Bradford Teaching Hospitals
NHS Foundation Trust

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

MATERNITY AND NEONATAL (PERINATAL) SERVICES UPDATE – AUGUST 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, August 2023.
- QPSA to note the initial narrative headlines from the SCORE cultural survey and description of next steps.
- Academy is asked to note that the Perinatal Leadership Quad joined the August bi-

monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.

- 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.
- There are 7 ongoing maternity SIs/Level 1 investigations, 4 HSIB and 3 Trust level.
- There are no completed HSIB/Internal Serious Incident reports to share with QPSA in August.
- Quality and Patient Safety Academy is asked to note that there 0 reportable Serious Incidents (SI) declared in August.
- Academy is asked to note that there will be a system wide thematic review of 4 indirect maternal deaths by suicide, and 1 attempted suicide occurring in 2020-2023. Any findings/recommendations will be shared at a future QPSA meeting.
- Academy to note that there were 3 occasions in August where the unit was assessed as needing to divert women to other organisations, but neighbouring units were unable to accept. 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 July 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 and concerns regarding the ability to achieve junior doctor compliance amongst the group starting in August before the 1 December deadline.
- Consultant Anaesthetic compliance is currently 66.66% and there is concern that the trajectory will not be met. This has been escalated to the anaesthetic leads to address.

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					g	

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shared goals						
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)
☐	☒	☐	☐

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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 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.

The service has now seen a brief demonstration of the 'Zesty' option, but requires a more in depth review and opportunity to speak to a service already using this solution. There is no further update in August.

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. An update on progress with delivering the 3 year plan will be provided in September.

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.

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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.

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 is in the process of being prepared for 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 20.6 WTE which includes the agreed uplift for maternity leave. There are currently 10.16 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 51.7 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.

The University of Bradford are commencing a 'shortened' midwifery programme for registered nurses in March 2024, with 15 funded places available from Health Education England. The service is keen to support this programme and is engaged with the University to understand the details.

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.

A detailed update describing current gaps was shared in the July paper and will be updated in September.

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.

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Stillbirth Position

There was 1 stillbirth in August. 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
July	1	14	1	0
August	1	15	0	0

Hypoxic Ischaemic Encephalopathy (HIE)

There 0 babies requiring cooling for HIE in August.

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 were 0 HSIB reportable cases occurring in August 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.

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Ongoing Maternity SIs:
Appendix 1 includes a position summary of ongoing maternity SI's. There are 0 completed reports for the attention of Quality and Patient Safety Academy and Closed Board this month.

There are 7 ongoing maternity SI's/Level 1 investigations, 4 HSIB and 3 Trust level.

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

Neonatal Deaths (NND)

There were 4 neonatal deaths in August. 1 Butterfly Baby expected death, 1 due to extreme prematurity and 24 week twins, born in poor condition in another organisation and transferred to Bradford for level 1 cots. Both babies died shortly after arrival.

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

Maternal Deaths

There have been 2 maternal deaths since the July update was presented to QPSA. Details can be found in Appendix 1. The deaths both occurred in the postnatal period following discharge from maternity care and have been externally reported to MBRRACE-UK by the service. Both deaths sit with Bradford District Care Foundation Trust for Serious Incident investigation, with 1 being a domestic homicide review.

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A 72 hour clinical review has been completed by the service and there are no immediate concerns or learning regarding the antenatal, intrapartum and immediate postnatal care provided by the service.

The service has escalated to system leads that one of the deaths was a suspected suicide, and that there have been 4 maternal suicides in Bradford, 1 in Airedale, and an attempted maternal suicide in Bradford 2020 to 2023. 2 of these, and the attempted occurred in 2023.

As a result of this escalation, there will be a system wide, thematic review of the cases to identify any learning and improvement work. This is likely to take place in late September/October.

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 were 0 cases meeting the HSIB referral criteria in August.

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 August.

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 August meeting included representation from the Perinatal Leadership Quad as discussed earlier in this report. The group agreed that there were no safety issues requiring escalation for Board level support.

The team discussed the ATAIN report and agreed that the ATAIN review process needs a review regarding engagement/learning/sign off by DOM and both CDs. This is for further

discussion outside of the meeting but likely that ATAIN will go through the Perinatal Services Forum, and also weekly case review meetings.

Bradford maternal deaths from suicide were briefly discussed and agreed that a multi system thematic review would be of benefit.

Monthly staff feedback from Safety Champions and walk-rounds

The August meeting was well attended by maternity and neonatal colleagues, thought to be due to being held face to face. It was agreed that a hybrid approach to the meeting will continue to see if attendance is sustained.

There were no safety concerns regarding escalation to Board. The removal of 24/7 security presence from the unit was discussed, including the plans to have volunteer 'meet and greeters' in the foyer.

Maternity Unit Diverts

There were 3 attempted unit diverts in August recorded on the closure log. 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. No women were diverted to other organisations as no other Trusts within the LMNS were in a position to accept. 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 and delay in the timeliness of transfers and some elements of care which will impact on the overall experience of some service users.

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
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.

Maternity Dashboard

Appendix 2 is a copy of the maternity dashboard including data up to July 2023.

1:1 care in labour dropped to below 90% in June to 86.1%. This is not unexpected 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.

Training Compliance

Appendix 3 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.

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Consultant Anaesthetic compliance remains 66.66% and there is concern that the trajectory will not be met. This has again been escalated to the anaesthetic leads to address.

Current training records shows 35 of 45 training compliances are within agreed target (improved from 32), 8 areas of training where compliance is between 75-85% and 3 with compliance below 75% (improved from 6).

3 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 and compliance has improved slightly from 40.1% in May 23 to 42.50% in August 23.
- 2 of the competencies relate to Blood Transfusion practical assessments. Due 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.

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 23 to 75.54% in August 23.
- 1 of the competencies relate to Blood Transfusion practical assessments

- Collecting Blood – this has been targeted and compliance has increased. It only is 3 Gynae staff - their line manager has been emailed and asked to arrange.

- 1 of the competencies Human Factors – Clinical for staff was added in July 2022 and compliance is progressively increasing and is now at 82.38% (was red in Jan 2023 now amber).

- 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 23 to 83.94% in August 23.

- 2 of the competencies are now being managed by line managers as part of the appraisal process:

  - Fire Safety
  - Infection Prevention & 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. Both competencies have increased this month. (Fire: 77.89% in June 23 to 83.33% in August 23, IPC: 79.56% in June 23 to 81.16% in August 23).

- 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 being booked (increased from Red to Amber since Feb 2023, now at 79.3%).

Perinatal Quality Surveillance Model minimum data set for Trust Boards

Appendix 4 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 were no formal MNVP meetings held in August and no escalations of concern were raised via the MNVP leads or networks. The next main meeting is planned for September.

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.

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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.

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, August 2023.
- QPSA to note the initial narrative headlines from the SCORE cultural survey and description of next steps.
- Academy is asked to note that the Perinatal Leadership Quad joined the August bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.
- 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.
- There are 7 ongoing maternity SIs/Level 1 investigations, 4 HSIB and 3 Trust level.
- There are no completed HSIB/Internal Serious Incident reports to share with QPSA in August.
- Quality and Patient Safety Academy is asked to note that there 0 reportable Serious Incidents (SI) declared in August.
- Academy is asked to note that there will be a system wide thematic review of 4 indirect maternal deaths by suicide, and 1 attempted suicide occurring in 2020-2023. Any findings/recommendations will be shared at a future QPSA meeting.
- Academy to note that there were 3 occasions in August where the unit was assessed as needing to divert women to other organisations, but neighbouring units were unable to accept. 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 July 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 and concerns regarding the ability to achieve junior doctor compliance amongst the group starting in August before the 1 December deadline.
- Consultant Anaesthetic compliance is currently 66.66% and there is concern that the trajectory will not be met. This has been escalated to the anaesthetic leads to address.

7 Appendices

- Appendix 1 - Maternity and Neonatal Harms August
- Appendix 2 - Maternity Services Dashboard July 2023
- Appendix 3 - Maternity Training Compliance report August.
- Appendix 4 - Perinatal Quality Surveillance Model minimum data set for Trust Boards.