Report to:	Board of Directors	Agenda item No:	12.0
Date of Meeting:	2 November 2022		

Title of Report:	Maternity and Neonatal Safety Report Quarter 2 Report
Board Sponsor:	Antonia Lynch, Chief Nurse
Author(s):	Sarah Merritt, Deputy Chief Nurse & Director of Midwifery
Appendices	Appendix 1.0 Maternity Services Scorecard

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) Board of Directors of present and/or emerging safety concerns.

This report identifies that the Trust is currently non-compliant with training in maternity services. Multi-disciplinary training (MDT) emergency skills training PRactical Obstetric Multi Professional Training (PROMPT) is below the recommended 90% for some staff groups. An action plan has been developed to address this, inclusive of doctors in training. A new Maternity Training Lead has been recruited and commences in October 2022. Consequently the Trust is at risk of non-compliancy with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

Staffing levels have continued to be challenging and this report details the steps that have been taken to mitigate staffing levels. The temporary suspension of home and community births continued in Q2. Recruitment has continued at pace. The staffing trajectory demonstrates a significant improvement in staffing levels in Q3. Additional shifts for staff have been financially incentivised. Community births are scheduled to resume at one midwifery led unit (Frome) from 31/10/22. Continuity of Care teams are also suspended except for the most vulnerable families.

In Q1, the Healthcare Safety Investigation Branch (HSIB) identified that there was an increase in referrals from the RUH. From 22 March 2022 to 14 May 2022 (within a six week period) there were seven referrals to HSIB for investigation. Due to this increased number of cases, all referrals made by the RUH were investigated in line with the HSIB criteria prior to April 2020. This interim intervention was reviewed by HSIB in August and the additional oversight and monitoring was stood down.

In July 2022 the Trust sourced external independent support from NHS England (NHSIE) to review maternity services to support the Trust to identify challenges, risks and actions required to provide safe maternity care. The initial findings identified challenges within the workforce for maternity services from capacity and capability of the maternity leadership and governance structure, the establishment in place and the structure of working.

The initial findings also highlighted 6 immediate key areas of action required to improve safety within the service, which are now being addressed.

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.)

1734	Day Assessment Unit patient safety risk – area not compliant or fit for purpose	15
1768	Maternity redesign staffing impact	4
1948	Obstetric ultra sound scan capacity	8
2013	Lack of adequate suturing lighting in birth rooms	4
2225	Vacancies in senior nursing and midwifery leadership within the family and specialist services	9
2175	Midwifery Staffing Vacancies	20
2353	Replacement of ultrasound machine	4
2359	Maternity Information System IT support/capacity	15
2396	Obstetric theatre emergency call bells	6

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.

7. References to previous reports

Previous monthly Perinatal Quality Surveillance reporting.
MIS Combined paper Q3 February 2022.
MIS Combined paper Q4 May 2022.
Maternity and Neonatal Safety Report Quarter 1 Report August 2022.
Safer Staffing Report - March 2022.
Safer Staffing Report – August 2022.
Nursing and Midwifery Establishment Review – Private Trust Board, January 2022.
Nursing and Midwifery Establishment Business Case – Private Trust Board, March 2022.

8. Publication

Private.

9. Sustainability

This report has no impact on the Trust's approach to environmental sustainability, including its commitment to achieve net zero carbon status by 2030.

10.	Digital
A number of the maternity workstreams have digital co-dependencies and a digital strategy for Maternity has been written.	

MATERNITY AND NEONATAL QUARTER 2 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	No

	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: 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-abouts	✓ 21/7/22	✓ 26/8/22	✓ 22/9/22
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	✗ 80%	✗ 80%	✗ 85%
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 - 67% Treatment - 79.6% (Staff Survey 2021)
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)

Table 1: Overview of safety metrics for maternity services

1. REPORT OVERVIEW

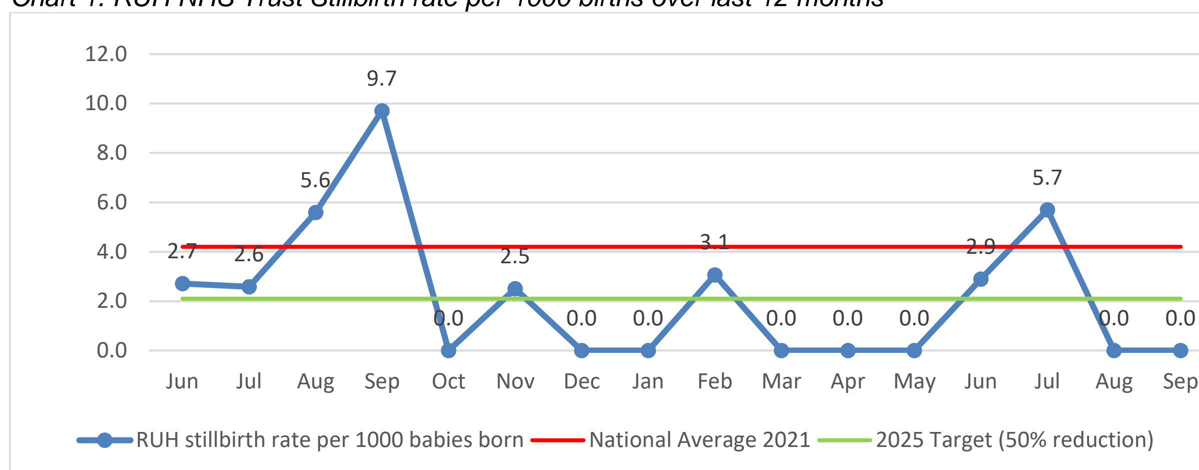
Progress update This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the LMNS Board and the Board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

2. PERINATAL MORTALITY RATE

The following graphs demonstrate how Royal United Hospital NHS Trust is performing against the national ambition.

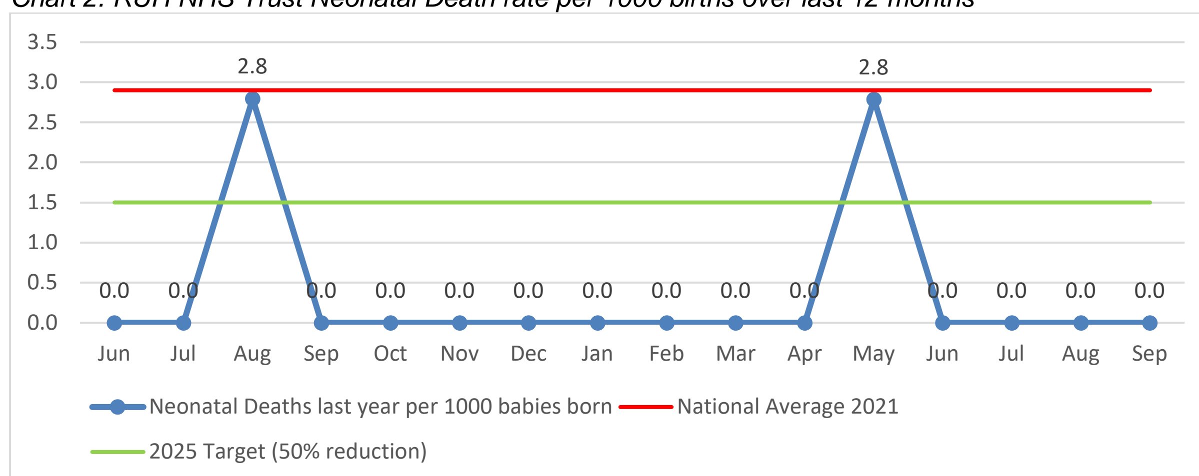
There were 2 still births in Q2, refer to section 2.1.

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



There were no reported neonatal deaths in Q2.

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



2.1 PERINATAL MORTALITY SUMMARY FOR QUARTER 2 2022/23

Table 2. Perinatal Mortality Summary Quarter 2 2022/23

2020/21 (excluding terminations for abnormalities)	Q2	Annual total
Stillbirths (>37 weeks)	0	0
Stillbirths(>24weeks-36+6weeks)	2	3
Late miscarriage (22+oweeks-23+6weeks)	0	2
Neonatal deaths	0	2
Total	**2**	**7**

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 Safety Standard 1 of the NHS Resolution (NHSR) Maternity Incentive Scheme year 4.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the 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.

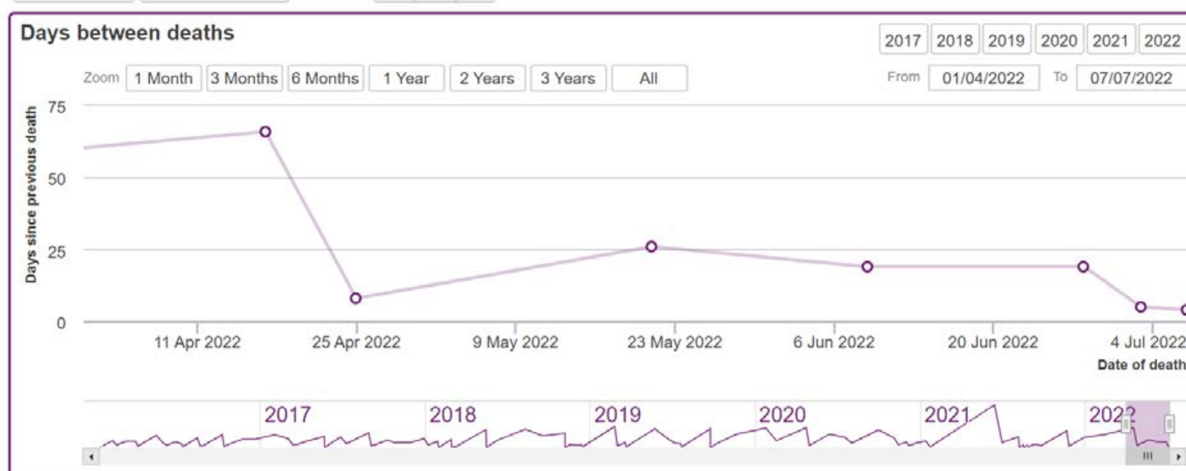
The RUH Electronic Patient Record records all stillbirths (24 weeks or greater gestation) and neonatal deaths.
There have been 3 perinatal deaths:

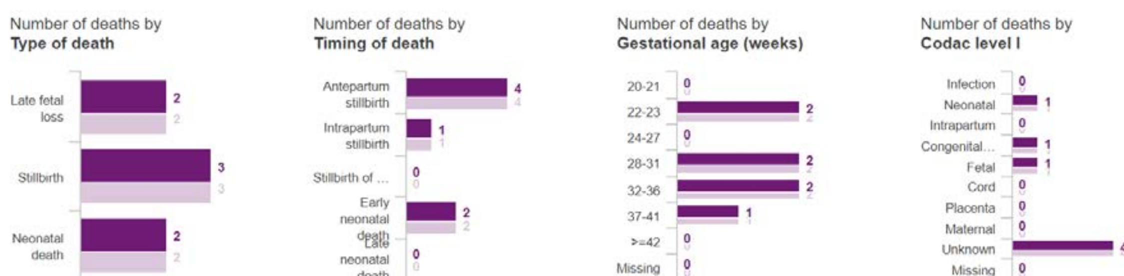
- 2 stillbirth (1 was an expected death of a co-multiple)
- 1 stillbirth where the pregnancy was terminated for fetal abnormalities (this is reported to MBRRACE but does not meet PMRT criteria)

The rate of stillbirth and perinatal death will be different.

All cases have been reviewed at the PMRT meeting, actions have been agreed and draft reports have been commenced. All parents have been informed and have contributed to the reviews. PMRT meetings include external panel members to ensure the process is robust and honest. Learning from the reviews is included in section 2.3.

*Chart 3. Reporting of RUH NHS Trust Deaths within Organisation 1/7/22 – 30/9/22**
**last perinatal death was in July. PMRT graph will only generate up to date of last death.*





Deaths within your organisation | 7 deaths between 01 Apr 2022 and 07 Jul 2022 | Clear snapshot

2.3 LEARNING FROM PMRT REVIEWS

Table 3. Actions arising from PMRT reviews Quarter 2 2022/23

PMRT Issues and Action Plans Extract for Royal United Hospital Bath NHS Trust from reviews of deaths from 1/07/2022 to 30/09/2022						
Perinatal Case ID	Issue Text	Outcome Contribution	Action plan text	Implementation text	Person responsible	Target date
81978/1	Cabergoline was not given to suppress lactation.	Relevant to the outcome, and action is needed.	Pathway to be updated including Lactation and Loss SOP	Bereavement Care Pathway to be updated and disseminated	Bex Walsh, Bereavement Midwife	30/11/2022
82268/1	Reduced fetal movement leaflet not provided in mother's first language. Family members were used to interpret at times during her antenatal care.	Not relevant to the outcome, but action is needed.	Reminder sent on how to access Reduced Fetal Movement leaflet in different languages. Reiterate an interpreter must be used.	Reminder sent to all staff on how to access Reduced Fetal Movements leaflet in different languages.	Patient Safety team	30/09/2022

One case had no actions or issues as there is an on-going serious investigation and the post mortem results have not been published.

3. HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB) AND MATERNITY SERIOUS INCIDENTS (SIs)

3.1 BACKGROUND

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

From 22 March 2022 to 14 May 2022 (within a six week period) there were seven referrals to HSIB for investigation. Due to this increased number of cases over a short period of time the Southwest Regional HSIB investigators held an internal round table meeting to discuss these cases to try to identify any common themes.

Due to the cluster of cases, we received a letter on 27 May 2022 from HSIB informing us that they would investigate all cases referred to them over a three month period until the end of August 2022. This would also include all babies that had a normal MRI scan after they had been cooled.

The Trust received an email from HSIB on 7 September 2022 advising they were stepping down the enhanced oversight as the Trust had only referred one case at the end of the three month period.

3.2 INVESTIGATION PROGRESS UPDATE

Table 4. HSIB referrals Quarter 2 2022/23

Ref	HSIB Reference	Confirmed level of investigation	Date confirmed Investigation	External Notifications and Other Investigations
108058	014673	Parents request despite normal MRI	12/10/22	
107283 *	013255	Normal MRI, however within HSIB cluster reporting timeframe	20/08/22	

3.3 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable.

3.4 MATERNITY SERIOUS INCIDENTS

During the month Quarter 2 there was 1 maternity Serious Incident. All cases referred to HSIB are investigated as serious incidents in the Trust.

Table 5. Maternity Serious Incidents Quarter 2 2022/23

Datix No	Category	Outcome	Immediate Learning
July			
None			
August			
107283*	Therapeutic cooling	MRI normal investigation however requires investigation by HSIB. Incident occurred during 3 month surveillance	
September			
104045	Post-natal care – Eclamptic fit	Incident occurred in Feb 22. RCA requested following complaint from family. SI not yet completed	Blood pressure monitoring and assessment of pre-eclampsia in the postnatal period

4. CONTINUITY OF CARE

4.1 BACKGROUND

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.

4.2 PROGRESS TO DATE

On the 21 September 2022, NHSEI published a letter regarding Maternity Continuity of Carer (MCoC). All target dates for implementation of MCoC have been removed and local services will instead be supported to develop local plans that work for them. MCoC teams were suspended at the RUH in 2021 due to staffing sickness and vacancy and will be re-implemented in line with safe staffing levels.

Table 6. Continuity of Care pathway Quarter 2 2022/23

Continuity of Care	Quarter 2 2022/23
Total Bookings 29/40 on CoC pathway	38.5%
BAME on CoC pathway 29/40	28.5%

N.B. Although women continue to be booked on the continuity pathway, there is recognition that true continuity (including intrapartum care) is not being delivered. Antenatal and postnatal continuity continues to provided where possible, with vulnerable/at risk groups and those from a Black Asian and Minority Ethnic group are

being prioritised.

5 OCKENDEN UPDATE

5.1 OCKENDEN INITIAL REPORT UPDATE

In response to failures at Shrewsbury and Telford NHS Trust, the initial Ockenden report was produced by Donna Ockenden (Chair of the Independent Maternity Review) in December 2020. The report set out recommendations and highlighted seven Immediate and Essential Actions (IEAs) for all maternity services to enable them to improve safety for mothers and babies. The final Ockenden report was subsequently published in March 2022 and included 15 additional IEAs for all Trusts to act upon.

Table 7. Initial Ockenden Immediate and Essential Actions

	Green Amber Red	**Actions/Mitigations:**
IEA 1 Enhanced Safety	Green	
IEA 2 Listening to women and families	Green	
IEA 3 Staff Training and Working Together	Amber	1. Training needs analysis completed. 2. Non complaint with twice daily ward rounds >90% -including one at night. 3. Obstetric workforce review underway. 4. Face to face training– MDT Emergency Skills Training (PROMPT) identified as below 90% for some staff groups. Action plan developed and new education lead commenced in post.
IEA 4 Managing Complex Pregnancy	Green	
IEA 5 Risk Assessment Throughout Pregnancy	Red	Documentation of Risk Assessments taking place at every contact has dropped to 48%. 1. Digital option being explored regionally to improve the capture of this. 2. A Lead Midwife has been recruited to introduce a dedicated Birth Options clinic and pathways are in place for referral to consultant clinic. 3. The digital record aspect of the personalised care and support plan is now in place on the Maternity Information System
IEA 6 Monitoring Fetal Wellbeing	Green	.

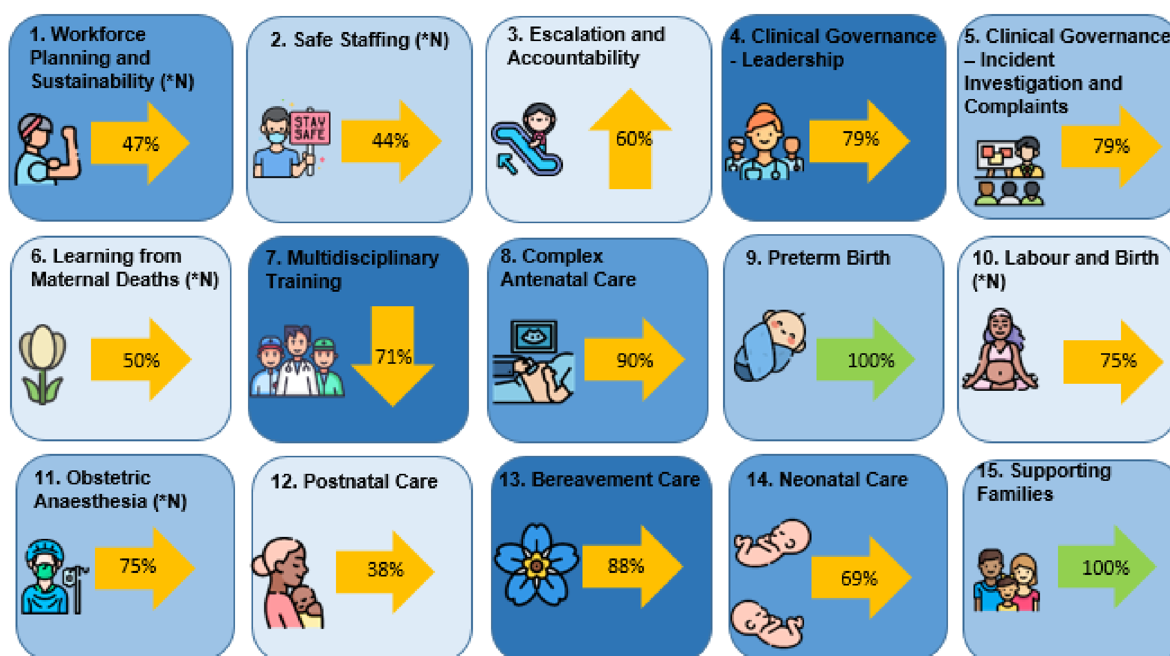
IEA 7 Informed Consent		
Workforce element		The Trust does not have a Consultant Midwifery although it is part of the Midwifery Oversight action plan.

Maternity Services have assessed themselves as fully compliant with 5 of 7 IEAs, partially compliant with 1 (IEA3) and non-compliant with 1 (IEA 5). The workforce element is an additional criteria which the Trust does not meet compliance. Whilst the Trust utilised the appropriate workforce planning methods, funding has not been identified to meet the shortfall in midwifery workforce. £331,795 was made available through Ockenden funding to the Trust to support the changes required from the initial report. This was utilised to fund an additional fetal monitoring lead consultant post, and mandatory training in fetal monitoring for all maternity staff. Any potential funding to support the final Ockenden report has not yet been announced.

5.2 OCKENDEN FINAL REPORT UPDATE – Q2 2022-2023

The Trust is not currently required to submit compliancy information or evidence to Ockenden on a regular basis. Initial assessment was completed in June 2021 and a resubmission of evidence was completed in November 2021. The next submission date for the final Ockenden report has not yet been confirmed.

Figure 1. Ockenden Final Report Position - Immediate and Essential Actions



Outstanding and completed locally identified actions are being tracked via a new Ockenden assurance tool.

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

6.1 BACKGROUND

Maternity training is specified in detail in the Maternity Training Needs Analysis. Mandatory training compliance is less than the required 90%, underpinned by an action plan to increase training rates and compliance.

Sharing of local maternal and neonatal outcomes from serious incidents, near misses and never events are disseminated to staff in a variety of formats including maternity newsletter, staff e-mails, patient safety 'Safety Catch' newsletter including case studies, incorporated into training days and quality and safety whiteboards displayed in clinical areas.

A training trajectory has been written and an action plan is in place to ensure compliance is met for each staff group for all mandatory training.

6.2 TRAINING DATA

Chart 4. Prompt and fetal monitoring Training Compliance (%) by staff group Q2 2022/23

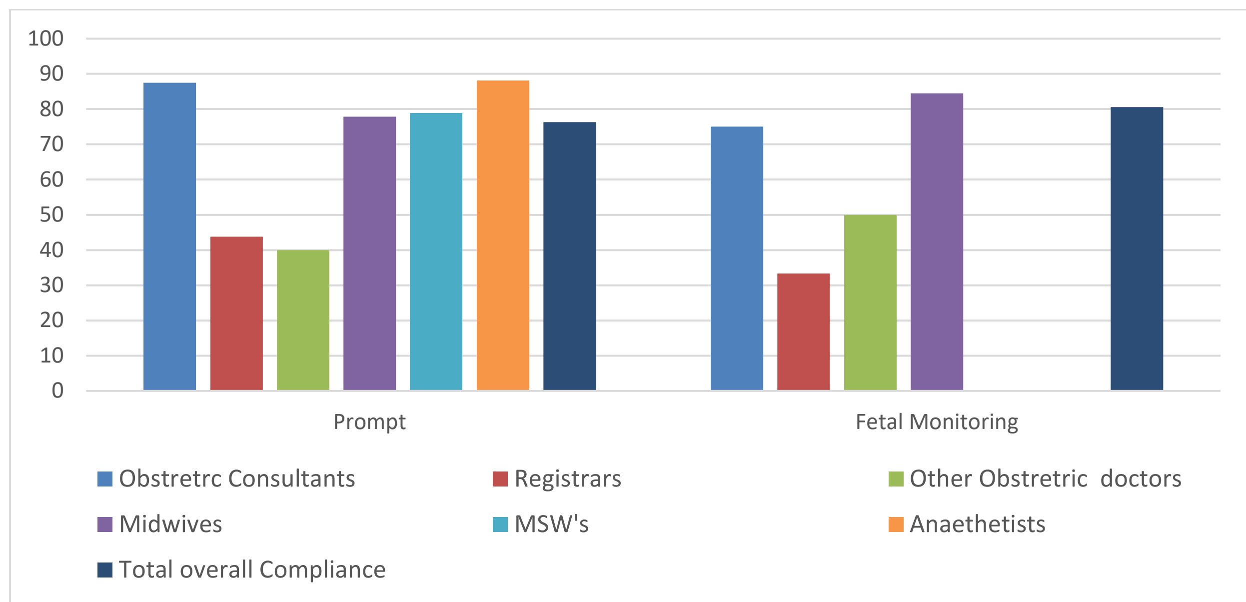
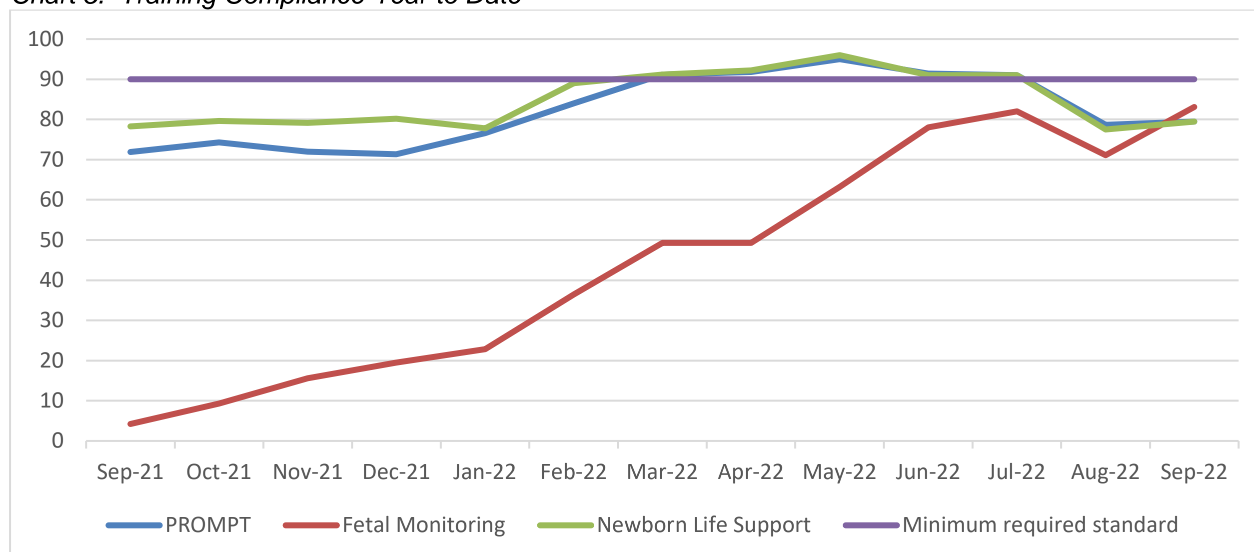


Chart 5. Training Compliance Year to Date



7. SAFETY CHAMPIONS PRODUCTION BOARD MEETINGS

All staff were invited to attend monthly meetings held with the Chief Nurse and the Non-Executive Director (Board Level Safety Champions on 21 July, 26 August and 22 September). The meetings in Q2 were attended by members of the maternity team from a range of areas, including community and specialist midwives.

Themes raised included:

- Reinstatement of community births and service readiness for this
- On call arrangements and planned staffing model
- Positive feedback received regarding the impact of the new Retention Support Midwife role
- Some concerns regarding community birth suspension being communicated to community midwives
- Incentives for additional bank shifts has been positively received and had a positive impact on staffing
- A noticeable shift in staffing levels and a more positive morale is evident
- Positive feedback regarding the inpatient service for smoking cessation
- Birth Reflections will be restarting in November 2022.

7.1 Board Safety Champions walkabouts

The Board Safety Champions undertook walkabouts across Maternity Services:

- 13 July – Chief Nurse visited the Bath Birth Centre
- 15 July – Chief Nurse visited Frome, Paulton, Chippenham and Trowbridge Maternity Units
- 24 August – Chief Nurse and Non-Executive Director visited: Day Assessment Unit and the Bath Birthing Centre
- 1 September – Chief Nurse and Chief Executive visited From, Paulton, Chippenham and Trowbridge Maternity Units
- 30 September – Chief Nurse and Non-Executive Director visited Mary Ward, Day Assessment Unit & Bath Birth Centre.

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

8. SAVING BABIES LIVES CARE BUNDLE V2

8.1 UPDATE

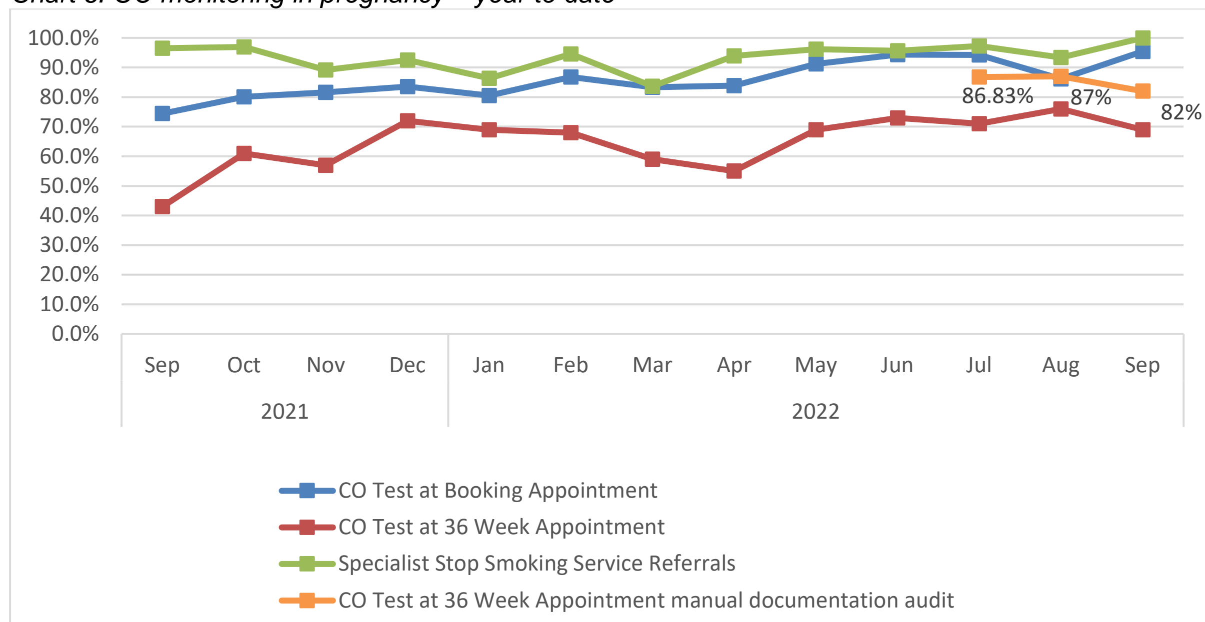
The Trust continues to work towards full compliance with all elements within Saving Babies Lives Care Bundle Version 2 (SBLCBv2). This is a requirement detailed in Safety Action 6 of the Clinical Negligence Scheme for Trusts. A full quarterly report shared with Quality Governance Committee which provide a detailed breakdown of all 5 elements.

- 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

The Trust is compliant with 3 elements. The Trust is working towards full compliance with Element 1: Reducing Smoking in Pregnancy.

- CO monitoring at booking are consistently above 90%.
- Bookings at 36 weeks rates recorded electronically are below 80%. A manual audit of hand held notes has identified compliance of 86.3% and is ongoing. When completed this audit will demonstrate full compliance.

Chart 6. CO monitoring in pregnancy – year to date



In line with element 4, fetal monitoring training was commenced in September 2021, and is being rolled out to all staff. Over 80% of all staff have now completed this training, and non-compliant staff are booked to attend. Once above 90% this will demonstrate full compliance. See section 6.2.

9. NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q2 2022/23

Following further amendments to the scheme in October 22, the reporting period has been confirmed as 5-5-22 to 2-2-23. The Trust is forecasting compliancy with the following MIS standards as of the end of that period:

Table 8. Maternity Incentive Scheme Update Q2 2022/23

No	Maternity safety action	RAG progress
1	National Perinatal Mortality Review Tool	Compliant.
2	Maternity Services Data Set (MSDS)	Compliant
3	Transitional Care and Avoiding Term Admissions to NICU	Compliant.
4	Clinical workforce planning	Compliant.
5	Midwifery workforce planning	Not fully compliant New required standard May 22: Funded establishment compliant with outcomes of BirthRate+ *or agreed plan, including timescale for achieving the appropriate uplift in funded establishment*. The plan must include mitigation to cover any shortfalls. Funding currently not agreed to meet increased establishment recommendations, but time specific plan in place to achieve. Repeat BirthRate + Review underway. Business case in development.
6	Compliance with all four elements of the Saving Babies' Lives V2	Not fully compliant See section 6. An average of > 80% required across a 4 month period, an action plan is also in place to improve performance
7	Service user feedback	Compliant.
8	Staff training	Not fully compliant Combined average for PROMPT is below 90%. See section 6.
9	Robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Compliant.
10	Reporting 100% of qualifying incidents under NHS Resolution's Early Notification scheme?	Compliant.

RAG rating	
RED	Not expecting to demonstrate compliance
AMBER	Expecting compliance – plan in place to achieve
GREEN	Currently compliant

10. THE NUMBER OF INCIDENTS LOGGED AND GRADED AS MODERATE OR ABOVE AND THE ACTIONS BEING TAKEN

Chart 7. Moderate or above incidents in Q2 2022/23

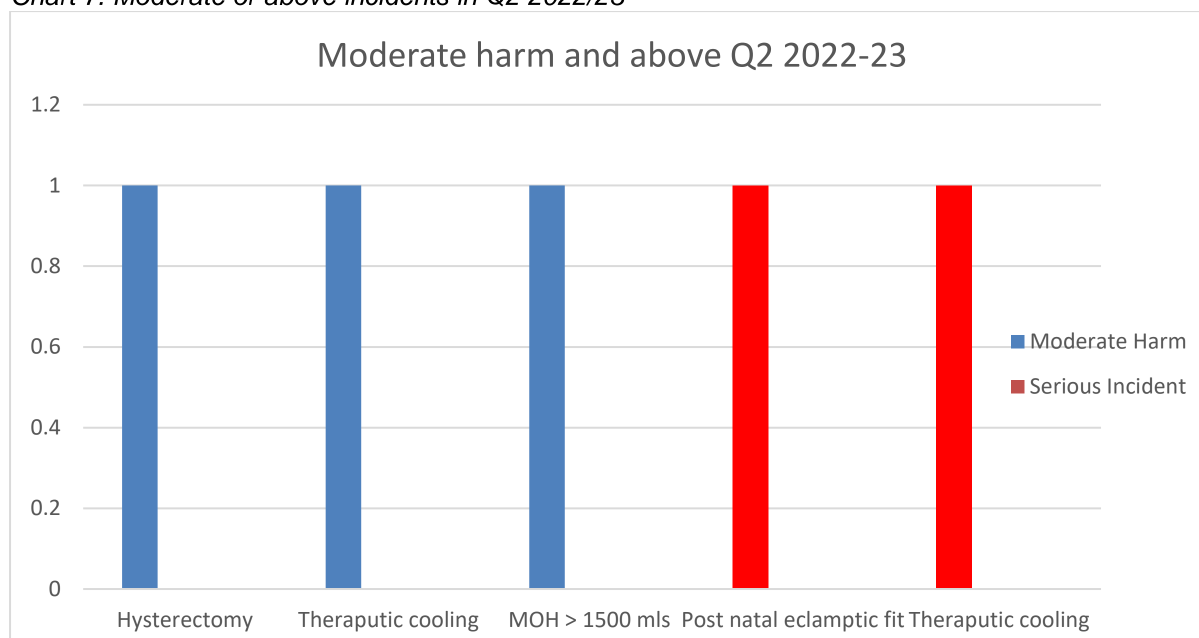


Table 9. Moderate or above incidents in Q2 2022/23

Month	Incident Category	Outcome/learning/Actions
July		
None		
August		
17/8/22	Post-partum Haemorrhage (PPH) > 1500	Post-operative observations, learning cascaded to obstetric theatre team
18/8/22	Therapeutic cooling	MRI normal investigation not required by HSIB
September		
13/9/22	Therapeutic cooling	MRI normal investigation not required by HSIB
14/9/22	Hysterectomy	Previous caesarean section x 5 and placenta praevia, expected complication of treatment
16/09/22	Post-natal eclampsia	Patient complained about care, investigation commenced

11. SAFE MATERNITY STAFFING

11.1 MIDWIFERY STAFFING

As of 18 October 2022, the budget vs actual midwifery staffing was -16.55 WTE (of which 5.56 WTE is maternity leave). This gives a substantive vacancy rate -10.99 WTE.

Chart 8. Midwifery Workforce staffing and forecast (not including long-term sickness) 18-10-22

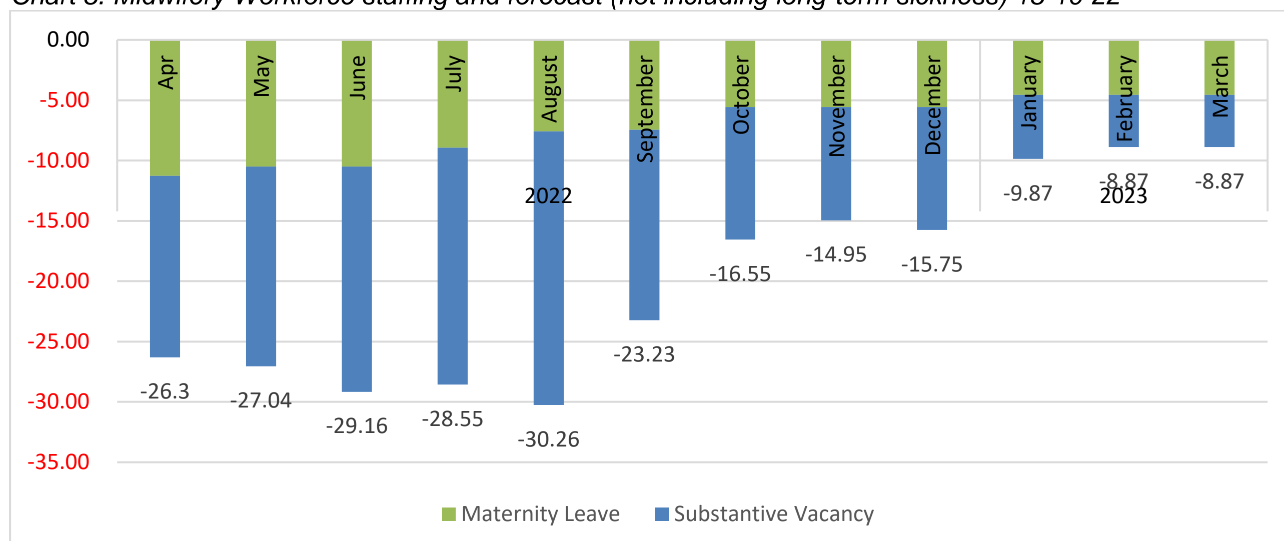


Table 10. Midwifery staffing safety measures

Measure	Aim	Jul 22	Aug 22	Sep 22
Midwife to birth ratio	≤1:27	1:34	1:38	1:35
Supernumerary labour ward coordinator status	100%	98%	100%	99%
1:1 care not provided	0	0	0	1

There was one occasion in September when it was reported that 1:1 care was not provided in Bath Birth Centre. No harm resulted, and an investigation has commenced to understand and address the contributing factors.

The Maternity services has continued to drive a robust recruitment campaign for qualified and support staff which is reducing the vacancy position.

The Director of Midwifery has a daily operational plan to safely deploy resources to manage the changes in demand and acuity. Initiatives to increase staffing levels include:

- Incentivising pay rates
- Registered nurses undertaking non-midwifery care
- Clinical support provided by members of the midwifery leadership team
- Repeat Birthrate+ assessment underway to reflect current acuity without Continuity of Carer, and utilising accurate headroom data.
- Recruiting to 100% maternity leave moving forward and over-recruiting by 8.9WTE
- Active recruitment campaign
- Agency Midwives employed
- Specialist rates for Registered Midwives, Maternity Care Assistants (MCAs) and Maternity Support Workers (MSWs) on bank.
- Career progression improvements for MCAs to MSWs.
- Local calculation of headroom reviewing three years of data for mandatory training, maternity leave, sickness and annual leave (32%).

Next Steps

- Stepped approach to reintroduce community births as safe staffing allows. Frome Birthing Centre re-opening to births on 31/10/22
- Resumption of all paused clinical services as safe staffing allows. Resumption of Birth Reflections services and Hello Baby antenatal classes
- Complete overhaul of e-rostering, including compassionate rostering
- Moving to weekly bank pay
- Review on-call arrangements for acute unit staff.

11.2 OBSTETRIC STAFFING

Table 11. Obstetric staffing safety measures

Measure	Aim	Jul 22	Aug 22	Sep 22
Consultant presence on BBC (hours/week)	≥60 hours	60	60	60
Consultant non-attendance in line with RCOG guidance	0	0	0	0
Twice daily MDT ward round	100%	97%	94%	100%

The ward rounds currently take place at 9am and 5pm in person, with a third virtual round by telephone at 10pm. The Obstetric team are working towards introducing a night shift ward round, and the need for this is incorporated in the ongoing Obstetric workforce review scheduled for completion in November 2022.

Consultant attendance at situations detailed in the RCOG Roles and Responsibilities of the Consultant Workforce guidance has remained 100% throughout Q2.

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

Table 12. Complaints and compliments Q2

	Jul 22	Aug 22	Sep 22
Number of compliments	3	0	2
Number of PALs contacts/concerns	6	6	7
Complaints	1	1	1

Formal complaints within Q2 related to:

- Retained products following birth
- Dissatisfaction with outcome of SI review following pregnancy loss in 2021
- Communication and support – traumatised with unanswered questions following birth 6 months ago

There has been increased contact with the Patient Advice and Liaison Service (PALs) particularly driven by the suspension of community and home births.

A small number of PALS contacts related to concerns around failure to diagnose

issues such as small or large babies.

Co-production with Maternity Voices Partnership (MVP) has continued throughout Q2, the Trust internet has a suite of local services providing signposting. A new range of virtual tours and birth options films are also in development co-designed with MVP representatives.

My Care Hub app (pilot) co-designed with MVP launched as a pilot in July 2022 for families in the Chippenham area. This includes signposting to the LMNS website and NHS information and guidance as well as the RUH internet page.

12.1 SERVICE USER INSIGHTS TAKEN FROM A RECENT CQC STYLE PEER REVIEW

MVP collated feedback is not yet available for Q2.

A series of MVP '15 step walk-about' are being undertaken in all maternity areas. The feedback will be presented when available.

13. QUALITY IMPROVEMENT PROJECTS / PROGRESS

13.1 MATERNITY TRANSFORMATION INCLUDING BETTER BIRTHS

The Transformation Project Lead Midwife is leading on the implementation of a new Perinatal Pelvic Health Service across Bath and North East Somerset, Swindon and Wiltshire (BSW). BSW is a fast-follower site and is currently funded by NHSEI. The service is expected to commence in April 2023.

In Q2 2022/23, the Pregnancy Loss Support Nurse and the Psychological Wellbeing Midwife commenced in post. The roles will support implementation of a perinatal trauma service supporting women experiencing birth trauma and trauma related to baby loss.

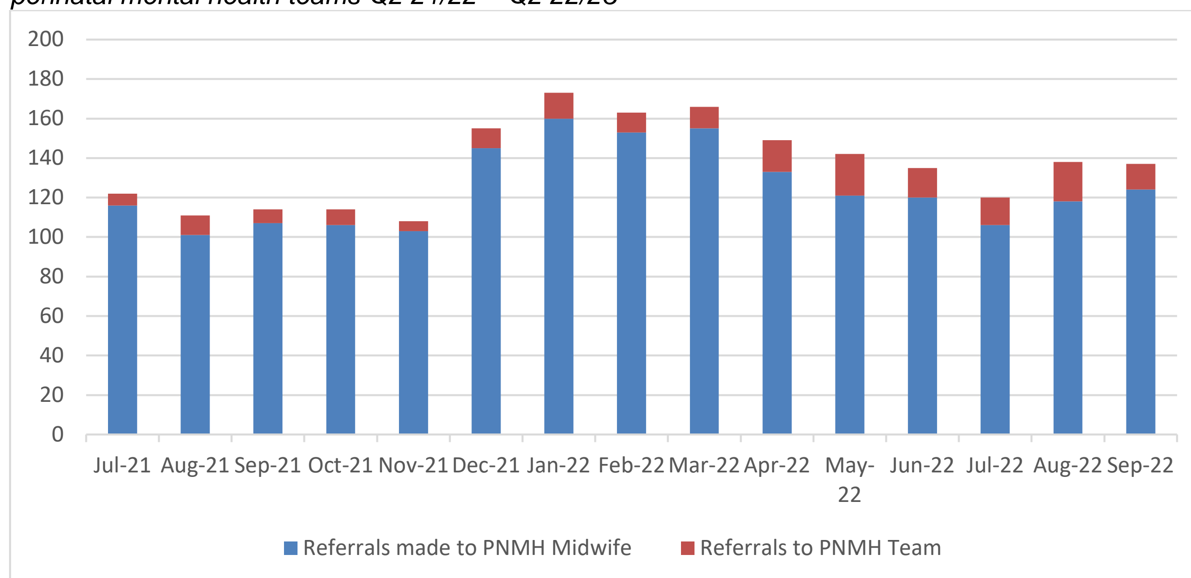
The Transformation Project Lead Midwife has been leading on a project to provide high-quality antenatal education videos across BSW. The professional videos will support women and families to make informed choices about their care, including place of birth. The scripts have been co-produced with the local Maternity Voices Partnership (MVP). Filming will take place in early Q2 2022/23.

Alternative plans for the building of an Alongside Midwifery Unit (AMU) and the re-design of a Day Assessment Unit (DAU) are being developed due to a lack of an identified funding route for the initial plans. In addition, floor plans for community hubs are being amended from feedback from staff and to ensure they are compliant with building regulations.

13.2 PERINATAL MENTAL HEALTH

The current Specialist Perinatal Mental Health Midwife (SPMHM) commenced in 2021 and provides specialist support to patients, ensuring pathways, policies and processes for at risk women are developed and implemented.

Chart 9. Women presenting with past or present mental health concern or referred on to the specialist perinatal mental health teams Q2 21/22 – Q2 22/23



As demonstrated in chart 9, there has been a sustained increase in the number of referrals to the SPMHM since December 2021 and the number of women with more severe mental health concerns requiring referral to the Perinatal Mental Health Team.

In Q2 22/23 there were no admissions to an inpatient psychiatric unit. There was no requirement for 1:1 observation on the ward. There were no known near-miss suicide attempts in pregnancy this quarter.

13.3 SAFEGUARDING

Maternity Safeguarding Key Performance Indicators (KPIs)
In Q2 there were 26 unborn babies on child protection (CP) plans across the service. This continues to be an increase on the data over the previous year (ranging from 17-23 per quarter).

The Safeguarding midwife undertook a case note audit of women with complex social factors to assess practice of women whose children were on the child protection register of had a Child in Need plan. 67% of women whose babies were on CP or had Child in Need plans had parenting observations documented during their postnatal stay on Mary ward. In 28% of the women audited, safeguarding concerns were documented on a pregnancy management note, however in 71% of the cases had a flag and safeguarding note had been created.

The Named Midwife for Safeguarding is working with the Midwifery Sister on Mary ward to produce a policy for the midwives to follow in the event of a suspected baby abduction. This will be presented to the Maternity Safeguarding Committee in Q3.

The Named Midwife for Safeguarding is producing a short guideline for the care of refugee women who are placed in the local bridging hotels. This will be presented to

the Maternity Safeguarding Committee in Q3.

The HOPE Boxes for women and their babies who are to be separated following the birth through the family court process have now been delivered and it is anticipated that we can start using these from Q3.

An action plan has been produced in response to the recommendations from the Wiltshire Child Safeguarding Practice Review of baby Eva. This will be presented to the Maternity Safeguarding Committee in Q3.

A rapid review has been conducted in Q2 in Wiltshire into the death of an 8 week old baby who was born at the RUH. The conclusion by the panel is that no Serious Practice Review is required.

13.4 INFANT FEEDING AND HEALTH IN PREGNANCY SPECIALIST SERVICES

The Trust are preparing for the UNICEF UK Baby Friendly Initiative (BFI) audit follow up visit in December. The Trust continues to work towards achieving UNICEF UK Baby Friendly Initiative (BFI) in anticipation of the audit in December 2022.

70 hours of breastfeeding peer support were delivered on Mary ward and the specialist infant feeding team provided 42 women with community based care. The tongue tie service delivered 75% of the funded provision (there is a plan to increase this to 100% when the vacancy factor reduces), providing an average of 14 appointments each week. Overall frenotomy rate remained within national recommendations at 4.7%.
Feedback from the local Maternity Voices Partnership (MVP) indicated service users would like to see a reduction in the triage-to-treat time which can be up to 7 days.

A fixed term role has been introduced to provide specialist breastfeeding support for families living in areas of highest deprivation score. This services commences in October.

The specialist health in pregnancy teams provided a blended approach to service delivery utilising face-to-face, virtual and telephone contacts to eligible service users. Weight management support was offered to 216 women across Wiltshire and Bath and North East Somerset (BANES) and 98 women were identified to be eligible for Stop Smoking intervention. Of these, approximately 77% accepted support. The overall Smoking Status at Time of Delivery (SATOD) across Wiltshire/BANES was 6.2% (0.2% above the national target of 6% by the end of 2022, detailed in the Tobacco Control Plan for England, 2017).

14. ADVOCATING FOR EDUCATION AND QUALITY IMPROVEMENT (A-EQUIP) AND PROFESSIONAL MIDWIFERY ADVOCACY THEMES

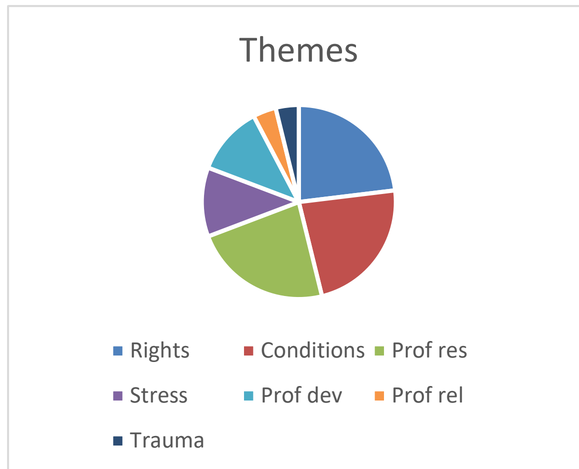
Professional Midwifery Advocates (PMAs) work within the A-EQUIP model to work with women in three ways:

- Supporting midwives to advocate for women

- Providing direct support for women within a restorative approach and
- Undertaking quality improvement in collaboration with women.

Requests for support in Q2 were received from across the maternity service, ranging from band 3-8.

Chart 10. PMA themes raised Q2



Themes Raised

1) Workplace rights
2) Working conditions
3) Professional responsibility
4) Work-related stress
5) Professional development
6) Professional relationships
7) Traumatic events

15. AVOIDABLE ADMISSION INTO THE NEONATAL UNIT (ATAIN)

Not yet available for Q2. Report to follow to Quality Governance Committee.

15.1 TRUST TRANSITIONAL CARE AND ATAIN RATES

Not yet available for Q2. Report to follow to Quality Governance Committee.

16.0 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 July 2022, the Trust sourced external independent support from NHSIE to review the services at the RUH and support the Trust to identify challenges, risks and actions required to provide safe maternity care. The review highlighted areas for improvement and areas of good practice focussed around 5 key themes

- Workforce
- Efficiency
- Safety
- Effectiveness
- Experience

The initial findings identified challenges within the workforce for maternity services

from capacity and capability of the maternity leadership and governance structure, the establishment in place and the structure of working.

The initial findings also highlighted 6 immediate key areas of action required to improve safety within the service. The Board Level Safety Champions are being briefed of progress in October 2022 prior to an update to the Board of Directors.

17.0 RED RISKS / RISK REGISTER HIGHLIGHTS

1734	Day Assessment Unit patient safety risk – area not compliant or fit for purpose	15
1768	Maternity redesign staffing impact	4
1948	Obstetric ultrasound scan capacity	8
2013	Lack of adequate suturing lighting in birth rooms	4
2225	Vacancies in senior nursing and midwifery leadership within the family and specialist services	9
2175	Midwifery Staffing Vacancies	20
2353	Replacement of ultrasound machine	4
2359	Maternity Information System IT support/capacity	15
2396	Obstetric theatre emergency call bells	6

18.0 RECOMMENDATION

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

APPENDIX 1. MATERNITY PERINATAL QUALITY SURVEILLANCE SCORECARD

		Alert (nat. standard)	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Comments
Workforce	Red flags: 1:1 care in labour not provided (Bath Birthing Centre only)	0	1	1	0	0	0	0	0	0	0	0	0	1	
	Percentage of supernumerary labour ward co-ordinator status (%)	100%	95	98	100	100	100	98	100	97	97	98	100	99	
	Rostered consultant cover on BBC - hours per week	<60 hours	60	60	60	60	60	60	60	60	60	60	60	60	
	Consultant non-attendance when indicated in RCOG Roles and Responsibilities (as reported via Datix)	0											0	0	New metric
	Bath Birthing Centre twice daily round achieved (%)	100%	77	67	84	81	79	94	93	90	93	97	94	X2 100 X3 83	TIMING OF ROUNDS – to be adjusted following obstetric staffing review
	Midwife to birth ratio (establishment)	>1:27	1:35	1:33	1:31	1:35	1:30	1:32	1:34	1:34	1:34	1:34	1:38	1:35	Directly linked to vacancy rate. **Including bank staff rate 1:31**
	Number of women booked onto a Continuity of Carer pathway (%)	>=35%	43.3	50.0	46.0	43.5	44.0	40.9	40.5	43.8	41.3	36.2	37.0	41.7	No. of women booked onto a CoC pathway (AN & PN only). No national standard in place from Sept 22.
Safety	Risk assessment at every contact (Antenatal) (%)		54	54	61	56	55	78	56	71	51	51	47	48	Risk assessment at Booking 100%. Documentation focus. Digital solution not possible.
	Stillbirth number	Actual	0	1	1	0	1	0	0	0	1	2	0	0	N.B. 1x SB incorrectly reported here in Aug.
	Neonatal deaths	Actual	0	0	0	0	0	0	0	1	0	0	0	0	
	Moderate Datix and above		2	3	3	2	0	2	5	2	3	0	1	2	
	HSIB		0	0	1	0	0	1	4	2	0	0	1	1	
Feedback	Number of compliments		1	2	0	4	1	1	1	1	4	3	0	2	
	Online compliments							291				*	*	*	Manual count of positive feedback via social media

	Number of PALS contacts/concerns		8	9	4	15	8	6	8	18	9	6	6	7	
	Complaints		1	2	2	1	3	2	1	1	3	1	1	1	
Training	PROMPT/Emergency skills all staff groups (%)	>90%	74.3	71.98	71.34	76.6	84.0	91.2	91.8	95	91.4	91	78.7	79.5	See detail on training page
Training	Percentage staff received fetal monitoring in labour training **(new from Sept 2021)** (%)	>90%	9.28	15.61	19.49	22.88	36.44	49.3	49.3	63.2	78*	82*	71.1	83.1	
Training	New-born life support (NBLS) (%)	>90%	79.65	79.15	80.20	77.8	89.0	91.2	92.2	96	91	91	77.5	79.5	
Training	Percentage of staff who have successfully completed mandatory CTG fetal monitoring annual competency assessment (%)	>90%	7.59	16.46	19.83	26.06	36.44	49.3	49.3	63.2	70.4	73	71.1	83.1	
	Coroner Regulation 28 made directly to Trust		Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	
	HSIB/CQC etc. with concern or request for action		Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	1	Nil	Nil	Nil	Normal HSIB surveillance now resumed