatal services' at the end of March. The purpose of the three year plan is to improve the safety and quality of maternity and neonatal services, incorporating recommendations from key reports such as Ockenden and Kirkup.

A summary of the plan was presented to Executive Team Meeting (ETM) and Trust Board in May, including the risks associated with delivering the plan. This includes a digital solution for the PCP and women being able to access and input into their digital records as described above.

Perinatal Cultural Leadership Programme

Following a reginal nomination process, 4 members of the senior maternity and neonatal (perinatal) leadership teams have embarked on a 6 month programme intended to support a positive and nurturing safety cultural in perinatal services.

The aim is to support all perinatal teams in England to create and craft the conditions for a positive culture of openness, safety and continuous improvement. Reviews of maternity services have highlighted cultural and leadership issues as a common theme that contributes to underlying patient safety failures across organisations. Strong and positive leadership creates effective teamwork and therefore improved clinical care.

The programme will focus on the perinatal quadrumvirate, or 'quad', groups of senior leaders in perinatal services (typically including senior midwifery, obstetric, neonatal and operational representation). Co-designed by frontline teams and leadership experts, this programme will bring together senior leaders from across maternity and neonatal services to improve the quality, safety and experience of care for women.

The programme commenced in January with the Director of Midwifery, Deputy Clinical Director for Obstetrics and Gynaecology, Consultant Neonatologist and General Manager for Women's CSU, attending a 3 day course in London.

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The 'quad' have continued to attend a series of individual action learning sets (ALS), focusing on their individual leadership styles and learning needs, in addition to a further session in London.

The SCORE culture survey was launched at the end of March and closed in May.

The quad team have a series of meetings planned with an external company who will support the analysis of the survey results and the associated actions required. This work continues and review of the survey results continues.

Midwifery Staffing

Safety Action 9 of the Maternity Incentive Scheme, Year 4, requires that there is evidence that discussions regarding safety intelligence, including minimum staffing in maternity services are taking place at Board level.

The most recent bi-annual midwifery staffing paper was presented to People Academy and Board in May, as an appendix to the overarching Nursing and Midwifery staffing paper.

The recommendations, including that the full Birth Rate Plus tool is recommissioned for autumn 2023, in line with the 3 yearly cycle national recommendation, were approved. This will ensure that there is an up to date, accurate calculation taking into account the decrease in birth rate but considering the acuity of the women and pregnant people using the service.

Based on the revised table top calculations the current vacancy against the safe staffing establishment is 20.3 WTE which includes the agreed uplift for maternity leave. There are currently 10.14 WTE midwives on maternity leave.

Achieving the safe staffing establishment continues to be our priority figure.

Current vacancy against the revised funded establishment, which includes the number of midwives required to provide Midwifery Continuity of Carer (MCoC) is 51.94 WTE.

Staffing gaps continue to be closely managed by the Bed Manager and staffing Matron of the day, utilising the amber risk assessment and escalation processes as required.

In direct response to staff safety concerns regarding staffing, the CSU applied for 'surge' rate TNR to be reinstated with immediate effect, for review at the end of July.
As yet, the CSU has not noted a positive response to the increased rate, which coincided with the pay increase awarded at the end of May.

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Obstetric Staffing

We continue to ensure a 100% consultant presence on the labour ward for 98 hours per week.

We continue to ensure safe cover of both Obstetrics and Gynaecology services during industrial actions.

We currently have 23 consultants in post, 24 posts financially approved plus a locum until September 2023. There are 4 pure Consultant Obstetricians on the Out of hours on call Obstetric rota and currently 3 pure Consultant Gynaecologists on the Gynaecology on call rota as well as colleagues who cover both (14).

We are soon to re advertise an Obstetric only substantive post (interest in Maternal Medicine).

The strain and burden on the consultant body is summarised in a risk assessment that has been escalated to the Trust Board in November 2022 and at the CBU to exec meeting in January 2023. The position is worsening with the significant build on the department general gynaecology back log.

Despite of the strain on consultant body, consultant colleagues have agreed to work above and beyond and provide extra clinical activity to increase the number of general gynaecology clinics. The GM and CD have been looking as well at agency consultant locums in the short term to help support the waiting lists for Gynaecology clinics. We have identified one suitable candidate and we are in the discussion stage to ensure that the skills required are present and appropriately utilised.

Labour ward is always covered by a consultant and there are no exceptions to report. Labour ward consultant led ward rounds (4 xs daily) and daily antenatal consultant ward rounds are embedded in the rotas (and job plans). The continuing problem of insufficient antenatal scan slots to meet the unit demands is an added burden on hot week consultant who is now asked repeatedly to re triage scan lists and find alternatives to ensure safe care.

The Acute out of hours Gynaecology on call rota (commenced 1/11/21) is in place ensuring a separate consultant is on call for Obstetrics and Gynaecology 24 hours/ day. Gynaecology ‘HOT WEEKS’ have commenced in January 2023 ensuring continuity and cover for Acute Gynaecology patients each week.

We still require 4 further consultants to contribute to the sheer volume of work and contribute to the extra sessions some of which always have to be covered as they are acute sessions. Following a job planning meeting on the 14th of March, a new rota to help

share the burden of the on calls more fairly across the consultant body is finished and will be in effect as of the 24th of April.

Registrars:-
Currently we have 4 registrars working only 80%, thereby creating a 0.8 gap to fill on the rota.
From January 2023 there are 2.3 gaps in the middle grade rota.

As of the 1st of August we will be having 4 gaps (one gap for Maternity leave, one for long term sickness, one for inter-deanery transfer and one for a trainee starting out of programme training). Out of these 4 gaps half a gap will be filled by a senior trainee returning from her leadership training course, this will leave us with 31/2 gaps till September.

From the 6st of September we will have a 1.2 gap (several trainees less than full time working hours).

We will have a further gap as of the 1st of December due to maternity leave. This leaves us with 2.2 gaps on the registrar rota.

Out of the number of registrars in post from 6th of September we will have 4 ST3 registrars that need senior cover and support with an SR or consultant present on each shift out of hours (to meet entrust ability standards set by the RCOG) until they acquire all the necessary skills.

There are 2 x staff grades + 1 clinical fellow

SHOs:-
We currently have SHO's working full time. There are currently 2 SHO gaps. We should have a full quota of 13 SHOs from August 2023.

Escalated junior locum rates have been confirmed and secured with HR until the End of June 2023 while we are in a position of having so many gaps for the existing trainees to cover. A further extension was sought in view of the ongoing gaps that will require cover for the foreseeable future.

Maternity Improvement Plan and CQC rating
The Maternity Services received an onsite inspection in January, focusing on 'Safe' and 'Well-Led' domains only.

The final report was received in May and reflects the positive improvements made and since the 2019 inspection. Whilst the overall rating remains 'Requires Improvement', the

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'Well-Led' domain has improved from 'Inadequate' to 'Good', with 'Safe' remaining as 'Requires Improvement'.

A separate update on the CQC report was presented to May QPSA and June board.

An action plan addressing the 2 'Must Do' actions and 5 'Should Do', has been returned to the CQC and presented to May QPSA, June Board and progress will be monitored through 'Women's Core Governance Group' and QPSA.

Stillbirth Position

There were 2 stillbirths in June. Details are included in Appendix 1.

Table 1 is the running total of stillbirths in 2023, including the number of cases requiring further detailed investigation, and the number of butterfly babies whose deaths were expected.

Table 1:

Stillbirths 2023			Expected deaths within total number	Further detailed investigation
Month	**Number of babies**	**Running total**	**Butterfly babies**	**Number of cases**
January	1	1	1	0
February	1	2	0	0
March	2	4	0	0
April	2	6	0	1 (HSIB)
May	5	11	1	0
June	2	13	1	0

Hypoxic Ischaemic Encephalopathy (HIE)

There was 1 baby requiring cooling for HIE in June. The baby has had a normal MRI scan but HSIB are progressing the investigation due to repetitive themes regarding HIE cases related to diabetic mothers and issues around transferring women requiring instrumental births to larger delivery rooms. The CSU are anticipating that HSIB may escalate this as a formal concern and are proactively reviewing any safety actions.

In addition, he service have reviewed the number of HIE cases reported in 2022/23 and consider that they are an outlier in comparison to other organisations within the Yorkshire and Humber. In order to understand the data and to identify any themes, trends which may require further attention, a multidisciplinary team deep dive/table top review of all cases is planned for the end of July. The findings will be presented to September Quality and Patient Safety Academy.

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Serious Incidents (SIs) and serious harms

The December 2020 Ockenden Report, independent review of Maternity services at the Shrewsbury and Telford Hospital NHS Trust, contained 7 immediate and essential actions (IAE) to improve care and safety in maternity services for all Trusts.

IAE 1: Enhanced Safety, recommends that all maternity SI reports and a summary of the key issues, must be sent to the Trust Board and the Local Maternity System (LMS).

There was 1 HSIB reportable case occurring in June and no internal SIs.

Safety Action 9 of the Maternity Incentive Scheme, Year 4, requires that there is evidence that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues, are taking place at Board level. It is anticipated that this standard will continue in the Year 5 publication.

Ongoing Maternity SIs:

Appendix 1 includes a position summary of ongoing maternity SI's. There are 2 completed reports for the attention of Quality and Patient Safety Academy and Closed Board in June appendices 1a and 1b.

There are 8 ongoing maternity SI's/Level 1 investigations, 4 HSIB and 4 Trust level.

There were 0 neonatal SIs declared in June and no ongoing neonatal SIs under investigation.

Neonatal Deaths (NND)

There was 1 NND in June. The baby was a 26 week twin born in Calderdale and transferred to Bradford for a neonatal cot.

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Please see Table 2 below:

Table 2:

NND 202			Expected deaths within total number	Further detailed investigation
Month	**Number of babies**	**Running total**	**Extreme preterm/congenital anomalies/life limiting conditions**	**Number of cases**
January	1	1	1	0
February	5	6	4	0
March	2	8	0	0
April	3	11	1	0
May	6	17	4	0
June	1	18	0	0

Perinatal Mortality Review Tool (PMRT) quarterly report:

Appendix 2 is a copy of the PMRT quarterly report, required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme, Year 5.

Quality and Patient Safety Academy is asked to note that the service has either met, or is within timeframe to meet the standard.

Improvements in the written communication regarding the provision of bereavement care and support remains a recurring learning theme. This will be addressed by the Bereavement Support Midwives. However, the Lead Bereavement Midwife is currently on maternity leave and has not yet been replaced; therefore there may be some delay in the rollout of learning in the short term.

HSIB Cases and Progress in achieving Maternity Incentive Scheme Safety Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Following the Ockenden Report, all cases referred to the Health Safety Investigation Branch (HSIB) will be declared as SIs. There was 1 case meeting the HSIB referral criteria in June.

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HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with the Trust

The implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

There were no direct requests for action made directly to the Trust in June.

Coroner Regulation 28 made directly to Trust

Again, the implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

The service can confirm that there have been no such requests to date this year.

Perinatal Bi-Monthly Safety Champion meetings

The Safety Champions met virtually at the beginning of June and reviewed the populated meeting template. The noted increase of attempted/unit diverts was agreed as an escalation to June Quality and Patient Safety Academy. This was completed. Acuity of women accessing the service and persistent staffing challenges were noted to be contributory factors. Surge TNR bank rates were reintroduced in an attempt to increase uptake of agency shifts. The impact of this will be reviewed at the end of July.

The safety champions also noted the increase in neonatal deaths in May/June and increase in stillbirths during May. Both of these issues were escalated to June QPSA, and assurance given that the cases have been reviewed as a table top exercise and no emerging themes/trends were identified.

Monthly staff feedback from Safety Champions and walk-rounds

There were no escalations to the Maternity and Neonatal Safety Champion June meeting. A 'You Said/We Did' safety feedback summary was shared with all staff in June (Appendix 3).

Outside of the meeting the CSU responded to staff concerns regarding the impact standard rate TNR is perceived to be having on the uptake of bank shifts. The surge rate has temporarily been reinstated until the end of July.

Maternity Unit Diverts

There were 3 partial unit diverts at the beginning of June recorded on the closure log including 2 consecutive days. These have been attributed to increased activity and an increase in the acuity of some of the women accessing the service, compounded by staffing levels. 10 women were affected by the divert. However, the service continued to see a high volume of women during the period of escalation.

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Table 4:

MONTH	Full Divert	Partial divert	Attempted Divert	Number of women diverted
JANUARY	0	0	0	0
FEBRUARY	0	1	0	TBC
MARCH	0	1	0	4 (no births)
APRIL	0	2	0	2
MAY	0	4	0	10
JUNE	0	3	0	10
Total	0	8	0	26

Midwifery Continuity of Carer (MCoC) Action plan

There has been no further progress on MCoC due to the ongoing focus on safe staffing. Acorn team resumed the provision of intrapartum care on 1 April and the team are reporting positive outcomes for both women and the midwifery staff providing care. This is still not achievable for Clover due to vacancy within the team. Clover continues to provide an enhanced level of antenatal and postnatal care to the vulnerable women on their caseloads, and may still receive care from a team member allocated to work in the intrapartum area.

Maternity Dashboard

Appendix 4 is a copy of the maternity dashboard including data up to May 2023.

- 3rd and 4th degree tears with assisted delivery increased to 4 cases after 2 consecutive months of 0. This is not statistically relevant.

Training Compliance

Appendix 5 is the monthly training compliance for maternity staff.

QPSA is asked to note that PROMPT training continues to be closely managed in order to meet the 90% compliance rate by November 10 2023. This is on trajectory.

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8 Competencies between 75-85%

- 1 of the competencies Dangers of Misplaced Naso Gastric tube applies to obstetrics- all non- compliant doctors have been notified and asked to complete. There are only 3 outstanding and they have been emailed again.
- 1 of the competencies Human Factors – Clinical for staff was added in July 2022 and compliance is progressively increasing and is now at 82.33% (was red in Jan 2023 now amber).
- 1 of the competencies Patient Safety Level 1- Essentials for staff was added in March 2022 and compliance is progressively increasing and is now at 84.94%.
- 1 of the competencies Safe Administration of Medicines was removed from Maternity Workshop as only required every two years. This is why compliance dropped. It is now included for all staff again on Maternity Day 1 so should increase.
- 2 of the competencies are now being managed by line managers as part of the appraisal process:

  - Fire Safety

  - Infection Prevention and Control

  A list of non-compliant staff has been sent to area managers and they have been asked to prioritise time for ESR for these individuals. All staff has also been asked to check compliance and prioritise when acuity allows.
- 1 of the competencies Moving and Handling - Level 2 - 3 Years has been targeted by the Moving and Handling lead and line managers and non-compliant staff are been booked (increased from Red to Amber since Feb 2023).
- 1 of the competencies Safeguarding Adults Level 3 only applies to staff at band 8 or above. 1 new band 8 has been appointed which has dropped compliance from 100% to 80%. This individual has completed so emailed again to ensure ESR has updated.

The Professional Development Midwife has reviewed the Maternity Incentive Scheme 5 (MIS5) and Core Competency Framework 2 (CCF2) to look at the training implications.

All midwifery staff irrespective of contracted hours will require 38hrs, equivalent to 5 days training annually to achieve the minimum CCF2 requirements. Support and obstetric staff need slightly less hours (24hrs and 30hrs respectively but much more MDT topics).

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This does not include the 13 hours a year required to meet Trust Mandatory training requirements.

The guide provides a tool to input current headcounts to calculate the annual cost and the additional WTE extra would be required to achieve CCF2 training targets, is calculated at 5 midwives, 1 Maternity Support Worker and 1 Obstetrician.

Quality and Patient Safety Academy is informed that this is an emerging concern for the CSU and will be discussed with the Chief Nurse regarding next steps.

Perinatal Quality Surveillance Model minimum data set for Trust Boards

Appendix 6 is the populated copy of the Perinatal Quality Surveillance Model minimum data set for Trust Boards. Much of the information required for presentation for Board is contained within the narrative of this report.

Service User Feedback

The Maternity and Neonatal Voices Partnership (MNVP) main meeting was held on 23 June, attended by representatives from the maternity service. There were no specific concerns raised at the meeting.

There are ongoing discussions regarding the MNVP leads attendance at core strategic maternity meetings and prioritisation of the work plan.

3 PROPOSAL

The service proposes that the Perinatal Update paper continues to be presented to Quality and Patient Safety Academy on a monthly basis with an assurance paper presented to Board bi-monthly.

This is to ensure that Trust Board receives timely information regarding perinatal quality and safety issues, in addition to quality improvement and transformation.

The service also proposes that the report will include the minimum data set described within the Perinatal Quality Surveillance Model.

Any urgent concerns emerging outside of the monthly reporting arrangements will be escalated by the Trust Level Safety Champions to the Board Level Safety Champion.

4 BENCHMARKING IMPLICATIONS

The service will continue to benchmark and monitor performance and position at both regional and national level, using the existing benchmarking tools including the Yorkshire and Humber regional maternity dashboard, MBRRACE-UK publications etc.

Continuity of Carer is monitored through the West Yorkshire and Harrogate LMS.

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5 RISK ASSESSMENT

Stillbirths and Midwifery Continuity of Carer pathways are on the maternity risk register, updated regularly and monitored through Women's Core Governance Group.

6 RECOMMENDATIONS

- Quality and Patient Safety Academy is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, June 2023.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 2, including the description of incidents and any immediate actions/lessons learned.
- Review of Yorkshire and Humber regional data for cases of Hypoxic Ischaemic Encephalopathy (HIE) occurring in 2022/23, suggests that BTHFT is an outlier. Academy is asked to note that multidisciplinary team 'deep dive' will take place in July and the findings shared with September Academy.
- There are 8 ongoing maternity SIs/Level 1 investigations, 4 HSIB and 4 Trust level.
- Appendices 1a and 1b are copies of a completed level 1 investigation and completed HSIB investigation including recommendations for Quality and Patient Safety Academy's information.
- Quality and Patient Safety Academy is asked to note that there was 1 HSIB reportable Serious Incidents (SI) declared in June.
- Academy is asked to note Appendix 2, Perinatal Mortality Review Tool, Quarterly report, including learning. This is required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme, Year 5. Academy is asked to note that the service has either met, or is within timeframe to meet the standard.
- Quality and Patient Safety Academy is asked to note appendix 5, Maternity Training compliance report including the improvement actions for the 8 areas falling below 80%.
- Academy is also informed that the CSU has an emerging concern regarding the Core Competency Framework training requirements and the significant increase required for each midwife to meet compliance. This is to be discussed with the Chief Nurse regarding next steps.

7 Appendices

- Appendix 1 - 1a and 1b - Maternity and Neonatal Harms and completed SI/HSIB reports June.
- Appendix 2 – 2a and 2b - PMRT Quarterly report.
- Appendix 3 – 'You Said/We Did' safety feedback to staff.
- Appendix 4 - Maternity Services Dashboard.
- Appendix 5 - Maternity Training Compliance report June.
- Appendix 6 - Perinatal Quality Surveillance Model minimum data set for Trust Boards.