Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item No:**	**14.1**
Date of Meeting:	**6 September 2023**		

Title of Report:	**Maternity and Neonatal Safety Report Quarter 1 2023/24**
Board Sponsor:	**Antonia Lynch, Chief Nurse**
Author(s):	**Zita Martinez, Director of Midwifery**
Appendices	**Appendix 1.0 Insights report** **Appendix 2.0 Transitional and ATAIN Audit report**

1. Executive Summary of the Report

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety. The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) and Board of Directors of present and/or emerging safety concerns.

The Trust declared full compliance with Year 4 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) in January 2023. MIS year 5 was launched during Q1 of 23/24, the service is evaluating the current position of compliance. Progress towards achievement will be reported in the coming quarters.

During Q1 of 23/24 there was a total of 1 perinatal death, the death was not supported for review via the Perinatal Mortality Review Tool (PMRT). There is currently one outstanding PMRT action relating to an Electronic Patient Record change request which is on-going.

One new referral was made to the Healthcare Safety Investigation Branch (HSIB) during Q1, which has been accepted for review. Full details are within this report.

This report outlines the Trust's current position for compliance with the 15 Immediate and Essential Actions (IEA) within the final Ockenden report of 2022. Work continues towards continued progression and completion of all actions.

Staffing levels are improving, the service has a strong retention and recruitment programme with a 100% Band 5 retention rate. The Clinical Facilitation Team has been extended to on boarding of the international midwifery recruits. The first three recruits joined the Trust during Q1 of 23/24. In June, the Midwifery Retention Team was awarded the Trust Team of the month award.

Continuity of Carer remain suspended except for the team caring for the most vulnerable families. The Homebirth and Community birth services in Chippenham recommenced full restoration of birth options to families. A homebirth lead midwife has been recruited to develop a dedicated home birth team. During Q1 there have been 65 community births of which 17 births were in Chippenham, 35 in Frome and 13 home births. The Director of Midwifery is leading engagement sessions to review models of care for community births.

Funding has been secured to create a Day Assessment Unit and Maternity Triage Unit; estate work is anticipated to commence in Q3 of 23/24.

Appendix 1 of this report contains the maternity and neonates 'Insights Report'. The East

Kent 'Reading the Signals', published in 2022 into failings within maternity services identified that 'it should be possible for individual Trusts to monitor and assess whether they have a problem'. Failure to listen and recognise the wider experience of staff and families was identified within the report as a contributor to poor care, experience and clinical outcomes. This report aims to collate the wide, and varied insights into maternity and neonatal services for cross correlation, thematic analysis, key areas of improvement and learning.

Appendix 2 contains the full Avoiding Term Admissions into Neonatal Units (ATAIN) report for Q1 of 23/24. During Q1 the ATAIN review meeting group identified 2 cases of avoidable admissions. Full details are within this report.

2.	**Recommendations (Note, Approve, Discuss)**
Discuss.	

3.	**Legal / Regulatory Implications**
It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).	

4.	**Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)**

In Q1, Maternity and Neonatal services presented 1 new risk assessment which was approved for the risk register. 'RUH Maternity and Neonatal Risk Register assessment for the provision of maternity care to birthing people who do not identify as a female gender'.

This risk was shared with the Local Maternity and Neonatal System (LMNS) to be featured on their risk register as a System wide issue, no current maternity digital system is able to facilitate a pregnancy for a male patient profile.

During Q1, 3 risks were closed.

1768	Maternity redesign staffing impact	4
1763	Lack of AHP support - Dietician, Psychology, OT and Physio in the Neonatal Unit (NNU)	8
2013	Lack of adequate suturing lighting in birth rooms	4

Following receipt of new information at the end of Q1 from the Neonatal Operational Delivery Network regarding funding for Neonatal Allied Health Professionals, it is anticipated that risk 1763 may be re-opened. This is subject to a repeat risk assessment which is scheduled to be carried out in July.

All open risks Maternity and Neonates are listed below.

1734	Day Assessment Unit patient safety risk – area not compliant or fit for purpose	15
1948	Obstetric ultra sound scan capacity	12
2353	Replacement of ultrasound machine	4
2359	Maternity Information System IT support/capacity	8

	2396	Obstetric theatre emergency call bells	12
	392	Obstetric and gynaecology workforce risk	15
	2417	Maternity triage	12
	2453	Lack of connectivity and IT facilities in Devizes health centre	8
	2467	Maternity workforce	12
	2481	Staff Entonox exposure in birthing environments	4
	2482	Assessment of minor and low harm Datix management in Maternity and Neonatal Division.	6
	2522	The Provision of maternity care to birthing people who do not identify as a female gender	8
	2483	Expiration of Maternity and Neonatal staff resources and guidelines	12

5.	**Resources Implications (Financial / staffing)**
Compliance with the Maternity Incentive Scheme for Trusts, which has financial and safety implications for the Trust. There is a financial commitment required by the Trust to achieve full compliancy.	

6.	**Equality and Diversity**
Equality and Diversity legislation is an integral component to registration.	

7.	**References to previous reports**
Previous monthly Perinatal Quality Surveillance reporting. Maternity and Neonatal Safety Report Quarter 3 - March 2023. Safer Staffing Report – August 2022. CNST Maternity Incentive Scheme – Year 4 declaration of compliance - December 2022. Maternity and Neonatal Safety Report Quarter 4 – July 2023	

8.	**Publication**
Public.	

9.	**Sustainability**
N/A	

10.	**Digital**
N/A	

Royal United Hospitals Bath
NHS Foundation Trust

MATERNITY AND NEONATAL QUARTER 4 2022/23 SAFETY REPORT

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:
Sept 2018 Inspection	Outstanding	Good	Good	Outstanding	Outstanding	Outstanding

Maternity Safety Support Programme in place	Select Y / N	**N**

	April	**May**	**June**
1.Findings of review of all perinatal deaths using the real time data monitoring tool	✓ see report	✓ see report	✓ see report
2. Findings of review of all cases eligible for referral to HSIB	✓ see report	✓ see report	✓ see report
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	✓ see report	✓ see report	✓ see report
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	✓ see report	✓ see report	✓ see report
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	✗ see report	✗ see report	✗ see report
3.Service User Voice Feedback	✓ see report	✓ see report	✓ see report
4.Staff feedback from frontline champion and walk-about	✓	✓	✓
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	✓ Nil	✓ Nil	✓ Nil
6.Coroner Reg. 28 made directly to Trust	✓ Nil	✓ Nil	✓ Nil
7.Progress in achievement of CNST 10	✓	✗ New MIS standards released 30 May 23	✗
8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment:			Work - 65% Treatment - 75% Staff Survey 2022
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours:			100% (GMC 2022)

1. REPORT OVERVIEW

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model*' (December 2020). The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) Board and the Board of Directors of present or emerging safety concerns. The information within the report reflects actions and progress in line with Ockenden and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

2. PERINATAL MORTALITY RATE

The following graphs demonstrate how Royal United Hospitals Bath NHS Foundation Trust (RUH) is performing against the national ambition. There were no stillbirths in Q1, please refer to section 2.1.

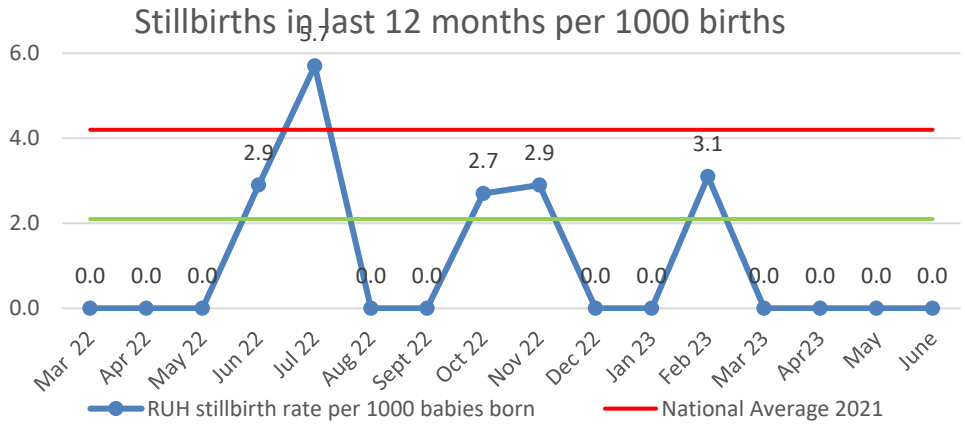


Figure 1. RUH NHS Trust Stillbirth rate per 1000 births over last 12 months

There were no reported neonatal deaths in Q1.

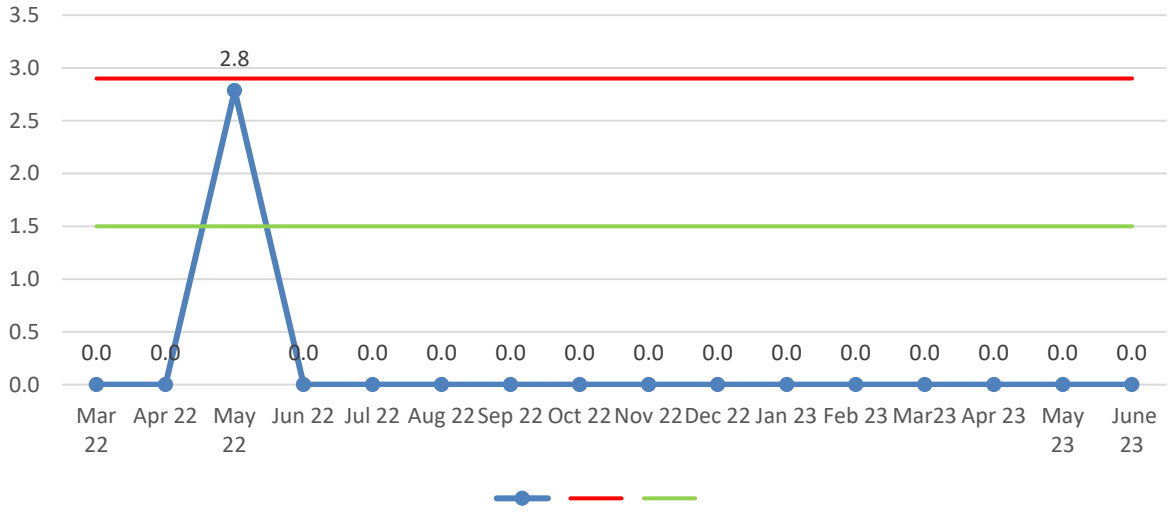


Figure 2. RUH NHS Trust Neonatal Death rate per 1000 births over last 12 months

2.1 PERINATAL MORTALITY SUMMARY FOR QUARTER 1 2023/24

2023/24 (excluding terminations for abnormalities)	Q1	Annual total 23/24
Stillbirths (>37 weeks)	0	0
Stillbirths(>24weeks-36+6weeks)	0	0
Late miscarriage (22+oweeks-23+6weeks)	0	0
Neonatal deaths	0	0
Total	**0**	**0**

Table 1. Perinatal Mortality Summary Quarter 1 2023/24

2.2 Perinatal Mortality Review Tool (PMRT) real time data monitoring tool

All perinatal deaths within the Trust have been reported using the PMRT tool since 2018. PMRT reporting is a requirement of Safety Standard 1 of the NHSR Maternity Incentive Scheme year 5.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquires-UK (MBRRACE-UK) collects data on perinatal death defined as babies born without signs of life from 22 weeks gestation to term and neonatal deaths at any gestation up to 28 days of age, excluding terminations of pregnancy.

The RUH Electronic Patient Record records all stillbirths (24 weeks or greater gestation) and neonatal deaths. Births between 22-24 weeks are pulled manually and added to the data set submitted to MBRRACE-UK and are reported in figure 1. Perinatal deaths are defined from 22 weeks and include neonatal deaths, but stillbirths are defined from 24 weeks. The rate of stillbirth and perinatal death may therefore be different.

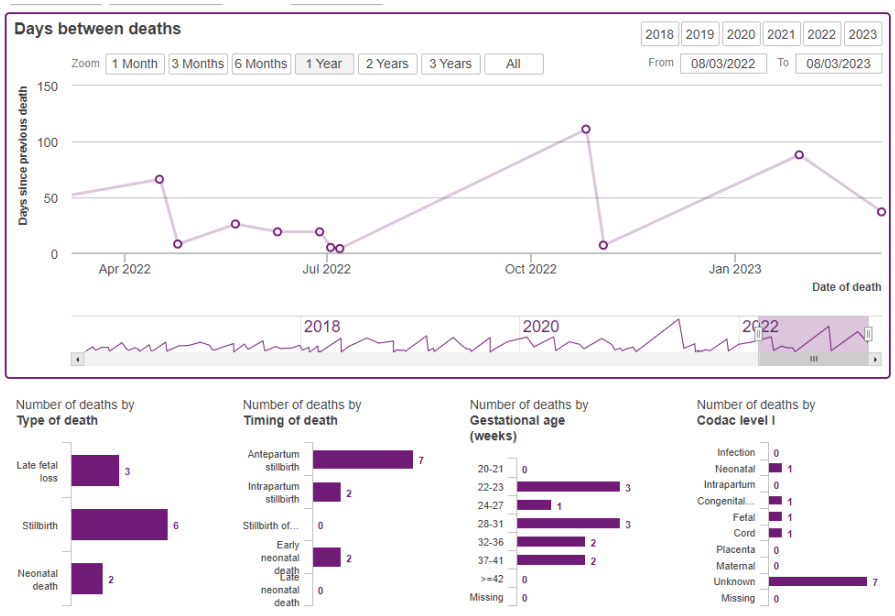


Figure 3. Reporting of RUH NHS Trust Deaths within Organisation.

There was one perinatal death in Q1 following a Medical Termination of Pregnancy this was reported to MBRRACE but was not supported for review via PMRT. Therefore, there are no published reviews via PMRT from Q1.

2.3 LEARNING FROM PMRT REVIEWS

Table 2 provides an update on the outstanding actions from reported cases in Q4 22/23 which were reviewed via PMRT. There is 1 current incomplete action which is on-going.

PMRT Action Plans Extract for Royal United Hospital Bath NHS Trust from reviews of deaths from 1/01/2023 to 30/06/2023						
Perinatal Case ID	Issue	Action plan text	Implementation text	Owner	Target date	Status
85900/1	It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	Added to checklist to improve documentation	Addition to checklist	Bereavement Lead Midwife	07/09/2023	Completed
86495/1	Parents were not asked if they are related at the booking appointment.	Digital Lead Midwife asked to request change when IT services are able to accommodate.		Digital Lead Midwife	07/07/2023	On-going
86495/1	This mother's progress in labour was not monitored on a partogram	Added to Safety Brief on Bath Birthing Centre. Ensure education to staff regarding importance of completion of partogram in labour even if fetal heartrate is not present.	Included in the content of the Bereavement study day	Bereavement Lead Midwife	31/05/2023	Completed

Table 2. Update on actions arising from Q4 22/23 PMRT reviews.

The cases from Q4 have been discussed at the PMRT meeting. The actions above were generated as incidental findings from the review process and were agreed as 'not relevant to the outcome' of the cases.

Of the PMRT cases from 22/23 aligned to the Saving Babies Lives Care bundle V2, 7.7% of cases (n=1) identified issues with the plotting of Symphysis Fundal Height Measurements to identify and appropriately manage Fetal Growth Restriction (FGR), however in this case it was not seen as causal to the outcome.

7.7% (n=1) of stillbirths were associated with reduced fetal movement management, this related to the provision of the reduced fetal movement leaflet in the mother's first language, this was not identified as causal to the outcome.

0% of the cases identified issues relating to the prevention, prediction, preparation and perinatal optimisation of pre-term birth

3. HEALTHCARE SAFETY INVESTIGATION BRANCH AND MATERNITY SERIOUS INCIDENTS

3.1 BACKGROUND

Healthcare Safety Investigation Branch (HSIB) undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

- Maternal Deaths
- Intrapartum stillbirth
- Early neonatal death
- Severe brain injury diagnosed in the first seven days of life

3.2 INVESTIGATION PROGRESS UPDATE

1 new referral was made to HSIB during Q1.

The case was a homebirth where the baby was born in poor condition requiring neonatal resuscitation at birth. The baby required transfer to a level 3 Tertiary Neonatal Intensive Care Unit for subsequent active therapeutic cooling. The baby has been identified as having MRI changes post cooling however it is not clear of the aetiology for these changes.

One HSIB report was returned in Q1.
There were two safety recommendations made to the Trust within this report. The findings from the report have been assessed for improvement and learning. HSIB identified in MI-0017511 that:

- ‘The Trust to ensure that all staff are supported to summon immediate help when they are unable to reassure themselves of a baby’s wellbeing if they are unable to hear the heart rate’
- The Trust should ensure that the investigations following an unexpected stillbirth are standardised and completed in line with national recommendations (Royal College of Obstetrics and Gynaecologists 2010).

In response to the recommendations, it has been identified that there is a lack of a Standard Operating Procedure relating to an inaudible fetal heartrate that has been previously normal within a care episode. This finding was shared within the LMNS Safety Forum and it has been recognised as an area of improvement across the System. A working party is being set up to agree key principles for the management and guidance provided to staff System wide.

The Trust Bereavement Midwife is supporting development of a 'Bereavement bloods profile' on Millennium to ensure the correct blood profiles are undertaken in the event of a perinatal death.

Table 3 identifies ongoing HSIB reviews into Q1. The outcomes of these reports will feature in future reports.

Ref	Details of Event	Date confirmed Investigation	External Notifications and Other Investigations
Ongoing			
N/A	N/A	N/A	N/A
New Referrals			
116486	Homebirth, baby born in poor condition requiring neonatal resuscitation at birth. Subsequent active therapeutic cooling and transfer to Tertiary Centre for ongoing care. MRI day 7 of life – MRI changes	10/05/2023	HSIB MI-026686 STEIS – awaiting from Central Risk Team

Table 3. HSIB referrals and ongoing investigations Quarter 1 2023/24

3.3 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable.

3.4 MATERNITY SERIOUS INCIDENTS

There were no new Serious Incidents reported during Q1.

There were 4 moderate harm events reported during Q4 which have not progressed to a Serious Incident review, all have received a local review, the multidisciplinary review team did not identify any acts or omissions in care casual to the event.

Ref	Details of Event	Review Response	External Notifications and Other Investigations
April			
115667	3/52 postnatal mother who birthed outside of the RUH was staying in Neonatal Unit (NNU) flats and became unwell – this was alerted to staff. A cardiac arrest call was made the mother transferred to Coronary Care Unit; a diagnosis of multiple pulmonary emboli (PE) was made. The mother was discharged after 3	MDT review conducted. Development of PEs deemed unavoidable from care perspective. Mother prescribed low molecular weight heparin by birth care provider; birth care provider informed of event. Incidental learning identified in relation to emergency care provided, and access into NNU parental flats. Learning being actioned and tracked via datix and Mat-Neo Action Tracker	

	days.		
115706	Baby fall from mother's lap in chair on postnatal ward. Subsequent fracture to the skull identified. Baby admitted to the NNU for observation. Currently at home with family.	MDT review conducted, risk of falls sticker in mother's notes to evidence staff discussion during the immediate postnatal period, audit 0ctober 22 indicate current compliance at 13.5% To review sticker and align to British Associate of Perinatal Medicine (BAPM) 2020 risk assessment for risk of falls. Noted signage around the ward environments could be stronger to raise awareness of the increased risk due to fatigue, sleep deprivation, reduced mobility and medications. Actioned to ward manager and leadership team midwife to begin quality improvement piece regarding parental information for the risk of baby falls in immediate postnatal period.	
May			
116544	Major Obstetric Haemorrhage (MOH) of 3034ml following a return to theatre for perineal haematoma excision and repair.	Counselled well about risks of prolonged 2nd stage, aware of risks but declined an Instrumental birth, episiotomy repaired by appropriate clinician. Co-incidental finding that oxytocin infusion not administered post-delivery, high risk of post-partum haemorrhage after prolonged 2nd stage. However blood loss was as a result of haematoma not uterine atony therefore not causal to outcome.	
June			
	Major Obstetric Haemorrhage (MOH) elective caesarean, 2 returns to theatre total WBL 5400mls. Mother transferred to Intensive Therapies Unit (ITU)	MDT review 30/06/2023. To look at the process of handover from Elective Lower Segment Caesarean Section (LSCS) to the ward – not contributory to the outcome. Care escalated in a timely manner with appropriate senior clinicians in attendance and care transferred to an appropriate setting onto ITU in response to the large blood volume lost. Consideration for radiological input. Haematology input obtained. Forward planning documented in notes.	

Table 4. Maternity and Neonatal Moderate harm Local reviews Q1.

4. CONTINUITY OF CARE

4.1 BACKGROUND

Maternity transformation sets out to support the implementation of The National Maternity Review (Better Births (2016), the NHS Long-Term Plan (2019) and the

national Maternity Transformation Plan.

4.2 PROGRESS TO DATE

Maternity Continuity of Carer (MCoC) remains paused in line with national guidance. As staffing levels have improved, the service has commenced planning to achieve the commitment to reintroduce the MCoC pathway. The Community Matron, Transformation Midwife and community teams are working together to scope how this can be achieved. Antenatal and postnatal Continuity of Carer continues to be provided where possible, with vulnerable/at risk groups and those from Black Asian and Minority Ethnic groups being prioritised.

5. OCKENDEN UPDATE

5.1 OCKENDEN FINAL REPORT UPDATE – Q1 2023-2024

The Trust is not required to submit evidence of compliance, although this is monitored at speciality level and will be included in the Perinatal Quality Surveillance Tool from Q2.

6. TRAINING COMPLIANCE FOR ALL STAFF GROUPS IN MATERNITY RELATED TO THE CORE COMPETENCY FRAMEWORK AND WIDER JOB ESSENTIAL TRAINING

6.1 SITUATION REPORT

Maternity training is specified in detail in the Maternity Training Needs Analysis. Compliance with fetal monitoring, neonatal resuscitation and multi-disciplinary training (MDT) Emergency Skills Training (PROMPT) during March of 2023 dropped to 83% (below the 90% standard) in response to a cancellation of March's PROMPT study day due to doctors in training industrial action.

During Q1 of 23/24, no training dates were cancelled. Training compliance continues to be monitored, noting the future dates for industrial action in Q2. Mandatory training dates will be paused during August of 2023 (Q2) in anticipation of optimum levels of annual leave being taken. To mitigate the risk, additional training dates have been made available during September, October, and November.

Sharing of local maternal and neonatal outcomes from serious incidents, near misses and never events are incorporated into training, and disseminated to staff in a variety of formats including: maternity newsletter, staff e-mails, staff safety briefings, patient safety 'Safety Catch' newsletter, Microsoft Teams RUH Maternity Team, case review posters with QR code links to full reports, and quality and safety whiteboards displayed in clinical areas with a 'Safety Hot Spot' of the month. Safety Hotspots are identified through service insights such as incidents, audit and, or family feedback.

A robust training trajectory has now been developed and a new monitoring and booking system is now in place to ensure current compliance is maintained and

continually improved.

The new Maternity Incentive Scheme (MIS) year five standards were released on 30 May 23. This includes the updated training core competencies standards. The services is currently assessing current compliance with 'Core Competencies version 2'.

6.2 TRAINING DATA

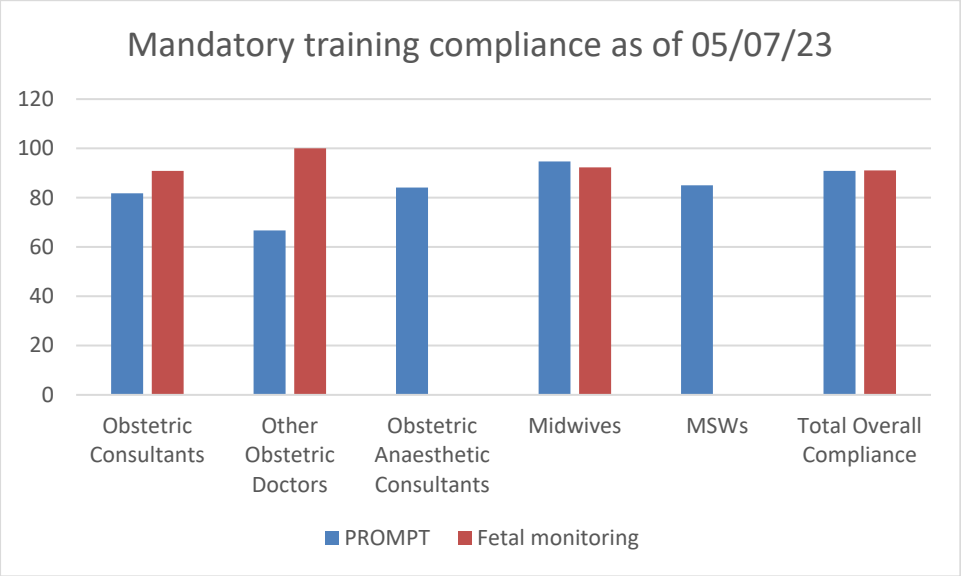
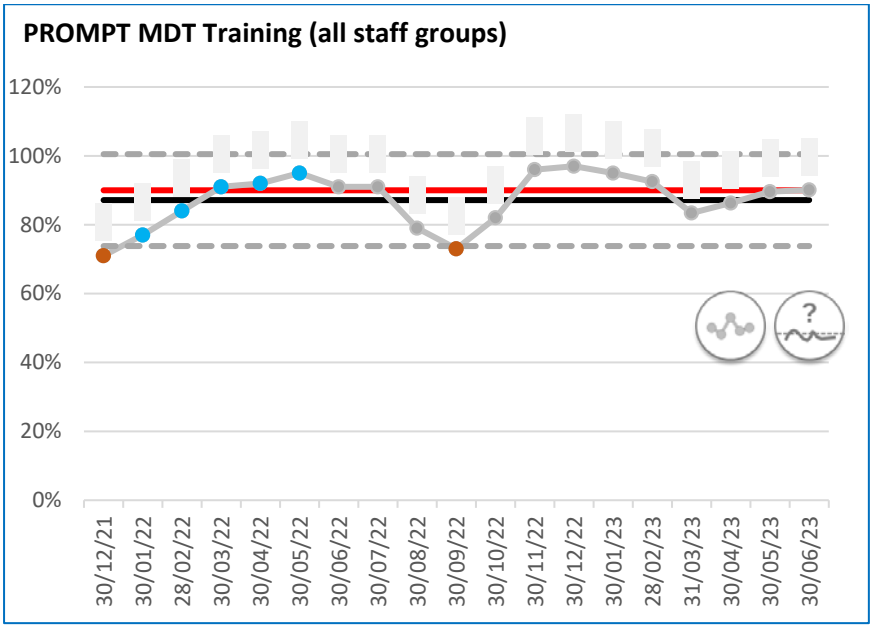


Figure 4. Prompt and fetal monitoring Training Compliance (%) by staff group Q1 2023/24



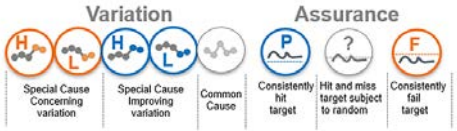
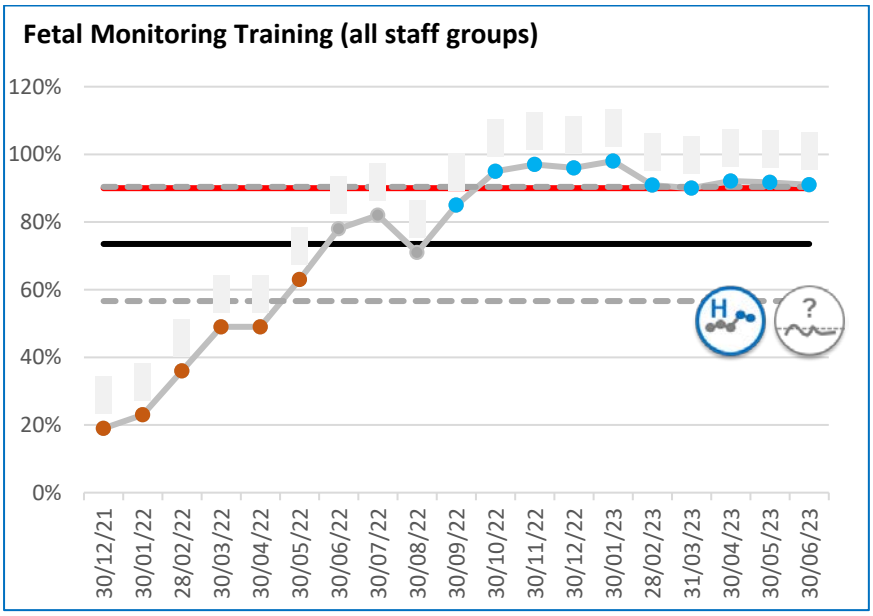


Figure 5. PROMPT compliance – all staff groups



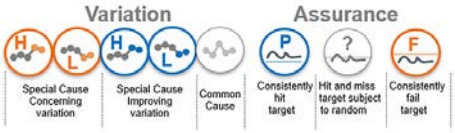


Figure 6. Fetal monitoring compliance – all Staff groups

7. BOARD LEVEL SAFETY CHAMPION MEETINGS

All staff are invited to attend monthly meetings held with the Chief Nurse and the Non-Executive Director (Board Level Safety Champions on 21 April, 18 May and 15 June). The meetings in Q1 were attended by members of the maternity and neonatal team from a range of areas, including community and specialist midwives.

Themes raised included:

- Recruitment updates, positive response to on-going recruitment to midwifery vacancies – first International midwives started in post during Q1.
- Positive response to self-rostering discussion from exit interviews feedback
- Community car permit issues
- Entonox emissions – risk assessment process in place for community services
- Discussions regarding homebirth team and models of care
- On call concerns

7.1 BOARD LEVEL SAFETY CHAMPION WALKABOUTS

The Board Safety Champions undertook walkabouts across Maternity Services: 20 April, 12 May and 5 June.

Actions from these visits are monitored via the Maternity and Neonatal Safety Champions meetings.

8. NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q1 2023/24

The Clinical Negligence Scheme for Trusts released their Safety Standards for Year 5 on 30 May 2023 including a new Saving Babies Lives Version 3. The services is currently benchmarking compliance and have scheduled planning meetings

throughout Q2 to ensure action planning is undertaken and carried out in identified areas of low or non-compliance.

Updates will be completed and shared within Maternity and Neonatal Speciality Governance meeting, Board Level Safety Champions, and in subsequent report from Q2.

9. SAVING BABIES LIVES CARE BUNDLE V3

9.1 UPDATE

Saving Babies Lives version 3 was released on 30 May 2023. The bundle forms a requirement for implementation as Safety Action 6 (SA6) of the Clinical Negligence Maternity Safety Incentive Scheme year 5.

Version 3 has incorporated a new element 'Element Six: Management of pre-existing diabetes'.

- Element 1: Reducing Smoking in Pregnancy
- Element 2: Risk assessment and surveillance for fetal growth restriction
- Element 3: Raising awareness for reduced fetal movements
- Element 4: Effective fetal monitoring during labour
- Element 5: Reducing pre-term birth
- Element 6: Management of pre-existing diabetes.

The Trust declared full compliance with all 5 elements of SBLv2 in January of 2023. The service is currently assessing current compliance for all elements of version 3, updates will be provided through Maternity Specialty Governance, and Maternity and Neonatal Safety Champion meetings.

The Trust awaits the launch of the national implementation tool to support evidence of compliance with MIS SA6. The required standard is:

1. Provide Assurance to the Trust Board and Integrated Care Board (ICB) that you are on track to fully implement all 6 elements of the SBLv3 by March 2024.
2. Hold quarterly quality Improvement discussions with the ICB, using the new national implementation tool once available.

It is of note that the percentages of compliancy within process and outcome indicator data sets have been removed from MIS SA6 but remain within the SBL v3 implementation tool.

10. SAFE MATERNITY STAFFING

10.1 MIDWIFERY STAFFING

As of 05 July 2023, the planned vs actual midwifery staffing was -11.74 whole time equivalent (WTE), (of which 1.6 WTE is maternity leave). This gives a substantive vacancy rate -10.14 WTE.

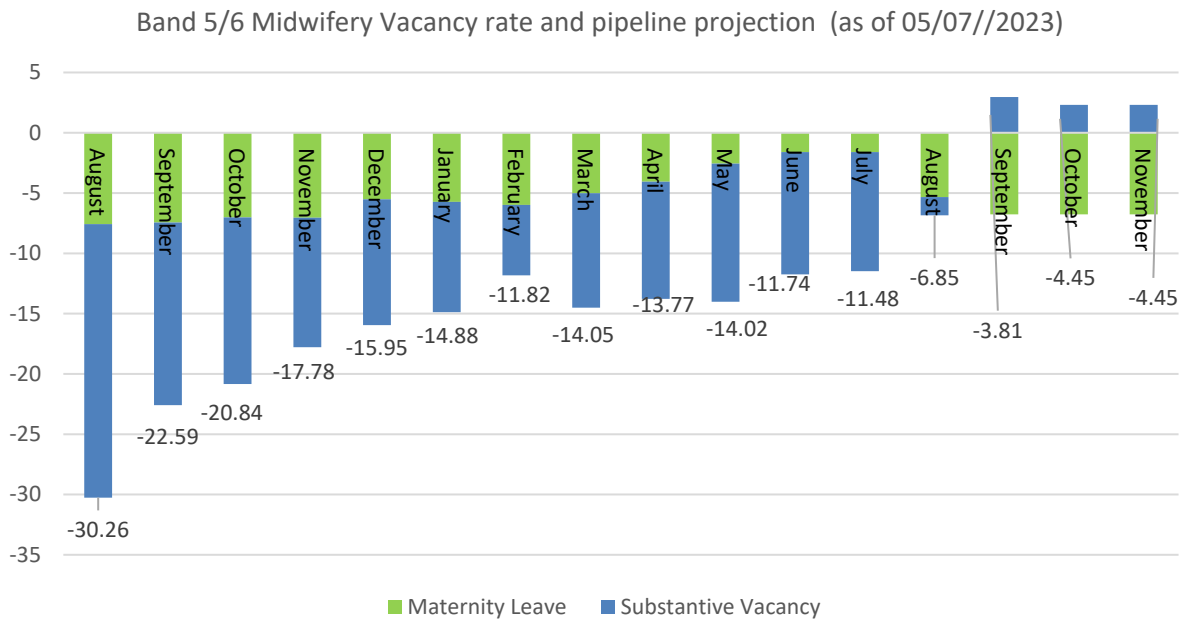


Figure 7. Band 5/6 Midwifery Workforce staffing vacancy and forecast (not including long-term sickness) 05 July 2023

Measure	Aim	Apr	May	Jun
Midwife to birth ratio	≤1:27	1:31	1:29	1:32
Midwife to birth ratio including bank	≤1:27	1:28	1:25	1:28
Supernumerary labour ward coordinator status	100%	100%	100%	100%
1:1 care not provided	0	0	0	0
Confidence factor in BirthRate+ recording	60%	83%	78%	69.4%

Table 5. Midwifery staffing safety measures

Following receipt of the Birth-rate+ report shared with board in June of 2023, the target midwife to birth ratio will be amended from Q2 23/24 to 1:24. This will lead to an anticipated decline in compliance to achieve the targeted midwife to birth ratio.

During Q1 we were joined by 3 international midwifery recruits. Their induction package has been developed by our recruitment and retention team to support their successful transition.

We have a robust staffing escalation policy, all exception reporting, analysis of utilisation of this policy, and next steps to ensuring progression towards safe staffing levels will be shared and reported on within the bi-annual board staffing paper.

10.2 OBSTETRIC STAFFING

Measure	Aim	Apr 23	May 23	June23
Consultant presence on BBC (hours/week)	≥90	98	98	98

	hours			
Consultant non-attendance (in line with RCOG guidance)	0	0	0	0
Twice daily MDT ward round	100%	100%	97%	93%

Table 6. Obstetric staffing safety measures

An Obstetric workforce review has been completed and has identified a risk within the current established funding of Obstetric Consultant posts. Currently there is a funded establishment for 9 Obstetric Consultants with a requirement for 11. The risk is mitigated by 2 locum posts which do not have recurrent funding. A risk assessment has been undertaken with action identified to mitigate the risk which will become live on the maternity risk register during Q2.

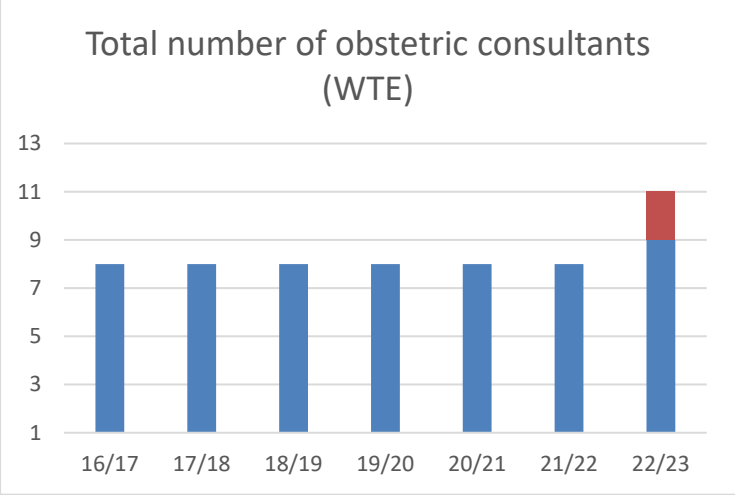


Figure 8: Total Number of Obstetric Consultants employed as of 11 July 23

11. INSIGHTS FROM SERVICE USERS AND MATERNITY VOICES PARTNERSHIP CO-PRODUCTION

11.1 COMPLAINTS/COMPLIMENTS/PATIENT ADVICE AND LIAISON SERVICE/CONTACTS

	Apr 23	May 23	Jun 23
Number of formal compliments	1	1	1
Number of Patient Advice and Liaison Service (PALS) contacts/concerns	5	2	5
Complaints	0	0	1

Table 7. Complaints and compliments Q1 23/24

One complaint was received in June, relating to the co-ordination and booking of an induction of labour, and the documentation of birthmarks at birth. The service is currently planning implementation of a neonatal body map to support staff accurately documenting any marks present at the birth. A new process for the organisation and management of the daily induction of labour list was launched during Q1 to mitigate the risk of lost information or accidental deletions.

There were no consistent commonalities identified between the PALS contacts received in Q1.
Themes from compliments related to the friendliness of midwives and staff.
.

12. SERVICE USER INSIGHTS FROM MATERNITY VOICES PARTNERSHIP PLUS

Co-production with Maternity Voices Partnership Plus (MVPP) has continued throughout Q1 on a range of antenatal information/birth options films.

13. QUALITY IMPROVEMENT PROJECTS / PROGRESS

13.1 MATERNITY TRANSFORMATION INCLUDING BETTER BIRTHS

Maternity transformation sets out to support implementation of The National Maternity Review (Better births, 2016), the NHS Long-Term Plan (2019) and the national Maternity Transformation Plan. Since 30 March 2023, all deliverables have been encompassed in the newly released Three Year Plan for Maternity and Neonatal Services (2023). Maternity and neonatal services have completed a period of review and benchmarking in relation to the deliverables in the plan.

In support of increasing clinical capacity in the acute unit, all routine planned care was relocated to community space in April 2023. Services are now taking place in Riverside and Mulberry Hub, providing care closer to home and easier to access.

A large focus of transformation work in Q1 has been related to the national requirement to implement personalised care and support plans to provide care that is personalised, shared decision making and informed consent and consistent evidence based information. In Q1 mandatory training was approved by the Nursing and Midwifery workforce group and will commence in September 2023.

Black Maternity Matters training commenced in Q1; seven members of staff are attending the programme delivered over a six month period with a focus on reducing health inequalities using Quality Improvement (QI) methods. The Transformation Lead has been appointed as QI lead for this project. There are a number of QI projects taking place including a pilot of a new translation app. Mandatory anti-racism training has also been approved and will commence for all maternity, obstetric and neonatal staff in September 2023. An Inclusion Midwife and performance audit co-ordinator have been appointed to support the health inequalities agenda.

The Perinatal Pelvic Health Service officially launched in Q1 and is now accepting referrals from professionals. The self-referral portal is in development and is due to launch in Q2, at which point the service will be fully established.

As part of the move to a new digital Electronic Patient Record (EPR) system and to meet national requirements a business case has been written for maternity and will be presented in Q2.

13.2 SAFEGUARDING

13.2.1 RAPID REVIEW IN WILTSHIRE

There was a rapid review request from the Wiltshire Safeguarding Vulnerable People Partnership (SVPP) in Q1. This review relates to the unexplained death of 5-week-old baby in the context of concerns about safe sleeping arrangements and parental neglect.

This case has however reinforced the importance of using a range of methods for sharing safe sleeping messages and the Review Group identified the value of using social media to share messages at pertinent times. For example, when parents are putting their babies down in the evening or in the run up to school holidays when families are more likely to be sleeping away from home and 'out of routine'.

13.2.2 SHARING INFORMATION REGARDING SAFEGUARDING

This is a planned pilot to gain any relevant safeguarding information about fathers of unborn babies from their General Practitioner (GP). The pilot will be for any women cared for by the Bath Lotus Team. This will involve attendance at the GP and Health Visitor (HV) meetings to share information.

13.2.3 SUDDEN UNEXPECTED DEATH IN INFANTS (SUDI) PREVENTION TASK AND FINISH GROUP

The Named Midwife has been part of a task and finish group looking at producing multi-agency guidelines and pathway for giving safe sleep advice to parents across BaNES Swindon and Wiltshire. The guidelines are currently in draft and will be shared once finalised. Going forward, there are plans to introduce a safe sleep risk assessment tool, to be used with families that have risk factors for SUDI.

13.2.4 DADS MATTER TOO

The Named Midwife has been a part of the focus group supporting this pilot in the West Wiltshire area that provides support workers for hard to engage fathers of unborn and babies under the age of one that have Children's Social Care involvement.
The programme is now a year old and there has been an evaluation carried out by Oxford Brookes. The findings are that the programme shows promise of positive impact and outcomes from the work done with these vulnerable families.
Going forward into the second year of the programme there will be no upper age limit for dads (previously was under the age of 30) and the programme will now cover the whole of Wiltshire.

14 INFANT FEEDING AND HEALTH IN PREGNANCY SPECIALIST SERVICES

14.1 INFANT FEEDING

The service continued to operate with the current funded establishment whilst awaiting response from the service review which identified additional resource to meet the Baby Friendly Initiative (BFI) requirements to meet BFI Standard 5 (Close, Loving relationships) in particular.

- 73 mother/baby pairs were offered specialist support

- 82.7% of all babies birthed were breastfed and the frenulotomy rate within tongue tie clinics was 2.8% this is below the recommended upper limit of 5% for frenulotomy rate as per NICE guidance.

A gap analysis identified a need to expand the infant feeding specialist team including the tongue-tie team, this was following identification that wait times for tongue tie assessments were increased. This is currently being recruited to.

14.2 HEALTH IN PREGNANCY

Smoking at time of Delivery (SATOD) across Wiltshire/BaNES was 4.8% which is below the national target of 6%. Smoking at time of booking also reduced slightly compared to the previous quarter to 9.4%.

Commissioned services for health promotion in pregnancy (Health In Pregnancy Service and The BLOOM Project) operated within usual staffing framework and both services were recommissioned albeit with a stepped reduction in funding from Wiltshire Council following the decommissioning of 'Maternal Healthy Me' (MHM) within the BLOOM project, which will cease to operate with effect from Q3 23/24.

The Tobacco Dependency Advisor (TDA) offered 1-1 care to women on site at the RUH (maternity inpatients and outpatients) for, on average, 15 hours per week.

15. ADVOCATING FOR EDUCATION AND QUALITY IMPROVEMENT (AEQUIP) AND PROFESSIONAL MIDWIFERY ADVOCACY THEMES

The Professional Midwifery Advocates (PMAs) support staff through the A-EQUIP model. The model consists of five PMAs, totalling 0.5 WTE which is an increase from 0.2WTE prior to the restructure of the service.

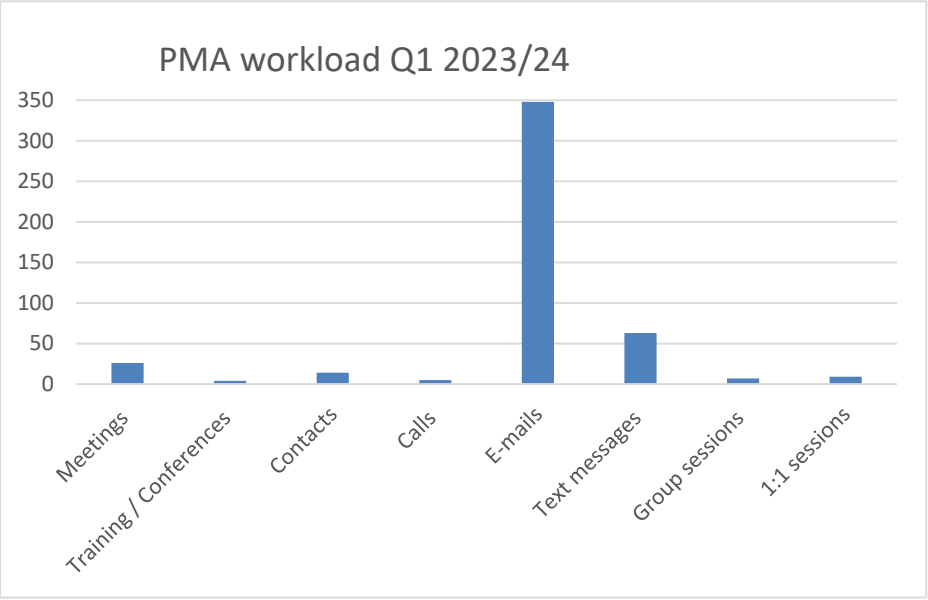


Figure 9: PMA workload

The team offer regular group reflections sessions in addition to individual support. In Q1, the themes were primarily focused on working conditions relating to community working patterns in particular ongoing concerns around the on call structure. The team

meet regularly with the senior midwifery leadership to discuss support, and action to address areas of concern.

16. AVOIDABLE ADMISSION INTO THE NEONATAL UNIT (ATAIN)

There were two recorded avoidable admission of a term babies to the Neonatal Unit in Q1 highlighted at the monthly MDT ATAIN review meetings.

One admission was identified as being avoidable, the delivery could have been expedited in response to a pathological cardiotocograph, with missed opportunities to undertake a septic screen during labour.

The second was identified as being avoidable within their neonatal care, as the baby had stabilised on admission to the Local Neonatal Unit (LNU) and did not need ongoing observations and could have immediately been reunited with its mother.

The relationship between the neonatal and midwifery teams continues to help facilitate enhanced care, particularly with plans of care and early interventions for high-risk babies e.g. assisting with thermoregulation and hypoglycaemia issues. This in turn helps to avoid admissions of the baby to the NNU.

This coordinated care was also highlighted as best practice on an occasion when the midwifery team completed all the observations on a baby as there were insufficient staff in the NNU to cover the Transitional Care Pathway (TCP) which avoided an unnecessary separation of the mother and baby.

16.1 TRANSITIONAL CARE PATHWAY

In Q1, 59% of the total number of admissions to the Neonatal Unit (97 babies*)* were cared for on the Transitional Care Pathway (TCP) for some or part of their admission. Out of this, 39% (64 babies) spent the entirety of their admission on the TCP.

No babies were identified as missed opportunity for TCP. The number of babies being cared for on the TCP is increasing each quarter, which demonstrates commitment to keeping mothers and babies together.

The TCP was staffed for 100% of shifts in Q1 which is an improvement and is reflective of the improvement on staffing levels.

Please see appendix 2 for the full Q1 ATAIN and TCP report.

17. SAFETY IMPROVEMENT PLAN

Every Trust is required to develop a bespoke Maternity Safety Improvement Plan which brings together existing and new plans to progress these projects into one place.

In August 2022, the Trust sourced an external review from NHSE to review Maternity Services at the Trust. The review highlighted areas for improvement and areas of good practice focussed around 5 key themes:

- Workforce

- Efficiency
- Safety
- Effectiveness
- Experience

Table 8 provides an update on the urgent required actions from the review.

Recommendation	Status	Update
Increase PMA team, and move to quality and safety team	Complete	PMA model in place
Recruit 3rd Maternity Matron	Complete	Commenced in February 2023
Develop maternity specific governance team	Complete	Introduced Quality and Safety Lead Midwife for Maternity Governance role. Commenced January 23
Remove CTGs from community settings	Complete	
Review pregnancy loss gestation for care on BBC. Align with National Bereavement Pathway	Complete	New standing operating procedure in place. Dependant on preferences and safe and appropriate staffing, less than 18 weeks for care under gynaecology and over 18 weeks for care on BBC under obstetrics
Appropriate pregnancy loss training for gynaecology nurses	Complete	Training for all staff including Emergency Department nurses
Swipe access in and out of BBC in-line with other maternity areas	Complete	
Review of current distribution and management of Datix	Complete	Rate of incident reporting low for staffing shortages following review. Benchmarking with LMNS peers shows similar reporting levels/trends. Updated reporting system circulated to all staff

Table 8. NHSE Action Plan – Key Areas for Action

18. RISK REGISTER

In Q1 Maternity and Neonatal, services presented one new risk assessment, which was approved for the risk register:

- 'RUH Maternity and Neonatal Risk Register Assessment for the provision of maternity care to birthing people who do not identify as a female gender'

Actions towards closing the gaps identified within the assessments, and mitigation of the risk, will be monitored through Speciality and Divisional governance with Trust Management Executive oversight to ensure the appropriate action is taken accordance with Trust framework outlined above.

All open risks within Maternity and Neonates are listed below.

During Q1 3 risks were closed.

1768	Maternity redesign staffing impact	4
1763	Lack of AHP support- Dietician, psychology, OT and Physio in the NNU	8
2013	Lack of adequate suturing lighting in birth rooms	4

Table 9: Closed risks in Q1

Following receipt of new information at the end of Q1 from the Neonatal Operational Delivery Network regarding the funding of the Neonatal Allied Health Professionals, it is anticipated that risk 1763 will be re-opened. This is subject to a repeat risk assessment which is scheduled to be carried out in July.

1734	Day Assessment Unit patient safety risk – area not compliant or fit for purpose	15
1948	Obstetric ultra sound scan capacity	12
2353	Replacement of ultrasound machine	4
2359	Maternity Information System IT support/capacity	8
2396	Obstetric theatre emergency call bells	12
392	Obstetric and gynaecology workforce risk	15
2417	Maternity triage	12
2453	Lack of connectivity and IT facilities in Devizes health centre	8
2467	Maternity workforce	12
2481	Staff Entonox exposure in birthing environments	4
2482	Assessment of minor and low harm Datix management in Maternity and Neonatal Division.	6
2522	The Provision of maternity care to birthing people who do not identify as a female gender	8
2483	Expiration of Maternity and Neonatal staff resources and guidelines	12

Table 10. Maternity and Neonatal Risk Register

19. RECOMMENDATION

The Quality Governance Committee is asked to receive and discuss the content of the report.

APPENDIX 1.

Report to:	**Quality Governance Committee**	**Agenda item No:**	
Date of Meeting:	**17 August 2023**		

Title of Report:	**Maternity and Neonatal Service Insights report Q1 23/24**
Board Sponsor:	**Antonia Lynch, Chief Nurse**
Author(s):	**Zita Martinez, Director of Midwifery**
Appendices	**Nil**

1. Executive Summary of the Report

The East Kent 'Reading the signals' report of 2022 into failings within maternity services identified that 'it should be possible for individual trusts to monitor and assess whether they have a problem.' Failure to listen and recognise the wider experience of staff and families was identified within report as contributory to poor care, experience and clinical outcomes. This report aims to collate the wide, and varied insights into maternity and neonatal services at the RUH for cross correlation, and thematic analysis to identify key areas of improvement and learning.

This report considers insights received by Maternity and Neonatal services from the findings and issues raised within the Perinatal Mortality Review Tool (PMRT), findings and recommendations from reviews undertaken by the Healthcare Safety Investigation Branch (HSIB), learning identified from internal Serious Incident investigations, review of low and no harm incident reports, the Trust's legal and claims scorecard of 2022, feedback from the 'Birth Reflections' service, complaints, compliments and Patient Advisory and Liaison Services (PALS), feedback from the Maternity and Neonatal Voices Partnership Plus, results from the Care Quality Commission family survey, staff feedback received during Safety Champion walk-around, staff feedback to the Professional Midwifery/Nurse Advocacy (PMA/PNA) service and the Trust Freedom To Speak Up Guardian (FTSU).

This report identifies areas of commonalities and current actions being undertaken to delivery improvements to the services. The identified areas will be subject to continued monitoring to ensure progression and improvement via maternity and neonatal speciality governance. Where applicable challenges, or risks, to the service have been escalated to the maternity risk register.

The following brief summaries identify the current position relating to the areas identified for potential improvement.

The RUH is part of a national pilot for the provision of a perinatal pelvic health service. A specialist perinatal pelvic health midwife commenced in post during November of 2022, a specialist pelvic health physiotherapist commenced in December of 2022.

A quality improvement initiative was launched in Q1 of 23/24 specifically focused on the provision of intermittent auscultation during the second stage of labour in response to local clinical audit findings, and initial learning from a recent HSIB referral. On 30 May 2023, the national Saving Babies Lives Care Bundle version 3 was released, which encompasses the element of 'intrapartum fetal monitoring', recommendations and standards. Progress towards full implementation of all elements and recommendations of this package will be monitored via Specialty and Divisional governance.

A case cohort review is being undertaken looking at postpartum haemorrhage and pre-disposing risk factors, identification of risk, identification of the emergency, emergency management, and any modifiable factors to inform future improvements, if required, with an aim to reduce haemorrhage post birth.

Paper personalised care and support plans (PCSP) have been developed with key stakeholders including the Maternity and Neonatal Voices Partnership (MNVP) and service users and roll out will commence in September alongside personalised care and support plan training for staff. As part of the digital transformation, the aim is to digitalise the record.

The PCSP contains information regarding decision-making and informed choices including the application of the 'BRAIN' pneumonic (Benefits, Risks, Alternatives, Intuition, Nothing). The aims to empower birthing people through shared decision making with clinicians, during pregnancy, labour, and birth.

It is pleasing that the kindness and friendliness of our staff featured through feedback.

2.	**Recommendations (Note, Approve, Discuss)**
Discuss.	

3.	**Legal / Regulatory Implications**
It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).	
4.	**Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)**
Link identified to risk 2417 'RUH Maternity and Neonatal Risk Register Assessment Expiration of Maternity and Neonatal Staff Resources and Guidelines'. (High Risk 12)	

5.	**Resources Implications (Financial / staffing)**
The presentation of legal data alongside incidents, as within this report, is described within safety action 9 of the Maternity Incentive Scheme which carries both safety and financial implications.	

6.	**Equality and Diversity**
Equality and Diversity legislation is an integral component to registration	

7.	**References to previous reports**
Previous monthly Perinatal Quality Surveillance reporting Maternity and Neonatal Safety Report Quarter 1 - July 2023 Maternity and Neonatal Insights Report, Q1 – Maternity and Neonatal Safety Champions, July 2023	

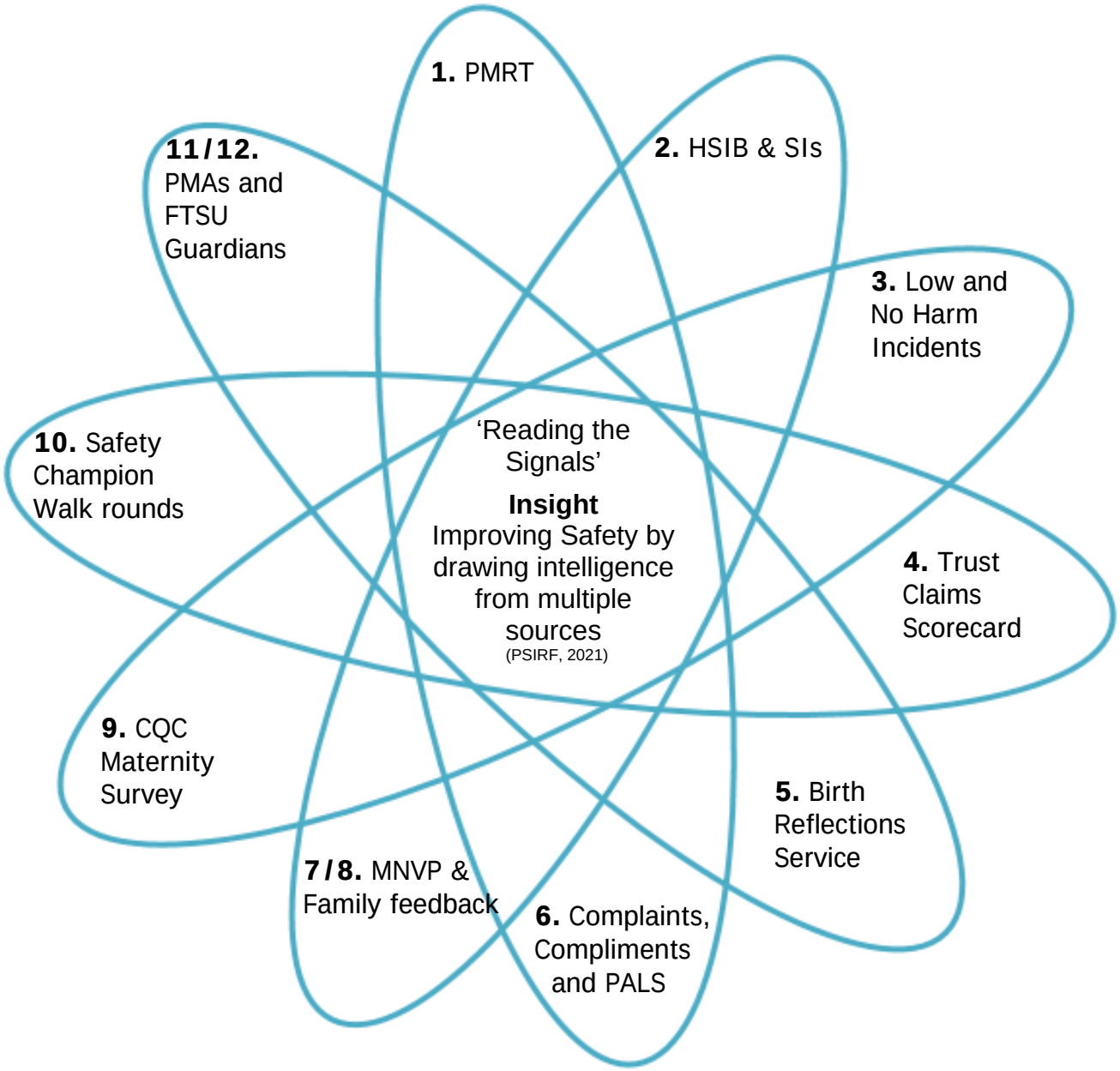
8.	**Publication**
Private	

APPENDIX ONE

REPORT OVERVIEW

'Reading the signals' report (Kirkup: 2022) from East Kent Maternity Services identified that 'it should be possible for individual trusts to monitor and assess whether they have a problem.' Failure to listen and recognise the wider experience of staff and families was identified within report as contributory to poor care, experience and clinical outcomes. It is acknowledged we have a large volume of information and feedback that can be difficult to collate to build a full picture of how our service looks, feels and provides care.

This report aims to draw upon the clinical insights across the Quarter, taking a thematic approach to identify commonalities or themes for the improvement, development and learning within our service.



1.0 PERINATAL MORTALITY REVIEW TOOLKIT (PMRT)

A retrospective review of the PMRT data for 22/23 has been undertaken to inform this first 'Insight Report' moving forwards this will be conducted Bi-annually. In 22/23, 7 deaths were eligible for a full PMRT review.

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
14	5	2	7	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
4	2	0	2	0

Table 1: PMRT outcomes

The issues have been sub categorised to enabler thematic review alongside other insights.

Category	Issue raised by PMRT	Total
Communication	2	**2**
Escalation		
Guidance		
Fetal Monitoring		
Clinical Oversight	3	**3**
Clinical Assessment	4	**4**
Triage		
Resuscitation		
Training		

Table 2: Issues identified by category

One perinatal death received care from RUH maternity services in Q1, did not require PMRT review as the baby was not born, nor died, within the RUH. No further cases were reported or reviewed via PMRT during Q1.

PMRT referrals	Total
Stillbirths <24/40	0
Late Loss >22<24	0
Neonatal Death	0
Total Perinatal Deaths	0

Table 3: PMRT referrals

2.0 HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB) AND MATERNITY SERIOUS INCIDENTS (SI)

2.1 HSIB FINDINGS

HSIB provide findings and recommendations to the Trust for service learning and improvements;

I. Findings reflect information that was discovered through analysis of the evidence collected during the investigation.
II. Safety recommendations are made to organisations when the findings identified during an investigation are considered to be contributory to the outcome.

A review of the findings and recommendations made by during 22/23 identified nine recommendations and 19 findings, some sit within two or more categories, therefore the overall totals below may differ from those above:

Category	Findings	Recommendations	Total
Communication		3	**3**
Escalation	5	3	**8**
Guidance	7	1	**8**
Fetal Monitoring	1	2	**2**
Clinical Oversight		3	**2**
Clinical Assessment	3	1	**4**
Triage	1		**1**
Resuscitation	1		**1**
Training	1	1	**2**

Table 4: Review of findings by category for 2022/23

One finalised report from HSIB during Q1 of 23/24 contained two safety recommendations; as the care episode occurred within Q3 of 22/23 these recommendations are incorporated above.

One HSIB referral was made within Q1 of 23/24; this has been declared as a Serious Incident (SI). Initial internal review of the care identified findings that have been categorised and incorporated into the table 5.

2.2 SI FINDINGS

No further internal SIs were declared in Q1.

2.3 SI CLOSURES DURING Q1

Two final reports were approved during Q1, the findings and recommendations have been categorised, some sit within two or more categories, therefore the overall totals below may differ from those above.

Category	Initial review finding/ Term Of Reference (incomplete reviews as of Q1 23)	Recommendations	Total
Communication	1	3	**4**
Escalation			
Guidance		4	**4**
Fetal Monitoring	1		**1**
Clinical Oversight			
Clinical Assessment	0	3	**3**
Triage			

Resuscitation	1		**1**
Training	1		**1**

Table 5: the findings and recommendations have been categorised

3.0 INCIDENT REPORTS

During Q1 there were 478 Datix submitted.

	Maternity	Neonatal Intensive Care Unit	Obstetrics
Apr 2023	125	12	12
May 2023	129	13	14
Jun 2023	140	15	18

Table 6: Incidents recorded on Datix by reporting speciality

Of these, the largest contributors were:

Category of report	Total
Unexpected Re-admission (inclusive of readmission of baby to ward)	60
Post-Partum Haemorrhage >1500mls	37
Perineal Tear -3rd Degree	29
Shoulder Dystocia	29
Apgar Score <7 at 5 minutes	24

Table 7: Clinical reason reported as an incident on Datix

A thematic review of neonatal re-admissions was conducted and presented to Speciality Governance in Q4. This identified problems with data capture and data quality, with significant disparity noted between the number of re-admissions recorded on the Millennium digital system and the Datix system.

This has been further complicated with staff 'work-around' developed to improve flow on the Maternity ward, postnatal ward attenders are being recorded on millennium as an admission to enable a quicker turnaround of laboratory results.

This process has caused difficulties capturing robust data for neonatal re-admissions into Maternity Services from one system. An in depth review of both our maternal re-admissions and postpartum haemorrhage rates is in progress.

4.0 TRUST CLAIMS SCORECARD - OBSTETRICS

The Trust's latest scorecard correlates open and closed claims received by the Trust legal team for 2022. We anticipate a new scorecard between July and September of 2023.

Obstetrics accounted for 18% of claims but represented 65% of the value of Trust claims. The scorecard outlines the top five injuries and top five causes resulting in legal claims because of care.

This is listed as volume of claims and value of claims.

Claims by value:

Top 5 injuries by value for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Cerebral Palsy	4	54,128,094	13,532,024	8%	45%
2	Brain Damage	4	33,960,551	8,490,138	8%	28%
3	Hypoxia	1	13,150,000	13,150,000	2%	11%
4	Not Specified	1	13,090,000	13,090,000	2%	11%
5	Renal Damage/ Failure	2	1,217,239	608,619	4%	1%
Total Top 5 injuries by Volume for Obstetrics		**12**	**115,545,884**	**9,628,824**	**24%**	**97%**

Top 5 causes by value for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Fail / Delay Treatment	9	27,435,620	3,048,402	18%	23%
2	Fail To Monitor 2nd Stg Labour	4	27,310,232	6,827,558	8%	23%
3	Fail To Make Resp To Abnrm FHR	3	20,242,379	6,747,460	6%	17%
4	Fail To Warn-Informed Consent	2	13,886,053	6,943,027	4%	12%
5	Fail To Act On Abnorm Test Res	1	13,600,000	13,600,000	2%	11%
Total Top 5 causes by Volume for Obstetrics		**19**	**102,474,284**	**5,393,383**	**37%**	**86%**

Table 8: Claims by value

Claims by Volume:

Top 5 injuries by volume for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Unnecessary Pain	11	775,997	70,545	22%	1%
2	Psychiatric/Psychological Dmge	7	479,644	68,521	14%	0%
3	Adtnl/unnecessary Operation(s)	6	627,939	104,657	12%	1%
4	Brain Damage	4	33,960,551	8,490,138	8%	28%
5	Cerebral Palsy	4	54,128,094	13,532,024	8%	45%
Total Top 5 injuries by Volume for Obstetrics		**32**	**89,972,225**	**2,811,632**	**63%**	**75%**

Top 5 causes by volume for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Fail / Delay Treatment	9	27,435,620	3,048,402	18%	23%
2	Failure/Delay Diagnosis	8	1,709,206	213,651	16%	1%
3	Intra-Op Problems	6	292,853	48,809	12%	0%
4	Foreign Body Left In Situ	4	60,437	15,109	8%	0%
5	Fail To Monitor 2nd Stg Labour	4	27,310,232	6,827,558	8%	23%
Total Top 5 causes by Volume for Obstetrics		**31**	**56,808,348**	**1,832,527**	**61%**	**48%**

Table 9: Claims by volume

5.0 QUALITATIVE FAMILY FEEDBACK DATA

Areas raised:

5. Birth Reflections
Women shared their experience of informed consent during their care feeling scared or coerced into decision making.

6. Complaints (n=1)/PALS (n=7):

- Bladder Care during care and subsequent follow up n=2

7. Maternity & Neonatal Voices Partnership (MNVP) Dec- Feb 23:
• Having to repeat history to different clinicians
• Support with breastfeeding to 'hold breast' inconsistency with breastfeeding advice
• Partners feeling ignored by sonography
• Lack of adequate meals for mothers who have 'missed meal times'
• Women feeling they have to agree to a vaginal examination
• Neonatal Care Service user engagement

8. Friends and Family forms:
Of 447 responses 4 forms identified their overall care as poor and 3 identified as very poor.

From the comments on all of the forms submitted these have been evaluated irrespective of overall experience and the sentiments have been subcategorised. Of all comments of our services the following themes were top contributors to negative sentiments:

- Timeliness n=6
- Communication n=6
- Resources n=5

Positive Feedback:

5. Birth Reflections
Positive experiences of transferring to theatre post birth with birth partners and babies.

6. Themes from compliments:

- HIPS service
- Care during an Induction of Labour (IOL)
  - Staff interactions
  – Kindness, compassion and friendliness of staff.

7. Feedback from MNVP Dec-Feb 23:
• Timely appointments
• Friendly midwives
• Midwives Supportive of decisions made to formula feed from birth
• Women choosing to birth at home felt supported in their decisions
• Explanations for medical processes clearly explained
• Good communication when a caesarean became necessary

8. Friends and Family forms:
Of the 447 response s received in Q1 397 rated their overall care experience as very good and 40 rated their care as good

From the comments on all of the forms submitted these have been evaluated irrespective of overall experience and the sentiments have been subcategorised. Of all comments of our services the following themes were top contributors to negative sentiments:

- Staff attitudes and Behaviour n=246
- Care and Treatment n=132
- Communication n=94

Table 10: Summary of family feedback

6.0 CQC SURVEYS – The 2022 Maternity CQC survey identified the following:

Table 11: CQC service user feedback

In response to these findings the service as developed an action plan as outlined in table 12.

Areas for improvement	Actions
B8 – Antenatal Care During your antenatal check-up, did your midwives or doctor appear to be aware of your medical history?	Paper personalised care plans (PCP) to mitigate time needed for procurement of new IT system. Commence PCP training for all staff Risk assessment at every contact.
C4 - Your labour and birth Were you given enough information on induction before you were induced?	Co-production of personalised care plans guideline. Co-produced guidelines and updated information leaflets which are easily accessible.
C5 - Your labour and birth of your baby Before you were induced, were you given appropriate information and advice on the risks associated with an induction of labour?	Co-production of personalised care plans. Co-produced and updated information leaflets which are easily accessible.
D7 - Postnatal care Was your partner or someone close to you able to stay with you as much as you wanted during your stay in hospital?	All visiting restrictions during COVID-19 have been lifted and partners/support person is able to stay throughout the whole hospital journey.

F14 - Care after Birth Were you given enough information about your own physical recovery after the birth?	Update discharge guidelines and information leaflet which are easily accessible. Ensure appropriate discussion at every postnatal contact. Implementation of pelvic health service.

Table 12: Action plan in response to CQC survey results

7.0 BOARD LEVEL SAFETY CHAMPION WALKABOUTS

Maternity and Neonatal Safety Champions complete monthly 'walk-around' and virtual listening events open to all with Maternity and Neonatal staff to discuss any concerns or queries they may have within the service.

The themes include:

- Staff awareness of recruitment into midwifery and progression from previous low staffing
- Staff interests in a self-rostering model
- Difficulties in car parking in community
- Concerns regarding Entonox emissions in community birthing environments
- Implementation of the home birth team and prospective models of care.

8.0 FREEDOM TO SPEAK UP GUARDIANS

No contacts have been made to the FTSU Guardians from Maternity or Neonatal Services in Q1 of 23/24.

9.0 COMMONALITIES & THEMATIC ANALYSIS 'INSIGHTS'.

Review of the above insights into RUH Maternity Services has allowed for the collation of themes and commonalities to be identified and present areas for focus, further exploration, and potential improvements.

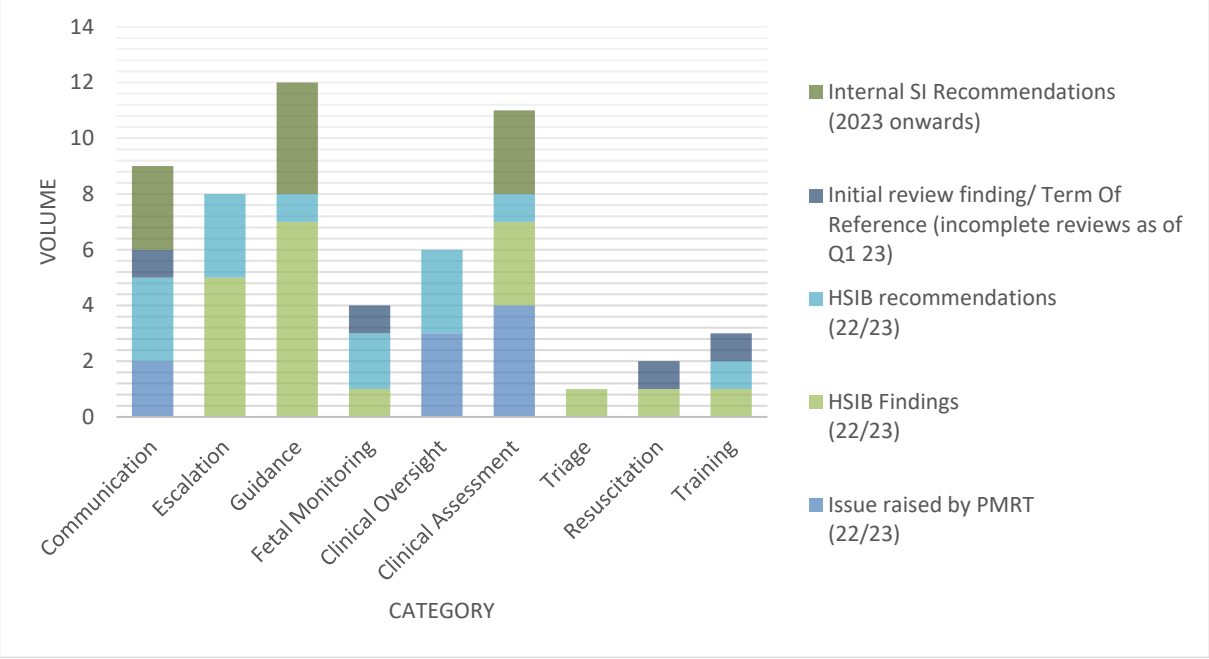


Table 13: Thematic and collated review of findings and recommendations by investigation route 22/23

Category	Issue raised by PMRT (22/23)	HSIB Findings (22/23)	HSIB recommendations (22/23)	Initial review finding/ Term Of Reference (incomplete reviews as of Q1 23)	Internal SI Recommendations (2023 onwards)	Total
Communication	2	0	3	1	3	**9**
Escalation	0	5	3	0	0	**8**
Guidance	0	7	1	0	4	**12**
Fetal Monitoring	0	1	2	1	0	**4**
Clinical Oversight	3	0	3	0	0	**6**
Clinical Assessment	4	3	1	0	3	**11**
Triage	0	1	0	0	0	**1**
Resuscitation	0	1	0	1	0	**1**
Training	0	1	1	1	0	**2**

Table 14: Identification of findings and recommendations by clinical category

When aligning the categories of recommendations and findings from case reviews in maternity and neonates from 22/23, the areas requiring improvement become clearer.

9.1 AREAS REQUIRING IMPROVEMENT

9.1.1 CLINICAL ASSESSMENT

Although identified as the top contributory category, further analysis of the individual findings, recommendations have shown a singular commonality within Symphysis Fundal Height Measurements within 2 HSIB findings and 1 PMRT issue raised. All other findings showed no commonalities.

Sub category of clinical assessment	Total n=11
Fundal Height measurements not plotted on a chart	3
Although indicated the mother was not offered infection screening for herself or her baby	1
Cabergoline was not given to supress lactation	1
The mother had a history of recurrent miscarriage but she did not receive appropriate pre-conception management	1
The Trust should ensure that the investigations following an unexpected stillbirth are standardised and completed in line with national recommendations (RCOG 2010).	1
The Mother was not reweighed at 36 weeks in line with local guidance	1
Decision for IOL	1
Provision of Intrapartum antibiotic prophylaxis	1
Mothers and their partners should be involved in all decisions regarding their care. These conversations should include a discussion of the options, risks, benefits and alternatives and should be clearly documented in the notes.	1

Table 15: Sub categories found within the clinical assessment category

We currently conduct 3 clinical audits featuring the measurement and plotting of SFH as an audit standard, these continue as part of the annual audit programme as per the Saving Babies Lives Care bundle V3. The latest audit results from Q4 of the reports for 22/23 are as follows:

	SFH measured	SFH Plotted on SFH chart	Referred for SFH abnormal	Normal Growth on USS	SGA identified
Abnormal SFH measurements x9	9/9	8/9	9/9	5	4
Normal SFH measurements x5	5/5	3/5	N/A	N/A X5 all normal SFH measurements	N/A
Totals x14	**100% 14/14**	**79% 11/14**	**100% 9/9**	**10**	**4**

Table 16: Findings of the SFH audit results for Q4 22/23

Risk Factor for SGA	Referred to Consultant Care	Aspirin indicated	SFH measured	SFH Plotted on SFH chart	Referral if SFH abnormal	Normal Growth on USS	SGA identified	Postnatal Stay of at least 3 days
Smoker x 1	1/1 (1/1 referred for smoking cessation.)	0/1(previous SGA)	1/1	0/1	N/A	0	1	yes
Twin x 2	2/2.	2/2	N/A	N/A	N/A	2	0	yes
Low Pappa x 1	1/1	1/1	1/1	1/1	1/1	1	0	yes
BMI 17 x 1	N/A	N/A	1/1	1/1	N/A	Normal SFH measurements x1	0	Yes
No Risk Factors X2	N/A	N/A	2/2	2/2	1/1 1 x N/A	1 + 1 with normal SFH measurements	0	1/2
Totals x7	**100%**	**75%(3/4)**	**100%**	**80%(4/5)**	**100%**	**4 + 2 with normal SFH measurements**	**1**	**86% (6/7)**

Table 17: Audit findings from the Small for Gestational Age audit under the 3rd centile Q4 22/23

Risk Factor	Referred to Consultant Care	Aspirin if indicated	SFH measured	SFH Plotted on SFH chart	Referred if SFH abnormal	Normal Growth on USS	SGA identified
Raised/Low BMI x 6	5/5 health in pregnancy 1 N/A 5/5 Consultant care 1N/A	6 N/A	6/6	5/6	1/1 5 N/A	5 + 1 who had no USS N/A to referral(low BMI)	0
Smoker x 13	10/10 3N/A to smoking cessation see comments	6/7 3 x SGA 4 x twins	9/9 4 N/A twin	5/9 4 N/A twin	3/3 6 N/A as normal	9	4
Previous SGA x 2	2/2	2/2	2/2	2/2	2/2	0	2
Low Pappa x 2	2/2	2/2	2/2	2/2	N/A	2	0
Twin x4	4/4	4/4	N/A	N/A	N/A	2	2
IVF	1/1	N/A	1/1	1/1	N/A	1	0
PV Bleed in Early Pregnancy	1/1	N/A	1/1	1/1	N/A	1	0
Totals	**100% 25/25**	**93% 14/15**	**100% 21/21**	**76%16/21**	**100% 6/6**	**21**	**8**

Table 18: Audit findings from the Small for Gestational Age audit under the 10rth centile Q4 22/23

The findings of the 3 clinical audit reports indicate an overall good compliance with the measurement and plotting of Symphysis Fundal Height in line with current local and national guidance, and 100% for referral further review where SFH is as abnormal.

9.1.2 GUIDELINES

A significant number of clinical guidelines have expired or are near to expiry which is on the risk register, risk 2147, score 12. All actions towards improvement and mitigation of this risk will be monitored via the risk register.

As of 30 June 23, there are 29 guidelines, 9 standard operating procedures and 4 policies out of date. This is a 45% reduction since March 2023. It is anticipated this risk will be reduced if projections are achieved in the next 3-6 months, however this will require close monitoring.

9.2 Triangulation of qualitative and quantitative data

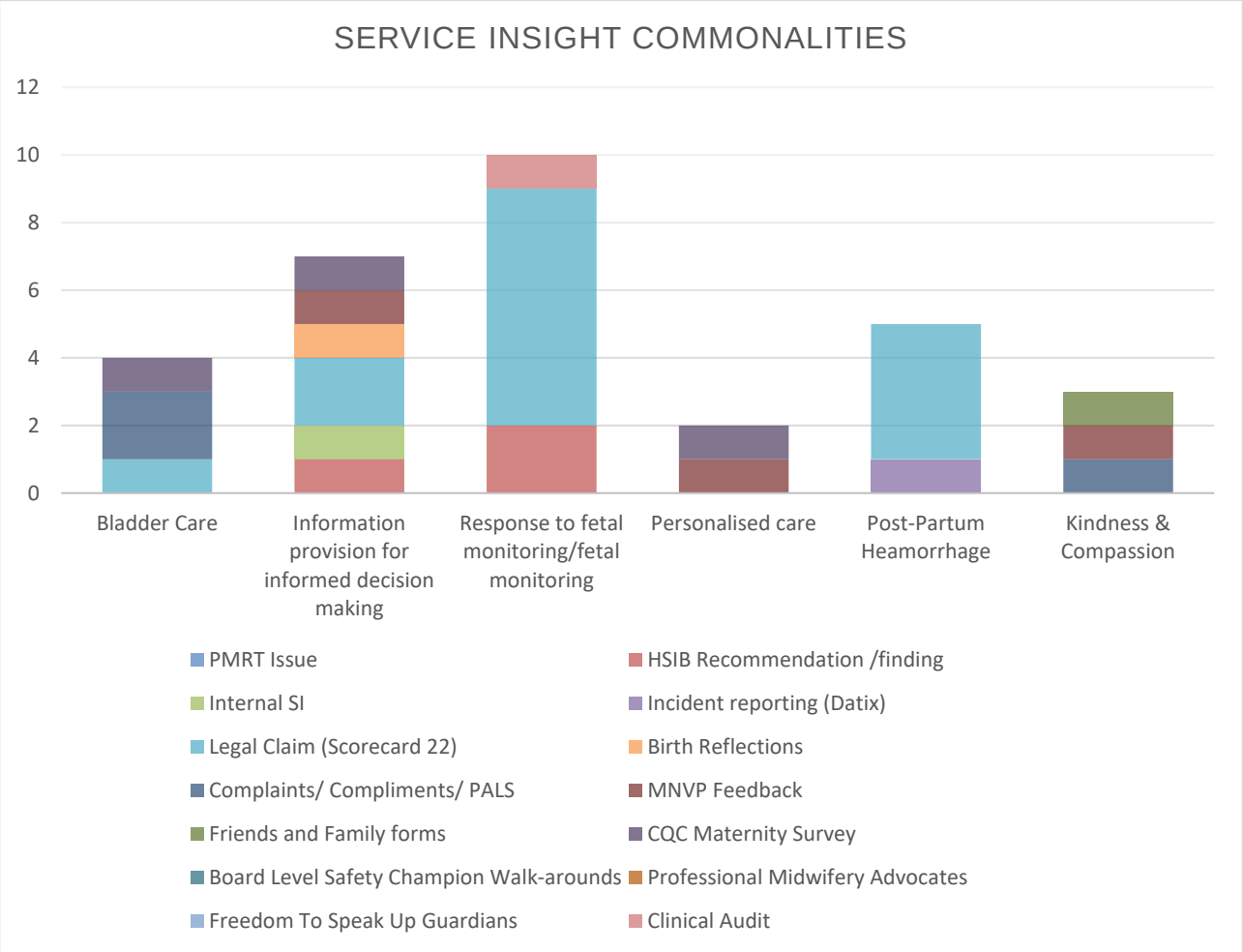


Table 19: Thematic and collated review of qualitative and quantitative service insights 22/23

9.3 AREAS REQUIRING IMPROVEMENT

9.3.1 BLADDER CARE

Bladder care issues fall under the remit of the perinatal pelvic health service, the RUH is part of a national pilot for the provision of a perinatal pelvic health service. A specialist perinatal pelvic health midwife commenced in post during November of 2022, a specialist pelvic health physiotherapist commenced in December of 2022. As part of their specialist roles they are reviewing bladder care provision and developing a bladder care policy with key stakeholders. The specialist midwife conducts a weekly ward round on our postnatal ward providing support and bedside training to midwives and identifying any potential areas for improvement within clinical practice. The services has recently procured two portable bladder ultra sound scanners (USS) to increase the access to bladder USS for women in maternity services.

9.3.2 RESPONSE TO ABNORMALITIES IN FETAL HEARTRATE/FETAL MONITORING

Fetal monitoring was identified in one HSIB recommendation, one incident finding, and internal clinical audit as an area for improvement. Fetal monitoring was identified within

seven claims featured within the 2022 claims scorecard; however, the dates of care within the scorecard range from 2012 to 2017. It is acknowledged that the opportunities and aspects of learning from these incidents may have been lost, as guidance, training requirements, and clinical practice regarding intrapartum fetal monitoring provision has changed since 2017. There is also a protracted period between birth and childhood diagnosis, which often precedes a legal claim.

Fetal monitoring has not been identified as a top contributory finding at RUH by HSIB; this is in contrast to the national theme in figure 1. Only one case identified fetal monitoring in 22/23, but it was not felt to have contributed to the clinical outcome.

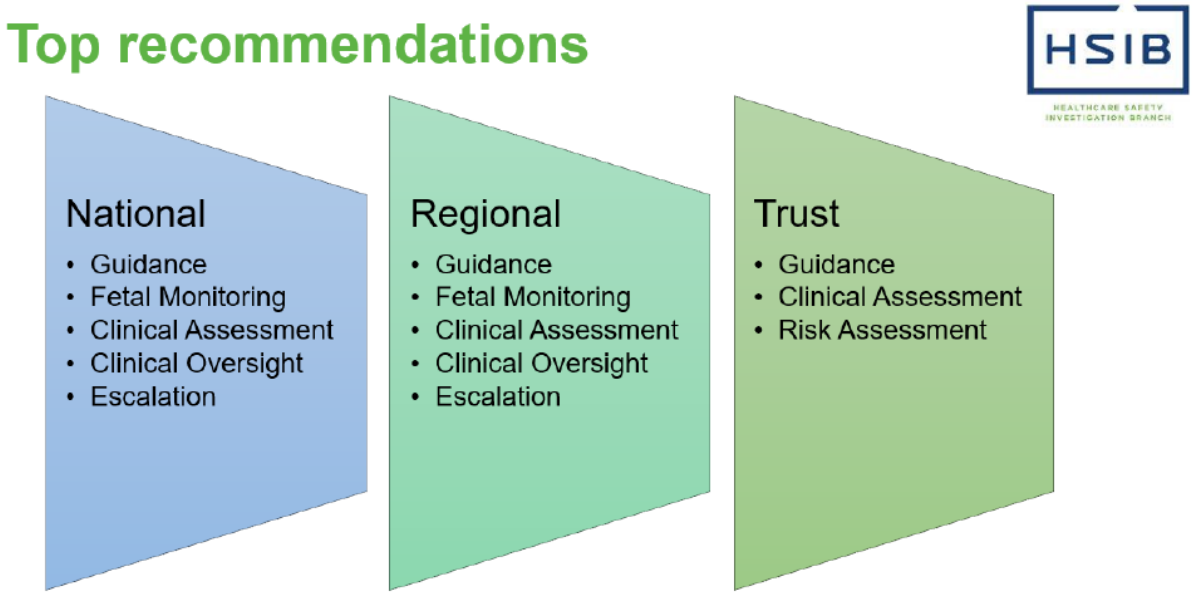


Figure 1: HSIB national thematic analysis featured within HSIB quarterly review for RUH Apr 23

A quality improvement initiative was launched in Q1 of 23/24, specifically focused on the provision of intermittent auscultation during the second stage of labour in response to our local clinical audit, and initial learning from a recent HSIB referral.

During Q1 of 23/24, the national Saving Babies Lives Care Bundle version 3 has been reviewed, which encompasses the element of 'intrapartum fetal monitoring', recommendations and standards. Progress towards full implementation of all elements and recommendations of this package will be monitored via Specialty and Divisional governance.

9.3.3 POST PARTUM HAEMORRHAGE

Postpartum haemorrhage was identified as a top contributor to local incident reports, on review of the 2022 claims scorecard, it identified that haemorrhages resulted in four claims within the varied categories of failure/delay treatment, inappropriate treatment and foreign body left in situ. The latest legal claim reported within the scorecard of 2022 relates to care in 2019.

It has been identified that the Trust is currently experiencing a higher-than-average rate of post-partum haemorrhage (PPH) in comparison to the national average. However, it is acknowledged that as a standard practice to weight all blood loss, unlike standard practice to estimate. This may account for the disparity when benchmarking against national averages, the higher-than-average rate is a shared finding with providers within Local Maternity and Neonatal Service (LMNS), all local providers weigh blood loss.

A case cohort review is currently taking place looking at the pre-disposing risk factors, identification of risk, identification of the emergency, emergency management, and any modifiable factors to inform future improvements, if required, with an aim to reduce haemorrhage post birth. Findings of this review will be shared within specialty governance, and the LMNS to report back via The LMNS to the South West Perinatal Quality Surveillance and Support Group (PQSSG)

9.3.4 PERSONALISED CARE

Paper personalised care and support plans (PCSP) have been developed with key stakeholders including the MNVPP and service users, roll out is scheduled for September, accompanied by staff training.

A working group has been established, following feedback to improve the user experience and reduce duplications. PCSPs will be used in conjunction with the birthing person's maternity record to ensure care is individualised.

9.3.5 INFORMATION PROVISION FOR INFORMED DECISION MAKING

The provision of all the information required for birthing people and their families to make informed decisions regarding their care, and what matters to them, is a legal obligation as outlined by the 'Montgomery ruling' of 2015. This ruling stated that 'patients can expect a more active and informed role in treatment decisions, with a corresponding shift in emphasis on various values, including autonomy, in medical ethics' (BMJ, 2017).

As part of the PSCP launch in September, the PCSP contains information regarding decision-making and informed choices including the application of the 'BRAIN' pneumonic:
B - Benefits
R - Risks
A - Alternatives
I - Intuition
N – Nothing

This is used to empower birthing people in shared decision making with clinicians, during their pregnancy, labour, and birth.

9.3.6 KINDNESS AND COMPASSION

It is pleasing to see that the kindness and friendliness of staff as a feature of feedback from the MNVPP received during December to February, formal compliments made to the service, and the Friends and Family form sentiment feedback during Q1. This feedback will be fed back to our teams via the Maternity Newsletter.

10. RECOMMENDATION

The Quality Governance Committee is asked to receive and discuss the content of the report.

Appendix 2.

Transitional Care Pathway and ATAIN Audit Q1 2023/2024

Contents

Executive Summary

Background

This audit has been completed to support the Maternity Incentive Scheme - year five, Safety Action 3.

Safety Action 3: To demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the avoiding term admissions (ATAIN) into Local Neonatal Units (LNU) programme.

Objectives

- Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising the separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.
- The pathway of care into Transitional Care (TC) has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care Board (ICB) quality surveillance meeting each quarter.
- The number of admissions to the neonatal unit that would have met TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues.
- The number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there. 34+0 - 36+6.
- A data recording process for capturing existing transitional care activity, (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc.) has been embedded. The data should capture babies between 34+0-36+6 week's gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.
- Analysis of staff/parent data captured via a questionnaire around satisfaction and quality and safety of care.
- Reviews of term admissions to the Neonatal Unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion evidence that progress with the action plan has been shared with the neonatal maternity safety champion, and Board Level Champion, LMNS and ICB quality surveillance meeting each quarter.
- Monthly reviews of unanticipated term admissions to the NNU to determine whether there were modifiable factors that could be addressed as part of an action plan.
- An audit trail is available which provides evidence that reviews of all term babies transferred or admitted to the NNU, irrespective of their length of stay.

A high-level review of the primary reasons for all admissions is completed, with a focus on the main reason(s) for admission through a deep dive, to determine relevant themes to be addressed. This is discussed at a monthly multi-disciplinary (MDT) ATAIN meeting.

Key findings

Standard	Compliance April 2023	Compliance May 2023	Compliance June 2023
Audit findings shared with neonatal safety champion	**100%**	**0 (Not in post)**	**0 (Not in post)**
The number of admissions to the Neonatal Unit (NNU) that would have met current TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues	**0**	**0**	**0**
The number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there. 34+0 -36+6	**10**	**0**	**7**
% of shifts TCP nurse provided as per TCP staffing model	**100%**	**100%**	**99%**
TCP open	**100%**	**100%**	**100%**
Number of babies readmitted to neonatal unit from TCP	**0**	**0**	**1**
Avoidable term admissions 37+0 weeks gestation and above to the neonatal unit	**0**	**1**	**1**
The number of term babies transferred or admitted to the neonatal unit from other areas – for example Emergency Department, Children's ward.	1	**0**	**0**

Clinical Audit Report

Audit Findings

The findings of the audit demonstrates that there has been an improvement throughout the quarter in achieving and providing the correct staffing model for the Transitional Care Pathway service as staffing levels improve. Achieving the correct staffing model has been assisted by an increase in the number of babies cared for on the Transitional Care Pathway this quarter, providing the TCP nurse to have a full allocation of babies.

Transitional Care Audit Findings

- In Q1, 59% of the total number of admissions to the Neonatal Unit (NNU) (97 babies) were cared for on the TCP, for some or part of their admission. Out of this 39%, (64 babies) spent the entirety of their admission on the TCP.

- No babies were identified as missed opportunity for TCP. The number of babies being cared for on the TCP is increasing each quarter, which demonstrates commitment to keeping mothers and babies together.

- One baby in Q1 was relocated from the TCP to NNU due to mother not able to stay for the duration of admission due to home personal circumstances.

- The TCP achieved 100% staffing in Q1. This is an improvement on previous audits and shows the continuing improvement on staffing levels.

ATAIN Audit Findings

- This quarter has highlighted at the MDT ATAIN meeting, two avoidable admissions to the NNU. One of these babies were identified by the maternity MDT team as avoidable and the other identified by the paediatric team.

- One case identified a delivery could have been expedited in response to a pathological Cardiotocograph, with missed opportunities to have received a septic screen during labour.

- The second case was identified as avoidable as the baby had stabilised on admission to the LNU and did not need ongoing observations, therefore could have immediately been reunited with its mother. However the baby stayed in the LNU for 3 hours.

The cases have both highlighted learning that will be cascaded to the teams. Learning has been highlighted on Safety Briefs and Quality Board displays. In the maternity case, an amendment has been made to the current fetal monitoring guideline to support staff with care provision.

In Q1, all term admissions that have been admitted to the LNU and required non-invasive respiratory support are being reviewed. The review includes treatment, length of stay, and time of admission and discharge. The rationale is to identify what care changes can be made to expedite the repatriation of the baby to the care of their mother when it is clinically safe to do so. This will potentially involve increasing our use of the transitional care services.

In line with the Standard 3, reviews are carried out of all Neonatal Unit transfers or admissions regardless of their length of stay, including internal transfers within the RUH to the LNU. This includes Emergency Department and the Children's ward. In Q1, one baby was admitted to the LNU from the Children's ward with significant apnoea, fitting and subsequent diagnosis of meningitis. Following stabilisation with medication for the seizures, the baby was transferred back to the Children's ward. This was reviewed and agreed as an appropriate management plan.

When babies are admitted to the LNU, wherever possible, parents are offered a bed; this may not always be beside their baby, in parent accommodation adjoining the LNU.

Q1 Practice Improvements

- New-born Early Warning Trigger and Track (NEWTT2) charts and toolkit are due to be implemented on TC babies in Q2 2023-2024. The NEWTT2 chart and framework encompass parental concern to acknowledge the importance of the opinion of the family in addition to the wider multi-disciplinary team. This extended framework provides an escalation tool and a standard response and review tool for the multidisciplinary team to use jointly. The framework uses the PIER principles adopted by the National Patient Safety Improvement Programme. The total NEWTT2 score informs the escalation response including who is responsible, and the timing of a review and supports further escalation if required.

- With improved staffing and compliance to the staffing model for TCP, we have been able to facilitate more babies who require nasogastric tube (NGT) feeding. Six babies were cared for on the TCP requiring some nasogastric feeding; this is four more than last quarter. Discussion for plans to move to next phase of TCP in progress to support more babies requiring NGT support on TCP, reducing rates of separation of mothers and babies.

- The LNU now have a named link midwife for TCP to improve communication and collaborative working. Formation of a TCP working group in the process of being established. This group will be made up staff across all grades from neonatal unit, to work collaboratively with a maternity representative. Aim: To work together to implement change and improve and progress TCP service.

- Assessment of all term admissions requiring non-invasive respiratory support, ensuring their plan of care optimises their chances in being safely reunited with their mother as soon as clinically possible.

- During Q1, excellent practice was noted. A baby being nursed on the TCP who needed triple phototherapy for ABO incompatibility and bruising. Previously a baby with the clinical history of ABO incompatibility and bruising would have been admitted to the LNU for treatment, with input from the TCP nurse. However, the baby stayed with their mother and received all its necessary treatment under the TCP.

Neonatal Services Transitional Care and ATAIN Action Plan

Action	No	Details	Progress	Lead	Due	RAG status	Completion date
1. What do we Need? **Pathways of care into transitional care have been jointly approved by both neonatal and maternity teams.** The aim of the transitional care pathway is to minimise separation of resident mothers and their babies.							
There are care pathways for those babies who meet the criteria for the transitional care pathway	1.1	Pathways and criteria have been agreed by both maternity and neonatal teams	Completed when the transitional care pathway was established	Maternity and Neonatal Transitional Care Lead			Complete
Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to BAPM transitional care framework for practice	1.2	Babies admitted onto the transitional care pathway have details recorded on the BadgerNet database. This database evidences that the baby has at least one element of the HRG XA04	Completed with each admission and validated by neonatal data clerk	Neonatal transitional care lead			Complete
2. What we need? **An explicit staffing model for the Transitional Care pathway** The staffing model needs to meet the BAPM staffing model for transitional care							
The neonatal rota provides an explicit	2.1	The rota allocates 1 neonatal nurse to care for 4 transitional care	Quarter 4 2022/2023 demonstrated compliance of the staffing model only 98% of the time.	Neonatal transitional care lead and Paediatri			complete

staffing model for nursing care of the babies on the transitional care pathway		babies Staff vacancy factors, maternity and sick leave, are impacting on the ability to provide a nurse to the transitional care pathway at times	Staff recruitment has been successful into the B5 vacancies and by Summer 2023 we will be fully established on B5 and B4 Whenever possible the separation of mother and baby has been avoided. At times, this has meant that the TC nurse has had to care for babies on the TCP and babies on NNU. When we feel the safety of all the babies under our care maybe compromised, and we are unable to provide a safe staffing model to babies on the transitional care pathway, babies are brought to the neonatal unit and separated from their mother. Prior to separating the mother and baby the neonatal escalation policy will have been actioned and a datix submitted. This has not occurred in Q4	c Matron			

3. What we need? **The Transitional Care policy has been fully implemented and quarterly audits of compliance with the policy and guideline criteria are conducted.** Audit findings are shared with the neonatal safety champion on a quarterly basis							
Audit findings are shared with the neonatal safety champion on a quarterly basis.	3.1	Where barriers to achieving full implementation of the policy are encountered, an action plan should be agreed and progress overseen by both the board and neonatal safety champions	Data is collected continuously Quarter 1 2023/2024 audit findings and the learning has been shared with the neonatal safety champion. A new nurse Consultant has been appointed and is now the neonatal safety champion.	Neonatal transitional care lead and Neonatal safety champion			

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**13.2**
Date of Meeting:	**6 September 2023**		

Title of Report:	**Bi-annual, Maternity and Neonatal Staffing Report**
Status:	**For discussion**
Board Sponsor:	**Antonia Lynch, Chief Nurse**
Author:	**Zita Martinez, Director of Midwifery**
Appendices	**None**

1. Executive Summary of the Report

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set their staffing establishment to maintain continuity of maternity services and to provide safe care at all times to women and babies in all settings.

This report gives a summary of all measures in place to ensure safe midwifery staffing; including clinical and specialist workforce planning, headroom requirement, fill rates, escalation, recruitment and retention, midwife to birth ratio, Birth Rate Plus (BR+) Live Acuity Tool compliance with supernumerary labour ward coordinator status, one to one care in labour, neonatal nursing and red flag incidents

BR+ is the only recognised national tool for calculating midwifery staffing levels. The Trust commissioned a full review in 2022 to meet Safety Action 5 of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST), Maternity Incentive Scheme (MIS); this report was published in April 2023. The report identified an increase in acuity and dependency across maternity services and therefore identified a need to increase establishments in clinical and non-clinical roles. This will require investment to meet year 5 of the Maternity Incentive Scheme. As a result of the change in acuity, the midwife to birth ratio will change in July from 1:28 to 1:24. Funding for an increase in establishment has not yet been sourced.

Bath and North East Somerset, Swindon and Wiltshire (BSW) Academy undertook a workforce planning review for the Local Maternity and Neonatal System (LMNS) in March 2023. The headroom for qualified midwives was reviewed, taking into consideration the statutory and mandatory training requirement, sickness, annual leave and maternity leave. The recommendation to the Local Maternity and Neonatal System was a headroom requirement of 28% for all midwives. The Trust's current headroom is 20% built into the funded establishment.

Over the past 12 months, maternity staffing has improved; by September 2023 there will be no substantive vacancies for band 5 and 6 midwives. There is a significant reduction in turnover and demonstrates stabilisation in the service.

Monthly audit of supernumerary status of the labour ward co-ordinator and 1:1 care in labour highlights a high level of compliance.

2. Recommendations (Note, Approve, Discuss)

To discuss

3.	Legal / Regulatory Implications
It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Trust to support Birth plus report 2022	

4.	Risk related to staffing (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)	
392	Obstetric and gynaecology workforce risk	15
2417	Maternity triage	12
2467	Maternity workforce	12
1763	Lack of AHP support- Dietician, psychology, OT and Physio in the NNU	8
1768	Maternity redesign staffing impact	4
1948	Obstetric ultra sound scan capacity	8

5.	Resources Implications (Financial / staffing)
Non-compliance with the Maternity Incentive Scheme for Trusts, which has financial and safety implications for the Trust. There is a financial commitment required by the Trust to achieve compliancy.	

6.	Equality and Diversity
Equality and Diversity legislation is an integral component to registration.	

	References to previous reports/Next steps
MIS combined Maternity and Neonatal Safety report, Q4 22-23 MIS combined Maternity and Neonatal Safety report, Q1 23-24 BirthRate + report data from 2022, presented 2023 Perinatal Quality Surveillance Tools, January – June 2023 MIS Year 4 Board declaration paper, January 2023	

8.	Freedom of Information
Public.	

BI-ANNUAL MIDWIFERY, MATERNITY AND NEONATAL STAFFING REPORT

1.0 Background

1.1 It is a requirement that NHS Providers continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

1.2 Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to provide safe care at all times to women and babies in all settings.

2.0 Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing; including clinical and specialist workforce planning, headroom requirement, fill rates, escalation, recruitment and retention, midwife to birth ratio, Birth Rate Plus Live Acuity Tool compliance with supernumerary labour ward coordinator status, one to one care in labour, neonatal nursing and red flag incidents

3.0 Birth rate Plus Workforce Planning

3.1 Birth Rate Plus (BR+) is the only recognised national tool for calculating midwifery staffing levels, the Trust commissioned a review in 2022 to meet Safety Action 5 of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST), Maternity Incentive Scheme (MIS). MIS established 10 Safety Actions to support safer care, Trusts that demonstrate achievement of all 10 Safety Actions recover the additional 10% of the maternity contribution charged under the scheme plus a share of the monies paid in to the scheme by the hospitals that did not achieve.

4.0 Maternity Incentive Scheme

4.1 Safety Action 5 - To demonstrate an effective system of midwifery workforce planning to a required standard.

i. Complete a systematic, evidence-based process to calculate midwifery staffing establishment
ii. Trust Board to evidence midwifery staffing budget reflects establishment as calculated in above
iii. In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BR+ or equivalent calculations
iv. Where Trusts are not compliant with a funded establishment based on BR+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls
v. The plan to address the findings from the full audit or table top exercise of BR+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners

4.2 The April 2023 report evidenced a variance between the current funded establishment and required clinical and non-clinical establishment (specialist midwives) to support safe staffing at the RUH. These findings are summarised in the table below:

Clinical and Non-clinical variance from current establishment.

Current Funded Clinical, Specialist, Management wte	% Uplift	Birthrate Plus wte	Variance wte
190.10	20%	202.03	-11.93
190.10	24%	211.01	-20.91
190.10	28%	220.70	-30.60

Table 1: Funded establishment vs the gap analysis required to uplift the establishment based on 20, 24 and 28% headroom

4.3 There is an ongoing maternity business case, which incorporates the BR+ findings; currently there is no identified funding stream to support an uplift in establishment. If funding is not identified, the Trust will not achieve compliance with year 5 of the Maternity Incentive Scheme.

4.4 The headroom for qualified midwives was reviewed by the BSW Academy in conjunction with the Directors of Midwifery across the Acute Hospital Alliance. Taking into consideration the statutory and mandatory training requirement, sickness, annual leave and maternity leave, the analysis recommended to the Local Maternity and Neonatal System that a headroom of 28% was required for all midwives; RUH currently has a headroom of 20% built into the funded establishment.

4.5 The Ockenden Final report advised maternity services, as part of effective workforce planning review, minimum staffing levels (to include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave).

4.6 The increase in establishment is influenced by a number of local and national drivers;

i. Increase of women and birthing people's complex needs
ii. Increase of cascade of interventions due to national ambition to reduce poor outcomes
iii. The Governance agenda, which includes evidence-based guidelines, on-going monitoring, audit of clinical practices and clinical training programmes all have an impact upon the required midwifery input
iv. Transitional care is now provided on the ward rather than in neonatal units.
v. Safeguarding needs require significant input, which put higher demand on the workload
vi. Reduced antenatal admissions and shorter postnatal stays requires sufficient community midwifery resource

vii. Community based care is expanding with the emphasis being placed on 'normal/low risk/need care being provided in community by midwives and midwifery support roles

viii. Triage covers a 24-hour period, seven days per week, with two midwives throughout the 24-hour period and an additional midwife for 24 hours per day is required to provide effective telephone triage

ix. Midwives undertake the Newborn and Physical Examination (NIPE) instead of paediatricians

x. Cross border, activity impacts on community resources

xi. The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks' gestation; consequently, more women are meeting their midwife earlier. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss.

4.7 In addition to these posts, consideration needs to be given to recommendations from national reports such as Ockenden and MIS concerning new roles required to support safer high quality maternity services, for example the inclusion of Consultant Midwife posts.

5.0 Recruitment and retention

5.1 Over the past 12 months maternity staffing has improved; by September 2023 we will have no substantive vacancy for band 5 and 6 midwives. The BR+ has evidenced a need for an uplift in establishment, once funded we will actively recruit into these vacancies.

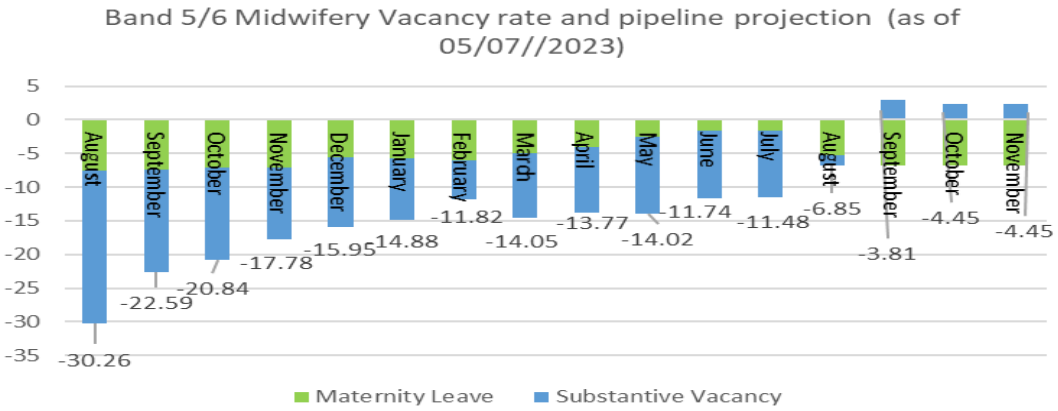


Figure 1: Band /6 midwifery vacancy rate and pipeline projection

5.2 Over the past 12 months, the service has had an active recruitment campaign, including national and local advertising, successful recruitment of eight Internationally Educated Midwives, two Nurses undertaking the nurse to midwife MSc conversion course.

5.3 The success of the retention team has supported 100% retention of our Newly Qualified Midwives (NQM) who commenced in August 2022.

5.4 The table below details the number of midwives who have left the maternity service since January 2023. This is a significant reduction in turnover and demonstrates stabilisation in the service.

Month	Band 5 Leavers	Band 6 Leavers
January 23	0	0
February 23	0	1.31
March 23	0	0
April 23	0	0
May 23	0	1
June 23	0	0
Total	0wte	2.31wte

Table 2: Midwifes leaving the Trust by month

6.0 Fill rates

6.1The chart below highlights the improved midwifery fill rates during over the past 6 months. There is a slight decrease in June 2023 rate; this is due recent appointments of midwives into specialist midwifery roles and NQM undertaking a 3-month placement into the community.

Month	Day qualified %	Night qualified %
Jan 2023	90.4%	95.9%
Feb 2023	90.9%	90.1%
March 2023	89.9%	85.1%
April 2023	83.7%	82.6%
May 2023	93.3%	93.1%
June 2023	88.2%	89.8%

Table 3: Fill rates by day and night

7.0 Escalation

7.1The service continues to monitor staffing on a daily basis; the improved staffing in the acute maternity unit has reduced the requirement to redeploy community midwives between January and May. However, in June there has been an increase in redeployment due to acuity and complexity in the acute setting.

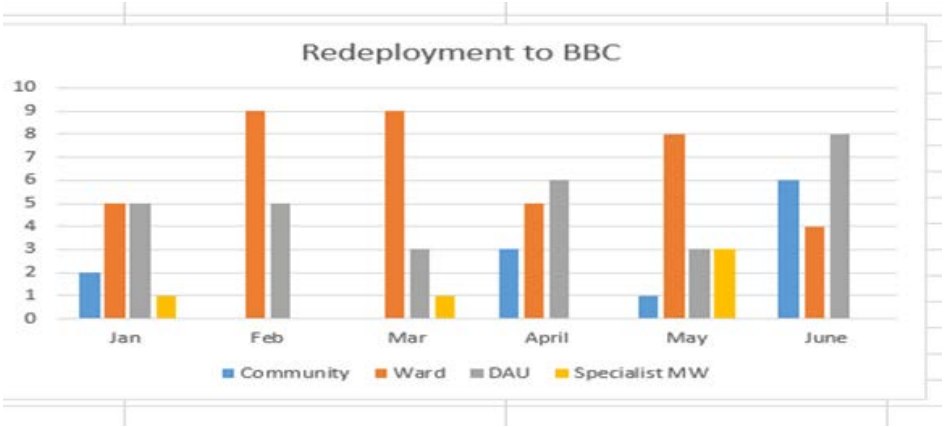


Table 4: Redployment encounters from community sites to the Bath Birthing Centre

7.2 When staffing is less than optimum, the following measures are taken to maximise staffing into critical functions to maintain safe care for the women and their babies in line with the Maternity Escalation Policy:

- Request midwifery staff undertaking specialist roles to work clinically
- Elective workload prioritised to maximise available staffing
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained
- Activate the on call midwives from the community to support labour ward
- Request additional support from the on call midwifery manager
- Liaise closely with maternity services at opposite sites to manage and move capacity as required (mutual aid)

7.3 Although the staffing position has stabilised over the past 6 months, there is an on-going requirement for out of hours on call support within the service. 73 hours of midwifery on call hours have been used in the last 6-month period to support activity and acuity within the acute unit.

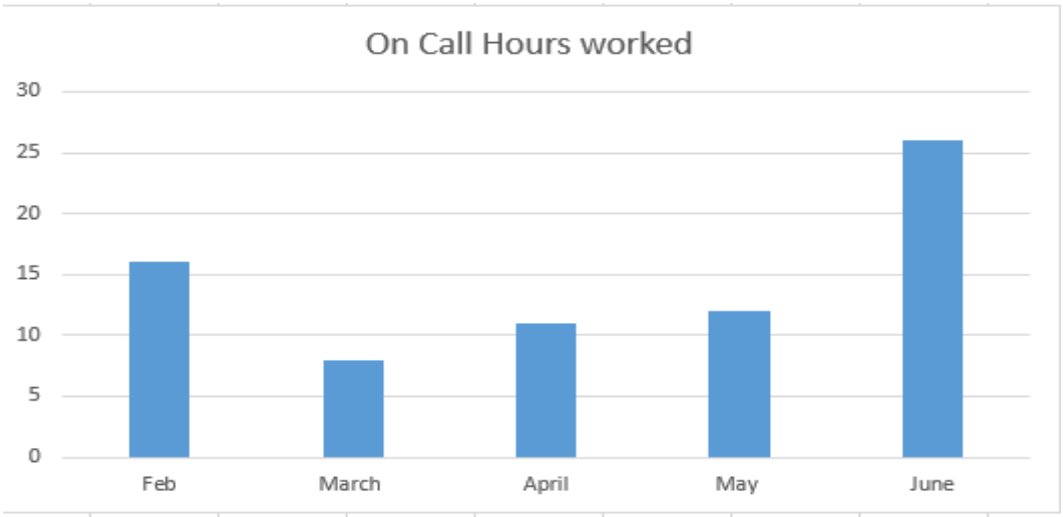


Table 5: On call hours used to provide safe midwifery care

8.0 Birth to Midwife ratio

The birth to midwife ratio was previously calculated by Birth Rate + as 1:28 and the compliancy is reported in table 6.

The birth to midwife ratio has been increased following the latest BR+ report to 1:24, and this standard will be introduced in July 2023.

Month	Target	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023
Birth to midwife ratio	1.28	1.33	1.28	1.31	1:31	1:29	1:32

Birth to Midwife ration (including bank)	1.28	1.30	1.25	1.29	1.28	1.25	1.28

Table 6: Compliance with the midwife to birth ratio

9.0 BR+ Live Acuity Tool

9.1 The BR+ Acuity Tool is utilised to assess 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatal care. It is a measure of 'acuity' and the system is based upon the clinical indicators used in the well-established BR+ workforce planning system.

9.2 The BR+ classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one to one care in labour for all women and increased ratios of midwifery time for women in the higher needs categories.

9.3 Availability of a supernumerary labour ward co-ordinator (LBW) is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support and guidance to clinical staff and able to manage activity and workload through the labour ward without having a caseload to manage or a labouring woman. Compliance for the past 6 months is demonstrated in table 7.

	Number of days per month	**Number of shifts per month**	**Compliance**
January 2023	31	62	99%
February 2023	28	58	99%
March 2023	31	62	97%
April 2023	30	60	100%
May 2023	31	62	100%
June 2023	30	60	100%

Table 7: Compliance with the supernummary labour ward coordinator

9.4 Table 7 identifies an improvement in staffing from April 2023. Review of incidents and outcome data provided assurance that the three months when 100% compliance was not achieved and did not require the LBC to provide 1:1 care in labour or negatively impact on safe care.

9.5 Women in established labour are required to have one to one care and support from an assigned midwife to ensure the safe, high quality provision of care. If there is an occasion where one to one care cannot be achieved then this will prompt the labour ward co-ordinator to follow the course of actions, which may be clinical or management actions or following the escalation policy.

Table 8 outlines compliance for the past 6 months

	Jan	Feb	March	April	May	June
1:1 in established labour- Bath Birth Centre	100%	100%	100%	100%	100%	100%

Table 8: Compliance with one to one care in established labour

10.0 Neonatal nursing staffing

10.1 The neonatal service has recently recruited to the Nurse Consultant post, this role provides clinical leadership within the unit, and this post was vacant from April to June. We have recruited into the B7 vacancy with anticipated start date in September. There is an active recruitment plan to address outstanding vacancies, the table below represents Neonatal WTE staffing vacancy for this period.

Neonatal Staffing Quarter 2 April – June 23.

Month	Band 5	Band 6	Band 7
April 23	**-2.34 WTE**	**-2.67 WTE**	**-0.52 WTE**
May 23	**-2.34**	**-2.67**	**-0.52**
June 23	**-2.34**	**-2.67**	**-0.52**
Total	**-1.34**	**-2.67**	**-0.12**

Table 9: Neonatal Staffing Q1

10.2 Neonatal nursing staffing

10.3 All ITU and HDU patients should be cared for by a nurse who is Qualified in Speciality (QIS) trained, for special care babies it is best practice if nurses are QIS trained although standards can still be met if supervised by a QIS nurse. The unit also requires one QIS trained nurse in charge and one for Traditional Care on each shift. The target is for 70% of the nursing staff to be QIS trained. The current QIS compliance is 63% with 3.4WTE starting their QIS training in September and December which would increase our QIS to 72%.

The following table represents the neonatal nursing staffing provision based on patient acuity in line with British Association of Perinatal Medicine (BAPM) service specifications over the review period. This demonstrates a stable position over the last 6 months.

BAPM SERVICE SPECIFICATION FOR NEONATAL NURSING STANDARDS

MONTH	DAY SHIFT	NIGHT SHIFT
JANUARY 2023	93.6%	87.1%
FEBRUARY 2023	89.3%	92.8%
MARCH 2023	100%	100%

APRIL 2023	96.7%	100%
MAY 2023	100%	100%
JUNE	96.7%	86.7%

Table 10: BAPM service specification for Neonatal Nursing Standards

10.4 Allied Health Professional Neonatal staffing

The BAPM standards also recommend integrating allied health professionals (AHP) within the neonatal service to enhance service provision to optimise short and long-term neurodevelopment and mental health of infants and their families; this is advocated in the Neonatal Critical Care Report (2019).

The Neonatal AHP staffing for this period is as below.

BAPM recommendations	Hours Funded by Operational Delivery Network funds	Total hours provided within Trust
0.8 WTE Physiotherapist	0.2 WTE	0.2 WTE
0. 7 WTE Dietitian	0.2 WTE	0.3 WTE
0. 8 WTE SALT	0.2 WTE	0.2 WTE
0. 9 WTE Psychology	0.2 WTE	0.4 WTE
0.8 WTE Occupational Therapy	0.3 WTE	0.3 WTE

Table 11: The Neonatal AHP staffing for this

The Division are reviewing the gap in funding and WTE provision.

11.0 Recommendations

Maternity services are a high-risk specialism where the impact of poor care can be life changing for women and their families. Investment in safe maternity staffing not only safeguards the provision of high quality care and best outcomes but also mitigates the reputational and litigious risk for the organisation.

1. The Trust to support the findings of the current BR+ report for both clinical and non-clinical midwifery and maternity funding stream.
2. Evidence of an agreed plan and timescales to ensure midwifery staffing budget reflects the new BR+ establishment report findings.
3. The senior maternity leadership team to continue to support a robust recruitment process.
4. The Trust to continue to seek funding for all externally funded posts.

5. The Trust to continue to seek funding for the additional clinical midwifery posts, senior specialist midwife and non-clinical leadership.

6. Continue to work towards compliance with British Associate of Perinatal Medicine standards for Neonatal Medical and Nursing staff.

The Trust Board is asked to discuss the report and note the position of staffing in maternity services.