Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.3

MATERNITY AND NEONATAL (PERINATAL) SERVICES UPDATE – SEPTEMBER 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 (QPSA) and Trust Board with a monthly update on progress with the Maternity Improvement Plan, including Care Quality Commission (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

as 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 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, September 2023.
- Quality and Patient Safety Academy is asked to note appendix 1, the Three year delivery plan for maternity and neonatal services improvement plan and associated narrative.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth

position of 4, including the description of incidents and any immediate actions/lessons learned.

- Academy is asked to note that there was 1 case of HIE reported in September.
- There were 2 neonatal deaths in September including 1 non-viable baby born with signs of life.
- Academy is informed that there were no maternal deaths in September and are asked to note the accompanying presentation which summarises maternal deaths including suicides over the last 3 years and the planned system wide learning event around maternal suicides.
- There are 6 ongoing maternity SIs/Level 1 investigations, HSIB and 2 Trust level.
- Academy is asked to note that there are no new neonatal SI's or ongoing neonatal SI's.
- There was 1 completed HSIB/Internal Serious Incident reports to share with QPSA in September.
- Quality and Patient Safety Academy is asked to note that there was 1 HSIB reportable case and 0 reportable Serious Incidents (SI) declared in September.
- Academy is asked to note appendix 3, the Quarter 2 PMRT report required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme, year 5. The report demonstrates that the service has either met, or is on target to achieve compliance with the required standard by 7 December 2023 to meet the conditions of the safety action. Appendix 3b is a copy of the learning and associated action plan.
- Academy is asked to note appendix 4, the quarterly Board level report and implementation plan for Saving Babies' Lives Care Bundle Version 3, which has had external review from LMNS and ICB representatives. The opinion is that It is anticipated that the Trust will be able to demonstrate 50% compliance in each element and 70% compliance overall across all 6 elements by this meeting.
- Academy to note that there were 8 occasions in September where the unit was assessed as needing to divert women to other organisations. This has impacted in the provision of 1:1 care in labour and the experience of some women.
- Academy is asked to acknowledge that 1:1 care in labour was again below the 90% target in August and September and the planned improvement work described. This correlates directly to ongoing staffing challenges, trigger of the escalation policy and attempts to divert women to other neighbouring organisations. There is no evidence to suggest that women not receiving 1:1 care at any point during labour incurred harm, although it is acknowledged that this would have impacted on birth experience.
- QPSA is asked to note that PROMPT training continues to be closely managed in order to meet the 90% compliance rate by the revised date of 1 December 2023.

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for our patients, delivered with kindness			g			

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.3

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 (*)					
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)
☐	☒	☐	☐

Meeting Title	Board of Directors		
Date	16 November 2023	**Agenda item**	Bo.11.23.3

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

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).

There has been a small amount of progress in relation to the PCP solution.

Shipley Community Midwifery team will be piloting 'Doctor, Doctor' an electronic PCP option, from October 2023. The team will share the PCP with women on their case load, and will utilise feedback on the functionality to decide if this is a viable option that can be rolled out across all teams. The one significant challenge with this option is that it is not an editable document, which means that a new document must be started in the event of any changes initiated by the woman and her preferences or as a result of changes to her clinical risk factors. However, it is appreciated that as options are very limited, this should not deter from piloting.

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. The three year plan has been benchmarked in September and shared with West Yorkshire and Harrogate, Local Maternity and Neonatal System, ahead of our planned assurance visit in November. Appendix 1 is a copy of the Three year delivery plan for maternity and neonatal services local improvement plan.

Compliance with the long standing Maternity Incentive Scheme 10 safety actions will support delivery of the plan in many areas. However, there are a number of areas which will prove challenging and may require Board level support.

- Achieve UNICEF accreditation- will involve a significant training input additional to the Core Competency Framework requirements.
- Progression of further Maternity Continuity of Carer teams when safe staffing achieved and sustained.
- Equality Lead within the service.
- Development of an in house equality dashboard and an improvement plan based on findings- will need support from BI and Digital colleagues.
- MNVP involvement in co-production of services - ongoing challenges with the current ICP resource available to support Bradford and Airedale.

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.

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. The quad team and additional members of the senior leadership team, met with the external survey support team on 31 August and the highlights and areas for consideration were shared.

- 41% response rate overall.
- Staff responded positively to the unit being:
    - Positive safety culture.
    - Improvement ready.
    - Providing a good work life balance.
    - Positive regarding job certainty.
    - Intention to leave was low.
    - Good opportunity for growth.
- Areas for improvement:
    - Staff rated emotional recovery related to work as low.

There was a short discussion within the group around improving emotional recovery, including learning from the access to psychology model available within the neonatal unit. The next steps will be to share the high level feedback with the wider team before commencing smaller focus groups to look at any improvement work the wider team wish us to consider.

A number of key staff received training as 'Culture Coaches' to support and facilitate conversations with staff.

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.3

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 next paper will be presented to October People Academy prior to sign off at November Board.

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 29.61 WTE which includes the agreed uplift for 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 54.03 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.

11 of the 22 newly qualified midwives (NQM) appointed in the spring will commence in post in October. Several NQM will hopefully join the service incrementally following exam board re-sit results and a number of others are delayed due to maternity leave or personal requests to delay start dates.

A further 2.34 WTE band 5/6 experienced midwives are also due to start imminently.

Obstetric Staffing

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

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.3

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. 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 have advertised an Obstetric only substantive post (interest in Maternal Medicine) on 5 occasions and no suitable candidate found hence we made a decision to advertise a 12 month fixed term locum consultant in Obstetrics and Gynaecology and awaiting closing date to short list with a plan to interview in November.

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 CSU 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 had one locum consultant for 6 weeks and that has contributed to our plan of clearing the post pandemic general gynaecology new appointments backlog in 30 weeks. Given the number of additional sessions needed to tackle the growing list of general gynaecology patients requiring review, we anticipate a further reduction in consultant cover for maternity triage (Maternity Assessment Centre). This is a recognised concern and was highlighted in the most recent CQC report.

This was shared as a concern in the most recent CSU to exec meeting with a proposal to support investing in additional staff grade doctors to support a two tear second on call rota. This will enable cover of maternity triage (MAC).

Labour ward is always covered by a consultant and there are no exceptions to report. Labour ward consultant led ward rounds (4 x 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.

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.3

Gynaecology 'HOT WEEKS' have commenced in January 2023 ensuring continuity and cover for Acute Gynaecology patients each week.
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 is in effect as of the 24th of April.

We are working on a new work force plan to assess the number of additional consultants required to contribute to the sheer volume of work.

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.

From the 6th September we 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 September we will have (4 +1) ST3 level 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 grade plus 1 clinical fellow.

SHOs:-
We currently 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 December 2023 while we are in a position of having so many gaps for the existing trainees to cover. A further discussion is planned 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

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

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.

Progress has been made in the last few months, particularly in relation to:

- Gynaecology out patients is now based on M2 rather than antenatal clinic. This has alleviated some of the footfall in the antenatal clinic waiting area which will improve the visibility of women waiting in the designated MAC area.
- Piloting the PCP in Shipley team supports the 'Should Do' recommendation around maternal risk assessments.

Stillbirth Position

There were 4 stillbirths in September. Details are included in Appendix 2.

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
July	1	14	1	0
August	1	15	0	0
September	4	19	0	1 (level 1)

Hypoxic Ischaemic Encephalopathy (HIE)

There was 1 baby diagnosed with HIE in September. See appendix 2. This case was referred to and accepted by HSIB.

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.3

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 cases occurring in September as previously discussed, 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 2 includes a position summary of ongoing maternity SIs. There is 1 completed report for the attention of Quality and Patient Safety Academy and Closed Board this month, appendix 2a.

There are 6 ongoing maternity SIs/Level 1 investigations, 4 HSIB and 2 Trust level. 1 Trust level will be closed at October Women's Quality and Safety meeting.

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

Neonatal Deaths (NND)

There were 2 neonatal deaths in September.

- 1 baby born at 21 weeks with signs of life.
- 1 baby born at 32 weeks. Presented with reduced movements, category 1 caesarean section, born in poor condition, care withdrawn soon after birth.

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.3

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
July	2	20	0	0
August	4	24	4	0
September	2	26	1	0

Maternal Deaths

There were 0 Maternal Deaths in September.

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 September.

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 September.

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.3

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 Mortality Review Tool Quarterly Update (PMRT):

Appendix 3 is the Quarter 2 PMRT report required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme, year 5. The report demonstrates that the service has either met, or is on target to achieve compliance with the required standard by 7 December 2023 to meet the conditions of the safety action.
Appendix 3a is a copy of the anonymised cases and review timeframes. Appendix 3b is a copy of the learning and associated actions.

Saving Babies' Lives Care Bundle Version 3:

Safety action 6 of the Maternity Incentive Scheme, Year 5, requires that assurance is provided to the Trust Board and the ICB, that services are on track to fully implement all 6 elements of the care bundle by March 2024.

The standard requires that two quarterly improvement discussions have been held between the ICB and the Trust, using the newly developed implementation tool.

The service can confirm that the 1st quarterly meeting was held on 4 October, and was attended by Ruth Shaw (ICB) and Debi Gibson, (LMNS). Appendix 4 is a copy of the Board Report and Implementation action plan.

The LMNS summary was positive. Progress towards increased compliance will be reviewed at the Perinatal Quality Surveillance meeting on 5th December 2023. Evidence in support of this meeting should be uploaded to the NHS Futures platform by 21st November 2023. Where detailed audit is not possible, snapshot audits can be undertaken to evidence compliance. It is anticipated that the Trust will be able to demonstrate 50% compliance in each element and 70% compliance overall across all 6 elements by this meeting

Perinatal Bi-Monthly Safety Champion meetings

There was no planned safety champion meeting in September. Next meeting is 17 October.

Monthly staff feedback from Safety Champions and walk-rounds

The September meeting had minimal attendance with 1 concern raised regarding the management of gestational diabetic women (not meeting NICE guidance). It was agreed

that this will be discussed with the Clinical Director and escalated via the bi-monthly Safety Champion route if required.

Maternity Unit Diverts

There were 8 attempted unit diverts/escalations in September recorded on the closure log. However, not all of the fields are populated in full and it is difficult to ascertain if some were attempted or partial diverts at this stage. These were all attributed to increased activity and an increase in the acuity of some of the women accessing the service, compounded by staffing levels. At least 2 women were diverted to other units for care, but this figure may be higher when all information is collected. Whilst we are unable to identify any physical harm to mothers and or babies during these episodes, there was an inability to provide 1 to 1 care in labour, which supports the ongoing rate of 1:1 care falling below 90%, identified on the maternity dashboard.

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
JULY	0	2	0	2
AUGUST	0	0	3	0
SEPTEMBER	0	TBC	TBC	TBC
Total	0	10	3	28

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.

It is worth noting that Bradford is one of the few organisations within the LMNS, which continues to provide continuity of carer, even on a limited basis. The priority remains focused on providing and sustaining safe staffing levels across the service, before increasing the number of continuity teams within the service. Bradford is not an outlier in this approach.

Quarterly meetings between the Chief Nurse, Director of Midwifery and Continuity of Carer Lead Midwife, have been reinstated from October 2023 to provide a regular progress update on work towards achieving this ambition.

Maternity Dashboard

Appendix 5 is a copy of the maternity dashboard including data up to August 2023, with some September fields partially populated.

1:1 care in labour has continued to fall below 90%. This continues to be as expected given ongoing staffing challenges and the requirement to divert services, but with limited organisations able to accept. No harm is reported as a result of failure to achieve 1:1 care. However, it is acknowledged that this impacts on the birth experience of some women. Mitigation including the redeployment of midwifery staff, is utilised but at times it remains challenging to provide 1:1 care. The inpatient ward Matron is working with teams to look at any efficiency that may improve flow of women through the unit, freeing capacity on the labour ward.

Training Compliance

Appendix 6 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% Maternity Incentive Scheme compliance rate by the revised date of 1 December 2023.

There are concerns regarding meeting the Obstetric Junior Doctor compliance rate as 22 rotated in August and are expected to attend training dates between now and 1 December, with the additional pressure of ongoing strike action. Currently, NHS Resolution remains adamant that there is no mitigation for rotating doctors and that they are included in the compliance numbers. This will be escalated via the Regional Maternity team as an area of concern.

Current training records shows 33 of 45 training compliances are within agreed target, 8 areas of training where compliance is between 75-85% and 4 with compliance below 75% (improved from 6).

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.3

4 competencies below 75%

- 1 of the competencies Fit Testing continues to drop due to the known challenges with appointments. There is no longer the option to be fit tested within maternity and staffs currently need to make an appointment with the Fit Test Clinic which is challenging due to ongoing clinical shortfalls and low volume of available appointments. This has been escalated at the Core Quality Meeting and there are investigations into availability of machine within maternity to resolve this issue. The Fit Testing lead has been emailed to ask to support a plan to target maternity staff but they're unable to offer the option to test within maternity at present. Line managers have been encouraging staff to book.
- 3 of the competencies relate to Blood Transfusion practical assessments. Do to clinical acuity it has been challenging for blood transfusion assessors to assess in practice. The Professional Development Midwife (PDM) has had assessor training and is targeting staff where acuity allows but this is a slow process as only one individual.
- Organising Receipt of Blood.
- Preparing to Administer/Administering Blood.
- Collecting Blood – It only affects 5 Gynae. Staff - Their line manager has been emailed and asked for assessment to be arranged.

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 Blood Transfusion theory (2 Year) was previously included on Maternity Workshop but discontinued in 2022 as only required every two years, this is why compliance dropped. The session is now 3 hours so too long to include on Mat Day 1. Line managers book their own staff and this has led to a small increase in compliance from 72.6% in May 2023 to 79.60% in September 2023.
- 1 of the competencies Human Factors – Clinical for staff was added in July 2022 and compliance was progressively increasing it has dropped slightly this month - line managers have been emailed and asked to target non-compliant individuals.
- 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 and has increased from 79.93% in June 2023 to 84% in September 2023.
- 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. Fire Safety has dropped slightly this month- an email has been sent to all line managers to check individuals in their area.
- 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 February 2023, now at 82.11%).
- 1 of the competencies Resuscitation - Level 2 = Adult Basic Life support does not accurately reflect our compliance as attendance at 2 sessions run in September 2023 have not been updated. The mandatory training team have been contacted to confirm they now have the registers to update. Maternity databases show that midwives, MSW and obstetric consultant compliance is greater than 90%.

Perinatal Quality Surveillance Model minimum data set for Trust Boards

Appendix 7 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

There was an in person MNVP meeting held in September. Meeting minutes are not available at this time. BTHFT maternity service feedback was provided by the Director of Midwifery. There was minimal feedback from service users or service user representatives.

The CQC Maternity Survey results were released in September. The MNVP will support the co-production of an action plan. A more detailed response will be shared in the October paper.

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.

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.3

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.

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, September 2023.
- Quality and Patient Safety Academy is asked to note appendix 1, the Three year delivery plan for maternity and neonatal services improvement plan and associated narrative.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 4, including the description of incidents and any immediate actions/lessons learned.
- Academy is asked to note that there was 1 case of HIE reported in September
- There were 2 neonatal deaths in September including 1 non-viable baby born with signs of life.
- Academy is informed that there were no maternal deaths in September and are asked to note the accompanying presentation which summarises maternal deaths including suicides over the last 3 years and the planned system wide learning event around maternal suicides.
- There are 6 ongoing maternity SIs/Level 1 investigations, HSIB and 2 Trust level.
- Academy is asked to note that there are no new neonatal SI's or ongoing neonatal SI's.
- There was 1 completed HSIB/Internal Serious Incident reports to share with QPSA in September.
- Quality and Patient Safety Academy is asked to note that there was 1 HSIB reportable case and 0 reportable Serious Incidents (SI) declared in September.
- Academy is asked to note appendix 3, the Quarter 2 PMRT report required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme, year 5. The report demonstrates that the service has either met, or is on target to achieve compliance with the required standard by 7 December 2023 to meet the conditions of the safety action. Appendix 3b is a copy of the learning and associated action plan.
- Academy is asked to note appendix 4, the quarterly Board level report and implementation plan for Saving Babies' Lives Care Bundle Version 3, which has had external review from LMNS and ICB representatives. The opinion is that it is

anticipated that the Trust will be able to demonstrate 50% compliance in each element and 70% compliance overall across all 6 elements by this meeting.

- Academy to note that there were 8 occasions in September where the unit was assessed as needing to divert women to other organisations. This has impacted in the provision of 1:1 care in labour and the experience of some women.
- Academy is asked to acknowledge that 1:1 care in labour was again below the 90% target in August and September and the planned improvement work described. This correlates directly to ongoing staffing challenges, trigger of the escalation policy and attempts to divert women to other neighbouring organisations. There is no evidence to suggest that women not receiving 1:1 care at any point during labour incurred harm, although it is acknowledged that this would have impacted on birth experience.

QPSA is asked to note that PROMPT training continues to be closely managed in order to meet the 90% compliance rate by the revised date of 1 December 2023.

7 Appendices

- Appendix 1 - Three year delivery plan for maternity and neonatal services improvement plan.
- Appendix 2 and 2a - Maternity and Neonatal Harms September and completed investigation report including learning.
- Appendix 3, 3a, 3b - PMRT Quarter 2 report and associated learning.
- Appendix 4 - Saving Babies' Lives Quarterly Board report.
- Appendix 5 - Maternity Services Dashboard July 2023.
- Appendix 6 - Maternity Training Compliance report August.
- Appendix 7 - Perinatal Quality Surveillance Model minimum data set for Trust Boards.