Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item No:**	**13**
Date of Meeting:	**22nd July 2024**		

Title of Report:	**Maternity and Neonatal Safety Report Quarter 4**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer**
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Appendices	**Appendix 1.0 Transitional and ATAIN Audit report** **Appendix 2.0 Maternity and Neonatal 'Insights' report**

1. Executive Summary of the Report

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

In March 24 the Trust received the MBRRACE (2022) Perinatal Mortality Report. This report outlined that the crude data values for stillbirth and neonatal death at the RUH during 2022 was more than 15% lower than the average the comparator group of Trusts or Healthcare Boards of a similar size. However, when stabilised and adjusted (to account for socioeconomic demographics reflective of the national averages) the RUH rate becomes increased, returning a result of up to 5% lower than the average for the group. No values, when excluding deaths due to congenital anomalies, were identified as being greater than the comparator group average. This report identifies new national averages for stillbirth and neonatal death, current RUH rate benchmarking tools (see figure 1 and figure 2) have been adjusted to reflect this from March 24.

This RUH Maternity and Neonatal Safety report identifies at the end of Q4, the Royal United Hospitals Bath NHS Foundation Trust (RUH) rolling 12-month average stillbirth rate is 1.96 per 1000 births; this is below the reported national average of 3.3 per 1000 births (2022), however is an increase on the calendar year average reported at the end of Q3 of 1.42 per 1000. The service is closely monitoring the increased incidence of stillbirth noted during Q4, no causal commonalities have been identified within the stillbirths.

The RUH Neonatal mortality rate for Q4 is 0.68 1000 births. All stillbirths and neonatal deaths during Q4 have been reported to Mothers and Babies Reducing Risk through Audit and Confidential Enquiries-UK (MBRRACE-UK) and undertaken a Perinatal Mortality Review Tool (PMRT) process.

Within Q4, the service made 3 referrals to the Maternity and Neonatal Safety Investigations (MNSI) team hosted by the Care Quality Commission (CQC). 1 case has been confirmed and is a currently being reviewed. 2 of the referrals have not progressed following the MNSI triage process. One new internal Patient Safety Incident Investigation was declared in Q4.

The service received the finalised CQC inspection reports during March 2024 following their visit to Maternity services during November 2023. The service is proud to have maintained the rating of 'Outstanding'. The reports outlined 6 'should do' actions for which action plan formation is underway.

During Q4 the service developed the first draft of the 'Single RUH Improvement plan' encompassing Ockenden 2022, the 3 year single delivery plan 2023, the RUHs NHSE visit in 2022, Saving Babies Lives Care Bundle v3 and locally identified safety priorities. This plan will be used for easy access and ability to demonstrate progression towards full implementation/compliance.

Following submission in February 2024, this report outlines a submitted position of compliance for all 10 Safety Actions detailed within the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) year 5, inclusive of a confirmed compliance of 73% implementation of the

Saving Babies Lives Care Bundle v3. On the 31st of March 2024 the service received Year 6 safety standards. Service evaluation is planned during Q1 of 24-25 with a gap analysis of year 5 to year 6 to identify next steps to ensure progression towards compliance.

The Avoiding Term Admissions into Neonatal Units (ATAIN) and Transitional Care reporting is included in this report. The ATAIN rate for Q4 remains stable, below the national target of 5%. This report outlines the quarterly statistics for external reporting as per MIS standards for Q4, and a thematic overview of the locally identified 'avoidable' admissions to the neonatal unit for 23/24 to identify any commonalties or trends for learning and continuous improvement.

In Q4 it was identified that the metric for '*babies remaining under Neonatal care rather than a transitional care pathway in response to the need for nasogastric tube feeding only, between 34-36+6 weeks*' has previously reported neonates staying on the Neonatal Unit as a corrected gestational age following an earlier pre-term birth as a missed opportunity to be cared for on the Transitional Care pathway. It is now understood, through discussions with MIS and the LMNS that this represents over reporting and these babies are being appropriately cared for on the Neonatal Unit as they do not fit the criteria for a transitional care pathway at their birth. Going forward, data will reflect this change.

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

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

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

In Q4 Maternity and Neonatal, services presented 3 new risk assessments, which was approved for the risk register:

2717	Shared Father/Partner information within the multi-agencies	10
2718	Bacillus Calmette-Guerin (BCG) Vaccination programme	8
2724	Risk of loss of Obstetric USS reporting System	9

Current Open Risks in Maternity and Neonates Q4 23/24:

1734	Day Assessment Unit patient safety risk – area not compliant or fit for purpose	12
1948	Obstetric ultrasound scan capacity	8
2359	Maternity Information System IT support/capacity	8
2417	Maternity triage	12
2467	Maternity workforce	8
2481	Staff Entonox exposure in birthing environments	4
2482	Assessment of minor and low harm Datix management in Maternity and Neonatal Division.	4
2522	The Provision of maternity care to birthing people who do not identify as a female gender	4
2562	There is a risk to the Electronic Patient Record (EPR) due to unsecured funding following withdrawal from Cerner Millennium	4

	2591	There is a risk that the current funded provision of Allied Health Professionals in the Neonatal Unit will not continue following cease of fixed term funding from the neonatal Operational Delivery Network.	9
	2649	Delays to commencement of induction of labour	8
	2679	Service provision of digital blood pressure monitors validated for use in pregnancy and pre-eclampsia	5
	2660	Tertiary level neonatal cot capacity in the region	8
	2680	Unavailability of Fetal FibroNectin (FFN) in Maternity Services	12
	2681	Mandatory Training room booking availability	9

5.	**Resources Implications (Financial / staffing)**
Compliance with the Maternity Incentive Scheme for Trusts, 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 Safer Staffing Report – August 2023 CNST Maternity Incentive Scheme – Year 5 declaration of compliance Q1, 2 and 3 Maternity and Neonatal Safety Reports – Quality Governance Committee & Board of Directors	

8.	**Publication**
Public.	

9.	**Sustainability**
n/a	

10.	**Digital**
n/a	

REPORT OVERVIEW

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) Board and the Board of Directors of present or emerging safety concerns within Maternity and Neonatal services. The information within the report reflects actions and progress in line with Ockenden 2022 and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

1. PERINATAL MORTALITY RATE

The following graphs demonstrate RUH performance against the national ambition to reduce stillbirth in the UK by 50%, and the local ambition for continual progression in reducing perinatal mortality at the RUH. From March 2024 the national averages have been adjusted to reflect the publication of the MBRRACE-UK report of 2022 perinatal mortality.

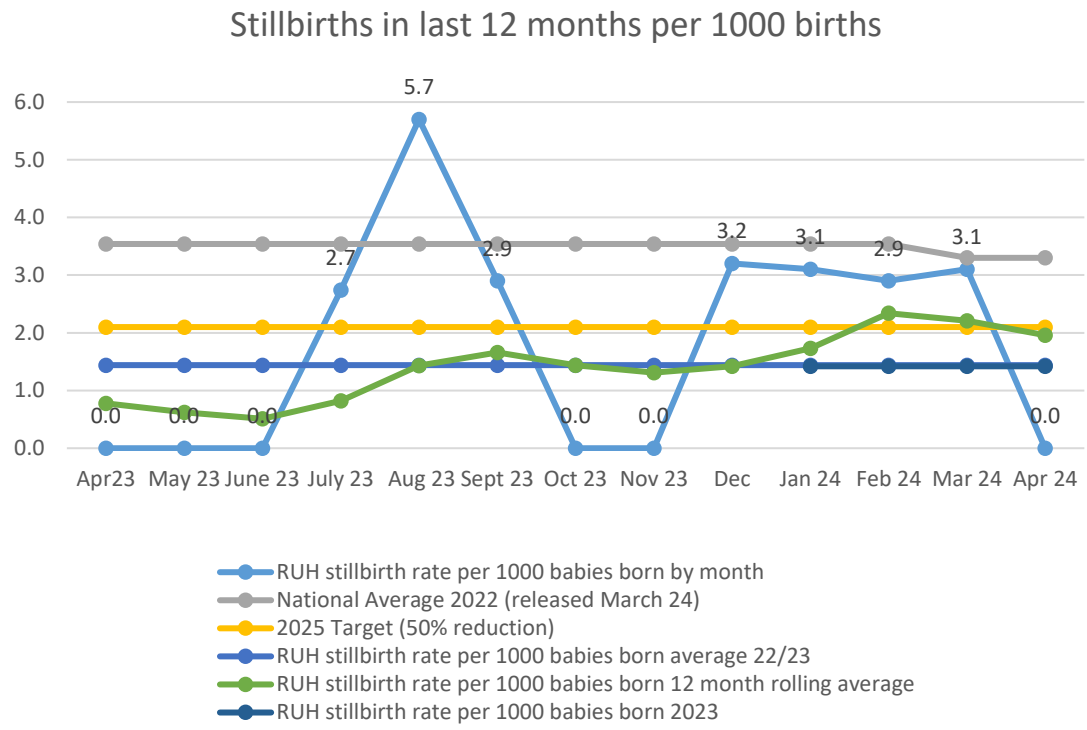

Figure 1: RUH NHS Trust stillbirth rate per 1000 births over last 12 months

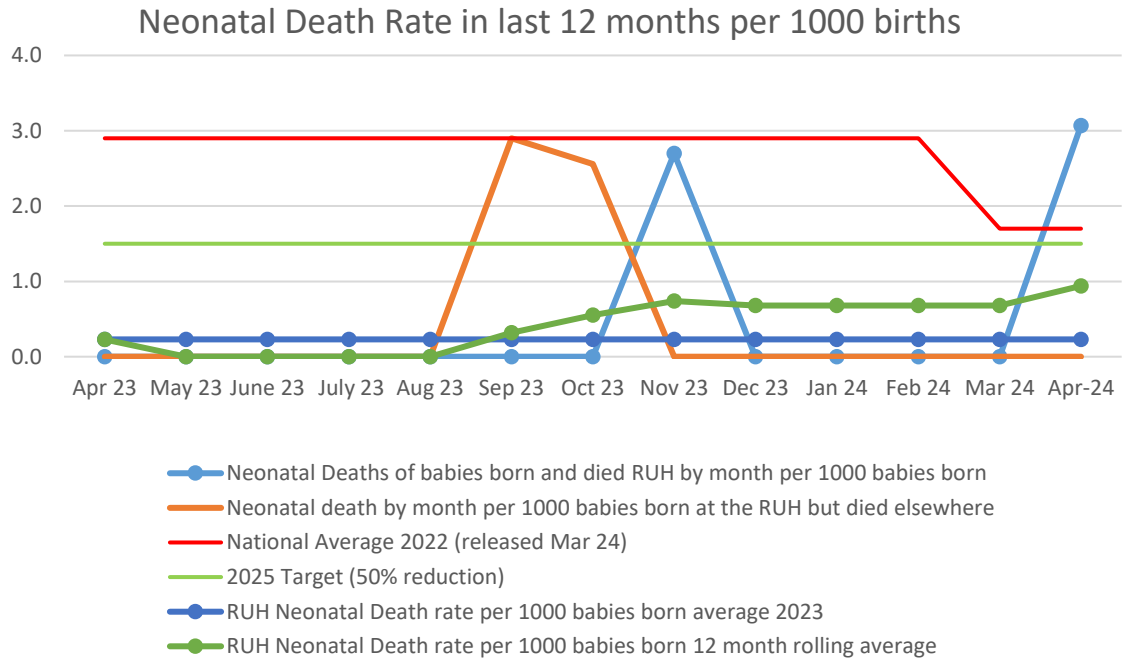

Figure 2: RUH NHS Trust Neonatal Death rate per 1000 births over last 12 months

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

The RUH Electronic Patient Record records all stillbirths (24 weeks or greater gestation) and neonatal deaths at the RUH. Births between 22-24 weeks are pulled manually and added to the data set submitted to MBRRACE-UK as in figure 1. Perinatal deaths are defined from birth after 22 weeks gestation and include neonatal deaths at any gestation where the baby is born with signs of life, but stillbirths are defined from 24 weeks at diagnosis of death. The rate of stillbirth and perinatal death may therefore be different.

Trusts are provided with initial MBRRACE-UK perinatal mortality rate per 1000 births, results are subsequently stabilised and adjusted to reflect RUH statistics if representative of the national socioeconomic demographics. MBRRACE-UK collates the data for those babies who were born at the RUH and subsequently died elsewhere. This report has therefore separated these values to ensure alignment of internal mortality data figures ahead of reported and adjusted MBRRACE-UK figures, see Figure 1 and Figure 2.

Three perinatal deaths (excluding Medical Termination of Pregnancies (MTOP)) were reported in Q4. This consisted of 3 stillbirths of which 2 were of a term gestation (>37 weeks).

2023/24 (excluding terminations for abnormalities)	**Q4 23/24**	**Annual total 23/24**	**Annual total 2024 (calendar year)**
Stillbirths (>37 weeks)	2	4	2
Stillbirths(>24weeks-36+6weeks)	1	4	1
Late miscarriage (22+weeks-23+6weeks)	0	1	
Neonatal death at the RUH	0	1	0

Neonatal death elsewhere following birth at the RUH	0	2	0
Total	**3**	**12**	**3**

Table 1: Perinatal Mortality summary by number of cases, quarter 4 2023/24

During March 2024 the service received the MBRRACE-UK perinatal mortality review report of 2022 statistics. This report outlined that the crude data values for stillbirth and neonatal death at the RUH during 2022 was more than 15% lower than the average the comparator group of Trusts or Healthcare Boards of a similar size.

The report identifies a positive declining trend in crude data values for stillbirth and extended perinatal mortality.

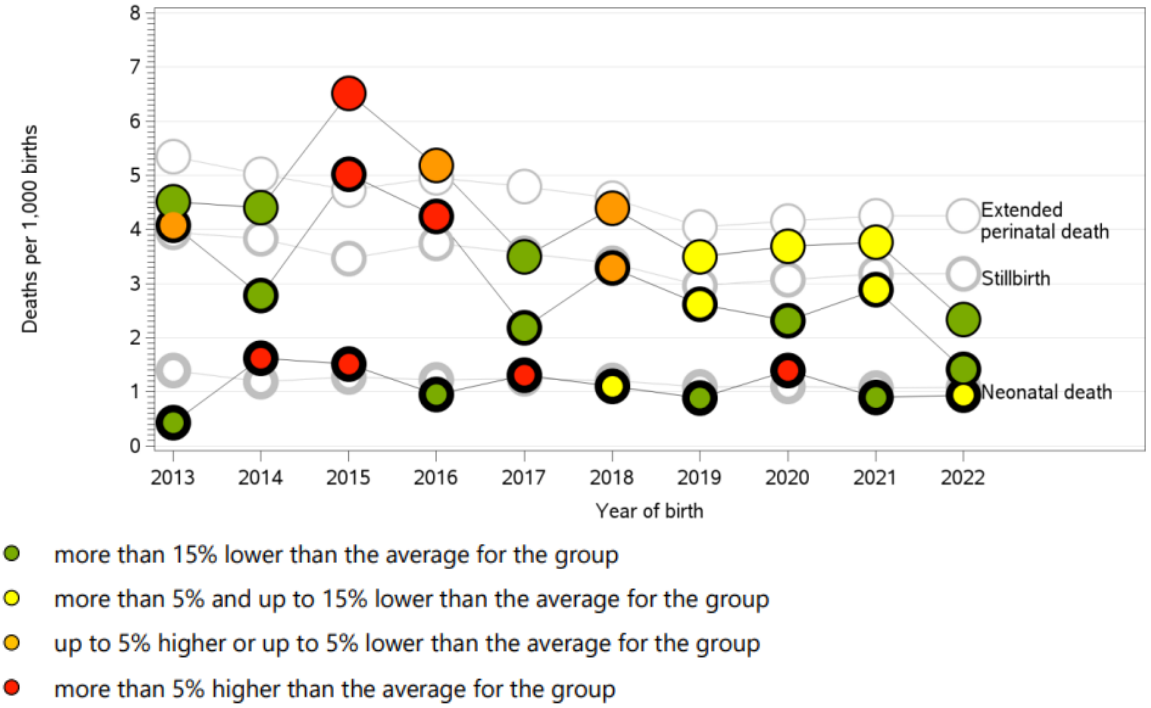

Figure 3: MBRRACE-UK perinatal mortality report relating to 2022 statistics

When the crude data has been stabilised and adjusted to reflect the national socioeconomic demographics such as ethnicity and Index of Multiple Deprivation (IMD), the RUH values become significantly increased from 1.44 per 1000 births to 3.12 per 1000 births. The aim of stabilisation and adjustment is to reduce the variance between service providers based upon those who access their services, this is often influenced by geographical location, ethnicity and IMD. For example, the disparity of maternity outcomes was identified within the MBRRACE-UK report of 2021 women of a black ethnic background are 2.3 times more likely to experience a stillbirth in the UK when compared to white women, and women from the lowest IMD are 1.98 times more likely to experience a stillbirth when compared to the highest. At the RUH the demographics of the women and birthing people we serve when compared to national averages, show an increased proportion of white women and higher IMD distribution. Therefore, the stabilised and adjusted rates for the RUH are increased on crude rates.

Figure 4: RUH stabilised and adjusted mortality rate by type of death in comparison to average mortality rate for Trusts and Health Boards in the same comparator group.

Following stabilisation and adjustment, the values place the RUH rates for 2022 within 5% of the comparator group average. When excluding deaths due to congenital anomalies, there were no categories identified within which the RUH statistics were greater than the group average.

2. PERINATAL MORTALITY REVIEW TOOL (PMRT)

All perinatal deaths that occur within the Trust have been reported using the PMRT tool since 2018. PMRT reporting is a requirement of Safety Action 1 of the NHS-R Maternity Incentive Scheme year 5. All Q4 cases have been reported to MBRRACE-UK via PMRT. See Figure 5 and Table 1.

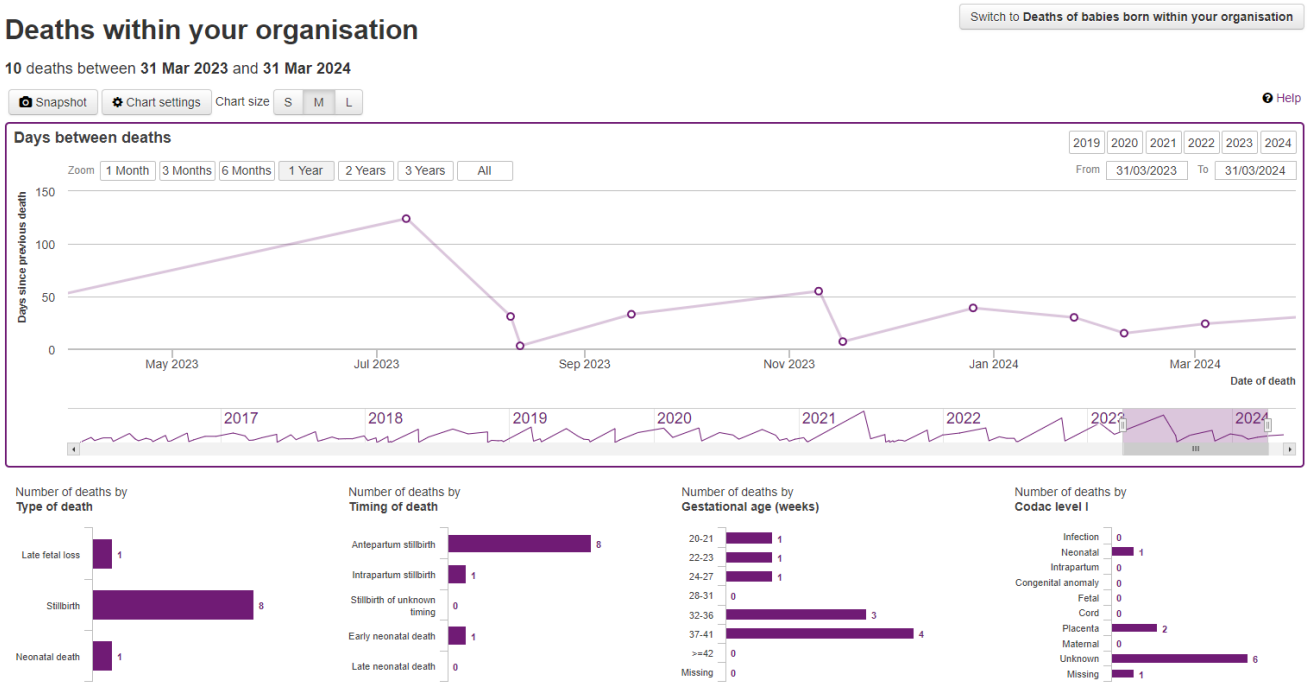

Figure 5: Reporting of RUH NHS Trust Deaths within Organisation for 2023/24

When reviewing the PMRT summary report of issues raised by PMRT for perinatal deaths within 23/24, aligned against the elements of the saving babies' lives care bundle version 3

18% (n=2) of the cases identified that on one occasion in each case the Symphysis Fundal Height (SFH) measurement was not plotted on the SFH chart. These have been retrospectively plotted and identified this would not have indicated a care pathway change.

0% of the cases were associated with reduced fetal movement management.

9% (n=1) of the cases identified care issues related to the prevention and prediction of pre-term birth, this related to a missed opportunity to have referred the mother to the pre-term birth clinic for cervical length scans in response to a uterine anomaly.

2.1 LEARNING FROM PMRT REVIEWS

1 PMRT reviews reached completion in Q4 of 2023. This pertained to the neonatal death of a baby in 2022 for which PMRT was re-opened in light of new information received by the service following post-mortem findings. This resulted in a re-grading of care and new PMRT report. This case is subject to an on-going coronial inquest.

The actions identified from this case are outlined in table 2:

Ref	Issue/area for improvement	Review Response/Action plan	Action target date
81294/1	Oxygen Saturation monitoring was not conducted in response to signs of respiratory distress.	• Universal Newborn Pre and Post ductal Oxygen saturation Screening referred to as Pulse Oximetry (POS) is currently being piloted by the neonatal team as part of all inpatient Newborn Infant Physical Examinations.	• November 2023 **Complete**
		• For POS monitoring to become part of all NIPE examinations	• Phased implementation in progress Phase 1 launched in Q3 of 23/24
		• Introduction of the national NEWTT 2 with prompt for oxygen saturation to be recorded if the family has concerns, already in place on Transitional Care, in progress for launch on the postnatal ward in April 24.	• April 2024 **Complete**
		• Increased signage attached to saturation monitors with pictorial information to support staff in undertaking oxygen saturation monitoring.	• December 2023 – **Complete**

		• Increased signage in the ward staff areas raising awareness of the importance of oxygen saturation monitoring when conducting observations in response to signs of potential increased work of breathing/respiratory distress.	• December 2023 **Complete**
		• We are developing additional training presentation for midwives as part of mandatory training programme on respiratory care; identifying increased work of breathing, things to consider, and importance of escalation.	• To be launched as part of Maternity Professional development day 2024/25
		• The family have also been in contact with the Quality Improvement and Patient Safety lead and have very kindly agreed to share their story as part of the education programme for staff in response to their care journey, highlighting the importance and difference oxygen saturation monitoring may make.	• Filmed recorded in March 24 **Complete**
		• The recording of oxygen saturation monitoring in response to respiratory distress will form part of the ongoing clinical audit programme to ensure improving trajectories towards high compliance monitored by Maternity and Neonatal Specialty Governance.	• On-going A repeat audit conducted in January 2024 showed increased compliance from 65% in October 2023 to 100%.
	The Child Death Policy was followed, which was appropriate, however in early neonatal deaths maternal serology may have provided additional information - the Child death policy does not currently outline a consideration to obtain/offer maternal serology, for early neonatal	For the Child Death Policy to be amended to include prompt for clinicians to consider the offer of maternal blood serology screening in the event of an early neonatal death.	• April 2024 **Complete**

	deaths.		

Table 2: PMRT Action plan

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

3.1 BACKGROUND

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

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

3.2 INVESTIGATION PROGRESS UPDATE

Three new referrals were made in Q4 to MNSI, two were rejected by MNSI following internal triage, and one progressed to review.

Table 3 identifies ongoing MNSI reviews into Q4. The findings and recommendations of these reviews, and the actions taken in response, will feature in future reports.

Ref	Details of Event	confirmed Investigation	External Notifications and Other Investigations
Completed in Q4			
MI-030349	Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling. Normal MRI post active therapeutic cooling, progressing at family request.	July 2023	N/A
Ongoing			
MI-034606	Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling. Normal MRI post	Sept 2023	N/A

	active therapeutic cooling, progressing at family request.		
MI-035529	Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling. Normal MRI post active therapeutic cooling, progressing at family request.	October 2023	N/A
New Referrals			
MI-036728	Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling. Normal MRI post active therapeutic cooling.	January 2024 N/A no family consent	
MI- 036929	Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling. Normal MRI post active therapeutic cooling.	March 24 N/A no family or Trust concerns regarding care	
MI-036771	Stillbirth of baby en route to hospital for labour assessment.	February 2024	MBRRACE/PM RT. Discussed with coroner.

Table 3. MNSI referrals and ongoing investigations Q4 2023/24

3.3 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable.

3.4 MATERNITY PATIENT SAFETY INCIDENT INVESITGATIONS

One patient safety review was completed in Q4, the findings and recommendations have been actioned as per paragraph 3.5. There were no Patient Safety Incident Investigations declared during Q4. See Table 4.

Ref	Details of Event	Review Response	External Notifications and Other Investigations
Completed reviews			
121463	Neonatal death at 27 weeks gestation following a difficult caesarean section birth.	Patient Safety Incident Investigation (PSII)	MBRRACE/PM RT STEIS
New reviews			

Table 4. Maternity and Neonatal Serious Incident reviews Q4

There were 6 moderate harm events reported during Q4, all have received a local review, the multidisciplinary review team (MDT) did not identify any care concerns casual to the event. Any and all co-incidental learning and findings have been actioned at specialty level feeding into the 'triangulation of feedback' data base to allow for assessment of commonalities or trends.

3.5 LEARNING AND IMPROVEMENT

One completed MNSI review and 1 completed local patient safety review were received in Q4 2023. The reports outlined co-incidental findings and safety recommendations, which have been assessed for future learning and improvement; action plans have been derived, and will be monitored via Maternity and Neonatal Specialty Governance for progress towards ensured completion.

Ref	Issue/area for improvement	Review Response/Action plan	Action target date
MNSI MI-030349	The Trust to ensure that staff are supported to escalate promptly to the obstetric team using the emergency call bell when fetal wellbeing is not assured.	Following receipt of this MNSI report in February 2024, a review of cases was undertaken where the use of the emergency bell has been raised as an issue. This triangulation of cases included the local review for case MI-036728 in January 24. Through informal discussions with staff members in maternity services it was identified that the culture pertaining to using the emergency bell is positive. However, in all 3 cases the learning pertained to the recognition that that a total loss of contact (LOC) of the Fetal Heartrate (FH) for a time period >3 minutes is an obstetric emergency. This should instigate emergency escalation inclusive of the emergency bell. Therefore, the action plan below is derived around this area of improvement. Actions towards implementation began in February 2024, it was identified in MI-036929 during March 24 the appropriate escalation took place in response to an inaudible FH.	
		Alignment of local staff guidance for consistent messaging regarding the management of an inaudible FH	• June 24
		This case to feature on the Maternity Mandatory Fetal monitoring study day as an index case to be shared alongside the other 2 case studies to demonstrate the link for the use of emergency bell in cases of LOC and perinatal outcomes, highlighting the importance and significance of escalation of LOC /inaudible FH as a recognition of an obstetric emergency	• May 24
		This case to be presented to the Multidisciplinary 'Perinatal' shared learning forum as above to support MDT care planning . To support MDT care planning	• April 24-complete

		Total LOC/inaudible FH and recognition that this is an obstetric emergency to be added to staff handover safety briefings	• Feb 24 - complete
		Staff sharing poster highlighting learning as above to be displayed in all staff areas and available electronically on Staff teams' new board. To be completed by March 24 in line with the quality hot spot	• March 24 - complete
		LOC/inaudible FH featuring this case to be the quality hot spot for the month of March 24	• March 24 - complete

Table: 5: Learning response action plan to MNSI case MI-030349

When reviewing Q4 incidents, learning and improvement alongside the claims scorecard for 2023, no direct correlations can be seen between the specifically identified improvements in LOC of the fetal heartrate and the claims made to the Trust. There are currently 9 open high value open claims, within which a failure to respond to abnormalities in the fetal heartrate is identified as a cause for claim in 3 cases. The direct context of these clinical scenarios cannot be extrapolated from the scorecard. The latest case related to care provided in 2018.

Learning and Improvement drivers from these events are fed back in a variety of formats including maternity newsletter, staff e-mails, staff safety briefings, patient safety 'Safety Catch' newsletter, Microsoft Teams RUH Maternity Team, case review QR code posters to full reports and quality and safety whiteboards displayed in clinical areas with a 'Safety Hot Spot' of the month. Safety Hotspots are identified through service insights such as themes of low and no harm incidents, audit and, or family feedback.

4. OCKENDEN UPDATE

4.1 OCKENDEN FINAL REPORT UPDATE – Q4 2023-2024

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

Ockenden 2022	
IEA	% of Compliance
1- Workforce Planning and sustainability	70.6
2- Safe Staffing	66.7
3- Escalation and Accountability	71.4
4- Clinical Governance Leadership	87.5
5- Incident investigation and complaints	77.8
6- Learning from maternal deaths	100.0
7- Multidisciplinary Training	58.8
8- Complex Antenatal Care	83.3
9- Pre-term Birth	60.0
10- Labour and Birth	63.6
11- Obstetric Anaesthesia	66.7
12- Postnatal Care	25.0
13- Bereavement Care	88.9
14- Neonatal Care	77.8
15- Supporting Families	75.0
Total	75.4

Table: 6: Q4 23/24 Ockenden 2022 Immediate and Essential Action (IEA) compliance

During Q4 an RUH single delivery improvement plan has been developed to align all national and local improvement drivers into a singular RUH Maternity Improvement plan, encompassing Ockenden 2022, the 3-year single delivery plan 2023, Saving Babies Lives Care Bundle v3, the NHSE visit in 2022, CQC report received in 2024 and locally identified safety priorities.

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

5.1 SITUATION REPORT

Compliance with fetal monitoring, neonatal resuscitation and multi-disciplinary training (MDT) Emergency Skills Training (PROMPT) across all staffing groups is required to be above 90% across all staff groups to fulfil the requirements set out within the CNST MIS, Saving Babies Lives Care Bundle v3 and the core competency framework v2.

During the CQC inspection in November 2023, the RUH Maternity and Neonatal Training compliance for Adult Basic Life support (ABLS) was below the local target of 90% at 66%. In response to the 'should do' recommendation, plans are in progress for this to become managed in specialty as part of the PROMPT programme to ensure progress towards high levels of compliance.

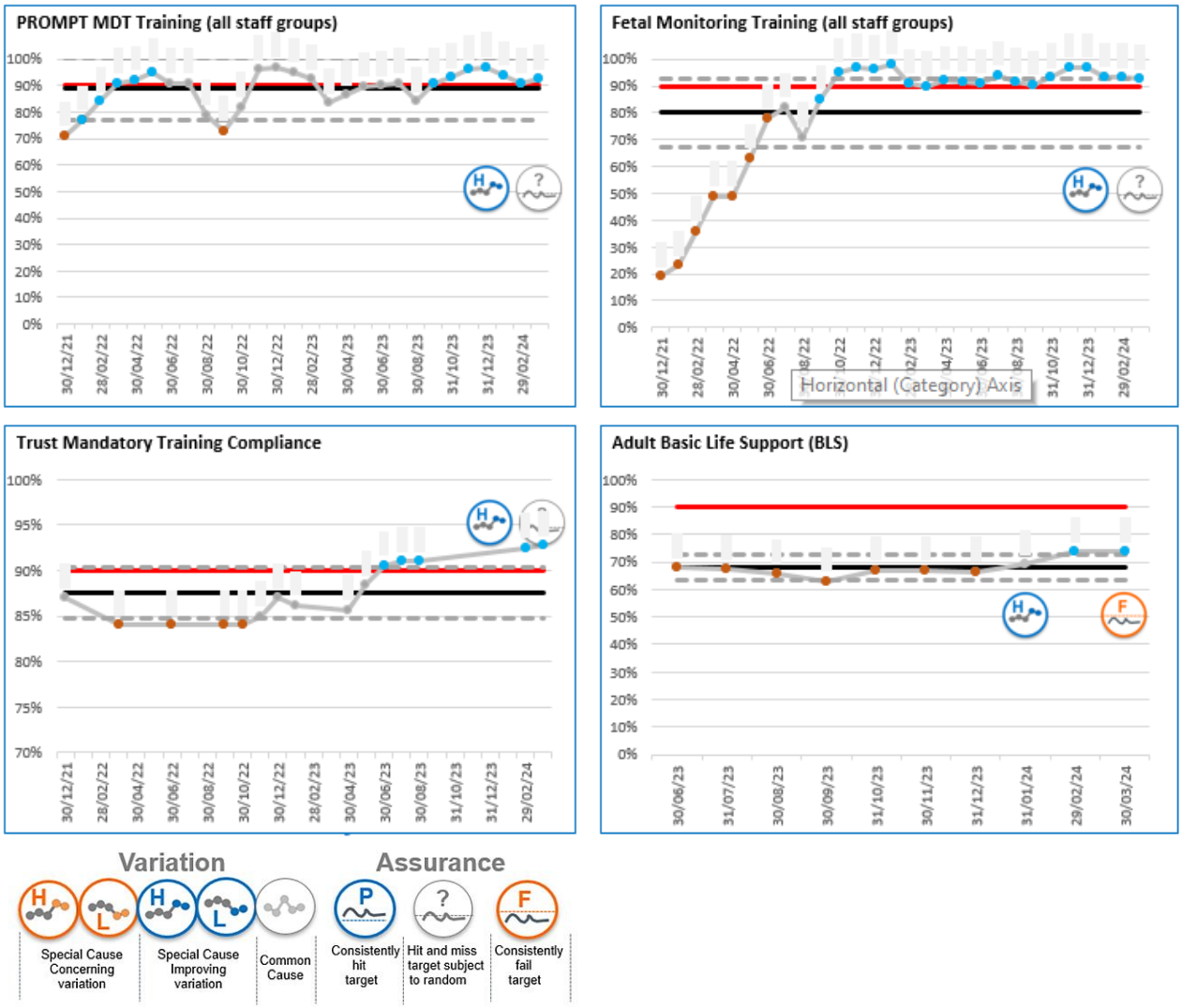

Figure 6. Maternity Training Statistical Process Charts for PROMPT, Fetal Monitoring, Mandatory Training compliance and Adult Basic Life Support compliance, as of 31/03/2024

6. BOARD LEVEL SAFETY CHAMPIONS

The Maternity and Neonatal Safety Champions are active in their role to listen to the staff voice in maternity services. All staff are invited to attend monthly 'listening event' meetings and interact with Safety Champions during walkabouts with the Chief Nursing Officer, the Non-Executive Director for Maternity and Neonatal services, and the Obstetric, Neonatal and Maternity Safety champions.

Members of the maternity and neonatal team attended the listening event meetings in Q4 from a range of areas, including neonatal services, community midwifery and specialist midwives.

Themes raised during Q4 were:

- A reduction in Bank shift availability subsequent to increased staffing levels
- Positive feedback for the development of the Maternity Triage service
- Positive feedback regarding the leadership team being supportive and approachable

- Neonatal Unit access challenges for families when no ward clerk available to manage the intercom or during high acuity
- Challenges in recruitment to the community birth team
- Challenges with the current Electronic Patient Record system for data capture requirements.

Current work is ongoing within the specialty to address the concerns raised:

- Anticipated completion of estates works and launch of Maternity triage in Q2 of 24/25
- The Neonatal Nurse Consultant is exploring facial recognition software for the intercom on the Neonatal Unit
- Maternity digital system – funding stream for new EPR system secured, implementation plans in progress with aimed 'go live' date of March 2025 - risk register entry 2467.

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

7. NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q4 2023/24

The service was able to declare full compliance with all 10 Safety Actions detailed in the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme in January 2024. See table 7.

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

	professional training?	
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?	
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?	

Table 7: Declaration for compliance with MIS Year 5.

The Clinical Negligence Scheme for Trusts released their Safety Actions for Year 6 on 31 March 2024. Current service evaluation is underway, updates on progress and monitoring towards achievement of the 10 Safety Actions outlined is completed and shared within Maternity and Neonatal Speciality Governance meeting and Board Level Safety Champions.

8. SAFETY ACTION 6 - MIS SAVING BABIES LIVES CARE BUNDLE V3.

Saving Babies Lives Care Bundle Version 3 implementation was assessed externally by the LMNS using the national implementation tool on NHS Futures Platform. The RUHs evidenced position in Q4 is reported in table 8.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	70%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	80%	Partially implemented	60%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	85%	Partially implemented	78%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	86%	Partially implemented	73%	CNST Met

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

Ongoing work has continued during Q4 working towards full implementation of all elements of Saving Babies Lives Care Bundle Version 3.

Key areas of focus are:

- Element 1- Increased assurance data regarding the care pathways for smoking mothers to increase compliance to 100% via a new 'smoking mother's care pathway'. Quarterly audit report triangulating process indicators to clinical outcome measures
- Element 2 - Capacity of Obstetric Ultrasound (USS) department to facilitate alignment to the national USS pathways, whilst fulfilling next working day targets for unscheduled USS in response to reduced fetal movements. Significant systems and practice

changes required in response. Risk Register entry 1948. Ongoing audit plan in place; to closely monitor service change impacts

- Element 2- Increased training compliance for obstetric radiographers, in the performance of uterine artery dopplers, target training compliance projection for June 2024
- Element 2 - Digital Blood Pressure (BP) monitors are not currently validated for use in pregnancy and pre-eclampsia. National procurement issue in response to Saving Babies Live v3. Risk register Entry 2679
- Element 5 - Current national shortage of evidence-based best practice Point of Care Bedside Biomarker for the assessment of Threatened Pre-Term Labour Risk currently under assessment for the risk register.

9.0 SAFE MATERNITY STAFFING

9.1 MIDWIFERY STAFFING

As of March 2024, the Band 5/6 Midwifery Vacancy rate was at an over establishment of 10.74 WTE of which 8.0WTE is to cover consistent 'gap' created in budget vs actual generated by Maternity leave within the Midwifery workforce. Therefore, the overall position is a 2.74WTE over recruitment.

The new funding attributed to the maternity business case comes into budget from Q1 of 24/25 resulting in the increase in budget seen in Figure 7 from April 24 onwards.

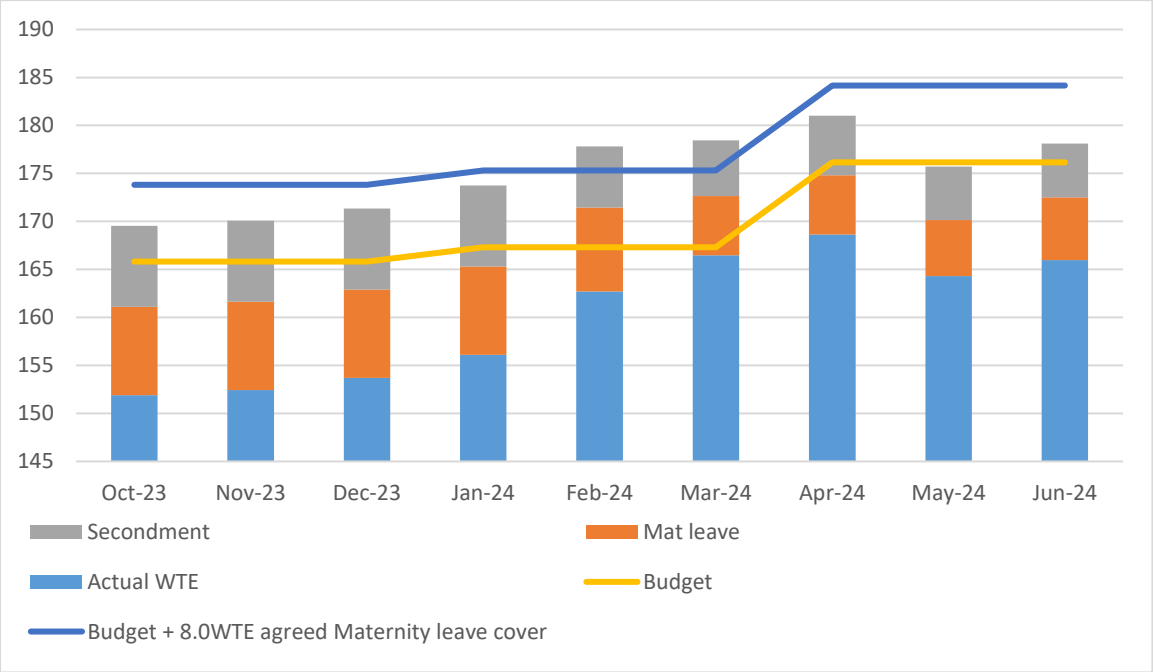

Figure 7. Band 5/6 Midwifery Workforce staffing vacancy and forecast (not including long-term sickness)

Measure	Aim	January	February	March
Midwife to birth ratio	1:24	26	27	25
Midwife to birth ratio including bank	1:24	23	24	23
Episodes of inability to maintain	0	0	0	0

Supernumerary labour ward coordinator status				
1:1 care not provided	0	0	0	0
Confidence factor in Birth-rate+ recording	60%	87.63	81.61	89.25

Table 9. Midwifery staffing safety measures

9.2 OBSTETRIC STAFFING

Measure	Aim	January	February	March
Consultant presence on BBC (hours/week)	≥90 hours	98	98	98
Consultant non-attendance (in line with RCOG guidance)	0	0	0	0
Twice daily MDT ward round	90%	87%	62%	73%

Table 10. Obstetric staffing safety measures

MDT ward round has been negatively impacted by a change in data capture from a paper based system to digital reporting. In Q4, the decision has been agreed to revert to a paper based system to provide assurance of true 'work as done'. Following receipt of assurance of a stable position; achieving consistence of ≥90% compliance, the service intends to move towards an exception reporting model.

An Obstetric workforce review has been completed and has identified a risk within the established funding of Obstetric Consultant posts. The maternity investment case has supported an increase of 2.0 WTE consultants, during Q4, there was successful recruitment into the available 2 posts due to commence their substantive posts in June of 2024 and the risk has been closed on the risk register.

10.0 INSIGHTS FROM SERVICE USERS AND MATERNITY VOICES PARTNERSHIP CO-PRODUCTION

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

	January	February	March
Number of formal compliments	5	9	0
Number of Patient Advice and Liaison Service (PALS) contacts/concerns	12	10	3
Complaints	0	1	1

Table 11. Complaints and compliments Q4 23/24

Compliments to the service were received across all areas of Maternity and Neonatal care including Bath Birthing Centre, Anaesthesia and Mary Ward. A continued theme amongst compliments to the service is the kindness and compassion showed to birthing people and their families from members of staff providing care. We are currently exploring a more robust method of capturing compliments received to the service as these are often received via informal routes, and kind gestures from families such as cards.

During Q4, the service received 3 complaints; no direct commonalities were identified between these three complaints, however the service insights from complaints, PALS and compliments received throughout 2023/2024 has been assessed to identify any commonalities or trends within family feedback data, see the Maternity and Neonatal Insights report (Appendix 2.0) where a key patient experience theme relating to postnatal care provision has been identified.

The information available to the service through review of the complaints, compliments and PALS contacts received are reviewed 'in month' within the Maternity and Neonatal Triangulation of Feedback group where key stakeholders with valuable insight into patient experiences across maternity and neonatal services meet to discuss their 'in month' data to allow for wider system collation and identification of emerging themes or concerns.

10.2 MATERNITY AND NEONATAL VOICES PARTNERSHIP PLUS (MVPP)

The Maternity and Neonatal Voices Partnership Plus (MNVPP) will hold a key stakeholder membership in the 'Insights' group and have been providing feedback into the meetings since their commencement in October 23.

The NHSE Maternity and Neonatal Programme have published the Maternity and Neonatal Voices Partnership Guidance in November 2023; a gap analysis was undertaken in Q4, the priorities for the service are currently undergoing system-wide agreement within the Local maternity and Neonatal System (LMNS).

MNVP hours have been increased and agreed via the LMNS Programme Board to support the work plan across the Bath and North East Somerset, Swindon and Wiltshire (BSW) system. This will support delivery of the key priorities:

- Listen to Women & Families from all backgrounds & ethnicities
- Support improvement of Antenatal and Postnatal care
- Support development of perinatal specialist services
- Improve digital systems and process for our families
- Improvement of intrapartum care – Induction of Labour (IOL) flow, supporting birth choices and consent
- Improved involvement in governance and communication to support delivery of the 3 year Maternity and Neonatal delivery plan and transformation.

11.0 AVOIDING ADMISSION INTO THE NEONATAL UNIT (ATAIN) & TRANSITIONAL CARE

During Q4, the Transitional Care service was facilitated 100% of the time with >50% of neonatal care provision within a Transitional Care Pathway (TCP), providing neonatal care at the mother's bedside.

The Avoiding Term Admissions into the Neonatal Unit (ATAIN) working group identified 3 avoidable admissions into the Local Neonatal Unit (LNU) in Q4. Of the 3 incidents, 2 cases featured a modifiable factor linked to timely escalation to the neonatal team in the immediate postnatal period when neonatal condition is not optimal. Due to the small number these cases, both have fed into a thematic review of all of the ATAIN cases of 23/24 to facilitate identification of themes or trends within the avoidable admissions.

The thematic review has identified 2 areas of commonality within the 'avoidable' admissions within 2023/24. This relates to the provision of thermoregulatory care of the newborn and subsequent physiological cascade, and an identified commonality of the care provision in the immediate postnatal period after birth (the first hour after birth of the baby).
Full details of the service's action plan in response to these findings to drive continuous improvement are detailed within the report.

12.0 RISK REGISTER

In Q4 Maternity and Neonatal, services presented three new risk assessments, which were approved for the risk register:

2717	Shared Father/Partner information within the multi-agencies	10
2718	Bacillus Calmette-Guerin (BCG) Vaccination programme	8
2724	Risk of loss of Obstetric USS reporting System	9

Table 12. New Risks for the Maternity and Neonatal risk register Q4 2023/24

During Q4 three risks were closed,

Risk No	Title of Risk	Rationale for closure	
2483	Expiration of Maternity and Neonatal staff resource and guidelines	As of March 2024 96% of maternity guidance is in date or currently under-review due for ratification, therefore the risk has been closed in response to significant reduction in likelihood of consequence meeting target risk rating	8
2581	Obstetric Workforce establishment	Successful recruitment took place in March 2024 for an additional 2 obstetric consultants, therefore likelihood of consequence significantly reduced to meet target risk rating.	8
2664	Maternity Ligature risk	The individual Maternity Ligature risk assessment has been enveloped within the trust-wide Ligature risk assessment	5

Table 13. Closed Risks for the Maternity and Neonatal risk register Q4 2023

A full summary of the Maternity risk register is detailed in table 14. Actions towards closing the gaps identified within the individual risk assessments on datix, and continued mitigation of risk, will be monitored through Specialty and Divisional governance with Trust Management Executive, oversight to ensure appropriate actions are taken in accordance with the Trust risk framework.

1734	Day Assessment Unit patient safety risk – area not compliant or fit for purpose	12
1948	Obstetric ultrasound scan capacity	8
2359	Maternity Information System IT support/capacity	8
2417	Maternity triage	12
2467	Maternity workforce	8
2481	Staff Entonox exposure in birthing environments	4
2482	Assessment of minor and low harm Datix management in Maternity and Neonatal Division.	4
2522	The Provision of maternity care to birthing people who do not identify as a female gender	4
2562	There is a risk to the Electronic Patient Record (EPR) due to unsecured funding following withdrawal from Cerner Millenium	4
2591	There is a risk that the current funded provision of Allied Health Professionals in the Neonatal Unit will not continue following cease of fixed term funding from the neonatal Operational Delivery Network.	9
2649	Delays to commencement of induction of labour	8

2679	Service provision of digital blood pressure monitors validated for use in pregnancy and pre-eclampsia	5
2660	Tertiary level neonatal cot capacity in the region	8
2680	Unavailability of Fetal FibroNectin (FFN) in Maternity Services	12
2681	Mandatory Training room booking availability	9

Table 14. Maternity and Neonatal Risk Register April 2024

13.0 RECOMMENDATION

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