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Maternity and Neonatal (Perinatal) Services Update August/September 2023 and Update on delivery of the Three Year Plan for Maternity and Neonatal Services

Sara Hollins, Director of Midwifery

Trust Board, November 2023

Together, putting patients first

August/September Highlights

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- The August and September perinatal update papers were presented to September and October Quality and Patient Safety Academies respectively
- As a delegated authority of Trust Board, Academy received and approved the August papers, appendices and recommendations
- Academy received the August papers, appendices and recommendations, and acknowledged some assurance but did not specify any concerns
- Details of harms, including stillbirths, neonatal deaths and hypoxic ischaemic encephalopathy, and completed investigation reports including learning, were shared and are also available to Trust Closed Board for information

Discussion Points

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- The number of harms occurring in August and September, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of HSIB and SI cases were discussed
- 1 completed internal investigations/SI reports closed in September was discussed including learning and progress on actions
- The PMRT quarterly report including learning, required to demonstrate compliance with safety action 1 of the Maternity Incentive Scheme was presented to October QPSA. On target to achieve this standard.
- August and September Maternity Training Compliance was presented and discussed respectively at September and October QPSA
- October QPSA were provided with an update on progress with the Three Year Plan for Maternity and Neonatal Services, including some of the areas which may need Board level support in the future.
- A summary of maternal deaths in the last 3 years was also provided to October Academy. A system wide learning event is to be arranged focusing on maternal suicides.
- October Academy were asked to note 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 the next meeting in December.

Three Year Plan Update

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- 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 was benchmarked in September and shared with West Yorkshire and Harrogate, Local Maternity and Neonatal System, ahead of our planned assurance visit in November.
- Compliance with the long standing Maternity Incentive Scheme 10 safety actions will support delivery of the plan in many areas.
- There are a number of areas which will prove challenging and may require Board level support in the next 12 months.

Challenges

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- Achieve UNICEF accreditation- will involve a significant training input additional to the Core Competency Framework requirements
  - May require short term increase to Infant Feeding Team to deliver required training and assess staff competence prior to accreditation assessment
- Progression of further Maternity Continuity of Carer teams when safe staffing achieved and sustained
  - Building blocks in place including Trust commitment to recruit to the number of midwives required to deliver MCoC
- Equality Lead within the service
  - This would be a new role to the structure
  - Early thoughts as to this being incorporated into a Consultant Midwife role leading on Public Health and Reducing Inequalities

Challenges

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- 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
  - Meeting to discuss current provision planned for November
  - Awaiting revised national MNVP guidance

Maternal Deaths 2020-2023

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- 4 antenatal deaths
  - 1 inpatient at time of death
  - 1 early pregnancy not booked
- 5 postnatal deaths (5 weeks -7 months)
- 4 of the postnatal deaths were suicide
  - All 4 discharged from maternity care at time of death
- Ethnicity
- Consistent with latest MBRRACE report and women from Global Majority more likely to die
  - 2 White British
  - 2 Black African
  - 2 South Asian
  - 3 Eastern European

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Reporting/Investigation

- All reported to MBRRACE-UK
- 4 HSIB
  - All had MDT clinical review
- 4 BDCT SI
  - All had MDT clinical review
- 1 BTHFT and BDCT SI

Maternal Deaths 2020-2023

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- Increase in Maternal Suicide noted
  - 4 BTHFT
  - 1 ANHSFT
  - 1 attempted BTHFT
- Number of cases subject to Domestic Homicide Review
  - Home Office reluctance for separate thematic review
- Agreed system wide learning event planned to identify opportunities to better identify postnatal women at risk of suicide, particularly where there is removal of a baby or significant safeguarding issues

Request of November Board

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- Trust Board to approve that they are assured that QPSA have reviewed and discussed the contents of the August and September Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority. Appendices 1 and 2.
- Trust Board to approve that they are assured that QPSA have reviewed the Quarter 2 Perinatal Mortality Review Tool (PMRT) quarterly report including learning, required to demonstrate compliance with safety action 1 of the Maternity Incentive Scheme as a committee of the Board with delegated authority.
- Closed Trust Board to note appendices 3 and 4 describing the stillbirths, HIE and neonatal deaths occurring in August and September 2023 and both newly reported and ongoing investigations
- Trust Board to acknowledge that Appendix 4a, completed internal incident report including learning, was shared with October QPSA and is available for the attention of Closed Board

Request of November Board

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- Trust Board to acknowledge that QPSA agreed that they were assured with the content of the papers and information presented in September and partially assured in October although no specific issues were raised, or requests for further information/clarification. Trust Board is asked to seek clarification from the Chair of QPSA, that the PMRT quarterly report was approved, as this is a compliance requirement for the Maternity Incentive Scheme, year 5.
- Trust Board to note the update on progress with delivery of the Three Year Plan.
- To note the summary of maternal deaths occurring in the last 3 years and the system wide learning event focussing on maternal suicide planned for 2024

- Further Information Required?
- Any Concerns?
- Are Board Assured by the information presented?