Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item No:**	**11**
Date of Meeting:	**1 March 2023**		

Title of Report:	**Maternity and Neonatal Safety Report Quarter 3**
Board Sponsor:	**Antonia Lynch, Chief Nurse**
Author(s):	**Zita Martinez, 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 fully compliant 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. Recruitment has continued at pace. The staffing trajectory continues to demonstrate improvement in staffing levels into Q4. A large number of newly qualified staff are now being supported in their preceptorship period in the acute unit, which now leaves the most significant vacancy in the community areas. Continuity of Carer teams remain suspended except for the most vulnerable families. The temporary suspension of home births continued in Q3. Community births resumed at one midwifery led unit (Frome) from 31 October 22 and the remained are scheduled to open in Q4.

As previously reported to Board of Directors, the Trust reported a cluster of seven cases to HSIB from 22 March 2022 to 14 May 2022 (six week period). As a result HSIB instigated enhanced monitoring and oversight for a 3 month period which ended in August 2022.

HSIB wrote to the Trust on 12 January 2023 to confirm their investigation found no evidence of systemic safety concerns or any underlying issues that require further escalation. Their review contained recommendations for clinical practice which are detailed in this report.

The report acknowledged the successful reaccreditation of the Trusts UNICEF UK Baby Friendly status. Following this there is to be a strategic working group established to plan out ‘next steps’ and to identify key work streams required to apply for ‘Gold’ accreditation.

The Trust appointed Zita Martinez as Director of Midwifery and Dr Claire Park as Obstetric Lead. In addition, Kerry Perkins was nominated and won the Midwife of the Year Award in the MAMMA Academy Awards.

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 – physical environment not 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
2353	Replacement of ultrasound machine	4
2359	Maternity Information System IT support/capacity	15
2396	Obstetric theatre emergency call bells	6
392	Obstetric and gynaecology workforce risk	15
2416	Fetal CTG monitoring in community	15
2417	Maternity triage	20

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

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

7.	References to previous reports
Previous monthly Perinatal Quality Surveillance reporting. Maternity and Neonatal Safety Report Quarter 2 - October 2022. Safer Staffing Report – August 2022. CNST Maternity Incentive Scheme – Year 4 declaration of compliance - December 2022.	

8.	Publication
Public.	

9.	Sustainability
None	

10.	Digital
None	

MATERNITY AND NEONATAL QUARTER 3 2022/23 SAFETY REPORT

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

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

	October	**November**	**December**
1.Findings of review of all perinatal deaths using the real time data monitoring tool	✓ see report	✓ see report	✓ see report
2. Findings of review of all cases eligible for referral to HSIB	✓ see report	✓ see report	✓ see report
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	✓ see report	✓ see report	✓ see report
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	✗ see report	✗ see report	✓ see report
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	✗ see report	✗ see report	✗ see report
3.Service User Voice Feedback	✓ see report	✓ see report	✓ see report
4.Staff feedback from frontline champion and walk-about	✓ 20/10/22	✓ 17/11/22	✓ 15/12/22
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	✗ 85%	✗ 95%	✓ 100%
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)

1. REPORT OVERVIEW

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) Board and the Board of Directors of present or emerging safety. 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 (RUH) is performing against the national ambition.

There were 2 stillbirths in Q3, please refer to section 2.1.

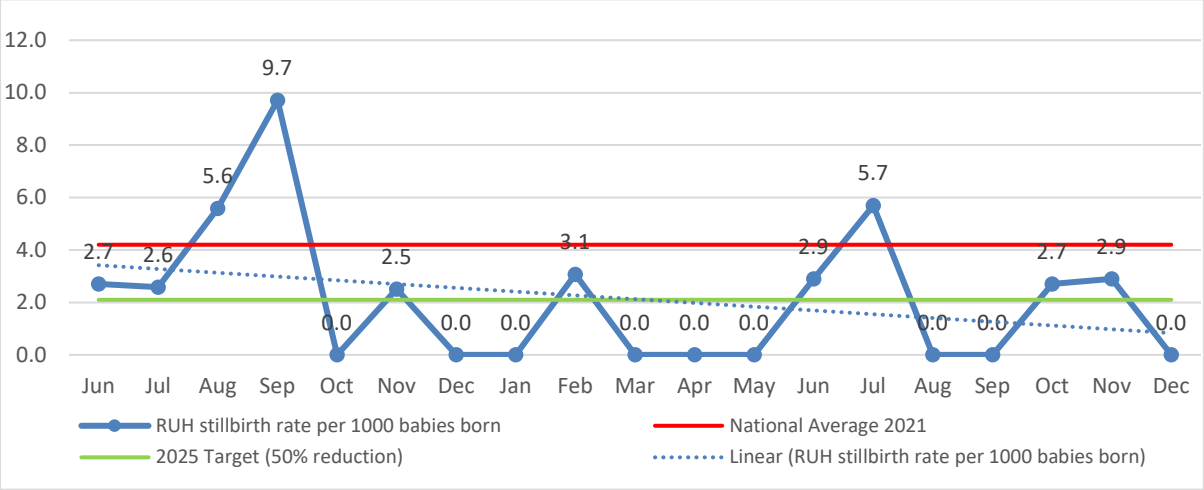

Figure 1. RUH NHS Trust Stillbirth rate per 1000 births over last 18 months

There were no reported neonatal deaths in Q3.

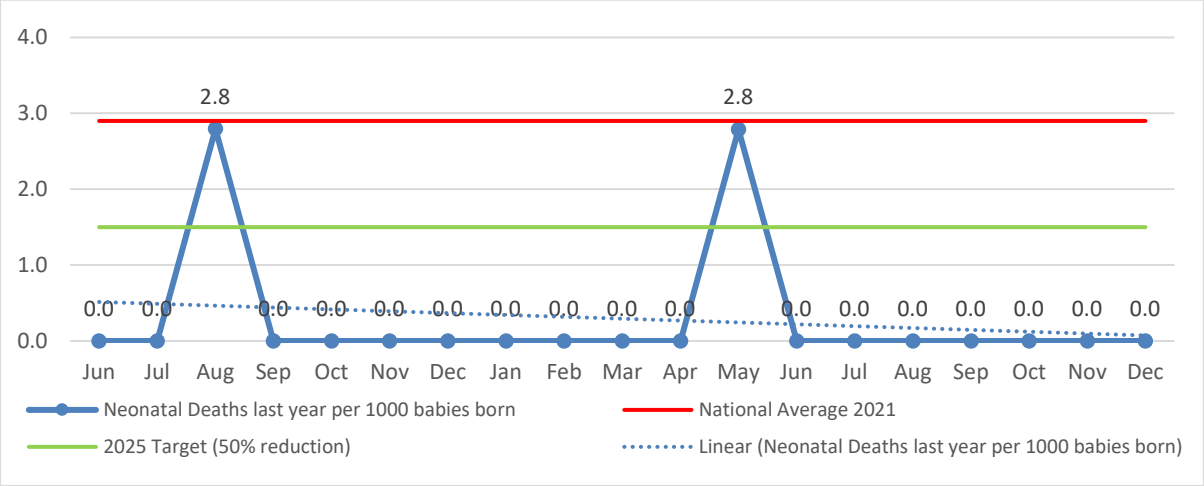

Figure 2. RUH NHS Trust Neonatal Death rate per 1000 births over last 18 months

2.1 PERINATAL MORTALITY SUMMARY FOR QUARTER 3 2022/23

2020/21 (excluding terminations for abnormalities)	Q3	Annual total 22/23
Stillbirths (>37 weeks)	1	1
Stillbirths(>24weeks-36+6weeks)	1	4
Late miscarriage (22+oweeks-23+6weeks)	0	2
Neonatal deaths	0	2
Total	**2**	**9**

Table 1. Perinatal Mortality Summary Quarter 3 2022/23

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

All perinatal deaths within the Trust have been reported using the PMRT tool since 2018. PMRT reporting is a requirement of Safety Standard 1 of the NHSR Maternity Incentive Scheme year 4.

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

The RUH Electronic Patient Record records all stillbirths (24 weeks or greater gestation) and neonatal deaths. Births between 22-24 weeks pulled manually and added to the data set submitted to MBRRACE-UK

Perinatal deaths are defined from 22 weeks and include neonatal deaths, but stillbirths are defined from 24 weeks. The rate of stillbirth and perinatal death may therefore be different.

In total there have been 2 perinatal deaths in Q3:

1. Stillbirth - death at term and during the induction of labour, this has been referred and accepted by the Healthcare Safety Investigation Branch (HSIB).
2. Stillbirth – umbilical cord compression.

All cases have been reviewed at the PMRT meeting and actions have been agreed. All parents have been informed of the PMRT review and have contributed to the reviews. PMRT will take place during scheduled meetings in January, February and March as required. PMRT meetings include external panel members to ensure the process is robust and honest.

Actions identified:

- Review Reduced Fetal Movements guideline
- Review triage process (on-going action from a previous case)

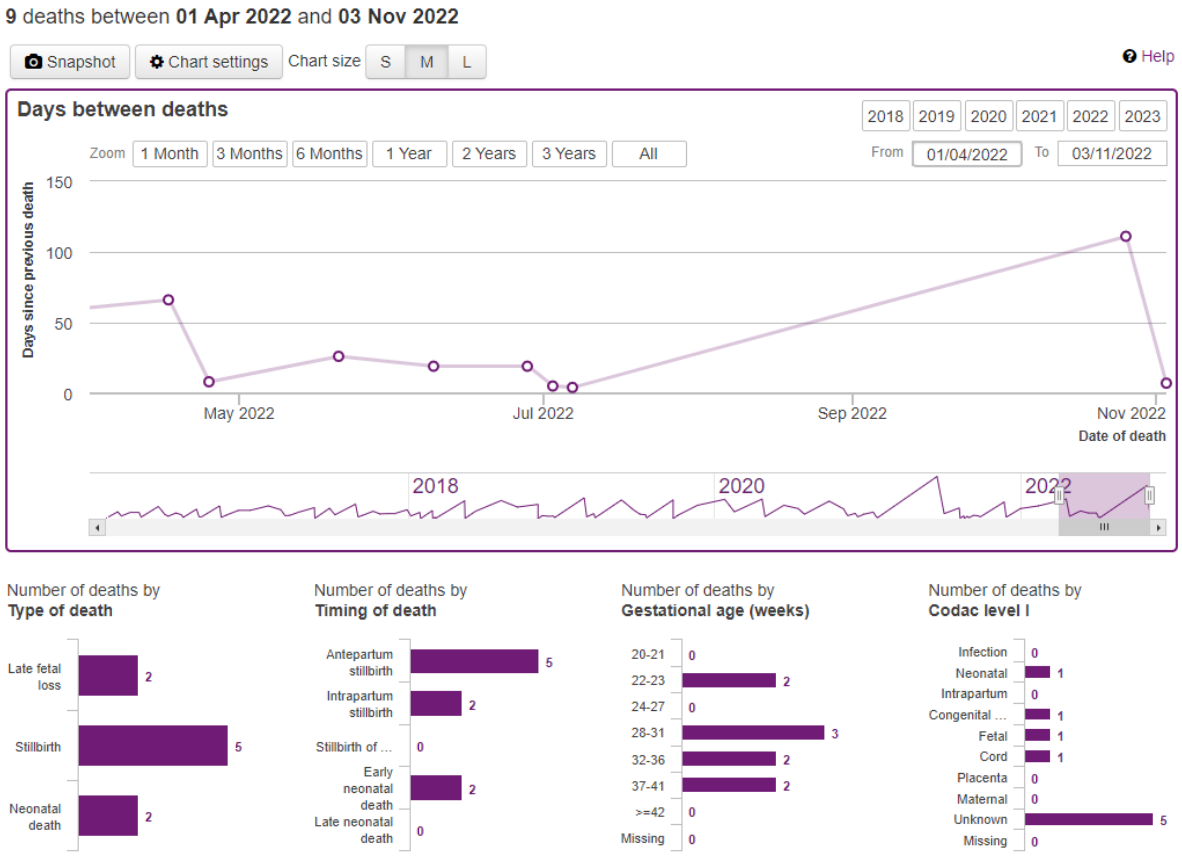

Figure 3. Reporting of RUH NHS Trust Deaths within Organisation
*last perinatal death was in November. PMRT graph will only generate up to date of last death.

2.3 LEARNING FROM PMRT REVIEWS

Table 2 provides an update on the outstanding actions from reported cases in Q1 and Q2. There are no outstanding actions other than those reported in Q3.

PMRT 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	Action plan text	Implementation text	Owner	Target date	Status
81978/1	Cabergoline (medication) was not given to suppress lactation.	Pathway to be updated including Lactation and Loss Standard Operating Procedure.	Bereavement Care Pathway to be updated and disseminated.	Bereavement Midwife.	30/11/22	Complete
82268/1	Reduced Fetal Movement leaflet was not provided in mother's first language.	Staff informed importance of & how to access Reduced Fetal Movement leaflet in different languages.	Staff informed of importance of & how to access Reduced Fetal Movements leaflet in different languages.	Patient Safety team.	30/09/22	Complete

Table 2. Update on actions arising from Q1-Q2 PMRT reviews 2022/23

The Q3 cases have been discussed at the PMRT meeting, their actions and outcomes will be included in the Q4 report. Early assessment of one case suggests that the triage process may have been a factor. This is an area we have identified previously as needing improvement, so work is already in progress to improve centralised triage services in the department. Early identification and risk assessment will support appropriate prioritisation and escalation. Until this work is completed, this has been added to the Trust Risk Register.

3. HEALTHCARE SAFETY INVESTIGATION BRANCH AND MATERNITY SERIOUS INCIDENTS

3.1 BACKGROUND

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

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

3.2 HSIB CLUSTER

As previously reported to Board of Directors, the Trust reported a cluster of seven cases to HSIB from 22 March 2022 to 14 May 2022 (six week period). As a result HSIB instigated enhanced monitoring and oversight for a 3 month period which ended in August 2022.

HSIB wrote to the Trust on 12 January 2023 to confirm their investigation found no evidence of systemic safety concerns or any underlying issues that require further escalation.

A review of the findings and recommendations highlighted that communication was a common recommendation category. The communication sub-categories were varied and included communication (three relating to emergency situations), information sharing, translation services and care planning with families.

The action plan will be shared as part of the Q4 report.

3.3 INVESTIGATION PROGRESS UPDATE

Table 3 identifies the referrals made to HSIB during Q3. The outcomes of these reports will feature if future reports.

Ref	Confirmed level of investigation	Date confirmed Investigation	External Notifications and Other Investigations
Ongoing			
107283	Therapeutic cooling following birth. No safety recommendations made to Trust.	18/08/22	2022/18296
108058	Therapeutic cooling following shoulder dystocia at birth. Normal MRI post cooling Ongoing HSIB review.	13/09/22	2022/21156
New referral			
110141	Intrapartum Stillbirth following Propess administration during an Induction Of Labour HSIB Investigation (see 3.4)	10/11/2022	STEIS 2022/25202 PMRT MBRRACE

Table 3. HSIB referrals and ongoing investigations Quarter 3 2022/23

3.4 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable.

3.5 MATERNITY SERIOUS INCIDENTS

There were 3 Serious Incidents reported Q3.
Whilst all cases referred to HSIB are automatically investigated by the Trust as a serious incident, the Trust may also investigate a case that does not meet the HSIB criteria, hence the differing cases in tables 3 and 4.

Datix No	Category	Outcome	Immediate Learning
October			
109848	Major Harm	Neonatal Seizures and subsequent HIE following an impacted fetal head and uterine rupture at LSCS.	Ongoing RCA. Declined by HSIB.
November			
110141	Stillbirth	Intrapartum Stillbirth following Propess administration during an Induction Of Labour	Review on-going with HSIB (see 3.2).
December			
111552	Moderate harm – maternal admission to ITU	Maternal Admission to Critical Care - HELLP syndrome	Review in progress.

Table 4. Maternity Serious Incidents Quarter 3 2022/23- Includes all cases of moderate harm or above

4. CONTINUITY OF CARE

4.1 BACKGROUND

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

national Maternity Transformation Plan.

4.2 PROGRESS TO DATE

Maternity Continuity of Carer (MCoC) remains paused in line with national guidance. The development and implementation of the long-term workforce plan, which includes recruiting internationally and expanding routes into midwifery which includes the registered nurse to registered midwife pathway. A large number of newly qualified staff are now being supported in their preceptorship period in the acute unit, which leaves the most significant vacancy in the community areas. The Trust remains committed to reintroducing maternity continuity of carer when staffing levels permit, this will be reviewed in Q4.

Antenatal and postnatal continuity of carer continues to be provided where possible, with vulnerable/at risk groups and those from Black Asian and Minority Ethnic groups being prioritised. All intrapartum continuity of carer has been suspended in line with NHSE guidance until safe staffing levels are achieved across the service.

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.

£331,795 was made available through Ockenden funding to the Trust to support the changes required following the initial report in 2020. This was utilised to fund an additional fetal monitoring Lead Consultant post, and mandatory training in fetal monitoring for all maternity staff. Further potential funding sources to support the requirements of the final Ockenden report have not yet been announced.

The Trust compliance in relation to the initial Ockenden report is detailed in table 5.

RAG	IEA	Actions/Mitigations:
IEA 1	Enhanced Safety	
IEA 2	Listening to women & families	
IEA 3	Staff Training and Working Together	Following obstetric workforce review, now fully compliant with twice daily ward rounds >90% including one at night from Jan 23. Face to face training– MDT Emergency Skills Training (PROMPT) now above 90% for some staff groups. Robust trajectory and action plan to maintain compliance.
IEA 4	Managing Complex Pregnancy	

IEA 5	Risk Assessment Throughout Pregnancy	Improvement required to capture documentation of Risk Assessments taking place at every contact. 1. Compliant for routine antenatal appointments. 2. Risk to compliance for ward attenders/Day Assessment Unit/ Midwife led Ultrasound. 3. Digital option being explored regionally to improve the capture at other contact points. 4. Working party meeting to develop action plan. 5. Differences to interpretation of IEA at regional partner Trusts.
IEA 6	Monitoring Fetal Wellbeing	
IEA 7	Informed Consent	
	Workforce element	Obstetric workforce review now completed.

Table 5. Compliance with initial Ockenden Immediate and Essential Actions

5.2 OCKENDEN FINAL REPORT UPDATE – Q3 2022-2023

The Trust is not currently required to submit evidence of compliance and submission date is not yet confirmed.

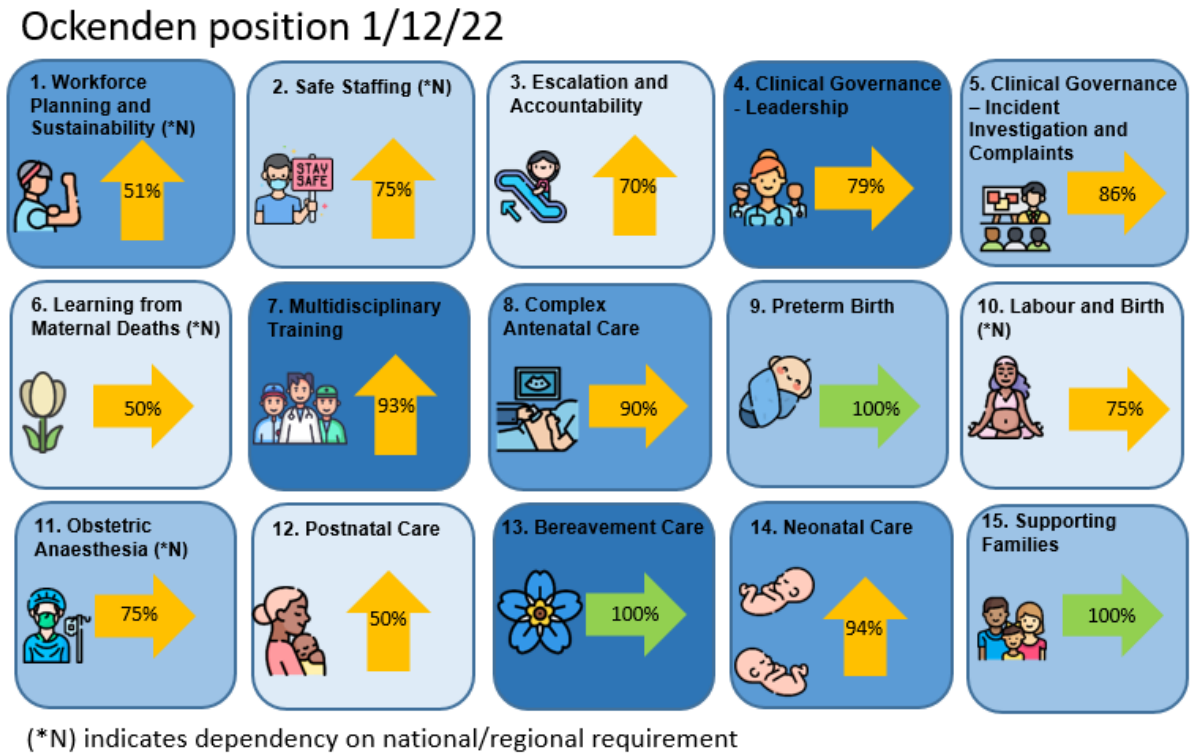

Figure 4. Ockenden Final Report Position - Immediate and Essential Actions

Outstanding and completed locally identified actions are being tracked via a local 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. Compliance with fetal monitoring, neonatal resuscitation and multi-disciplinary training (MDT) Emergency Skills Training (PROMPT) is now above the required 90% (figures 5 and 6) for all staff groups, underpinned by an action plan to continue to maintain and improve training rates and compliance.

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

A robust training trajectory has now been developed and a new monitoring and booking system is now in place to ensure current compliance is maintained and continually improved for all mandatory training.

6.2 TRAINING DATA

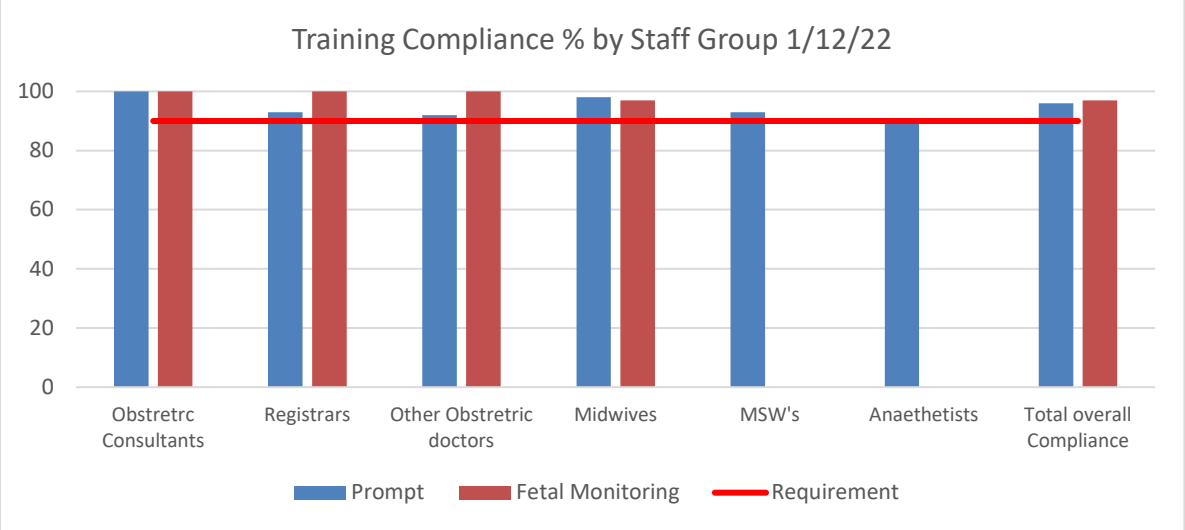

Figure 5. Prompt and fetal monitoring Training Compliance (%) by staff group Q3 2022/23

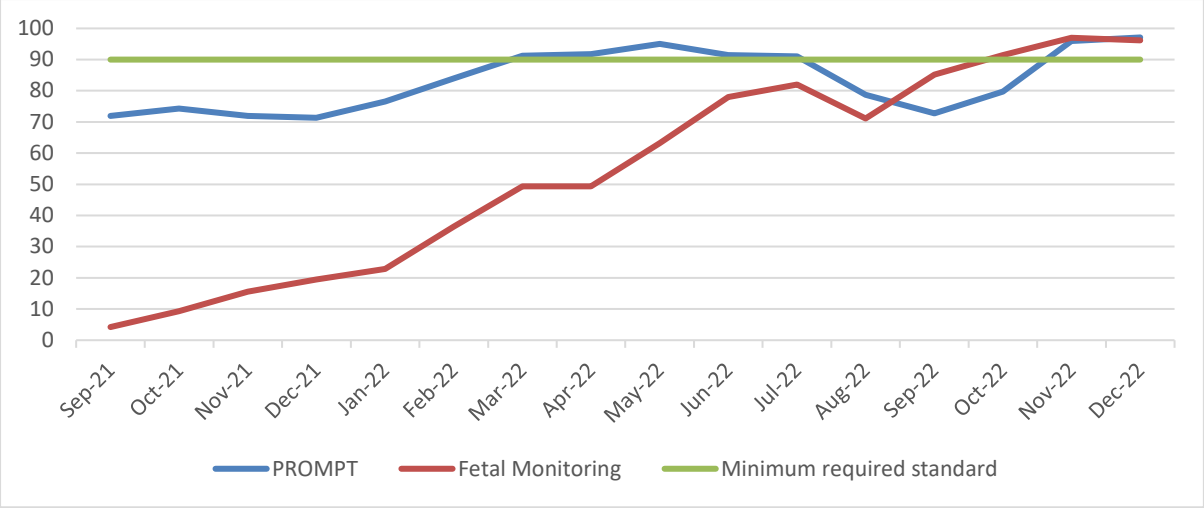

Figure 6. Training Compliance – All staff groups

7. BOARD LEVEL SAFETY CHAMPION MEETINGS

All staff are invited to attend monthly meetings held with the Chief Nurse and the Non-Executive Director (Board Level Safety Champions on 20 October, 17 November and 15 December). The meetings in Q3 were attended by members of the maternity and neonatal team from a range of areas, including community and specialist midwives.

Themes raised included:

- In-house apprenticeship for Maternity Care Assistants/Maternity Support Worker – in discussion
- Community vacancy affecting services and morale – recruitment campaign continues
- Reinstating community and home births – Frome open to births, Chippenham will reopen in March 23, home birth services will recommence in March 23.
- The physical environment of the Day Assessment Unit is not fit for purpose – refurbishment and relocation plans being developed
- Request for weekly bank pay – now completed
- On-call rota principles – on-call plan to be confirmed and progressed
- Birth reflections cessation – service now reinitiated
- Space challenges to undertake midwife sonography clinics – escalated the Divisional Director of Operations

7.1 BOARD LEVEL SAFETY CHAMPION WALKABOUTS

The Board Safety Champions undertook walkabouts across Maternity Services:

- 21 October – Chief Nurse and Non-Executive Director visited the Bath Birth Centre and Day Assessment Unit
- 18 November – Chief Nurse visited Chippenham Maternity Unit
- 16 December – Chief Nurse and Non-Executive Director visited the Neonatal Unit, Bath Birth Centre and Mary ward.

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

Champions meetings.

8. SAVING BABIES LIVES CARE BUNDLE V2

8.1 UPDATE

Full compliance with all elements within Saving Babies Lives Care Bundle Version 2 (SBLCBv2) is a requirement detailed in Safety Action 6 of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme. A quarterly report, shared with the Board Level Safety Champions provides 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 all 5 elements.

In Q2, the Trust reported non-compliance with Element 1 in relation to Carbon Monoxide monitoring. Evidence to support compliance with Carbon Monoxide monitoring in pregnancy was collated using a manual audit of documentation (figure 7) which is necessary due to a hybrid use of paper and digital records.

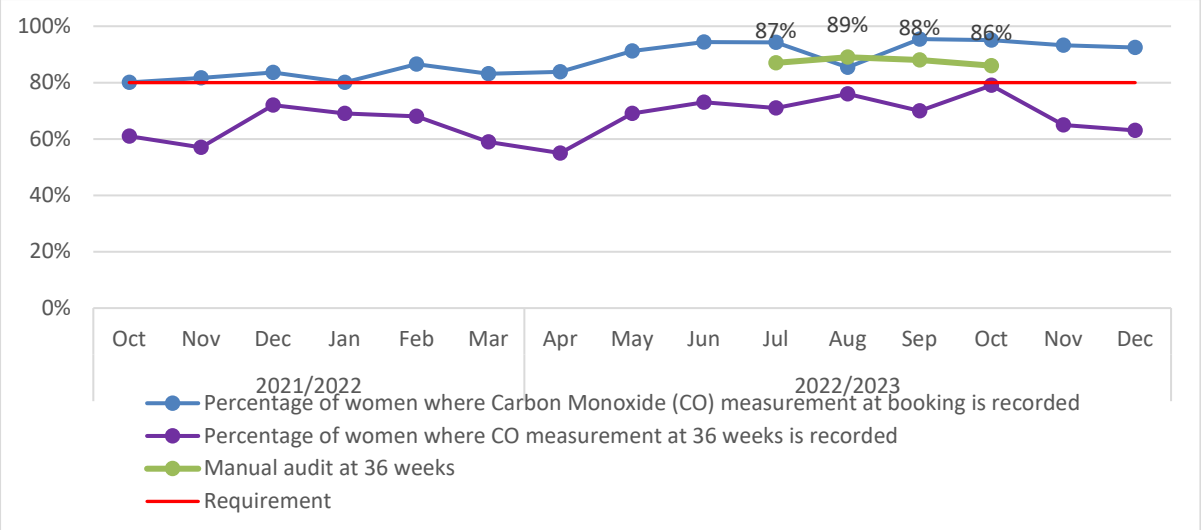

Figure 7. CO monitoring in pregnancy – year to date

The Trust is currently exploring alternative digital options for a maternity information system in partnership with other Bath and North East Somerset, Swindon and Wiltshire Trusts and the LMNS.

9. NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q3 2022/23

Following further amendments to the scheme in October 22, the reporting period was confirmed as 5 February 2022 to 2 February 2022. Following a robust assurance process, the Trust has now declared full compliancy with all Maternity Incentive Scheme (MIS) Safety Actions.

	Safety Action	Evidence Summary	Self-assessment
1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?	*Quarterly and monthly perinatal quality surveillance reporting demonstrates that the PMRT has been used appropriately.* *The Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries-UK (MBRRACE-UK) MIS report demonstrates full compliance.*	
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	*The MSDS MIS report confirms full data quality compliance.* *A maternity digital strategy is in place along with dedicated digital leadership.*	
3	Can you 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 into Neonatal units Programme?	*ATAIN and transitional care pathways are established. These pathways are described in detail in divisional guidelines.* *Ongoing audits and action plans are demonstrated in quarterly reports.*	
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	*The principles of Royal College of Obstetrics and Gynaecology (RCOG) Roles & Responsibilities of the Consultant workforce document are embedded.* *Dedicated duty anaesthetic cover at all times.* *Neonatal nursing action plan to meet BAPM staffing compliance. Progress noted against year 3.*	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	*Funded clinical establishment in line with last full BirthRate+ assessment in 2019. 2021 plan disregarded due to suspension of Continuity of Carer (CoC). New BirthRate+ assessment now underway which will require increased funding support in 2023 business planning.*	
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two (SBLCBv2)?	*Each element of the SBLCBv2 has been implemented to the required standard. This is evidenced through audits in quarterly reporting, guidelines, and Trust maternity dashboard.*	
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	*Multiple mechanisms for gathering feedback.* *Evidence of coproduction with Maternity Voices Partnership Plus (MVPP).* *MVPP chair attends maternity governance meetings.* *Terms of reference for MVPP, and minutes of regular Local Maternity and Neonatal System (LMNS) meetings.*	

8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and new-born life support, starting from the launch of MIS year 4?	*Training Needs Analysis is in place. A training database and trajectory is maintained to support forward planning and to demonstrate compliance.* *Multidisciplinary training is in place, including all required elements.* *Over 90% of all staff within each staff group are compliant with training for:* • *Maternity emergency multi-professional training* • *Fetal monitoring (including assessment)* • *Neonatal life support*	✓
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?	*Perinatal Quality Surveillance Tool in use. Shared with Safety Champions and Board monthly.* *Board level Safety Champions engage with staff at monthly feedback sessions.*	✓
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?	*HSIB and NHS Resolution records demonstrate reporting. HSIB referrals included within monthly perinatal quality surveillance reporting to Board.*	✓

Table 6. Maternity Incentive Scheme Update Q3 2022/23

10. SAFE MATERNITY STAFFING

10.1 MIDWIFERY STAFFING

The Trust appointed Zita Martinez as Director of Midwifery and Dr Claire Park as Obstetric Lead.

As of 21 December 2022, the planned vs actual midwifery staffing was -15.66 whole time equivalent (WTE) (of which 6.48 WTE is maternity leave). This gives a substantive vacancy rate -9.18 WTE.

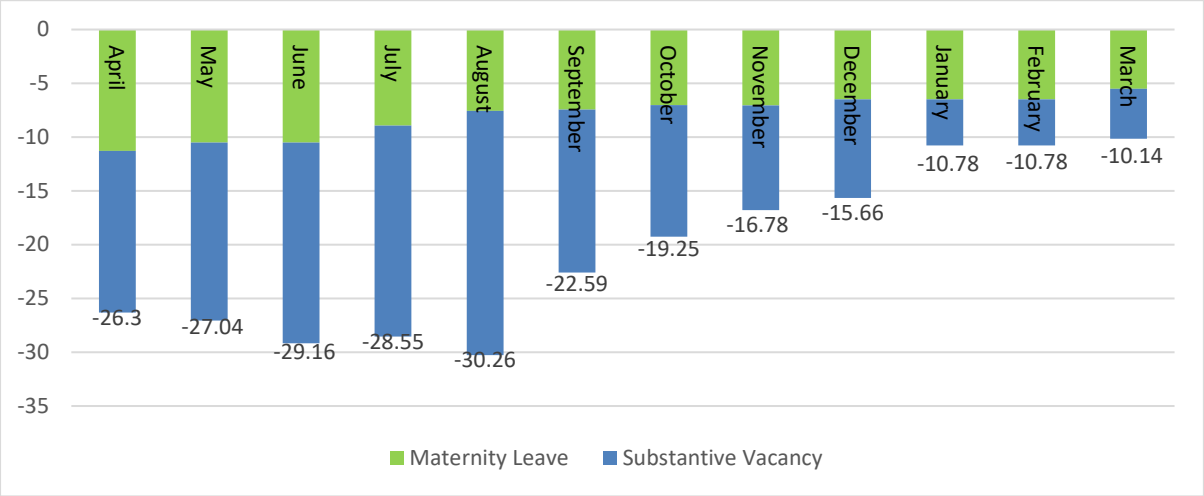

Figure 8. Band 5/6 Midwifery Workforce staffing vacancy and forecast (not including long-term sickness) 21-12-22

Measure	Aim	Oct 22	Nov 22	Dec 22
Midwife to birth ratio	≤1:27	1:34	1:31	1:30
Midwife to birth ratio including bank	≤1:27	1:29	1:26	1:27
Supernumerary labour ward coordinator status	100%	99%	100%	99%
1:1 care not provided	0	0	0	0
Confidence factor in BirthRate+ recording	60%	73%	70%	70%

Table 7. Midwifery staffing safety measures

At periods when the labour ward coordinator was not supernummary, no harm resulted.

A large number of newly qualified staff are now being supported in their preceptorship period in the acute unit, which now leaves the most significant vacancy in the community areas.

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:

- Registered nurses undertaking non-midwifery care
- Clinical support provided by members of the midwifery leadership team
- Repeat BirthRate+ assessment underway. The results are expected imminently
- Recruiting to maternity leave moving forward and over-recruiting by 8.9WTE
- Active rolling recruitment campaign
- Implementation of a preceptorship and retention support package
- Career progression improvements for MCAs to MSWs
- System calculation of required headroom, reviewing three years of data for mandatory training, maternity leave, sickness and annual leave (32%)
- Weekly bank pay commenced Trust wide

Next Steps

- Stepped approach to reintroduce community births as safe staffing allows. Frome Birthing Centre re-opened to births on 31 October 22. Resumption of community births and home births across the service will commence at the end of Q4.
- Review of Continuity of Carer provision.
- Complete overhaul of e-rostering, including compassionate rostering.
- Review on-call arrangements for acute unit staff ongoing.

10.2 OBSTETRIC STAFFING

Measure	Aim	Oct 22	Nov 22	Dec 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%	100%	100%

Table 8. Obstetric staffing safety measures

An Obstetric workforce review has now been completed. Effective from January 2023, ward rounds will take place at 0830 hours and 2030 hours, in person, with a third afternoon round in place if required. Consultant attendance at situations detailed in the Royal College of Obstetrics and Gynaecology Roles and Responsibilities of the Consultant Workforce guidance has remained at 100% throughout Q3.

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

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

	Oct 22	Nov 22	Dec 22
Number of formal compliments	1	0	0
Number of Patient Advice and Liaison Service (PALS) contacts/concerns	7	8	9
Complaints	3	2	1

Table 9. Complaints and compliments Q3

Formal complaints within Q3 related to:

- Restrictions in visiting during the pandemic
- Communication with neighbouring Trust impacting on care
- Communication regarding induction of labour
- Communication while in theatre – complex care
- Concerns around management of care in labour
- Dissatisfaction with HSIB findings following review of care

An increase in contacts with the Patient Advice and Liaison Service (PALS) team was noted in 2022, driven primarily by the suspension of community and home birth services. Families raised concerns about the impact this had on their birth choices. A number of PALS contacts related to queries about appointments or scan services.

Local staff training will be undertaken to improve communication and help staff support families with informed decision making and personalised care planning. This is to be introduced in Q4.

12. SERVICE USER INSIGHTS FROM MVPP

Co-production with Maternity Voices Partnership Plus (MVPP) has continued throughout Q3 on a range of antenatal information/birth options films. My Care Hub app (pilot) co-designed with MVPP, launched as a pilot in July 2022 for families in the Chippenham area. This includes signposting to the LMNS website, NHS information and guidance and the RUH webpage. Due to limitations with the digital options, this will be rolled out using a paper personalised care and support plan booklet until such

time as a digital option can be made available to all families.

Feedback from families collated from surveys in September to November 22 has been provided by the MVPP. Themes included:

- Concerns around induction of labour (IOL) communication – Being told this is clinically necessary, but then experiencing delays
- Improvement in care experiences reported post COVID-19
- Call from MVPP for compassionate language, not fear based
- Feeling well informed and not pressured in labour
- Lack of homebirth option
- Birth reflections service highly valued
- Examples of excellent feeding support
- Lack of food for Dads/partners – now available
- Good explanations reported to whole family/Dads
- Clear explanations not always given
- Longer postnatal stay requested

A 'You Said, We Did' format action plan to address this feedback is currently in development.

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

12.1 SERVICE USER INSIGHTS TAKEN FROM A RECENT CQC PEER REVIEW

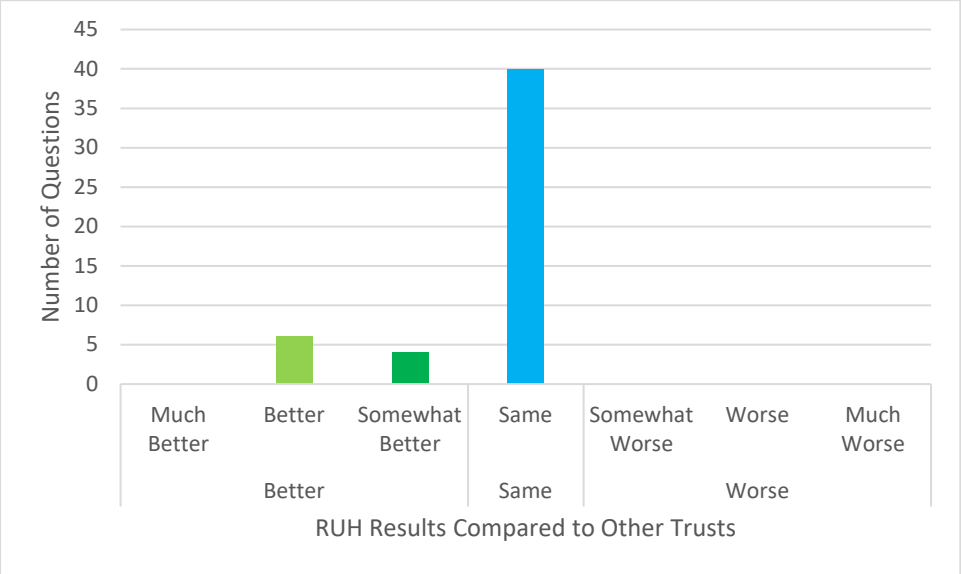

Figure 9. How the RUH scored in the CQC Maternity Survey 2021

214 Royal United Hospitals Bath NHS Foundation Trust patients responded to the CQC Maternity survey. The response rate was 65.64%. Overall, the RUH scored better than most other Trusts relating to care in the antenatal period.

Respondents reported they felt involved in decisions about their care and had appropriate information about the choices available to them. They had confidence and

trust in the staff caring for them in labour, and reported high levels of skin to skin care with their babies after birth.

13. QUALITY IMPROVEMENT PROJECTS / PROGRESS

13.1 MATERNITY TRANSFORMATION INCLUDING BETTER BIRTHS

There remains a lack of national funding to support the local maternity transformation plan to build to build an Alongside Maternity Unit (AMU) and re-design the Day Assessment Unit (DAU). Further plans have been developed to design the AMU and DAU within the current Trust footprint. Agreement of the plans will be finalised in Q4 and architects will be instructed to develop high level plans.

Work is required to understand the impact of health inequalities on the birth outcomes for people from different ethnic groups and areas of deprivation. A maternity health inequalities working group will commence in Q4 and align with the LMNS equity action plan. The purpose of the working group is to develop quality improvement projects supported by champion clinicians.

13.2 PERINATAL MENTAL HEALTH

Ongoing discussions continue regarding the new Pregnancy in Mind (PIM) service that will be piloted within Wiltshire. This is a National Society for the Prevention of Cruelty to Children (NSPCC) 6 week course for women and their partners with low to moderate mental health concerns. Pilot areas will be Trowbridge, Warminster and Westbury. If successful this will be extended to whole of South West. Referrals into service will commence in January 2023.

The Specialist Perinatal Mental Health (PNMH) midwife role has commenced in addition to the birth trauma and loss midwife, providing 1:1 triaging and support and referral to therapeutic support for post-traumatic stress disorder where necessary.

There has been a sustained increase in women with more complex mental health needing referral onto specialist perinatal mental health services as demonstrated in figure 10.

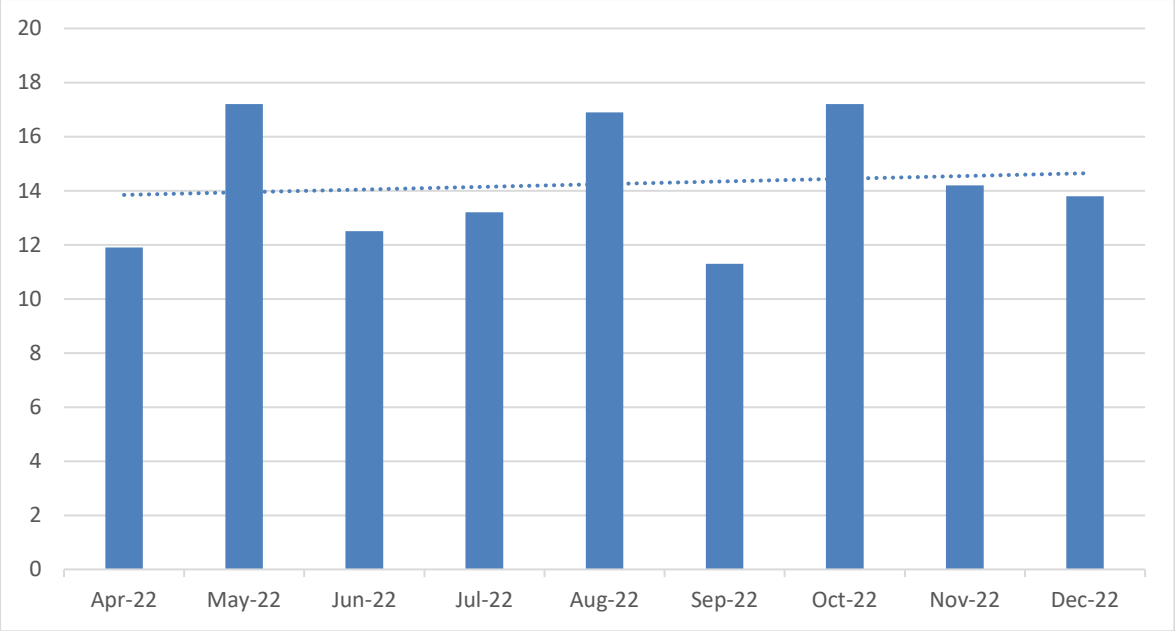

Figure 10. % of completed screening tools prompting referral onto PNMH service year to date 22/23

In Q3 there was one admission 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

The maternity spot check safeguarding audit with a focus on routine domestic abuse enquiry was commenced in Q3. The initial findings are very positive with 92% of women having been asked about domestic abuse and 85% on more than one occasion. This is a big increase from last year's audit when only 58% of women were asked more than once. The full report from the audit will be shared via the Maternity Safeguarding Committee at the end of Q4.

The Named Midwife for Safeguarding has updated the maternity guideline M63, for staff working with pregnant women who misuse substances. The previous separate cannabis guidelines have now been amalgamated into this guideline.

The RUH Independent Domestic Abuse Advisor (IDVA) no longer works for the Trust. Funding has not been secured for a future IDVA role within the Trust. This has also impacted on 7.5 hours per week of Specialist Support Midwife hours as the IDVA had a dual role. This will have an impact on the support that maternity services are able to provide to women with domestic abuse concerns. An alternative solution is being sought.

13.4 INFANT FEEDING AND HEALTH IN PREGNANCY SPECIALIST SERVICES

A key highlight during Q3 was the successful reaccreditation of the Trusts UNICEF UK Baby Friendly status. Following this there is to be a strategic working group established to plan 'next steps' and to identify key work streams required to apply for 'Gold' accreditation.

The Infant Feeding specialist service continued to provide care for women and babies experiencing complexities and the fixed term 'Milk Project' service commenced; enabling women and families living in areas of highest deprivation to access extra, unlimited breastfeeding support. Feedback from the families and maternity staff has been extremely positive.

In addition, provision of tongue tie assessment and division appointments increased from that in Q2 and triage-to-treat times reduced as a result. Telephone audits of service users found a high level of satisfaction with several people specifically highlighting the 'compassion and kindness' they had received in relation to infant feeding and tongue tie support. Volunteer Breastfeeding peer support on Mary ward continued to be well received by families and staff.

Feedback from the MVPP survey was particularly positive in relation to breastfeeding support following caesarean births. Areas for action included looking at how families can be better supported whilst on the postnatal ward and raising awareness of how and where they can seek breastfeeding support following discharge. In response, we have increased communication around the MVPP 'Infant Feeding Padlet' and other local/national resources. Furthermore, work is underway to reframe the 'going home' messages shared with families on the postnatal ward; highlighting how to recognise if their baby is getting enough milk and how to contact a midwife for extra support. To align with this, communications with staff have reiterated the importance of proactively offering feeding support to new parents following discharge from hospital; in particular face-to-face contact and direct observation of feeding. Recruitment of a Lead Maternity Support Worker (MSW) to support MSWs in their role is expected to further enhance this as Infant Feeding support will be a key area of focus.

Q3 saw expected levels of engagement from women for smoking cessation support and service user feedback was exceptionally positive. Face to face support was increased from Q2 with advisors offering women more choice regarding where and when they are seen; e.g. at home, in the hospital, in a community venue. Further work is underway to determine clinical areas in which smoking cessation support can be offered within the RUH.

In line with the wider work around the 'Treating Tobacco Dependency' programme, for which Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB) has received national funding in preparation for the implementation the Trust successfully appointed a 'Treating Tobacco Dependency Advisor' (0.4 WTE) and approval of a new standing operating procedure regarding dispensing of nicotine replacement therapy.

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

The Professional Midwifery Advocate (PMA) continues to offer restorative support, one to one and in groups, as well as signposting to further sources of support, information and assistance. As a critical part of the advocating for education and quality improvement (A-EQUIP) model, the PMA focuses efforts on empowering midwives to confidently handle situations themselves, improve relationships with peers and managers, and to seek ways to increase service quality, safety and excellence.

Requests for support this quarter were from community and acute staff, ranging from Bands 2-8. All staff self-referred, and much of the support offered was in response to one-to-one requests from midwives, or on an ad hoc basis. Support was also provided to non-maternity nursing staff. The PMA continues to travel to all areas of the service regularly, both in response to requests and merely to raise awareness and build trust.

In addition, the PMA Team Proposal, submitted in September 2022, was accepted and from February 2023, 5 more PMAs will be in post and are currently planning a launch and activities to engage staff.

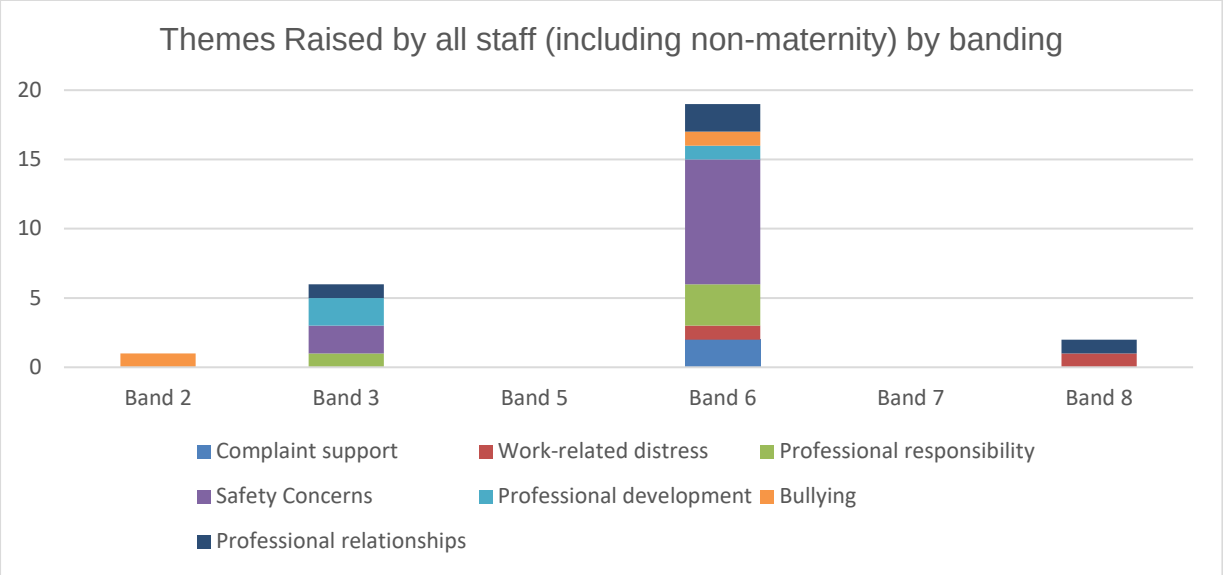

Figure 11. PMA themes raised Q3

Themes Raised

- Safety Concerns
- Bullying
- Professional development
- Complaint support
- Professional responsibility
- Work-related distress

It should be noted that no newly qualified/band 5 midwives sought additional support from the PMA during Q3. This can be attributed to the level of personalised support provided by the preceptorship programme.

15. AVOIDABLE ADMISSION INTO THE NEONATAL UNIT (ATAIN)

There were 3 avoidable admissions of term babies to the neonatal unit in Q3 highlighted at the MDT ATAIN review meetings.

The relationship between the neonatal and midwifery teams continue to help facilitate some enhanced care, particularly with plans of care and early interventions for high risk babies e.g. assisting with thermoregulation and hypoglycaemia issues. This in turn

helps to avoid admissions of the baby to NNU. Reducing avoidable admissions of term babies remains a focus.

15.1 TRUST TRANSITIONAL CARE AND ATAIN RATES

Standard	Oct 22	Nov 22	Dec 22
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	**1** discharge to Mary ward	**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	**0**	**0**	**0**
% of shifts TCP nurse provided as per TCP staffing model	**89%**	**94%**	**77%**
TCP open	**100%**	**100%**	**100%**
Avoidable term admissions 37+0 weeks gestation and above 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.	**0**	**2**	**5**

Table 10. ATAIN and TC data Q3 22/23

Seven term babies were transferred or admitted to the Neonatal Unit from other areas in Q3. This was driven by an increase in babies attending the Emergency Department and the Paediatric Assessment Unit with acute respiratory illness.

Three of the five babies required respiratory support/1:1 nursing for severe respiratory compromise. Four of the babies were transferred to a Paediatric Intensive Care Unit.

16. SAFETY IMPROVEMENT PLAN

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

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

- Workforce
- Efficiency
- Safety
- Effectiveness
- Experience

Table 11 provides an update on the required actions.

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

Table 11. NHSE Action Plan – Key Areas for Action

17. RISK REGISTER

In Q3 Maternity and Neonatal services reported one new risk for Maternity triage services ID 2417.

A centralised triage system is required to ensure appropriate prioritisation of care. Actions are being taken to achieve a centralised system and therefore reduce the risk.

Risk 2175 relating to midwifery staffing vacancies has been closed and this has been merged with two new risks (awaiting approval). The two new risks relate to midwifery workforce and the impact on service provision. These are rated 12 and 8 respectively.

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
2353	Replacement of ultrasound machine	4
2359	Maternity Information System IT support/capacity	15
2396	Obstetric theatre emergency call bells	6

392	Obstetric and gynaecology workforce risk	15
2416	Fetal CTG monitoring in community	15
2417	Maternity triage	20

Table 12. Maternity and Neonatal Risk Register

18. RECOMMENDATION

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

APPENDIX 1. MATERNITY PERINATAL QUALITY SURVEILLANCE SCORECARD

		Alert / standard	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Comments
Workforce	Red flags: 1:1 care in labour not provided (Bath Birthing Centre only)	0	0	0	0	0	0	0	0	0	1	0	0	0	Reporting issue. Labour care not affected. No harm.
	Percentage of supernumerary labour ward co-ordinator status (%)	100%	100	100	98	100	97	97	98	100	99	99			Monitoring changed to report by episode (see below). Not involved in labour or 1-2-1 care.
	Labour ward co-ordinator not supernumerary episodes												0	2	(6x episodes per day for Birthrate + recording)
	Confidence factor in BirthRate+ recording	60%	62	62	61	58	60	67	66	67	64	73	70	70	Percentage of possible episodes for which data was recorded
	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		1	0	0	0	0	0	0	0	0	0	0	New metric
	Bath Birthing Centre twice daily round achieved (%)	100%	81	79	94	93	90	93	97	94	100	97	100	100	TIMING OF ROUNDS – to be adjusted from Jan 23
	Midwife to birth ratio (establishment)	>1:27	1:35	1:30	1:32	1:34	1:34	1:34	1:34	1:38	1:35	1:34	1:31	1:30	**Including bank staff rate 1:27**
	Number of women booked onto a Continuity of Carer pathway (%)	>=35%	43.5	44.0	40.9	40.5	43.8	41.3	36.2	37.0	41.7				No national standard in place from Sept 22. Reporting on hold.
Safety	Risk assessment at every contact (Antenatal) (%)		56	55	78	56	71	51	51	47	48	58	61	60	Risk assessment at Booking 100%. Documentation focus. New IT systems being explored regionally. Working group developed.
	Stillbirth number	Actual	0	1	0	0	0	1	2	0	0	1	1	0	N.B. 1x SB incorrectly reported here in Aug.
	Neonatal deaths	Actual	0	0	0	0	1	0	0	0	0	0	0	0	
	Moderate Datix and above		2	0	2	5	2	3	0	1	2	1	1	1	
	HSIB		0	0	1	4	2	0	0	1	1	1	1	0	
Feedback	Number of compliments		4	1	1	1	1	4	3	0	2	1	0	0	
	Online compliments				291				*	*	*	1			Manual count of positive feedback via social media

	Number of PALS contacts/concerns		15	8	6	8	18	9	6	6	7	7	8	9	
	Complaints		1	3	2	1	1	3	1	1	1	3	2	1	
Training	PROMPT/Emergency skills all staff groups (%)	>90%	76.6	84.0	91.2	91.8	95	91.4	91	78.7	79.5	82.4	96	97.1	See detail on training page
Training	Percentage staff received fetal monitoring in labour training **(new from Sept 2021)** (%)	>90%	22.88	36.44	49.3	49.3	63.2	78*	82*	71.1	83.1	94.8	97	96.2	
Training	New-born life support (NBLS) (%)	>90%	77.8	89.0	91.2	92.2	96	91	91	77.5	79.5	82.4	96	97.1	
Training	Percentage of staff who have successfully completed mandatory CTG fetal monitoring annual competency assessment (%)	>90%	26.06	36.44	49.3	49.3	63.2	70.4	73	71.1	83.1	94.8	97	94.6	
	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	1	Nil	Nil	Nil	Nil	Nil	Nil	Normal HSIB surveillance now resumed