

Report to:	Public Board of Directors	Agenda item No:	13
Date of Meeting:	10 January 2024		

Title of Report:	Maternity and Neonatal Safety Report Quarter 2
Board Sponsor:	Antonia Lynch, Chief Nursing Officer
Author(s):	Zita Martinez, Director of Midwifery
Appendices	Appendix 1.0 Maternity Training Needs Analysis (TNA) Appendix 2.0 Transitional and ATAIN Audit report

1.	<p>Executive Summary of the Report</p> <p>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.</p> <p>This report identifies a stable rolling average of perinatal mortality, with a rate of 1.66 per 1000 births at the Royal United Hospitals Bath NHS Foundation Trust (RUH), which is below the national average of 4.2 per 1000 births. Q2 reporting now includes babies who were born at RUH and died elsewhere to align to the stabilised and adjusted rates received via Mothers and Babies: Reducing Risk through Audits and confidential Enquiries across the UK (MBRRACE-UK) national reporting.</p> <p>On 30 September 2023, the Healthcare Safety Investigation Branch transitioned to become the Maternity and Neonatal Safety Investigations (MNSI) team hosted by the Care Quality Commission. The Trust made 4 referrals in Q2, 2 reviews have been confirmed at the family's request. No new internal Serious Incidents were declared in Q2.</p> <p>The Trust's current compliance with the 15 Immediate and Essential Actions (IEAs) within the Ockenden report is detailed within this report and actions to align to the National Maternity Quality Improvement drivers in the Three Year Delivery Plan, providing clarity and cohesion on improvement reporting in maternity services. It is of note that the Trust is not required to submit evidence of compliance with all 15 Immediate and Essential Actions, this is managed within NHS Trusts.</p> <p>This report outlines the Trust's progress towards full compliance of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), Year 5. The submission of evidence is due in February 2024 which is detailed in a separate paper to the Board of Directors.</p> <p>This report seeks Trust Board sign off of the new Maternity Training Needs Analysis of 2023/2024 which encompasses all elements of the Core Competency Framework v2 (CCFv2), and signposts current training compliance trajectories into Q3 on target to achieve the 90% standard required for MIS and SBLv3 compliance.</p> <p>Staffing levels are improving; the service has a strong retention and recruitment programme with a 100% band 5 retention rate. The current turnover rate for the maternity service is 8.7%. One of the Internationally Educated Midwives (IEM) passed their OSCE exam during this quarter, they are now working through their midwifery competencies, once achieved they will be part of the midwifery workforce. We are expecting 4 new IEM recruits to join us by December 2023.</p> <p>The Avoiding Term Admissions into Neonatal Units (ATAIN) and Transitional Care reporting is included in this report. The Q2 ATAIN rate of 4.6% remains consistently below the national threshold of 5%. 3 avoidable admissions were identified, learning identified and disseminated to staff. In Q2, 56% of the total number of admissions to the Neonatal Unit, (106 <i>babies</i>) were cared for on the Transitional Care Pathway (TCP) for some or part of their admission.</p>
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2. Recommendations (Note, Approve, Discuss)
Discuss and approve.

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.)
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In Q2, Maternity and Neonatal services presented 3 new risk assessments which were approved for the risk register.

2562	There is a risk to the Electronic Patient Record (EPR) due to unsecured funding following withdrawal from Cerner Millennium	12
2581	There is a risk that we will be unable to meet the service demand for obstetric medical staging with the current unsecured establishment of Obstetric Consultant.	12
2591	There is a risk that the current funded provision of Allied Health Professionals in the Neonatal Unit will not continue following cease of fixed term funding from the neonatal Operational Delivery Network.	9

Current open risks

1734	Day Assessment Unit patient safety risk – area not compliant or fit for purpose	15
1948	Obstetric ultra sound scan capacity	12
2359	Maternity Information System IT support/capacity	8
2396	Obstetric theatre emergency call bells	12
2417	Maternity triage	12
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
2562	There is a risk to the Electronic Patient Record (EPR) due to unsecured funding following withdrawal from Cerner Millennium	12
2581	There is a risk that we will be unable to meet the service demand for obstetric medical staging with the current unsecured establishment of Obstetric Consultant.	12
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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 Q1 report – August 2023 Safer Staffing Report – August 2023. CNST Maternity Incentive Scheme – Year 4 declaration of compliance - December 2022 Maternity and Neonatal Safety Report Q2 report, Quality Governance Committee – December 2023	
8.	Publication
Public.	

MATERNITY AND NEONATAL Q2 23/24 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
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	July	August	September
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:	✓ see report	✓ see report	✓ see report
2a. The number of incidents logged graded as moderate or above and actions			
2b. Training compliance for all staff groups in maternity related to the core competency framework v2 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	✗ 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)

REPORT OVERVIEW

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSE 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 within Maternity and Neonatal services. The information within the report reflects actions and progress in line with Ockenden 2022 and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

1. PERINATAL MORTALITY RATE

The following graphs demonstrate how RUH is performing against the national ambition to reduce stillbirth in the UK by 50%, and the local ambition for continual progression in reducing perinatal mortality at the Trust.

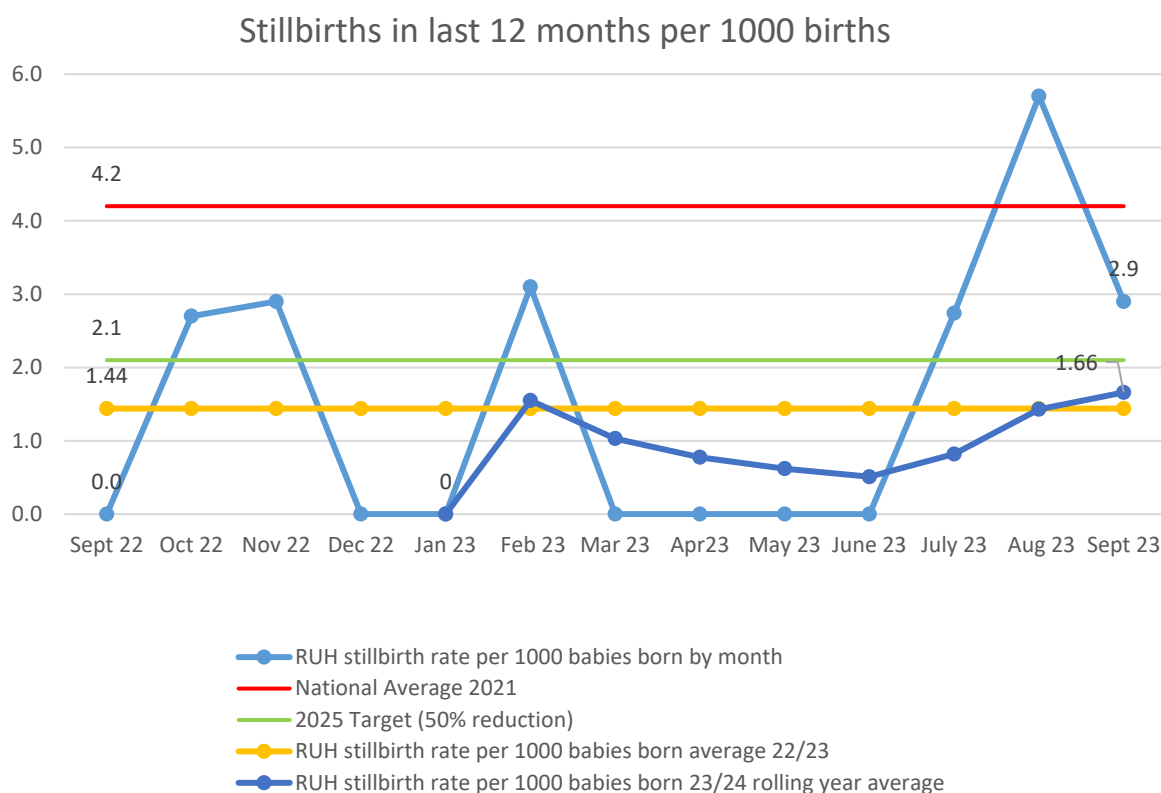


Figure 1. RUH NHS Trust stillbirth rate per 1000 births over last 12 months

Neonatal Death Rate in last 12 months per 1000 births

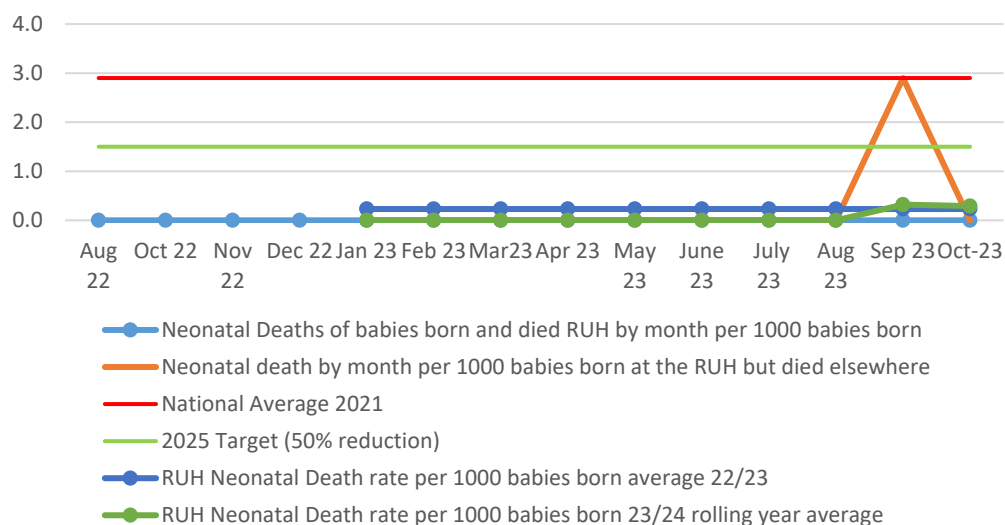


Figure 2. RUH NHS Trust Neonatal Death rate per 1000 births over last 12 months

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 at the RUH. Births between 22-24 weeks are pulled manually and added to the data set submitted to MBRRACE-UK and are reported as in figure 1. Perinatal deaths are defined from birth after 22 weeks gestation and include neonatal deaths, but stillbirths are defined from 24 weeks at diagnosis of death. The rate of stillbirth and perinatal death may therefore be different.

Trusts are provided with initial MBRRACE perinatal mortality rate per 1000 births, results are subsequently stabilised and adjusted to include deaths of babies who were born in providers but subsequently died elsewhere. This report has therefore separated these values to ensure alignment with internal mortality data figures ahead of reported and adjusted MBRRACE-UK figures, see Figure 1 and figure 2.

Five perinatal deaths (excluding Medical Termination of Pregnancies (MTOP)) are reported in Q2. The Trust was informed of one neonatal death due to extreme prematurity of a baby born at the RUH and transferred to a tertiary Neonatal Unit (NNU).

2023/24 (excluding terminations for abnormalities)	Q2	Annual total 23/24
Stillbirths (>37 weeks)	1	1
Stillbirths(>24weeks-36+6weeks)	3	3
Late miscarriage (22+weeks-23+6weeks)	0	0
Neonatal death at the RUH	0	0
Neonatal death elsewhere following birth at the RUH	1	0
Total	5	5

Table 1. Perinatal Mortality summary by number of cases Quarter 2 2023/24

2. Perinatal Mortality Review Tool (PMRT)

All perinatal deaths that occur within the Trust have been reported using the PMRT tool since 2018. PMRT reporting is a requirement of Safety Action 1 of the NHS-R Maternity Incentive Scheme year 5. All Q2 cases have been reported to MBRRACE via PMRT.

Deaths within your organisation

Switch to Deaths of babies born within your organisation

4 deaths between 01 Apr 2023 and 15 Sep 2023

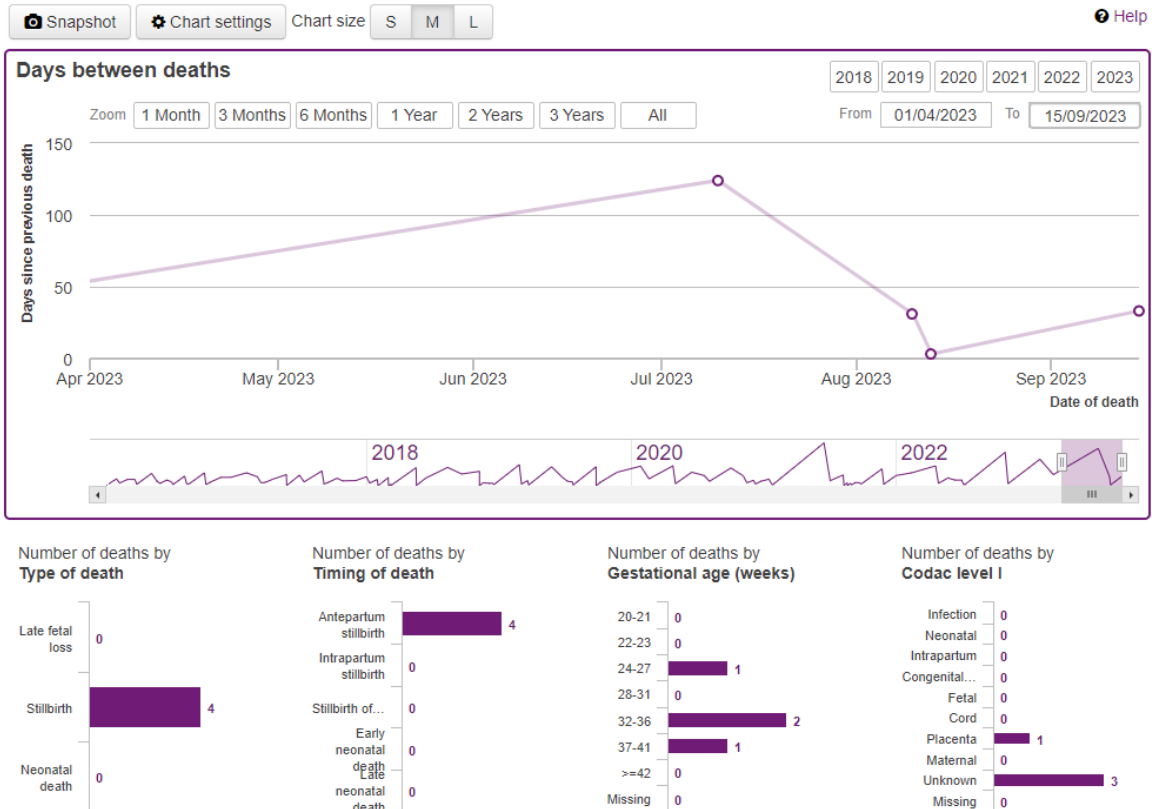


Figure 3. Reporting of RUH NHS Trust deaths within Organisation.

The Trust was informed of 3 perinatal deaths of babies where the mother was receiving maternity care at the RUH. In all cases, there was an in-utero transfer of care from the RUH to a hospital with a tertiary Neonatal Unit due to premature gestation, and presentation of threatened preterm labour. The babies identified were neither born, nor died at the RUH therefore will not be presented in RUH MBRRACE statistics, however we will be collaborating with the birth hospitals as part of the PMRT review.

2.1 LEARNING FROM PMRT REVIEWS

One PMRT review was completed in Q2. The PMRT process facilitates multidisciplinary reviews of care with external representation and generates an agreed alphabetical grading of care as outlined below. No cases in Q2 were reported with a care grading of 'C' or 'D'

indicating that there were no identified issues with care that may have impacted upon the outcome.

Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						Total
	Ukn	22-23	24-27	28-31	32-36	37+	
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up to the point that the baby was confirmed as having died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	1	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	0	0	1	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 2 PMRT Grading of care for completed reviews in Q2 2023.

3.0 MATERNITY AND NEONATAL SAFETY INVESTIGATIONS (FORMERLY THE HEALTHCARE SAFETY INVESTIGATION BRANCH) AND MATERNITY SERIOUS INCIDENTS

3.1 BACKGROUND

In September 2023, the Healthcare Safety Investigation Branch (HSIB) were formerly re-branded in line with their transformation to become hosted by the Care Quality Commission (CQC) as the Maternity and Neonatal Safety Investigations (MNSI) team.

MNSI 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

Five new referrals were made in Q2 to MNSI of which three were rejected by MNSI following their internal triaging, and two have progressed to review at family request.

Table 3 identifies ongoing MNSI reviews into Q2. The findings and recommendations of these reviews, and the actions taken in response, will feature in future reports.

Ref	Details of Event	confirmed Investigation	External Notifications and Other Investigations
Ongoing			
MI-026685	Neonatal resuscitation following home birth	May 2023	N/A
New Referrals			
118965	Neonatal transfer to tertiary Neonatal Unit for ongoing care and active therapeutic cooling	MNSI review confirmed normal MRI post active therapeutic cooling progressing at family request	N/A
119205	Baby admitted on day 2 of life transferred to tertiary Neonatal Unit for ongoing care	MNSI rejected due to diagnosis of metabolic disorder	N/A
119326	Baby required transfer to tertiary neonatal unit for increased care requirements.	MNSI rejected due to diagnosis of metabolic disorder	N/A
119365	Baby born in poor condition at birth requiring resuscitation. Neurological examination at 20 minutes abnormal baby referred to tertiary Neonatal Unit for active therapeutic cooling	MNSI rejected due to normal MRI post active cooling and no family care concerns	N/A
121264	Transfer to tertiary Neonatal Unit for active therapeutic cooling following resuscitation at birth	MNSI review confirmed normal MRI post active therapeutic cooling progressing at family request	

Table 3. MNSI referrals and ongoing investigations Q2 2023/24

3.3 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable.

3.4 MATERNITY SERIOUS INCIDENTS

There was 1 new Serious Incident identified during Q2. See Table 4.

Ref	Details of Event	Review Response	External Notifications and Other Investigations
July			
118499	Mother birthing outside of guidance. Shoulder dystocia at birth, baby born in poor condition requiring resuscitation at birth. Transferred to Bath Birthing Centre (BBC) no blood gas analysis performed.	Volume of learning identified at multidisciplinary review team (MDT) regarding current care provision for women who choose to birth outside of guidance Neonate's deviation from care pathway missed opportunity for blood gas on admission and potential Cerebral Function Monitoring.	STEIS 2023/15926

Table 4. Maternity and Neonatal Serious Incident reviews Q2

There were 8 moderate harm events reported during Q2 which have not progressed to a Serious Incident review, all have received a local review, the MDT did not identify any acts or omissions in care casual to the event.

Any incidental learning from these events are fed back 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 QR code posters 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 themes of low and no harm incidents, audit and, or family feedback.

It is of note that 2 moderate harm events in Q2 were in response to children's safeguarding suspected non-accidental injuries. Both cases were reviewed via the multidisciplinary team with no clinical care concerns identified. The MDT report generated was returned to the children's safeguarding team to inform further review.

3. OCKENDEN UPDATE

4.1 OCKENDEN FINAL REPORT UPDATE – Q2 2023-2024

The Trust is not required to submit evidence of compliance with all 15 Immediate and Essential Actions outlined within the Ockenden report of 2022. Monitoring of compliance and improvement towards compliance is monitored via Specialty Governance, Maternity, and Neonatal Safety Champions via the Internal Performance Review (IPR) presentation every month.

Current compliance as of August 2023.

Ockenden Final 2022 Action Tracker August 2023					
IEA	Green	Amber	Red	RAG of full compliance	
1- Workforce Planning & Sustainability	10	2	3	62.5%	
2- Safe Staffing	↑ 8	3	0	72.7%	
3- Escalation and Accountability	4	3	0	57.1%	
4- Clinical Governance -Leadership	15	1	0	93.8%	
5- Incident Investigation and complaints	↑6	3	0	66.7%	
6- Learning from Maternal Deaths	↑ 4	0	0	100%	
7- Multidisciplinary Training	13	3	1	70.6%	
8-Complex Antenatal Care	6	0	0	100%	
9- Pre-term Birth	5	0	0	100%	
10- Labour and Birth	9	2	0	81.8%	
11- Obstetric Anaesthesia	5	1	0	83.3%	
12- Postnatal Care	1	3	0	25%	
13- Bereavement Care	7	0	0	100%	
14- Neonatal Care	4	2	0	66.7%	
15 supporting families	4	0	0	100%	

Table 5. RUH Maternity & Neonatal position with Ockenden 2022 IEAs

Key Achievements:

- MDT High Dependency training co-produced and implemented for senior midwives working on the Bath Birthing Centre
- Provisional agreement provided of business case to fund consultant staffing establishment

Next Steps for Progressions:

- Continued work towards compliance with 10 safety actions for MIS
- Patient safety partners new in post, to confirm scope of role and attendance at SI panel/ Patient Safety Incident Response Framework (PSIRF) sign off process
- Collation and alignment of the Ockenden IEAs into the Three-year delivery plan of 2023 to ensure cohesive tracking of progress.

Key Risks to full compliance:

- IEA 12 - Postnatal care, the BirthRate+ ward acuity tool remains unavailable at present due to system updating, this is due for re-launch in Q3.

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

5.1 SITUATION REPORT

The maternity training programme is specified in detail in the Maternity Training Needs Analysis (TNA). Please see supplementary paper of the new Maternity TNA for 2023/24 (appendix 1) outlining the new maternity training programme to fulfil all requirements outlined within the Core Competency Framework v2 in line with Safety Action 8 of the NHS-R MIS. The plan outlines how the service will be incorporating the sharing of local maternal and neonatal 'insights' and learning within the maternity training programme.

Compliance with fetal monitoring, neonatal resuscitation and multi-disciplinary training Emergency Skills Training (PROMPT) across all staffing groups within maternity services is required to be maintained above 90% across all staff groups to fulfil the requirements set out within the CNST MIS and Saving Babies Lives care bundle v3.

During Q2, in response to industrial action, and staffing pressures over the summer months mandatory training dates were paused, which resulted in a drop in compliance to below the 90% target. To mitigate the risk of non-compliance, additional training dates have been made available. Improving trajectories were seen at the end of September returning towards 90% compliance. A key area of focus in Q3 is obstetric medical attendance at PROMPT and fetal monitoring, which is currently sitting below the desired target. See figures 4, 5 and 6.

Author: Jodie Clement Quality Improvement and Patient Safety Lead Midwife	Date: 30 December 2023
Approved by: Zita Martinez, Director of Midwifery & Antonia Lynch, Chief Nursing Officer	Version: 3
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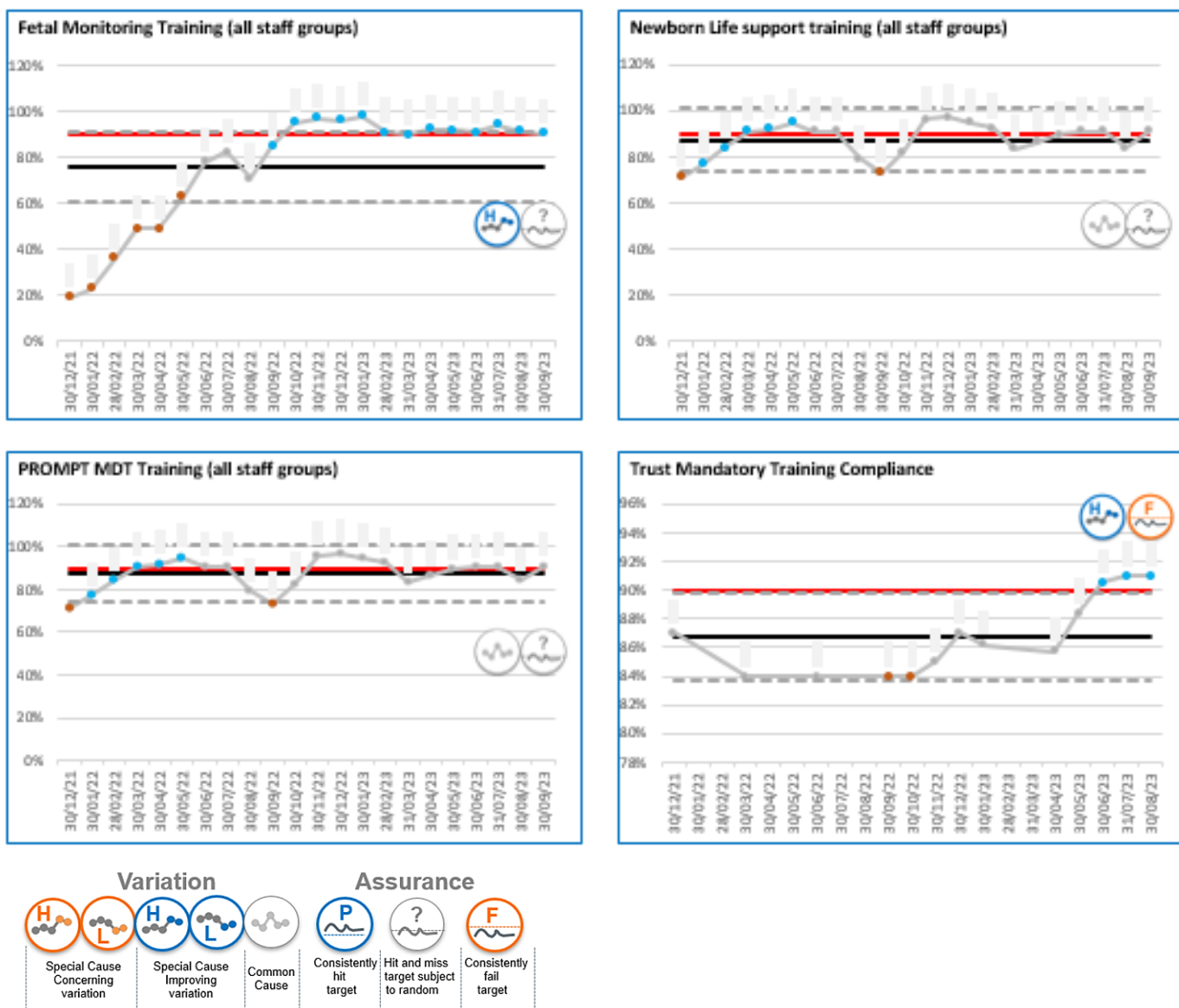


Figure 4. Maternity Training Statistical Process Charts as of 30/09/2023

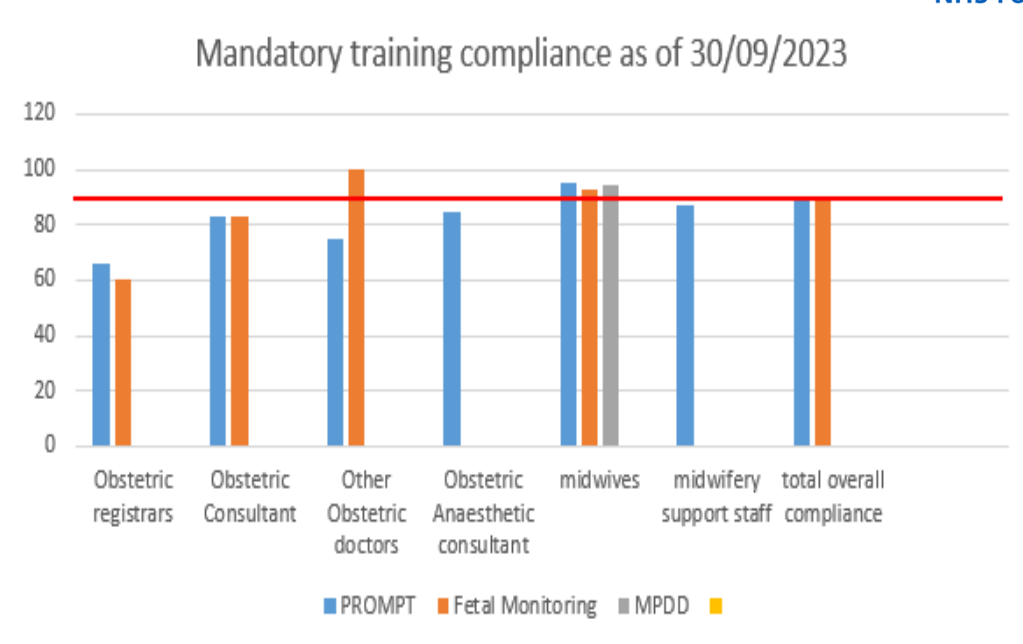


Figure 5. Prompt and fetal monitoring Training Compliance (%) by staff group Q2 2023/24

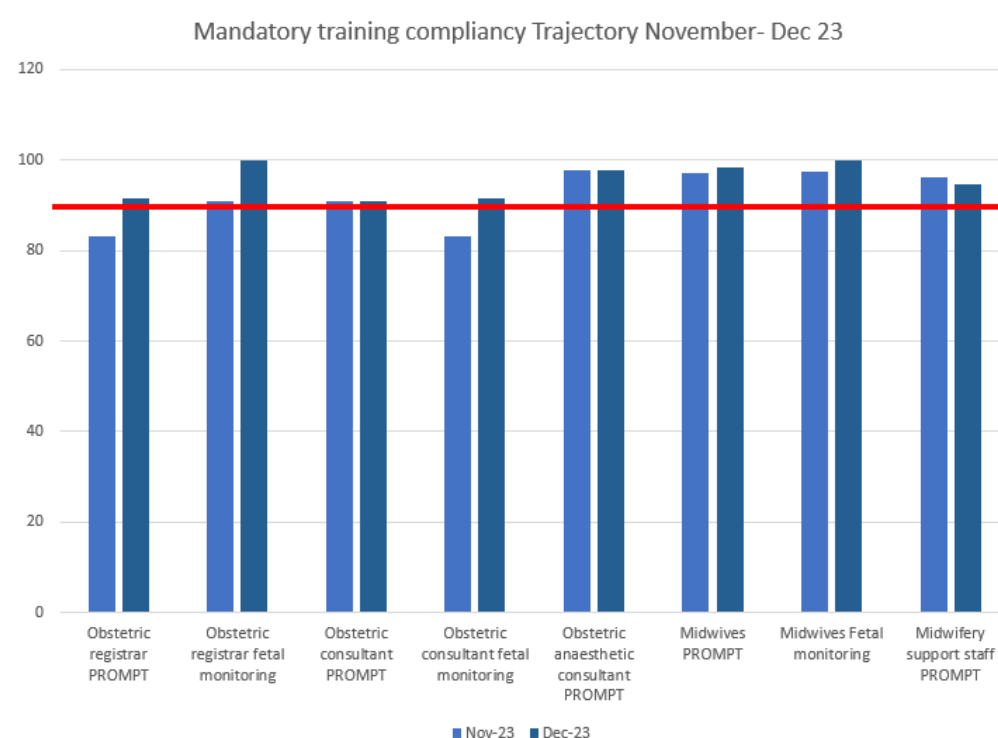


Figure 6. Mandatory training trajectories for Q3 2023/2024

5. BOARD LEVEL SAFETY CHAMPIONS

The Maternity and Neonatal Safety Champions are active in their role to listen to the staff voice in maternity services. All staff are invited to attend monthly 'listening event' meetings and walkabouts with the Chief Nurse, the Non-Executive Director for Maternity and Neonatal services, and the Director of Midwifery. Members of the maternity and neonatal team attended the meetings in Q2 from a range of areas, including community and specialist midwives.

Themes raised during Q2 were:

- Retire and return payment issues following return
- Digital electronic patient records
- The system for on calls
- Community birth team now commenced
- Early pregnancy booklets – timing of distribution to birthing people prior to booking.

Themes, commonalities and actions from this feedback is monitored via the Maternity and Neonatal Safety Champions meetings and is triangulated with further service insights in the Maternity and Neonatal Bi-annual 'Insights' report to drive continuous improvement work.

6. NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q2 2023/24

The Clinical Negligence Scheme for Trusts released their Safety Actions for Year 5 on 30 May 2023 including a new Saving Babies Lives Version 3. Updates on progress and monitoring towards achievement of the 10 Safety Actions is completed and shared within Maternity and Neonatal Speciality Governance meeting, Board Level Safety Champions.

The service's current position towards achievement and projection for submission in January 2024 is outlined in table 6.

	Maternity Incentive Scheme - Safety Action Detail	RAG (Oct 2023)	Projected Submission RAG
1	Are you using the National PMRT to review perinatal deaths to the required standard?	Green	Green
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Green	Green
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Green	Green
4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?	Yellow	Green
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Green	Green
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Red	Red
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Green	Green
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yellow	Green
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Green	Green

10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?		
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Table 6. Progress and trajectories for compliance with MIS Year 5.

Safety Action 4 outlines that:

'Trusts/organisations should implement Royal College of Obstetricians and Gynaecologists (RCOG) guidance on compensatory rest where Consultants and Senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.'

Following local assessment, it has been identified that the RUH is currently unable to facilitate full compliance with the RCOG compensatory rest document, which outlines provision of a period of 11 consecutive hours of undisturbed rest following contact during an on-call.

Current practice for the provision of compensatory rest for medical professionals following an on-call is outlined within the Maternity Standard Operating Procedure MSOP 002 'Staffing – Bath Birthing Centre' and is based around a constructive discussion following an on-call (Manager/clinical director/ clinician) to stand down activity or support appropriate cover.

An anonymous staff survey has been disseminated to consultant staff who contribute to the Obstetric on-call rota to assess the current system effectiveness and efficiency. This survey sought to provide assurance, or to identify improvements required to ensure a safe and robust process for the provision of compensatory rest within RUH maternity services.

The staff survey consisted of five questions as outlined below:

- Q1 - Do you feel supported in taking compensatory rest following an on-call?
- Q2 - Would you feel able to escalate if compensatory rest was not adequate following an on-call?
- Q3 - Have colleagues offered to cover for clinical duties following an on call, to facilitate compensatory rest?
- Q4 - Have you felt safe to return to clinical duties after working you on call?
- Q5 - Are you willing to cover colleague's clinical duties at short notice to provide compensatory rest?

Responses have been received as below:

Response	Average % across all responses
Always	67.5%
Sometimes	30%
Rarely	2.5%
Never	0%

Table7. Responses to anonymous Obstetric on-call rota survey September 23

Next steps:

- To ensure accurate data collection for the number of out of hours worked on top of allocated hours as part of the on-call consultant commitment, to inform future planning and risk mitigations as required
- To ensure a process for the accurate recording of when cover/cancellations have been made in response to the provision of compensatory rest. This will form future evidence submissions for MIS SA4.

The mitigated plan to achieve compliance with the compensatory rest was submitted to Quality Governance Committee in December 2023 and approved by the Board Level Safety Champions in December 2023.

This year KPMG undertook an internal audit assessing the evidence to demonstrate compliance with all 10 Safety Actions for MIS. This audit commenced in October of 2023 with a finalised draft report anticipated in November 2023 and provided in the Q3 update.

Safety Action 6 of MIS has been excluded from the audit as this element of MIS is being overseen by the Local Maternity and Neonatal System (LMNS).

7. SAFETY ACTION 6 OF MIS SAVING BABIES LIVES CARE BUNDLE V3.

Saving Babies Lives version 3 was released on 30 May 2023. Version 3 has incorporated a new element 'Element Six: Management of pre-existing diabetes'. The Trust's compliance with implementation of all interventions outlined is being assessed externally by the LMNS using the national implementation tool on NHS futures platform. The Trusts current evidenced position is detailed in table 8.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	70%	Partially implemented	20%
Element 2	Fetal growth restriction	Partially implemented	40%	Partially implemented	5%
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%
Element 4	Fetal monitoring in labour	Partially implemented	60%	Not implemented	0%
Element 5	Preterm birth	Partially implemented	78%	Partially implemented	63%
Element 6	Diabetes	Fully implemented	100%	Partially implemented	33%
All Elements	TOTAL	Partially implemented	66%	Partially implemented	33%

Table 8. RUH Maternity Current position for implementation of Saving Babies Lives v3.

Ongoing work continues towards compliance with significant improvement trajectories seen in evidenced compliances during Q3

Key areas of focus and risk to non-compliance are:

- Element 2 and the capacity of Obstetric Ultrasound (USS) department to facilitate alignment to the national USS pathways. Significant systems and practice changes required in response, phased implementation planned with phase one aiming for implementation at the end of Q3 2023. Risk Register entry 1948.

- Element 2 not all digital BP monitors are currently validated for use in pregnancy and pre-eclampsia. National problem with procurement in response to Saving Babies Live v3.
- Element 4 please see Figure 6 within this report for training trajectories and recovery for compliance anticipated in Q3.

CNST MIS compliance requires 70% implementation compliancy by submission in February 2023 encompassing of a minimum of 50% compliancy in each of the elements. The current projection is for 71% of compliance by submission in February 2024.

8. SAFE MATERNITY STAFFING

9.1 MIDWIFERY STAFFING

As of 05 September 2023, the band 5/6 Midwifery vacancy rate as +ve1.48 whole time equivalents (WTE), of which 5.29 WTE are on maternity leave giving an overall substantive absence rate of 3.81 WTE.

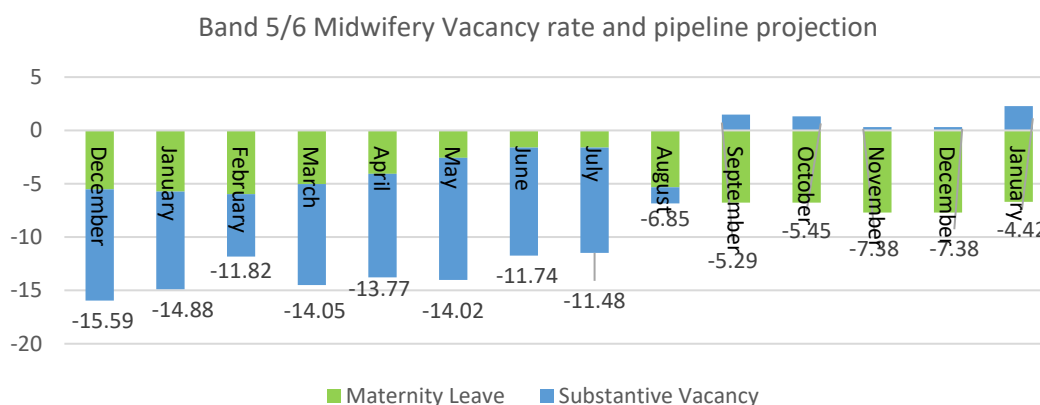


Figure 7. Band 5/6 Midwifery Workforce staffing vacancy and forecast (not including long-term sickness)

Measure	Aim	July	August	September
Midwife to birth ratio	1:24	1:32	1:29	1:29
Midwife to birth ratio including bank	1:24	1:29	1:26	1:26
Supernumerary labour ward coordinator status	100%	98%	99%	99%
1:1 care not provided	0	1	0	0
Confidence factor in Birth-rate+ recording	60%	83%	78%	69.4%

Table 9. Midwifery staffing safety measures

A. OBSTETRIC STAFFING

Measure	Aim	July 23	Aug 23	Sep 23
Consultant presence on BBC (hours/week)	≥90 hours	98	98	98
Consultant non-attendance (in line with RCOG guidance)	0	0	0	0

Twice daily MDT ward round	90%	97%	94%	67%
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Table 10. 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. Risk 2581.

A business case has been presented to convert the current unsubstantiated posts into establishment. The funding for these posts was approved in Q3 and therefore the risk will be re-assessed with potential for closure.

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

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

	July 23	August 23	September 23
Number of formal compliments	1	4	4
Number of Patient Advice and Liaison Service (PALS) contacts/concerns	6	1	3
Complaints	0	0	0

Table 11. Complaints and compliments Q2 23/24

No complaints have been received in Q2. 10 PALS enquiries have been received over the quarter, including a car parking fine, birthing choices outside of guidance seeking a point of contact, call handling responses, care on Mary ward and delay's in induction of labour. There were no consistent commonalities identified.

The service is currently reviewing the risk of delays to induction of labour and is anticipated to feature on the risk register in Q3 including actions to mitigate the risk to both safety and patient experience.

A new role commenced during Q2 to focus on patient flow and experience, working collaboratively with an Obstetric Consultant and the Maternity and Neonatal Voices Partnership Plus (MNVPP). As a result of service user insights and local patient safety reviews there is a plan to launch a Birth Options Clinic to support birthing people/women and families with pregnancy and birth preferences outside of guidance, which will commenced in Q3.

Compliments received thanked staff for their high standard of care and care provided during the birth of a premature baby. The service is currently exploring data capture to accurately represent the number of compliments received by the service via informal routes such as social media.

10. AVOIDABLE ADMISSION INTO THE NEONATAL UNIT (ATAIN) & TRANSITIONAL CARE

In line with the Safety Action 3 of MIS, all term admissions ≥ 37 weeks gestation to the NNU are reviewed including Neonatal Unit transfers regardless of their length of stay. During Q2, 3 avoidable term admissions to the NNU were identified.

All term NNU admissions that required non-invasive respiratory support have been reviewed. This review seeks to identify care changes to expedite the repatriation of the baby to the care of their mother.

In Q2, there were 5 babies admitted into the NNU from outside of maternity, this was noted as

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an increase on the previous quarter where there was 1. The admissions have been discussed and ascertained that the NNU was an appropriate care setting, no themes have been identified with the readmissions.

In Q2, 56% of the total number of admissions to the Neonatal Unit, (106 *babies*) were cared for on the transitional care pathway (TCP) for some or part of their admission. Of which 40%, (75 *babies*) spent the entirety of their admission on the TCP. No babies were identified as missed opportunity for TCP.

Staffing met the Maternity Safety Action for TCP, 100% of shifts in July and August, in September this dropped to 88%, due to the Neonatal Unit capacity and acuity, in conjunction with vacancies in B6 and B5 posts, and increased annual and study leave. On one shift in September midwives supported TCP by carrying out observations on the babies under the TCP. This showed collaboration between maternity staff and neonatal staff and facilitated the mother and baby staying together. For the full Q2 TC and ATAIN report please see appendix 2.

11. RISK REGISTER

In Q2 Maternity and Neonatal, services presented three new risk assessments, which was approved for the risk register:

2562	There is a risk to the Electronic Patient Record (EPR) due to unsecured funding following withdrawal from Cerner Millennium	12
2581	There is a risk that we will be unable to meet the service demand for obstetric medical staging with the current unsecured establishment of Obstetric Consultant.	12
2591	There is a risk that the current funded provision of Allied Health Professionals in the Neonatal Unit will not continue following cease of fixed term funding from the neonatal Operational Delivery Network.	9

Table 12. New Risks for the Maternity and Neonatal risk register Q2 2023

During Q2 one risk was closed, as felt accounted for within Risk 1948

2353	Replacement of ultrasound machine	4
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Table 13. Closed Risks for the Maternity and Neonatal risk register Q2 2023

A full summary of the Maternity risk register is as below. Actions towards closing the gaps identified within the individual risk assessments on datix, and continued mitigation of risk, will be monitored through Specialty and Divisional governance with Trust Management and Executive oversight to ensure appropriate actions are taken in accordance with the Trust risk framework.

Areas of emerging risk currently under assessment are:

- Delays to induction of labour
- Service provision of digital blood pressure monitors validated for use in pregnancy and pre-eclampsia
- Tertiary level neonatal cot capacity in the region
- Family Origin Questionnaire processing for screening of Haemoglobinopathies
- Room bookings for mandatory training programme as outlined in the maternity TNA – section 6.

1734	Day Assessment Unit patient safety risk – area not compliant or fit for	15
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	purpose	
1948	Obstetric ultra sound scan capacity	12
2359	Maternity Information System IT support/capacity	8
2396	Obstetric theatre emergency call bells	12
2417	Maternity triage	12
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
2562	There is a risk to the Electronic Patient Record (EPR) due to unsecured funding following withdrawal from Cerner Millennium	12
2581	There is a risk that we will be unable to meet the service demand for obstetric medical staging with the current unsecured establishment of Obstetric Consultant.	12
2591	There is a risk that the current funded provision of Allied Health Professionals in the Neonatal Unit will not continue following cease of fixed term funding from the neonatal Operational Delivery Network.	9

Table 14. Maternity and Neonatal Risk Register September 2023

12. RECOMMENDATION

The Board of Directors is asked to receive and discuss the contents of the report.

Appendix 1. Maternity Training Need analysis 23/24

Appendix 2. TC and ATAIN report Q2 23/24

Information for Clinicians

Appendix 1: Maternity Department Training Needs Analysis

Purpose

To provide guidance to all maternity staff on their training requirements. To be transparent regarding the identification of training needs throughout maternity to ensure safe and effective service delivery. This Training Needs Analysis (TNA) relates to:

- Midwives
- Obstetricians
- Anaesthetists and Paediatric Staff who work in maternity
- Maternity Support Workers

This document aims to support the achievement and maintenance of training compliance at or above 90% across all aspects of maternity training requirements, in line with maternity standards. Compliance is monitored monthly, using the Perinatal Quality Surveillance Tool and non-compliance escalated to the Divisional Lead for Quality and Safety in Family and Specialist Services.

Background

Education and Training are key to providing safe and compassionate maternity care for birthing people and their families. The Ockenden Report (2020) listed seven Immediate and Essential Actions to help improve safety in maternity services across England. Essential Action 3 stated that “Staff who work together must train together”. Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the Local Maternity and Neonatal System (LMNS), 3 times a year.

The TNA is informed by the Core Competency Framework and content within training days has a large focus on; service user experience and feedback, learning from incidents and excellence in clinical practice, human factors and escalation. All training has equality, diversity and inclusivity threaded throughout; exploring deterioration in black and brown women and babies, service user experience and inclusivity of language.

The Maternity Safety Strategy set out in the Department of Health and Social Care's vision, incentivises to reward services where action has been taken to improve maternity safety. Royal United Hospitals Bath NHS Trust continues to follow the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) scheme (2021). The criterion relevant to training is Maternity Safety Incentive Scheme safety action 8 (Appendix 1).

During the COVID-19 pandemic, the 10 criteria were amended in line with the evolving situation and updates sent to Trusts. The most current update to Safety Action 8 issued in October 2021 requires Trusts to evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of the Maternity Incentive Scheme (MIS) year four.

Throughout COVID-19 training was modified to an online format to ensure it continued. From June 2020, all staff were able to access online training resources. In 2021 a blended approach was adopted and in line with the previous training needs analysis; a review was conducted and method of facilitation changed to face to face in 2023 with the exception of externally provided courses and the maternity professional development day.

Blended learning components

Sessions are offered using the following learning and teaching methods;

- Classroom based - Trainer led
- Practical workshops/ scenarios - MDT approach
- E-learning - included midwifery and obstetrician access to K2 Perinatal Training Programme
- Self-directed study - resources provided

Training will always include fetal monitoring in labour and integrated team-working, including Situation, Background, Assessment, Recommendation (SBAR) and Modified Early Obstetric Warning Score (MEOWS), with relevant simulated emergencies and/or hands on

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workshops. The annual syllabus is based on current evidence, national guidelines/recommendations, any relevant local audit findings; risk issues and case review feedback, and includes the use of local charts, emergency boxes, algorithms and proformas. Feedback on local maternal and neonatal outcomes is always included. The example specific curriculum is included within the training matrix (Appendix 2).

All sessions are evaluated and feedback and feedforward actioned.

Definitions

Statutory training

Statutory training is defined by law, is covered by a Statutory Instrument and is compulsory for staff to attend if appropriate to their role. Statutory training does not relate to the requirements of professional registration. The statutory training requirements can be accessed through the Learning Together platform.

Mandatory training

Mandatory training is not covered by a Statutory Instrument but is determined by the Trust as compulsory for staff to attend in accordance with the terms and conditions of their contract of employment. Mandatory training is essential to enable staff to practice safely and effectively in order to maintain their professional competence in keeping with national standards. It is concerned with minimising risk, supporting the implementation of policies and ensuring the Trust meets required standards.

Additional Training and Continuing Professional Development

Additional training comprises any training that is either arranged by Maternity/Trust education teams or training that a member of staff may wish to attend individually. This will include clinical skills/drills sessions in the clinical area, discussion groups or meetings and one-off specialist sessions in line with learning actions identified from investigations into incidents and service/training needs. It also encompasses training that is not essential to your current role.

All members of the midwifery team are encouraged to continue with professional development through reading relevant materials to attending training days. Additional funding and support can be accessed through both the continuous professional development (CPD) fund (midwives only) and the Maternity Professional Development Panel (all staff).

Attendance on CPD in the majority will not be supported within the applicant's working hours or as bank payments and travel (if external) will not be agreed.

Examples of CPD training includes and is not limited to:

- CTG masterclass training
- In House Maternal High Care training
- Emergencies in the community training
- Bereavement training

Examples of training which (with discussion with line managers) may be approved to be attended within clinical hours/bank pay:

- Examination of the Newborn
- Newborn Life Support

All applications will be highlighted in the Maternity Development Panel meeting.

Responsibilities

Maternity staff attendees should include obstetricians (including Consultants, staff grade and trainees); obstetric anaesthetic staff (Consultants and relevant trainees); midwives (including midwifery managers and matrons, specialist midwives; community midwives; birth centre midwives; maternity care assistants) to be included in the maternity skills drills as a minimum and other relevant clinical members of the maternity team. Maternity theatre and critical care staff undertake their own departmental training and the vision is to include into maternity PROMPT when COVID restrictions allow.

Role of Individual staff members in maternity

Individual staff members in maternity are responsible for:

- Completing all training required by the Trust and Maternity service and within the required timeframe.
- Undertaking sufficient preparation to enable full participation, keeping records of all training completed and being prepared to change practice through the development of knowledge and skills.

- Being aware of their own individual education/training needs and understand how these fit with the organisation and service objectives.
- Being prepared to share learning with their colleagues, discussing the impact of education events with their line manager and colleagues.
- Ensuring their managers are aware of any circumstances that might prevent attendance/participation in a timely manner.
- Accepting their personal responsibility for professional updating to include booking training dates via the Learning Together platform & employee on-line.

Role of Education Leads and Trainers in maternity

Education leads and trainers in maternity are responsible for

- Ensuring the training programme is dynamic and responsive to a changing workforce and clinical environment.
- Co-ordinating training programmes, venues and communication.
- Liaising closely with the Workforce Development Team and Senior Managers in maternity.

Within maternity services, the Quality Improvement and Education Midwife facilitate the process of reviewing and setting the training framework for maternity services in addition to the above they are responsible for:

- Reporting on training to the Maternity Senior Leaders.
- Coordinating the PROMPT training for the multi-disciplinary team.
- Contributing to the delivery of essential training.
- Assessing the evaluation of education events.
- Support staff to learn and develop essential practical skills including emergency skills/drills.

- Maintains the training databases locally, cross references with the Trust Electronic Staff Record (ESR) and submits monthly and quarterly reports of training compliance to the senior team as required.

Role of Maternity Services managers and Consultant Obstetricians

Maternity Services managers are responsible for:

- Ensuring an annual programme setting out the priorities for training dates and protected training for midwifery staff is in place.
- Ensuring that compliance, remedial actions, capability and performance are monitored with correct process followed.
- Ensuring that responsibility for the training requirements of each clinical speciality has a designated lead with direct accountability.

Administration support

- The Training Administrator assists with practical tasks relating to booking, arranging and updating compliance around training.
- The Workforce Development Team is responsible for centrally updating attendance at training on the Electronic Staff Record (ESR) produce monthly reports on attendance and non-attendance of staff/staff groups in relation to mandatory and essential training.

Training Requirements and compliance

The RUH Maternity Training Matrix (Appendix 2) provides the specific training requirements, content, frequency and compliance requirements for maternity staff. Appendix 3, 4 and 5 demonstrate the schedule of the days. Management of staff who fail to engage in training is documented in Appendix 6.

Other

The Quality Improvement and Education Midwife is allocated a budget for the training of maternity staff to ensure it is ring-fenced and used for this purpose only. Existing training has been reviewed to ensure it is fit for purpose and identifies any new training requirements.

Appendix 1: CNST Standards



Core competency framework

In collaboration with national maternity partner organisations including the Royal Colleges, HSIB, NMC and NHS Resolution, the Maternity Transformation Programme has led on the development of a Core Competency Framework to address known variation in training and competency assessment and ensure that training to address significant areas of harm are included as minimum core requirements for every maternity and neonatal service.

Further work is being undertaken to develop support tools, particularly in relation to fetal monitoring. In meeting the requirements of the Core Competency Framework, clinical teams will also need to take into account the need for training to be undertaken safely during COVID. The training content might need to be delivered remotely or digitally and should include fetal monitoring as well as standard emergencies to share and address learning from local maternity and neonatal outcomes. Furthermore, in the current circumstances, there should be training for local Covid-19/PPE emergency care and maternity critical care (see requirements 7 and 8 and Covid-19 maternity specific e-learning training).

Delivery of the training requirements must include consideration of human factors, local transfer processes and policies (hospital and community settings), use of locally agreed safety language and communication with women, families and staff, particularly where debrief is required as part of emergency scenario training.

The training syllabus should be delivered locally and based on current evidence, national guidelines/recommendations, any relevant local audit findings, risk issues and case review feedback, and include the use of local charts, emergency boxes, algorithms and proformas. The local training faculty should be multi-professional so that they are representative of the current maternity teams, and therefore, in addition to the midwifery educators, there should be protected time for obstetricians and anaesthetists to be able to support this local training.

The teams involved in each of the eight priority areas below are set out in **Safety Action 8** of the Maternity Safety Incentive Scheme.

Document Control Information

Consultation Schedule

Name and Title of Individual	Date Consulted
Jodie Clement	October 2023
Samantha Hayward	October 2023

Appendix 2: RUH Maternity Training Matrix

Training	Delivery Method	Staff Group	Frequency	Provider	Compliance Target
Mandatory e-learning modules on Learn Together record					
See own Learn Together Record	e-learning	All maternity staff	As detailed on personalised Learning Together Records	RUH	≥90%
Maternity PROMT					
<p>Pre course reading provided prior to training day.</p> <p>Presentations: Civility and benefits of MDT training Psychological Safety and support systems available Communication with families in an emergency. Human Factors Deteriorating Woman with base based discussions (including learning from excellence):</p> <ul style="list-style-type: none"> - Cardiac conditions - DVT - Sepsis <p>Impacted Fetal Head</p>	<p>Blended Learning Approach Delivered as a rolling programme every month. Programme changes annually with different simulations and presentation content developed as an MDT faculty.</p> <p>Face to face session.</p> <p>Pre course reading provided: Civility and Workplace behaviour</p>	<p>Midwives Obstetricians MSW Anaesthetists working in Maternity</p>	<p>Annually 1 day</p>	<p>RUH PROMPT Multidisciplinary Team Faculty</p>	<p>≥90%</p>

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<p>Breech Scribe session specific for Maternity Support Workers.</p> <p>Simulations taking place in the clinical areas:</p> <ul style="list-style-type: none"> - Cord Prolapse - Anaphylaxis - Shoulder Dystocia - APH <p>All simulated in both community and acute settings with discussion about transfer, escalation and SBAR.</p>	<p>SBAR</p> <p>Sever Hypertension and Pre-eclampsia</p> <p>Impacted fetal head</p> <p>Shoulder dystocia</p> <p>Vaginal breech birth</p> <p>Post-partum haemorrhage</p> <p>Umbilical cord prolapse</p> <p>Anaesthetic Emergencies</p> <p>Failed intubation</p> <p>High Block</p> <p>Maternal Collapse and Anaphylaxis</p> <p>Uterine Rupture</p> <p>Support</p> <p>Operative Vaginal Birth</p>				
<p>Newborn Life Support</p>					

Local Trust training Community/homebirth and acute unit scenarios. Wide variety of equipment used.	Face to Face 4 stage approach Content reviewed if NLS Guidelines change	Midwives Obstetricians MSW's Paediatricians attending births	Annual Update 1 hour	NLS Instructors, resuscitation team or senior neonatal providers.	≥90%
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Newborn Life Support UK Resuscitation Council Course					
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UK Resus Council (NLS)	Face to Face	All Labour ward coordinator midwives, offered to band 6 midwives	Every 4 years 1 day	Local providers/ RUH/ Bristol and Swindon/ any NLS provider	
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Fetal Monitoring, Saving Babies Lives and K2 Assessment					
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Smoking in Pregnancy Local Pathways Very Brief Advice (VBA) training CO monitoring and discussion of results Local Pathways Reduced Fetal Movements Local Pathways and protocols Learning from case histories. Fetal Growth Restriction	Face to Face	Midwives Obstetricians	Annually	Fetal Monitoring Lead Midwives Lead Obstetrician	≥90%
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<p>Referral pathways and identification of risk factors, Local Learning including case reviews of missed cases locally. SFH plotting and interpretation of results.</p> <p>Pre-term Birth Risk factors Optimisation and stabilisation of preterm infant – Peri-prem package Risk assessment and management of multiple pregnancy</p> <p>Diabetes Risk factors Referral process Glucose management Care of the diabetic woman in labour</p> <p>Fetal Monitoring Fetal physiology Risk Assessment Monitoring Growth Restriction/ SFH Fetal Movements Surveillance of multiple pregnancies Fetal Monitoring K2 assessment IA, Role of the 2nd Midwife Latent Phase of labour Local case histories and learning from incidents GBS VBAC Human Factors/Civility</p>					
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RCOG escalation toolkit					
Infant Feeding					
	New starter training face to face session (BFI Recommendation)	Midwives MSW	Once only	Infant feeding lead midwives	≥90%
Infant Feeding					
	Practical Skills assessment	Midwives MSW	Every 2 years (alternates with MPPD)	Infant feeding keyworkers	≥90%
Smoke Free Pregnancy					
	New starters elearning supporting Smoke Free Pregnancy	Midwives MSW	Once only	Smoke Free Pregnancy Lead Midwife Jo Coggins	≥90%
Bereavement care					
	Face to Face session	All new starters	Once only	Bereavement Lead Midwife	90%

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		Midwives			
OASI and Perineal Suturing					
	Face to face skills session	All new starters Midwives. CPD opportunity. Obstetricians in training	As required At least 2 session each year	Senior Obstetrician/ OASI Lead	100%
Adult Basic Life Support					
	e-learning Respect Face to face session	Midwives Obstetricians MSW Anaesthetists	Every 2 years 2.5 hours	RUH Resuscitation Team	≥90%
Maternal Mental Health					
	Update session face to face or virtual	Midwives	Currently part of MPDD Session as part of maternity lv 3 safeguarding study day	Specialist Mental Health Midwife	≥90%
Blood Transfusion Competencies					
	E-learning Competencies	Midwives	Every 2 years	RUH ESR Online training/ RUH Transfusion team	≥90%

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Cannulation					
	Workbook	Midwives MSW	Within 1 year	RUH Trust competencies/ workbook	≥90%
Safeguarding					
Adults Level 2 Children Mat Specific	E- Learning through Learning Together Face to face study day	All new starters Midwives 16 hours level 3 safeguarding All midwives require 12-16 hours training All MSW's - Level 3 Safeguarding	On starting Every 3 years	RUH Safeguarding Team	≥90%

Equality, Equity and Personalised Care

<p>Personalised Care and Support Planning What matters to you conversation Principles of Personalised Care Overcoming Barriers to Personalised Care Standardised method of discussion around informed consent and shared decision making Montgomery Ruling Service User Feedback Local Learning and Guidelines Referral Process for Birth Choices Lead</p> <p>Anti-Racism Training Increase knowledge of white body normalising Unconscious bias Service User experience and Voice</p>	<p>Face to Face 2.5 hours 1 hour pre course training video – online. once only</p> <p>3 hours online training</p> <p>Once only</p>	<p>Midwives, Maternity Support Workers Obstetricians</p> <p>Midwives, Maternity Support Workers, Obstetricians, Anaesthetists Neonatal team including doctors, nurses and ANNPs. Maternity administrators,</p>	<p>Once only</p> <p>Once Only</p>	<p>Transformation Lead and facilitators</p> <p>BCohCo – external</p>	<p>≥90%</p> <p>≥90%</p>
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Maternity Professional Development Day					
University of West England update Maternity in the media Patient Safety Update – ATAIN Screening update Epidural Update/GA recovery Infant Feeding Pelvic Health/OASI update Research Update Human Factors – RCOG escalation “Team of the shift”. Inclusivity with a service user input NICU QI Updates: - Deterioration of black and brown babies - Neonatal Blood Sampling Digital Update	Online		Every 2 years 1 day	Senior Midwives/ Specialist Midwives	≥90%
ROBuST					
	Face to Face	Obstetricians	Completion of competencies	Consultant Lead	All O & G trainees by end of ST3
Newborn & Screening					

Newborn hearing screening Elearning	E-learning on E-LFH	Anyone completing newborn hearing screening	yearly	E-LFH	
Newborn Infant Physical Examination	See separate training guideline Neo 096 Clinicians performing the NiPE	All NiPE practitioners	Annual competency (4 elements)	NiPE Peer Assessors	≥90%
Newborn blood spot	E-learning on E-LFH	Day 5 screeners	yearly	E-LFH	
Population screening	E-learning on E-LFH	Screening team	2 yearly	E-LFH	
Downs, Edwards and Patau's Syndrome screening	E-learning on E-LFH	Antenatal screening team	2 yearly	E-LFH	

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Appendix 3: Example Maternity PROMPT Day Timetable

Subject	Time	Venue
Shoulder Dystocia (Obstetrician)	08:30	RUH Education Centre Room TBC
Impacted Fetal Skull (Obstetrician)	09:00	
Postpartum Haemorrhage (Obstetric Anaesthetist)	09:30	
Newborn Life Support (NLS Instructor/ Resuscitation Team)	10:30	
Breech Birth (Obstetrician)	11:30	
Discussion and Finish	12.00	
Introduction to MBBRACE 2021 Preventing Maternal Deaths – we are all part of the solution (Obstetrician)	13:30	Teams
Covid Update (Anaesthetist)	14:00	Teams
Pre-Eclampsia and Eclampsia including local scenario (Education Midwife)	14:45	Teams
PERIPREM (Education Midwife)	15:30	Teams
RCOG Situational Awareness and Discussion of Human Factors including Haemovigilance update (Transfusion Nurse Specialist)	15:45	Teams

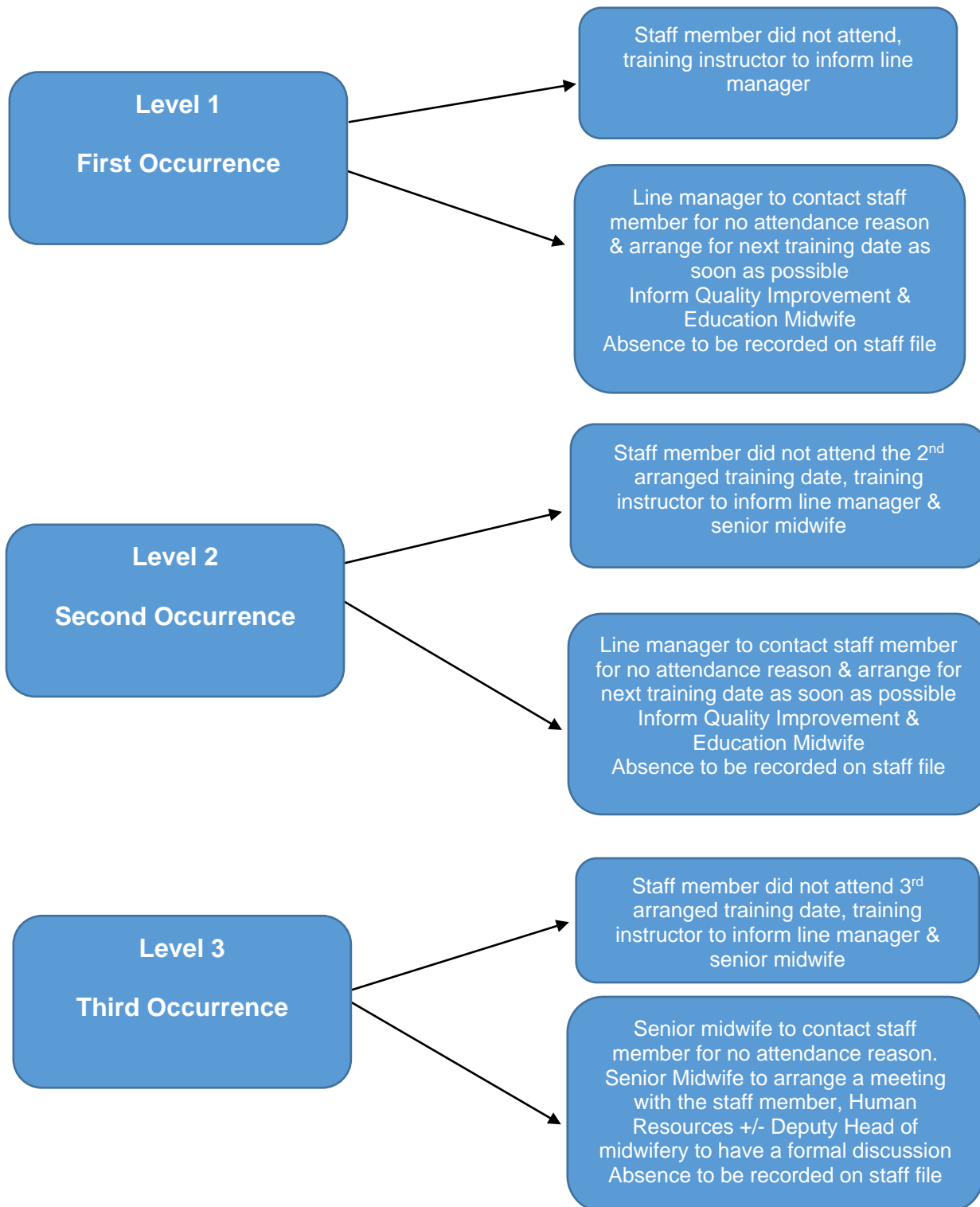
Appendix 4: Example Maternity Professional Development Day Timetable

8.15am- 08.30am	Welcome and Introductions- Senior Team e.g. Deputy Director of Midwifery or Quality Improvement and Education Midwife to relay message if senior team unavailable
8.30am – 9.00am	University of West of England Supporting Students Update– University Lecturer/PALM
9.00am – 9.15am	Research at RUH Maternity- Research Team
9.15am – 10.15am	Perinatal Mental Health (PNMH) - PNMH Specialist Midwife
10.15am – 11.15am	Antenatal and Newborn Screening – Screening Team
11.15am – 12.30pm	Bereavement Care – Bereavement Lead Midwife
12.30pm – 1.00pm	Lunch- Please stay on Teams and network with your colleagues if you wish.
1.00pm – 1.30pm	Patient Safety Update- Patient Safety Midwife
1.30pm – 2.30pm	HIPS / BLOOM update Infant Feeding Workshop Infant Feeding Specialist Midwife
2.30pm – 3.30pm	Diabetes management- Diabetes Specialist Midwife
3.30pm – 4.00pm	Human Factors – Maternity Matrons
4.00pm – 4.30pm	Digital Maternity Update– Maternity IT digital lead
	Evaluations to be emailed to Quality Improvement and Education Midwife

Appendix 5: Example Fetal Surveillance Day Timetable

Time	Activity MORNING STUDY SESSION
08.30-8.40	Welcome
08.40-9.00	Why have a fetal monitoring study day? Saving babies lives, maternity incentive scheme, Ockenden report
09.00-9.45	What is 'normal' physiology of fetal heart rate control? Intermittent auscultation
9.45-10.15	Group case study activity
10.15-10.45	What happens when things start to go wrong? Pathophysiology and features of fetal hypoxia with scenario
10.45-11.00	BREAK
11.00-11.45	Completion of e-lfh elearning Detection and surveillance of fetal growth restriction https://portal.e-lfh.org.uk/myElearning/Index?HierarchyId=0_44592&programmeld=44592
11.45-12.30	Risk factors (SGA, oxytocin, meconium and temperature). Discussion of case studies displaying these risk factors
11.45-12.15	BREAK
12.15-16.30	Completion of K2 if not already completed prior to session

Appendix 6: Failure to attend training procedure



Document Control Information

Consultation Schedule

Name and Title of Individual	Date Consulted
Jodie Clement, Patient Safety Midwife	October 2023
Samantha Hayward, Obstetric Consultant	October 2023

The following people have submitted responses to the consultation process:

Name and Title of Individual	Date Responded

Name of Committee/s (if applicable)	Date of Committee
Clinical Effectiveness SBL	5/10/2023

Ratification Assurance Statement

Dear Julia Hogg

Please review the following information to support the ratification of the below named document.

Name of Guideline: M113 - Training Needs Analysis

Name of author: Natasha Browne

Job Title: Education and Quality Improvement Lead Midwife

I, the above named author, confirm that:

- The Guideline presented for ratification describes best practise known to me at the time of the development of the guideline.
- I will bring to the attention of my clinical director or line manger any information which may affect the validity of this Guideline as soon as this becomes known to me;
- I have undertaken appropriate consultation on this Guideline and have considered all responses.
- I acknowledge that the policy will be kept under review, and that I may be asked to refine the guideline. If no interim changes are required it will then be formally reviewed on its documented review date.

Signature of
Author:



Date: October 2023

Name of Person
Ratifying this
Guideline:

J Hogg

Job Title:

Consultant Obstetrician and
Gynaecologist

Signature:



Date: 13/10/2023

To the person approving this Guideline:

Please ensure this page has been completed correctly, then print, sign and **post this page only** to: Director's Office, Wolfson Centre (D1), Royal United Hospital

The **whole guideline** must be sent electronically to: ruh-tr.policies@nhs.net

Clinical Audit Report

Appendix 2: Transitional Care Pathway and ATAIN Audit Q2 2023/2024

Speciality: Local Neonatal Unit

Division: Family & Specialist Services Division

Project team				
Kirstie Flood	Title/grade:	Senior Sister	Data period:	Q2 July 2023 – Sep 2023
Sarah Goodwin	Title/grade:	Quality and Education Neonatal Sister	Report completion:	October 2023

Title: RUH TC and ATAIN Audit Q2 2023/2024 July 2023 – September 2023	Authors: Kirstie Flood Senior Sister Neonatal Unit Sarah Goodwin Quality and Education Neonatal Sister
Date October 2023	Version: 1

Transitional Care Pathway and ATAIN Audit Q2 2023/2024

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Disciplines involved
Project leads
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Transitional Care and ATAIN Action Plan

Appendix 1: Detailed analysis of babies requiring TCP

Appendix 2: Detailed analysis of term babies admitted to the Neonatal Unit

Title: RUH TC and ATAIN Audit Q2 2023/2024 July 2023 – September 2023	Authors: Kirstie Flood Senior Sister Neonatal Unit Sarah Goodwin Quality and Education Neonatal Sister
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Executive Summary

Background

This audit supports Safety Action 3 of the Maternity Incentive Scheme.

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 Neonatal Units (NNU) 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 System (ICS) quality surveillance meeting each quarter.
- The number of neonatal unit admissions that met TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues.
- The number of babies (34+0 - 36+6) admitted to, or remained on NNU because of the need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there.
- An embedded data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care, postnatal ward, virtual outreach pathway etc.). The data should capture babies between 34+0-36+6 weeks 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 that findings and action plans are shared with the Board Level Safety Champions, LMNS and ICS quality surveillance meeting each quarter.
- Monthly reviews of unanticipated term admissions to the NNU to determine whether there were modifiable factors as part of an action plan.

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- 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 with a focus on the main reason(s) for admission to determine relevant themes and addressed at a monthly Multi-disciplinary Team (MDT) ATAIN meeting.

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Key findings

Standard	Compliance July 2023	Compliance August 2023	Compliance September 2023
Audit findings shared with neonatal safety champion	100%	100%	100%
The number of admissions to the neonatal unit 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	4	6	5
% of shifts TCP nurse provided as per TCP staffing model	100%	100%	88%
TCP open	100%	100%	100%
Number of babies readmitted to neonatal unit from TCP	0	0	0
Of the cases reviewed, the number of avoidable term admissions 37+0 weeks gestation and above admitted to the neonatal unit	0	2	1
The number of term babies transferred or admitted to the neonatal unit from other areas – for example Emergency Department, Children’s ward.	3	1	1

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Clinical Audit Report

Project title

Transitional Care and ATAIN Audit Q2 2023/2024 July - September 2023

Division

Family & Specialist Services Division

Specialty

Local Neonatal Unit

Disciplines involved

Neonatal Nursing Team

Obstetric MDT

Project leads

Kirstie Flood Senior Sister

Sarah Goodwin Quality and Education Neonatal Sister

Standards

Maternity Incentive Scheme - year five. Safety action 3.

Sample

All admissions to NNU (Neonatal Unit) and TCP (Transitional Care Pathway) were assessed to determine if correct location of care was achieved.

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All babies born at 37+0 weeks gestation and above had their antenatal and postnatal care assessed at a multi-disciplinary meeting involving both the obstetric and neonatal team to determine if their admission to the LNU could have been avoided.

Data source

BadgerNet, NNU, and TCP admission book and individual medical notes.

Audit type

Retrospective and live data collection.

Transitional Care Audit Findings

- In Q2 56% of the total number of admissions to the Neonatal Unit (NNU) (106 *babies*) were cared for on the transitional care pathway (TCP) for some or part of their admission. Out of this 40%, (75 *babies*) spent the entirety of their admission on the TCP. This was similar data to last quarter.
- No babies were identified as missed opportunity for TCP.
- The explicit staffing model required for the Maternity safety standards for staffing the TCP supported 100% of shifts in Q2 for July and August, and 88% for September, due to the neonatal unit being over capacity and high acuity, in conjunction with vacancies in B6 and B5 posts, higher than average annual leave and study leave. Some shifts showed the TCP nurse looking after more than the 4 recommended babies. Due to the workload on the NNU, staff could not be redeployed from NNU to assist on TCP. One shift resulted in the midwives supporting TC by carrying out observations on the baby on the TCP and communicating with the NIC for neonatal unit. This showed collaboration between maternity staff and neonatal staff and facilitated the mother and baby staying together when they would have been separated.

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ATAIN Audit Findings

- This quarter has highlighted 3 avoidable admissions to the NNU.
- One case involved a mother whose condition could have been escalated sooner and her delivery been expedited, the admission may have been avoided.
- The second case was identified as avoidable, the baby had delayed cord clamping but the cord was not adequately observed and had ruptured resulting in a foetal blood loss requiring an admission.
- The third case was an admission of a baby requiring phototherapy and intravenous fluids. On review it was assessed that this baby could have been managed on the TCP with additional oral feeds via a naso-gastric tube, rather than insertion of a cannula and intravenous fluids.
- The cases have highlighted learning that will be cascaded to the teams. Learning has been highlighted on the Safety Briefing and Quality Board displays and is shared at the Maternity Neonatal Governance meeting.
- In this quarter, all term admissions that have been admitted to the NNU and required non-invasive respiratory support are being reviewed. The review includes treatment and length of stay and time of admission and discharge. The rationale for this is to identify what care changes can be made to expedite the repatriation of the baby to the care of their mother. The aim is to develop a pathway to reduce the length of admission of term babies with mild respiratory distress in order to reunite the baby with their mother when it is clinically safe to do so.
- All neonatal unit transfers or admissions to the neonatal unit from other areas within the RUH have been reviewed (Emergency Department and Children's ward). In Q2, 23/24, 5 babies were admitted, an increase on the previous quarter (n=1). These admissions are all discussed to ascertain that the NNU was an appropriate care setting, no themes have been identified with the readmissions,

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Q2 Practice Improvements

- Newborn Early Warning Trigger and Track (NEWTT2) charts and toolkit has been implemented for all 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 total NEWTT2 score informs the escalation response including who is responsible, and the timing of a review and supports further escalation if required.
- Audit results for the use of NEWTT2 charts will be available for Q3.
- TCP guideline updated, criteria for admission now includes all 35/40 babies, and babies less than 2nd centile, whom previously may have been admitted to midwifery care.
- Fund raising continues to covert room G into a 4 bedded TCP room for additional TCP space and to offer TCP for 34/40 week babies where postnatal ward may not be correct environment.
- Introduction of a named Link Midwife for TCP to improve communication and collaborative working.
- Formation of TCP working group in the process of being established to improve collaborative working across the maternity/neonatal pathway.
- Assessment of all term admissions requiring non-invasive respiratory support underway, ensuring their plan of care optimises their chances in being safely reunited with their mother as soon as clinically possible.

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Transitional Care and ATAIN Action Plan

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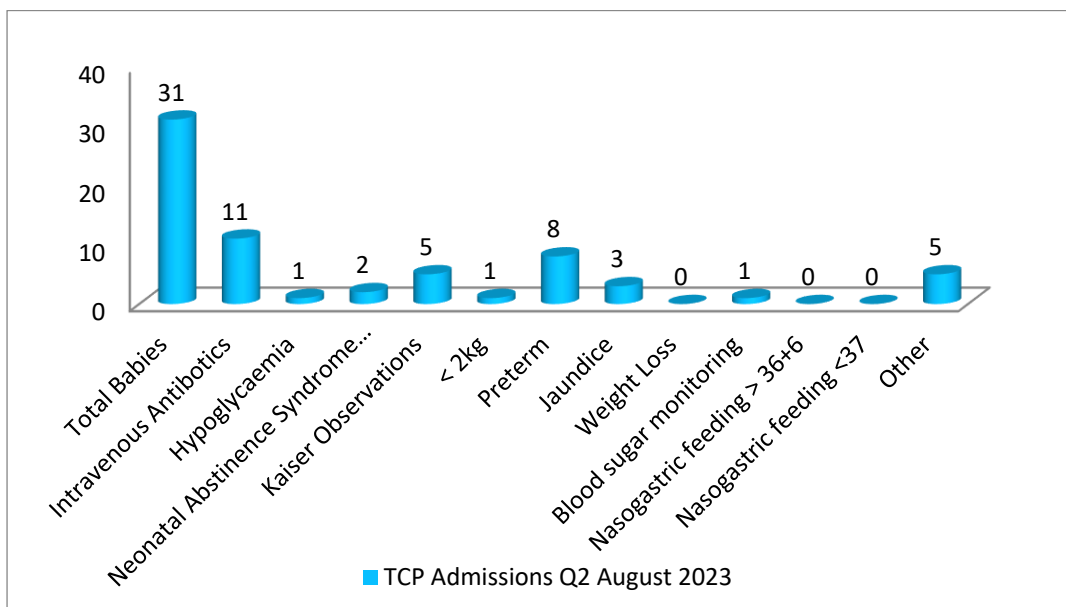
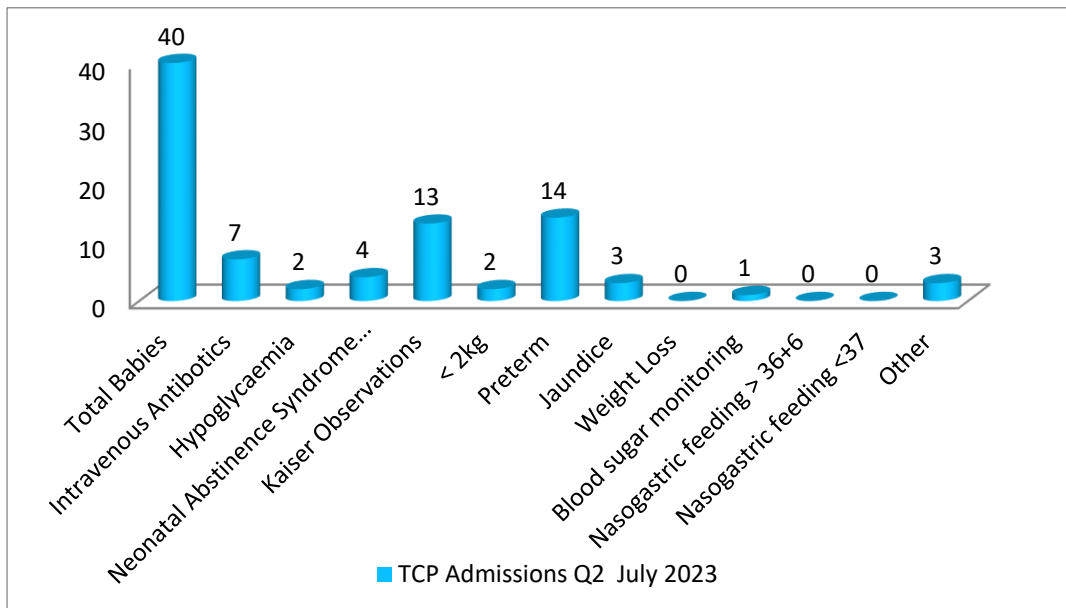
Action	No	Details	Progress	Lead	Due	RAG status	Completion date
1. What do we Need? Pathways of care into transitional care have been jointly approved by both neonatal and maternity teams. The aim of the transitional care pathway is to minimise separation of resident mothers and their babies.							
There 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 (clinical coding) but could extend beyond to British Association of Perinatal Medicine (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 staffing model for nursing	2.1	The rota allocates 1 neonatal nurse to		Neonatal transition			Complete

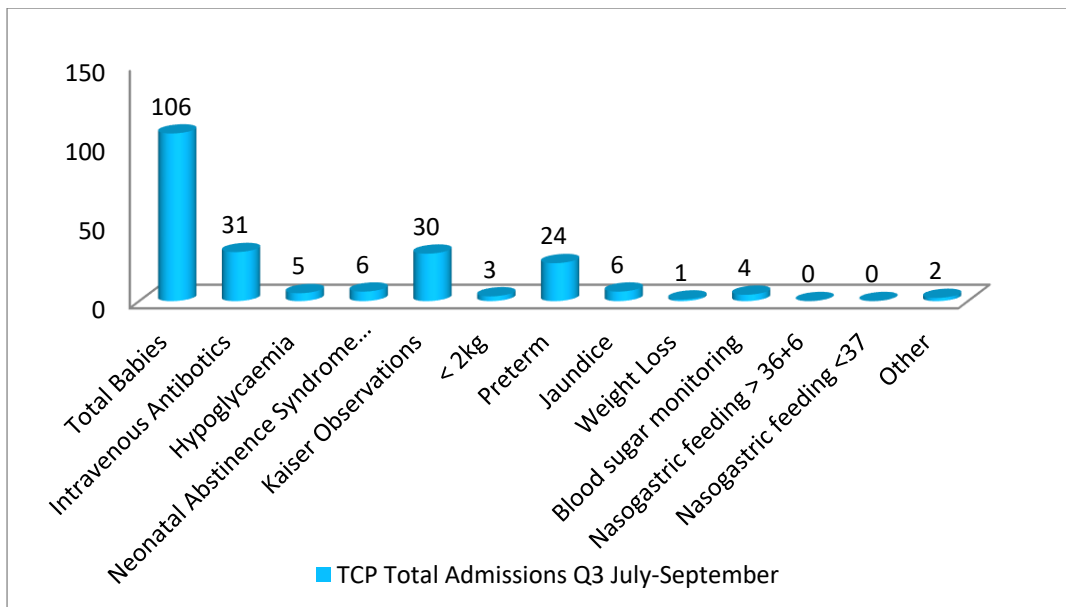
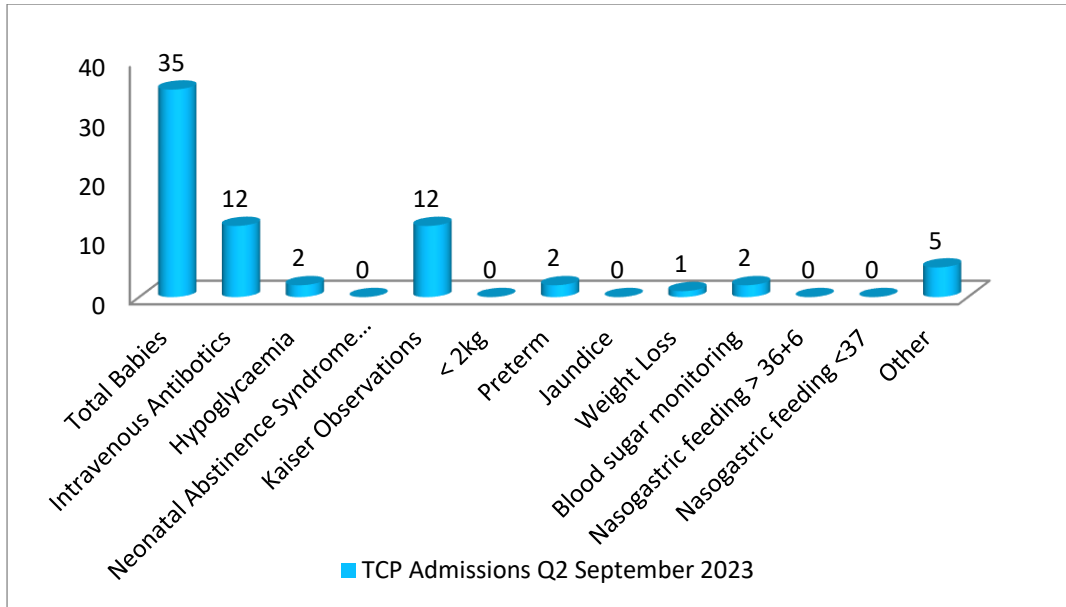
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<p>care of the babies on the transitional care pathway</p>		<p>care for 4 transitional care babies</p> <p>Staff vacancy factors, maternity and sick leave, are impacting on the ability to provide a nurse to the transitional care pathway at times</p>	<p>Quarter 2, 2023/2023 demonstrated compliance of the staffing model only 88% for September.</p> <p>Staff recruitment commenced for the B6 and B5 vacancies.</p> <p>Whenever possible the separation of mother and baby is avoided. At times, this has meant that the TC nurse has had to care for more than 4 babies on TCP.</p>	<p>al care lead and Paediatric Matron</p>			
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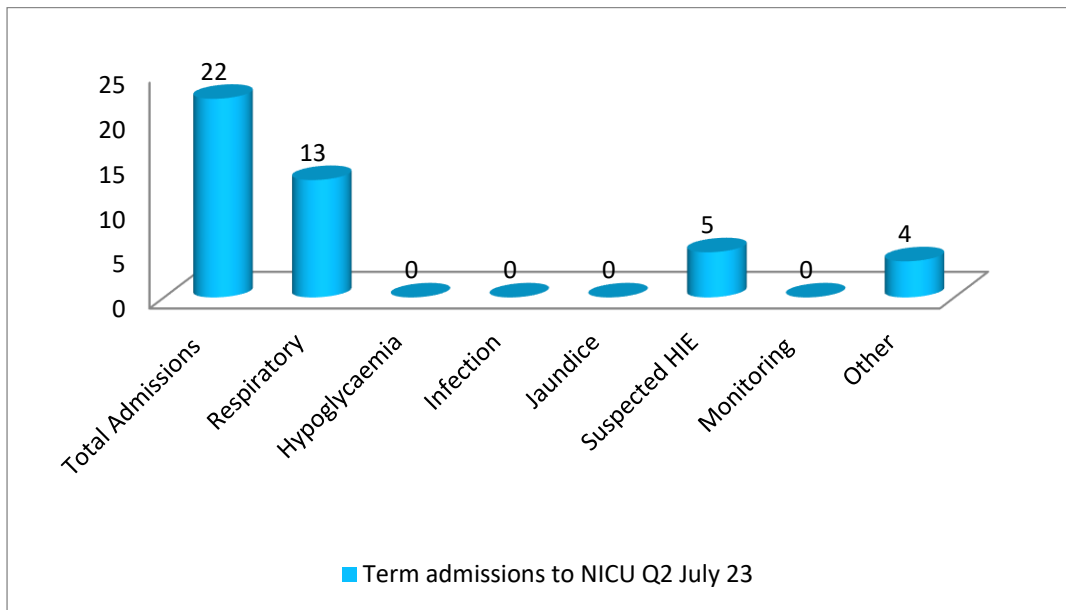
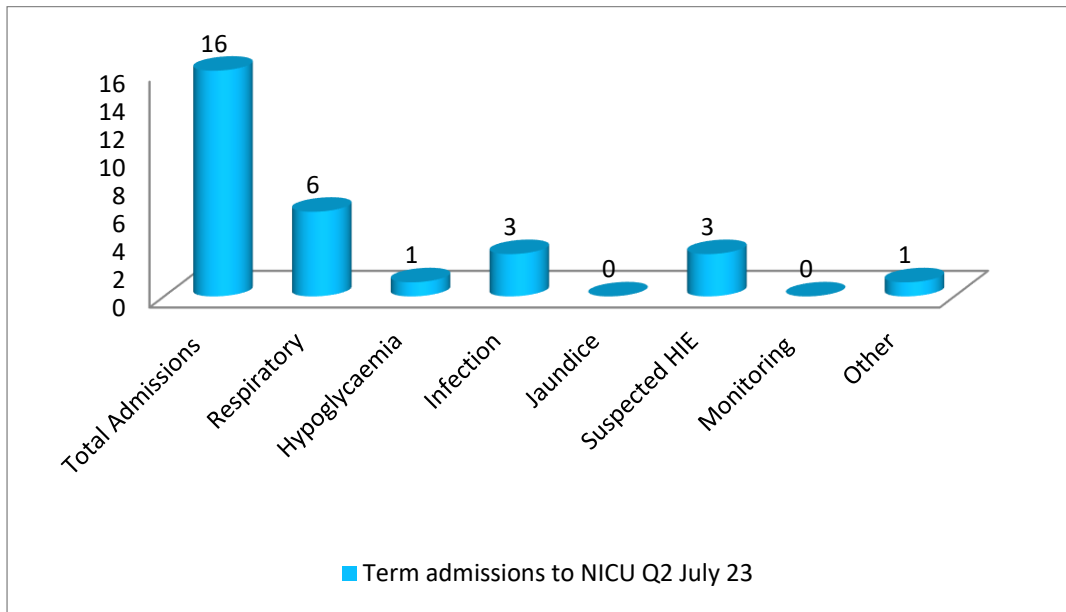
Appendix 1: Detailed analysis of babies requiring TCP

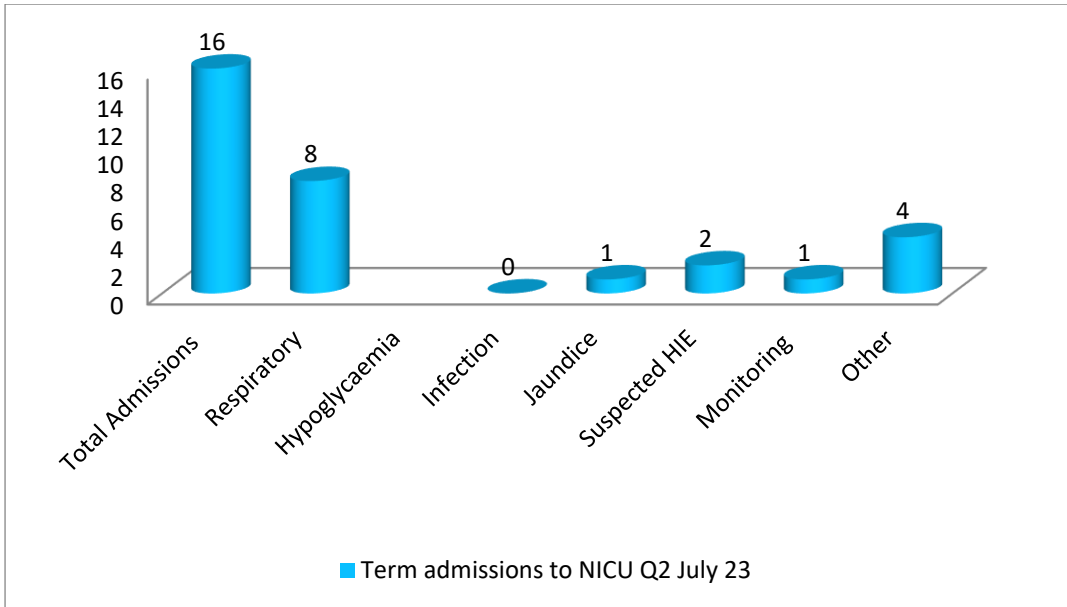




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Appendix 2: Detailed analysis of Term admissions to NNU





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