Bradford Teaching Hospitals
NHS Foundation Trust

Board of Directors: **12.07.2018**
Agenda Item: **Bo.7.18.36**

MATERNITY ANNUAL REPORT

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Previously considered by:	Quality Committee – 25.07.18		

Key points	**Purpose:**
1. To provide the Quality Committee with an annual summary and report of the activities of the Maternity Service at BTHFT during 2017/18.	To receive

Executive Summary:

Bradford Maternity Services are located on a single site at Bradford Royal Infirmary (BRI) and are also integrated within secondary care settings throughout the district (community midwifery) where the majority of antenatal and postnatal care is provided. 5,711 babies were born to 5,631 mothers in 2017/ 2018.

2017/18 has been a challenging year for maternity services at BTHFT, but has also included exceptionally positive progress on the Maternity Improvement Plan. It is very clear that lessons have been learned from the Serious Incidents which resulted in the 2016 Maternity Quality Summit, and that changes in practice have been accepted by staff and embedded in practice.

Of most significance for the service is the reduction of stillbirths, particularly those considered to be potentially avoidable. Whilst we celebrate this achievement, we are not complacent and fully at acknowledge that the preventative work to date needs to be sustained, and that further work is needed to further reduce the rate, particularly around smoking cessation and raising awareness of reduced foetal movements in certain hard to engage groups.

Priorities

- The reviews and risk assessments of high priority areas listed on the Maternity Improvement Plan are to be added to the maternity action tracker and be subject to regular assurance checks, monitored through Women's Core Governance Group.
- Perform regular assurance checks to ensure that actions from Serious Incidents are truly embedded in practice
- Ensure that any changes to practice, new ways of working are evaluated and embedded in practice
- To replicate the success achieving CTG training compliance year on year, and not become complacent in our approach to training.
- Ongoing focus on midwifery staffing
- Completion of mandatary training
- Achieve required staffing to provide 24/7 obstetric theatre cover
- Achieve required staffing to open MAC 24/7
- Review antenatal services
- More integrated working for antenatal care to see if we can achieve greater continuity of

care for women seeing both midwife and obstetrician, • Address some of our ambulatory care challenges-increasing numbers of women attending hospital for reduced FM and having growth scans. • Review community based clinic locations and consider creating hubs to modernise and improve access for women from more deprived areas or backgrounds. • Work with interpreting services and community members/schemes/doulas e.g. to help us integrate care /inform community groups re antenatal care in some European migrant groups who often arrive in the UK advanced in their pregnancies. • Continue to work with the WY & H LMS and local commissioners to achieve the Better Births recommendations, prioritising continuity of care. • Continue to develop service user engagement and partnership working

Financial implications:
No

Regulatory relevance:

Monitor:	

Equality Impact / Implications:	**Is there likely to be any impact on any of the protected characteristics?** (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights) Yes ☐ No ☒ If yes, what is the mitigation against this?

Other:	

Strategic Objective: *Reference to Strategic Objective(s) this paper relates to*	To provide outstanding care for patients
	To deliver our financial plan and key performance targets
	To be in the top 20% of NHS employers
	To be a continually learning organisation
	To collaborate effectively with local and regional partners

Bradford Teaching Hospitals
NHS Foundation Trust

MATERNITY SERVICES ANNUAL REPORT

2017/2018

DIVISION OF WOMEN AND CHILDREN

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June 2018

1.0 Introduction / Executive Summary

This report is to inform the Trust Board of the activities of the Maternity Services at Bradford Teaching Hospitals NHS Foundation Trust during the financial year 2017/18.

Bradford Maternity Services are located on a single site at Bradford Royal Infirmary (BRI) and are also integrated within secondary care settings throughout the district (community midwifery) where the majority of antenatal and postnatal care is provided. 5,711 babies were born to 5,631 mothers in 2017/ 2018.

The population served live mainly in the inner city with some areas having amongst the highest indices of deprivation in the UK. The diversity and complexity of the women who use the service has increased exponentially, evidenced in a recent Birth Rate Plus staffing review.

Around 70% of women are from a BME background, mainly with South Asian heritage; providing services which meet the individual needs of women from diverse cultural backgrounds is a challenge, particularly in ensuring that key public health messages which improve maternal and neonatal outcomes are received and understood.

There has also been an increase in Eastern European, African and Middle Eastern women, asylum seeking and refugee women and some young victims of trafficking. The social complexities and safeguarding needs of such women cannot be underestimated and have significantly increased in number during this reporting period.

A change to the clinical profile has also been seen, with large numbers of women with diabetes, obesity and co morbidities making risk assessment and care planning more complex, time consuming and requiring a high level of expertise from staff.

2017/18 has been a challenging year for the Maternity Services, as the unit worked hard to complete and embed the Maternity Improvement Plan (MIP), which were the combined recommendations from the 2016 Maternity Quality Summit and the Royal College of Obstetricians and Gynaecologist (RCOG) review, held in April 2017.

The team have shown great unity, excellent multi-disciplinary team working, demonstrating respect and care for one another. They have also displayed a high level commitment to the service and have achieved successes whilst working in some difficult conditions.

1.1 Overview of the Service

Antenatal, intra-partum and postnatal care provided by a multidisciplinary team across the hospital and community setting for the population of Bradford and beyond. Including:

- Seven Community Midwifery teams.
- Consultant led antenatal service
- Joint and Speciality Consultant and Midwifery led antenatal clinics
    - Diabetes,
    - Epilepsy
    - Infectious diseases
    - Haematology
    - Twins
- Foetal Medicine
- Antenatal Day Unit
- Obstetric led Labour Ward, including pool room
- Snowdrop Bereavement Suite
- 2 Obstetric theatres
- HDU rooms
- Low risk Birth Centre (BC) with 7 rooms including 2 pools
- Maternity Assessment Centre (MAC)
- Inpatient beds including transitional care.

1.2 Overview of Staffing:

Obstetric staffing is comprised of a combination of substantive staff and junior doctors in training:

- 14 Consultant Obstetricians
- 11 Middle Grade Doctors
- 13 First On Call Doctors

The total midwifery funded midwifery establishment was 206.81 WTE registered midwives, 25.17 WTE Maternity Support Workers (MSW) and 19.57 WTE Health Care Assistants (HCA).

1.3 Overview of Key Events:

Key Improvements / Successes:

- Reduction in Stillbirth rate, particularly Stillbirths at term
- No intra-partum stillbirths or deaths occurring during the induction of labour process
- Appointment of Labour Ward Manager and restructuring of the leadership
- Participated in the National Maternal Neonatal Collaborative first wave
- Successful transition from traditional supervisory model to A Equip model

- Community Maternity Support Worker (MSW), Lucy Downing won the national RCM MSW of the year award
- Introduction of PROMPT multi-disciplinary obstetric emergency training
- Over 90% K2 (CTG) training package completion for all staff
- Review and implementation of revised governance structures
- Positive engagement with regional and Local Maternity Systems (LMS) work
- Achieved full compliance with the Saving Babies Lives stillbirth care bundle

Key areas for further focus and challenges:

- Pace of change to complete Maternity Improvement Plan
- Provision of 1 to 1 care in labour
- Staff morale following concerns raised in 2016 and the subsequent RCOG review
- Staffing (vacancies and sickness)
- Recruiting Band 5 theatre staff and experienced Band 6 midwives
- Cancellation of training over the summer (2017) due to EPR training
- Implementation of EPR alongside Medway system
- Engaging with specific groups of hard to reach women
- Maintaining obstetric staffing rotas

1.4 Overview of Key Recommendations

- Assurance of evidence against the Maternity improvement Plan
- Regular assurance checks to be implemented to ensure that actions from serious incidents are truly embedded in practice
- Embed and evaluate new ways of working
- To replicate the success achieving CTG training and include all areas of mandated training.
- Continue to work towards a sustainable obstetric theatre staffing model.
- Work towards the implementation of a 24/7 Maternity Assessment Centre (MAC)
- Review antenatal services, including access to Outpatients
- Improve the continuity of care for women seeing both midwife and obstetrician
- Develop our ambulatory care model to address increasing numbers of women attending hospital.
- Continue to develop service user engagement and partnership working including working with hard to reach groups

2.0 Staffing

There are many staff who make up the multidisciplinary team within Maternity Services.

2.1 Obstetrics & Gynaecology Consultant Staffing

A variety of changes have occurred to Consultant Obstetrics & Gynaecology staffing during the 2017/18 reporting period, some of these have been temporary pressures due to maternity leave or longer term changes due to changes in job plans.

We have maintained capacity through a combination of covering out of hours work with internal locum shifts, use of flexible sessions in colleague's job plans and extra sessions. When both substantive colleagues' maternity leave overlapped, external agency locums were employed to cover both the elective and out of hours work as limited capacity remained within the department.

The availability and reliability of locums has been variable and, coinciding with the return of one colleague from maternity leave, we have endeavoured to reduce dependence on external locum staff. To support some of the gaps in the service, we also recruited a post CCT fellow, who has provided senior level care across a variety of services.

Following the resignation of a Gynaecologist with an interest in oncology in March 2018 we have internally reconfigured job plans to enable a suitable existing consultant to do this workload. This change will allow us to recruit a substantive Consultant Obstetric post with an interest in maternal medicine to ensure ongoing provision of existing services, as well as provide an additional antenatal clinic and obstetric emergency training lead.

Throughout the period of changes described the service has had continuous provision of obstetric care both within and out of hours, but importantly has enabled an increase in the number of consultant antenatal clinics which should improve clinic waiting times and consultant input into individual antenatal care plans.

2.2 Midwifery Staffing

The Midwifery staffing position at the end of 2017/18 reflects the positive investment supported by the Trust Board to increase the midwifery establishment and obstetric theatre staffing following reviews of the service, including Birth Rate Plus.

At the end of March 2018 the midwifery vacancy was 19.78 WTE, which included the additional 4.57 WTE agreed increase to establishment to cover for turnover throughout the year.

Retention of substantive midwifery staff is not considered to be a concern, with very few midwives leaving the organisation for reasons other than re-location or retirement. The recruitment and

retention of Maternity Support Workers (MSW) and Health Care Assistants (HCA) is not an issue, with no current vacancies.

A positive recruitment drive in June 2017 resulted in 14 newly qualified midwives choosing Bradford Maternity services to start their midwifery careers. We are repeating this exercise in June 2018. All midwives new to the Trust underwent a Trust Induction, local induction and preceptorship package and have received protected time to attend the New Midwives Forum which is held monthly.

There has been less success attracting experienced band 6 midwives, which is in line with the national profile of midwifery recruitment and the national shortage of midwives. Succession planning, leadership development and career opportunities were a focus in 2017, with the creation of developmental roles such as Deputy Ward Manager posts and opportunities for Band 7 midwives to gain experience in acting Band 8 roles.

2.2.1 A-Equip of supervision model and the Professional Midwifery Advocate (PMA)

Statutory Supervision of Midwives (SOM) and The Midwives Rules were removed from regulation on the 31 March, 2017. The legislative change has also brought an end to the Local Supervisory Authority (LSA) and Local Supervisory Authority Midwifery Officer (LSAMO) functions.

From 1 April 2017, the existing SOM team have continued to perform the non-statutory functions of the Midwifery Supervision model, and have continued to provide a 24 hour 'on-call' service, which although is no longer a statutory requirement, was felt to make a significant contribution in maintaining safety in maternity to women and babies.

Staff have now undertaken the Professional Midwifery Advocate (PMA) training as part of the transition into the A-EQUIP model, they are known as Midwifery Advocate's and the 24 hour on call rota is now the 'Senior Midwife On-Call rota'.

The role of the PMA will be to deploy the A-EQUIP model, support and develop the advocacy role of midwives, support and guide midwives through actions that will be of benefit to women and their families and provide support and feedback to develop progress and strengthen the capabilities of the midwifery workforce. We currently have 5 PMA's with a further 4 in training.

The provision and delivery of A-EQUIP is included in The NHS Standard Contract 2017/18-2018/19 and is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care. In accordance with this contract, the provider must ensure that arrangements are in place for all midwives to receive the new national model of midwifery supervision.

2.3 Birth Rate Plus Maternity Staffing Review

In May 2017 the Birth Rate Plus study was carried out, Birth Rate Plus is a framework for workforce planning and strategic decision making, and is sensitive to local factors such as demographics of the population, socio-economic factors, complexity of associated neonatal services.

The 2017 study confirmed that the acuity of women accessing maternity services at BTHFT has risen exponentially since the 2014 study with 25% of births in the lower risk categories (1&2), 21% in the moderate (3) category and 54% in the high categories (4&5) compared to 2014 when 34% of births were in the lower risk categories compared with just 25% in 2017. This significant increase in the acuity of mothers and babies does impact on the midwifery staffing resulting in an increase in establishment, especially when women are in category 5.

The Birth Rate Plus study showed a requirement for 15.87 WTE midwives. However, consideration was given to how different ways of working may have a positive impact on midwifery staffing, and it was also acknowledged that the recent investment in obstetric theatre staffing would impact positively. It was concluded that 9.69 WTE midwives plus further investment in some specialist roles would significantly improve the ability to provide safe and effective maternity care.

3.0 Training and Appraisals

There has been a focus on the delivery of training to support learning from incidents and the Trust implementation of EPR

3.1 Training

Maternity Services has a dedicated Professional Development Midwife (PDM) who organises and facilitates all mandatory obstetric skills related training for the service as well as making provision for midwives to update their mandatory Trust training. This is organised as a package of 3 days including emergency drills and skills training. All of these days are run at least once a month, and increased if staff demand necessitates additional resources.

Maternity Workshop Content	**Care & Compassion Content**	**PROMPT**
Fire Safety Update	Human Factors/Resilience	Human Factors/Teamwork
Clinical Risk Update	Tissue Viability/Pressure Care	Basic Life Support
Breastfeeding Update	Screening Update	Cardiac Disease in Pregnancy

Safeguarding Children (Level 3)	Adult Safeguarding (Level 2)	Major Obstetric Haemorrhage
Blood Transfusion Update	Smoking Cessation Update	Sepsis/Recognition of unwell patient
Infection Prevention Control	Pelvic Floor Training	Foetal Monitoring
Research Update	Perinatal Mental Health	Obstetric Emergency Work Stations:
Mentorship Update	IV Skills Update	Breech/Shoulder Dystocia
E-Learning- ATAIN- session for MSWs (Reducing avoidable admissions to Neonatal Unit)	SAMS Update	Cardiac Arrest Haemorrhage Neonatal Resuscitation

The training and preparation of staff for the Trust wide Electric Patient Record (EPR) go live, impacted on mandatary training rates during August and September, as EPR sessions took priority.

The service works very closely with higher education institutions (HEIs, predominantly University of Bradford) to provide education and development to staff. Senior members of the midwifery team attend the university course management programme meetings and are responsive to any issues or concerns raised by student midwives via the university faculty. BTHFT midwives also support the interview and selection process for prospective midwifery students on an annual basis.

Specialist midwives have provided bespoke teaching sessions at the university to enhance the taught curriculum, including sessions on the complex needs of women with drug and alcohol problems, asylum seekers and significant mental health issues delivered by the Specialist Midwife for Vulnerable Women.

Training doctors within Obstetrics & Gynaecology all have allocated Educational Supervisors and receive local induction and are offered regular teaching and simulation training sessions coordinated by the College Tutor.

3.1.1 PROMPT Training

BTHFT Maternity was successful in their bid for monies from Health Education England specifically for training packages and plans to improve maternal and foetal outcomes. This is in line with the Government strategy to reduce the number of stillbirths, neonatal and maternal

deaths by 50% by 2030. A comprehensive bid was submitted and in December 2016 the service was awarded £79,000.

This money has enabled us to train faculty members and deliver Practical Obstetric Multi-disciplinary Training (PROMPT), which launched in October 2017. This new approach to multi-disciplinary obstetric emergency training has a strong focus on human factors and has evaluated very well by the delegates who have attended so far. In addition to this, neighbouring organisations have expressed an interest in attending our sessions so that they can take good practice back to their own units.

3.1.2 Responsiveness

A number of the Serious Incidents (SI's), which led to the 2016 Maternity Quality Summit, involved poor interpretation of cardiotocography (CTG). By December 2017, 98% of obstetric and midwifery staff had completed the required amount of the training package. This was a major achievement and provided assurance that staff interpreting CTG's had the required training and competence to do so.

3.1.3 Other Training Rates

Currently 79% compliant with Trust Mandatory training:

- Compliance rates for the obstetric and midwifery competencies are slightly lower:
- Obstetric Skills and Drills 90%
- Midwifery Workshop - 72%
- Currently 83% for all training

Plans are in place to move to full compliance by end of Quarter 3 18/19.

3.2 Appraisals

The annual appraisal is based on service development needs, the BTHFT Personal Responsibility Framework and focuses on performance in relation to the 6Cs. The annual appraisal rate for the unit is currently 79%. Plans are in place to move to full compliance by end of Quarter 3 18/19.

3.3 Consultant Job Plans

All Consultants had a job plan review in 2017. Flexibility is a key component required for covering essential duties including on call responsibilities and labour ward cover.
In addition to job planning, the Consultant appraisal rate was 100% in 2017/18.

3.4 Students and Learners

A key function of the service is to train the health professionals of tomorrow. There are a range of students from different disciplines who are placed in the service to gain experience. The majority are student midwives. Numbers are a challenge but it has been agreed with the University of Bradford that the Trust will accommodate 25 students per year as this enables good mentorship

and support. The service has excellent links and collaboration with the University in both undergraduate and post graduate education and was absolutely delighted to hear that the Nursing and Midwifery faculty are ranked number 4 in the 2018 national university league table.

This accolade is reflected in the high calibre of student midwives we see on clinical placements. A significant number of Newly Qualified Midwives, who started their careers at BTHFT in September/October 2017, were graduates from the University of Bradford and had done clinical placements in the unit.

Medical Students on clinical placements at BTHFT Maternity experience a good variety of obstetric and midwifery attachments, which receives excellent feedback consistently.

Medical student training is overseen by a lead consultant Obstetrician & Gynaecologist for undergraduate education in the trust in conjunction with the education and training team.

4.0 Risk and Governance

From the period 1 April 2017 to 31 March 2018, there were 5631births with a total of 5711babies. This indicates a drop of approximately 200 births from 2016/17 and local analysis indicates that this is a regional decline, with neighbouring units reporting a similar drop in rates. The impact of a reduction in births has not been felt by frontline staff on labour ward, as the acuity and complexity of cases has increased, compounded by other pressures including the volume of high risk inductions.

To support the implementation of safe care there is a risk management structure in place with identified roles and responsibilities in relation to the management of risk and governance, these have been reviewed throughout the year and adapted to the ever changing environment.

4.1 Incident Reporting

All incidents that result in harm are discussed at the monthly Clinical Incident Panel and the minutes from this meeting are cascaded within the directorate and to Trust level. Any potential serious incidents are escalated immediately via Datix, directly to the lead manager or as an escalation to the Quality of Care meeting. Other issues are discussed at the Women's Services Quality and Safety (Q&S) meeting which feed into the Divisional Q&S and are escalated to the Trust committees.

All staff are encouraged to complete Datix reports following incidents and near misses and a robust risk reporting culture has continued. As a result of lessons learned from incidents and investigations staffs have been able to change and influence practice

Communication on the outcomes of clinical incidents and investigations to all midwifery staff and medical staff is delivered via the Quality & Safety speciality meeting, Risk Management newsletter, closed Facebook group, Risk key workers, Consultants, Matrons and Senior Sisters.

4.2 Clinical Outcomes

Clinical outcomes have remained consistently positive during 2017/18, which is reflected quarterly in the Yorkshire and Humber Regional Maternity dashboard.

Bradford consistently achieves a higher than average percentage of women booked below 13 weeks gestation, has a higher than regional and national average of normal births and a lower than regional and national average of caesarean sections.

Stillbirth rates and neonatal clinical indicators remain higher than average, which will be discussed further in the report.

Public health indicators, including smoking at booking and time of delivery also remain higher than average, and again will be discussed further in the report.

Figure 1 (below) shows the regional dashboard Quarter 3, 2017/18 (latest position at time of report).

Figure 1 - Yorkshire and Humber Regional Dashboard, Quarter 3, 2017/18

Indicator	Measure	Threshold	Trust's Quarterly Data		Y&H Ave
			Previous	Latest	
ACTIVITY INDICATORS					
Number of bookings	number of women booked		1209	1189	127
% Bookings <13 weeks	% of women booked <13 weeks	≥ 90%	97.4%	96.9%	91.8%
Women delivered	total number of all women delivered		1380	1401	119
Total births	number of all babies born		1394	1420	121
Live births	number of live babies born		1389	1412	120
Live births at term	number of live babies born at term		1309	1285	110
WORKFORCE INDICATORS					
Midwife to birth ratio	Ratio of midwives to total births		1:30	1:29.1	
MATERNAL CLINICAL INDICATORS					
Normal births	% of women - normal births	≥ 60.9%	68.6%	67.5%	63.6%
Assisted vaginal births	% of women - assisted vaginal births	12.9%	9.0%	8.9%	11.0%
Elective C/S deliveries	% of women - El C/S	≤ 11%	7.8%	8.6%	10.7%
Emergency C/S deliveries	% of women - Em C/S	≤ 15.2%	13.6%	14.1%	14.6%
C/S deliveries	% of women - Total all C/S	≤ 26.2%	21.4%	22.7%	25.3%
3rd/4th degree tear - normal birth	% of women delivered - normal births		2.3%	3.2%	2.3%
3rd/4th degree tear - assisted birth	% of women delivered - assisted births		4.0%	6.4%	5.7%
PPH ≥ 1500ml	% of women delivered		1.8%	2.2%	2.8%
NEONATAL CLINICAL INDICATORS					
Preterm birth rate < 37 weeks	% of babies <37 weeks		9.0%	9.0%	8.1%
Preterm birth rate < 34 weeks	% of babies <34 weeks		3.7%	3.2%	2.3%
Preterm birth rate < 28 weeks	% of babies <28 weeks		0.7%	1.2%	0.5%
Low birth weight at term - live births	% of live babies at term < 2200g		1.8%	0.7%	0.9%
STILLBIRTHS					
Total stillbirths	total number of babies stillborn		5	8	4
Stillbirth rate - Antenatal	annual rate for antenatal stillborn babies / 1000 births		7.1	6.7	3.7
Stillbirth rate - Intrapartum	annual rate for intrapartum stillborn babies / 1000 births		0.0	0.0	0.1
Stillbirth rate - Total	annual rate for ALL stillborn babies / 1000 births	< 4.7	7.1	6.7	3.8
Stillbirth rate - adjusted to exclude lethal abnormalities	annual stillborn babies / 1000 births excluding babies with lethal abnormality		7.1	6.7	3.2
Stillbirths at term with low birth weight	annual % of stillborn babies < 2200g		0.0%	0.0%	1.1%
PUBLIC HEALTH INDICATORS					
Breast feeding initiation rate	% of women commenced breastfeeding	≥ 74.4%	72.5%	71.0%	64.9%
Smoking at time of booking	% of women who smoke at booking	≤ 11%	21.2%	15.4%	20.4%
Smoking at time of delivery	% of women who smoke at time of delivery	≤ 11%	15.9%	16.1%	16.4%

4.3 Maternal and Perinatal Mortality

Maternal deaths are rare events and their consequences are devastating for all involved. The maternity service participates in MBRACE a national reporting system which collates all data relating to maternal deaths and perinatal statistics in order to drive improvements in maternal and child health, there were no maternal deaths during the reporting period 2017/18.

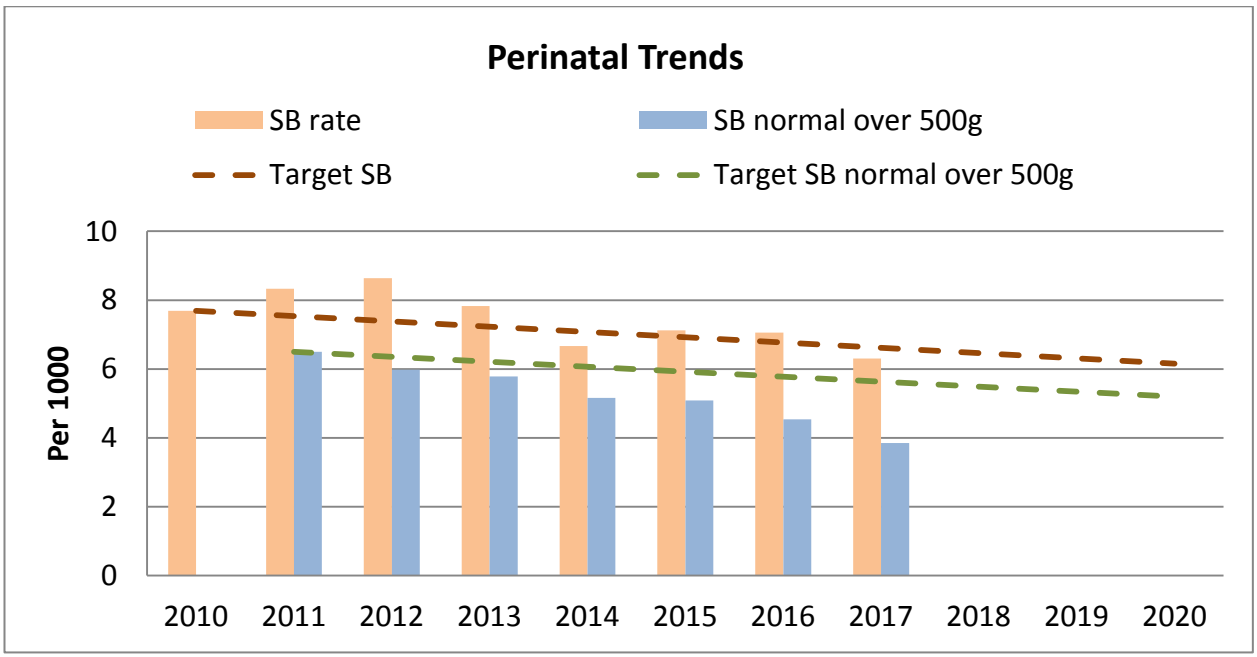
Perinatal mortality is defined as the death of a foetus or new-born in the perinatal period that commences at 24 completed weeks' gestation and ends before seven completed days after birth. Stillbirth is defined as; a baby delivered without signs of life after 23+6 weeks of pregnancy.

Prevention of Stillbirths has remained a major priority during 2017/18 and as the figure 2, below, indicates a significant reduction in stillbirths for this period including a continued reduction in the death of potentially avoidable, normally formed fetuses over 500 grams.

We are also able to report zero intra-partum stillbirths, or stillbirths occurring during the induction of labour process in 2017/18, both of which featured in the 2016 cluster of Serious Incidents. This reassuringly suggests that lessons have been learned from incidents and that staff have embedded this learning in practice and are able to demonstrate competence in essential skills including the interpretation of CTG's.

The 'hashed' lines shown on the graph represent the reduction required to meet the Secretary of State's 'Halve it Campaign' trajectory, and clearly demonstrate that the service is making extremely good progress towards achieving this target.

Figure 2 – Perinatal Trends



All stillbirths/IUDs are reviewed using the National Patient Safety Agency (NPSA) Intra-partum Tool; to gather information and identify causal factors. In each case clinical management is assessed and benchmarked against current local and national guidance. The Intra-partum Tool gathers information on socio-demographic factors, maternal health and pregnancy history as well as any admissions and events occurring during pregnancy. Understanding the way in which a number of factors could combine to impact on maternal and foetal wellbeing gives midwives and obstetricians opportunities for improvement in care planning to be made.

The service has achieved full compliance with all 4 domains of the National Stillbirth Care Bundle which includes smoking cessation and focus on reduced foetal movements. This is a positive achievement and has made a positive impact on our outcomes.

4.4 Serious Incident Reporting

During the period 1 April 2017 to 31 March 2018 Maternity Services reported 4 serious incidents (SI) to the Clinical Commissioning Group (CCG), 1 of which was subsequently de-logged as an SI following investigation.

1	26/09/2017	Intrauterine Death at 36 weeks gestation – Failure to act on an abnormal scan	Complete
2	20/11/2017	Pathology Joint Venture- Antenatal screening for HIV and Hepatitis B status	Complete
3	08/02/2018	Neonatal Death following emergency caesarean section at 36 weeks	De-logged as SI by CCG following investigation
4	08/03/2018	Missing haemoglobinopathy screening on antenatal blood samples	In progress

There has been a reduction in the number of SI's declared in this reporting period from 8 declared in 2016/17. Reassuringly there are no recurring themes including poor Cardiotocograph (CTG) interpretation or SI's relating to failings with the induction of labour process. This suggests that lessons have been learned and changes in practice embedded as a result of the 2016 Quality Summit and resulting Maternity Improvement Plan.

Whilst a reduction in the amount of SI's is positive, the service is not complacent and acknowledges that this number may increase or decrease over the next reporting period due to the high risk nature of the speciality.

4.5 Maternity Services Risk and Governance processes and lessons learned

Maternity Risk and Governance processes are overseen by a multidisciplinary team of professionals. Further oversight of the risk and governance process is provided by the Deputy Divisional Clinical Director (DDCD) and Head of Midwifery (HOM)

All adverse and near miss incidents are discussed at a weekly case review with multidisciplinary team key members which include representation from consultant obstetricians, the trust clinical risk manager and midwifery leaders. The lessons that are identified are cascaded amongst the whole of the division via a variety of communication methods.

The lessons learned provide information on the current themes and trends. The risk champions in each area are responsible for highlighting this information at handovers ward meetings and safety huddles.

Serious and internal investigations are monitored through the monthly clinical Incident panel meeting. Comments and discussions regarding reports and recommended action plans are discussed. An incident tracker is completed to ensure that all incidents are reviewed in a timely manner.

Incidents requiring further escalation are discussed with the Divisional Clinical Director (DCD) and Head of Midwifery (HOM) and are then submitted to the Incident Management Performance Group. If further escalation is required a summary and rationale is presented to the Quality of Care Panel which confirms the level of investigation to be undertaken.

The Quality & Safety Core group discusses completed investigations, plans how and who the lesson learnt plans are actioned by a named individual or team. Concerns when an investigation and / or action plan needs attention are managed within this group.

Outstanding issues are escalated to the Divisional Quality & Safety Group. Divisional risk registers monitored and updated bi monthly. A Risk assessment data base profile is monitored within the division. Urgent messages and immediate lessons learned are cascaded at staff handovers and during multi-disciplinary safety huddles.

All lessons from investigations are presented in the Quality & Safety Specialty meetings and escalated to staff via the Quality & Safety Newsletter, Risk Management Newsletter, closed Facebook group, Consultants, Matrons, Senior Sisters and Risk Key workers.

To facilitate good governance and in the context of the Maternity Improvement Plan, the Division has made a number of changes to its Risk and Governance processes over the past year. The overarching aim of this has been to clearly describe lines of responsibility and accountability, to

make sure learning is shared successfully, and that agreed actions and quality improvement work are completed and monitored to provide sufficient assurance that the quality of care we deliver continues to improve.

4.6 Improvements made to the identification, investigation and escalation process.

A focused piece of work has been completed in partnership with the Corporate Risk team to improve the process and flows of information:

- Revised Datix incident reporting form developed within W&C Division with an aim to reduce length of time taken to complete form and encourage accurate reporting. This has evaluated well and is now in routine use.
- Development of risk management flow chart to clearly describe to all professionals the process of incident investigation, escalation to trust risk, timescales for investigation completion and the individuals responsible for delivery of this.
- A revised “Investigation tracker” for use by the Risk team to ensure investigations are completed in a timely way, and that Duty of Candour responsibilities are fulfilled. Closer working with Trust risk team with agreed roles / responsibilities and agreed process for rapid “72 hour” review and escalation in cases of potential harm to a patient.
- Review of process for how learning is shared across the division, incorporating relevant lessons from perinatal mortality and morbidity meetings, investigation reports from outside the division, as well as national updates that may have implications for practice (e.g. NPSA / MHRA alerts).
- Wider use of formal Risk Assessments to accurately describe identified problems. These are reviewed regularly in the context of any related incidents to monitor risk scores, agree mitigation/escalation and provide a more dynamic and flexible means of managing the Divisional Risk Register.
- Ensuring compliance with nationally mandated reporting e.g. Each Baby Counts, NHS resolution, ATAIN and CNST requirements.

4.7 Infection Control

Infection control for Women’s Services is monitored via the bi-monthly Divisional Infection Control Team, chaired by Consultant Obstetrician, Dr Hema Dadi, and by the Trust’s Infection Control Committee.

Monthly audits on the Matron’s report include: hand hygiene; cannula insertion; work wear and uniform; commodes and infection control *High Impact Interventions*. Cleaning audits are carried out in all the areas by the Trust’s monitoring team; the frequency of these audits depends on the area. The Labour Ward is monitored on a weekly basis, whilst the outpatient areas are monitored quarterly.

All staff are expected to attend their annual mandatory infection control training and infection control is a standing agenda item at the weekly ward manager meetings. There were no cases of MRSA, MSSA or Clostridium Difficile in Maternity Services

4.8 Clinical Policies & Guidelines

Maternity policies & guidelines are formulated and reviewed in line with the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists and National Institute of Clinical Excellence (NICE) recommendations. All policies and guidelines are evidence based and developed by the relevant personnel (who is also responsible for updating). There is a virtual guidelines group for comments and amendments which includes Consultants, Matrons, Head of Midwifery, and Risk Manager. Ratification takes place at the Maternity Services Forum (MSF) or Directorate Quality and Safety meeting.

4.9 Audit and Research

The Maternity Service has a robust research and audit programme which is driven by the Clinical Governance Support Officer, Obstetric Lead and Lead Research Midwife.

4.9.1 Quality and Safety, Clinical Audit

In order to be effective audit must address areas of practice to ensure provision of safe, appropriate and quality care. This implies a standard is available (local, regional or national) which is supported by evidence. During 2017/18, the local audit plan was dictated by the Maternity Improvement Plan (MIP) in order to provide ongoing assurance of the improvements and progress made.

We believe it is important, from a training perspective, to involve all staff at all levels in the audit process. Staff wishing to undertake an audit must be registered on the Clinical Audit Online (CAO) system and should be approved before commencing. The audit should ideally be part of the yearly plan and be relevant to and required by the service.

Following completion of the audit, a report is expected including an action plan. The report is submitted to the monthly Quality & Safety Core Group for discussion. The group decides whether further work/clarification is required and where/how it should be formally presented and disseminated. Audits, incidents and any research are usually presented at Quality & Safety specialty meetings which are multidisciplinary meetings held 6 times per year.

Between April 2017 and March 2018, 21 audits were registered. Of which:

- 12 are complete
- 7 in the process of collecting data
- 2 in the planning & design phase

4.9.2 Action Tracker

This was developed in order to maintain a central record of the actions from audit, incidents and recommendations from other bodies. It also provides ongoing assurance and monitoring for elements of the MIP which are unable to be closed and have become 'business as usual'. Some actions are similar and therefore are themed. The action tracker was added to the core group meeting as an agenda item to be discussed and updated. However, due to the volume of items for ongoing monitoring, it has been agreed that the action tracker requires a separate meeting and that any issues for concern will be escalated to the core group by exception.

4.9.3 Research

We are very proud of the research we participate and lead in at Bradford, the team consists of:

- Prof Derek Tuffnell (Obstetrician and joint team lead)
- Dr Diane Farrar (midwife, National Institute for Health Research Post-doctoral Research Fellow and joint team lead)
- Ms Jennifer Syson (midwife and trials lead)

In addition there are a number of research midwives and nurses who support the ongoing work and developments.

The team aims to contribute to the generation of evidence in the NHS in a number of ways. Firstly by conducting clinical trials supported by the clinical research network, this generally consists of trials funded by the NIHR.

The programme of research, part of which is currently funded by the NIHR fellowship programme, focuses on hypertensive disorders of pregnancy. A member of the team is a collaborator on MBRRACE which produces reviews of maternal and perinatal mortality across the UK and the UK Obstetric surveillance system which investigates rare obstetric conditions including amniotic fluid embolism, sepsis and anaphylaxis. Members of the team have published research in leading journals and have been invited speakers at international conferences.

The team facilitates educational research projects including masters and PhD projects. They provide training and updates to the clinical staff in the form of one to one training, emails, newsletters and research meetings. Training can be specific to a trial such as how to recruit and provide an intervention, it can be more general, such as providing information on a specific methodology or it can be about the interpretation of evidence around a specific intervention. We disseminate new research evidence to the staff in the unit, with the ultimate aim of improving care and outcomes for women and their infants.

In terms of the clinical research network trials, Maternity are one of the highest recruiting clinical teams in the Trust and as of the end of financial year 2017-2018 have achieved 106.25% of our

portfolio recruitment target. The team has a national and international reputation for achievements in trial recruitment and are approached regularly to contribute to new and existing trials.

The team strives to continue with excellent performance and identify new trials in order to continue to develop the portfolio. We will continue to progress our own research and facilitate that of other researchers and clinicians wanting to access women and staff in the maternity unit. There is a healthy research ethos in our maternity unit and the team work hard to nurture this. The work means we can continue to offer women the opportunity of taking part in trials and enhance the care of women.

5.0 Women's Experience

Experience is measured in a number of ways, including participation in the mandated surveys and friends and family tests as well as the traditional review of complaints and compliments.

5.1 National Survey

The National Maternity Survey 2017 was the 5th National Maternity Survey since 2007, and has now become an annual survey. 133 Trusts took part and in summer 2017, it was sent to all the women aged 16 and above (18,426), who had a live birth in February 2017 regardless of the place of birth. This was a 12 page paper survey of 59 questions and sent out in English only.

In Bradford our sample size was 425 with 118 surveys returned giving a response rate of 28.4% compared to a response rate of 33% in the last survey in 2015. National response rate was 37% and 41% retrospectively. Our overall mean scoring rate was 79% which is slightly higher than in 2015. The 16-18 years age group were specifically asked to take part in the survey as there was no representation in the 2015 survey and in Bradford there was a 1% uptake compared to 0% in all other Trusts in 2017. All other age groups were representative as were women from BME background.

5.1.1 Findings

A number of themes were found from the report, including:

- Inconsistencies highlighted with positive and negative feedback received from all areas.
- Overall national ranking:
    - top 20% of Trusts in 7 questions
    - Middle 60% in 43 questions
    - Bottom 20% in 9 questions.
- Better than other Trusts in 3 questions; Advice at the start of labour, staff introducing themselves (this was an action from the 2015 survey) and length of hospital stay being the right amount of time.

- Poorest category was where women felt they were not able to move around in labour and choose the position they felt most comfortable in.
- Skin to skin contact fell into the bottom 20% of Trusts when previously this was in the top 20%
- Statistical improvement in 3 questions compared to 1 in the 2015 survey:
    - Staff introducing themselves
    - If required attention during labour and birth, were able to get a member of staff in a timely manner
    - Length of stay post birth was felt to be adequate.
- No questions have been flagged as statistically worse since the 2015 survey.
- High scoring questions included;
    - Being treated with dignity and respect
    - Having a contact number for the midwifery team carrying out care
    - Being given appropriate advice at the start of labour
    - Concerns raised by the woman/partner taken seriously by staff
    - Partners/named person involved in care able to stay as much as the woman wanted.
- Bradford's score remained low for the question on cleanliness of the hospital room or ward compared to the other Trusts despite this being one of our actions from the 2015 survey but scoring had improved from 7.7/10 in 2015 to 8.2/10 in 2017.

5.2 Maternity Voices Partnership

In March 2018, the Maternity Voices Partnership (MVP) was launched, replacing the Maternity Services Liaison Committee, which had declined in attendance and effectiveness over the last few years. The event successfully brought together service users, local charities and voluntary organisations, and good obstetric and midwifery representation, to start to inform how services should be best shaped to meet the needs of the Bradford population.

5.3 Complaints and PALS

The table below, figure 3, shows the total number of complaints and the compliance against complaint standards

Figure 3 - Complaints

Total Number of Complaints Received	62	
Complaints resolved & responded within 25 working days	**19**	**30.6%**
Responded over 25 working days	**26**	**41.9%**
Under Investigation within Division	**17**	**27.4%**

The top three themes for complaints were:

- 7% Communication
- 7% Attitude and behaviour
- 33% Care and Treatment issues.

Figure 4 (below) shows the total number of PALs by theme.

Themes	Total
Appointment	6
Attitude & behaviour	4
Care and treatment issues	29
Communication	5
Delay in diagnosis	5
Discharge	1
Patient procedure issues	4
Total	54

5.3.1 Learning Lessons

We identify themes for learning from complaints in the final investigative response to the complainant and also discussing on a regular basis within the Divisional weekly/monthly meetings. Individual members of staff are supported in learning and reflection through midwifery supervision as well as the Trust Line Management process. Medical Staff are supported by their Clinical Supervisor or appraiser, to ensure learning is actioned.

Complaint themes are communicated through the monthly midwifery matron's meeting which has representation from all departments; this ensures shared learning and feedback of actions or improvements which have been made. Information regarding complaint themes is also included in the Open and Honest Care Document on a monthly basis and includes both patient and improvement stories based on results of feedback or learning within the Division.

6.0 Team Dynamics and Staff Safety Culture Survey

Team Dynamics (TD) is a local initiative to promote multi-professional staff engagement. We are currently doing team working and communication self-assessments in areas and have also been working with the Yorkshire and Humber Improvement Academy to complete a staff safety culture survey in all departments in maternity services.

The results will be collated to create a dynamic plan for improvement from a multi-professional perspective.

In addition the most recent themes from the staff survey results have been reviewed and the service is looking ways to improve staff work/life balance, such as break times, using the Royal College of Midwives 'Caring for you Campaign'.

Team Dynamics is an arena to listen to staff, embrace their concerns, challenges and ideas whilst also providing a strategy and structure in which they can contribute to solutions, improvements and personal responsibility in growing themselves, others and our services.

7.0 Maternal and Neonatal Health Safety collaborative

The aim of this national programme is to

'Improve outcomes and reduce unwarranted variation by providing a safe, high quality healthcare experience for all women, babies and families across maternity settings in England'.

BTHFT maternity services were successful in an application to join the first wave, wishing to be proactive in learning and safety improvements. Support was provided to the improvements leads in the form of quality improvement training and regional improvement manager's guidance in setting up four improvement projects aligned to the national ambition with local prioritisation and focus. Regional support was provided by the Yorkshire and Humber Improvement Academy, as well as extremely valuable local ongoing support from BTHFT QI team.

We have four specific projects ongoing, with multi-professional teams set up, they are working and learning well:

- Creating a learning system that shares learning from excellence and incidents
- Ensure an effective pathway of care for women undergoing induction of labour within antenatal ward
- Reducing avoidable term admissions to neonatal unit due to hypothermia and hypoglycaemia-Keep me warm keep me safe campaign.
- Explore the social and psychological barriers to women presenting to maternity services with changed or no foetal movements-service user engagement focus

Quality improvement methodology is used and the wider aim, as well as the specific improvement projects, is to provide access to QI training for all staff towards building a culture of collaboration and personal contribution to safety and quality improvements and learning.

Already we can see evidence of improvements in our stillbirth rate falling, women are contacting us earlier when they are concerned about their baby movements, and women undergoing induction of labour on the antenatal ward are having more timely and effective care by less midwives due to a cohort model of working.

8.0 Public Health

Addressing the public health needs of the population of Bradford childbearing women is becoming a significant challenge in the current economic climate. Funding cuts within the local authority are having a direct impact on the ability to provide appropriate services for pregnant women, and is leading to an increased workload for some specialist midwives and services.

Bradford has some of the highest levels of social deprivation in the country and has a high fertility rate, particularly in its more deprived communities. There are a high percentage of women from a BME background, again, many living in the most deprived areas of the city. Approximately 10% of women booked at BTHFT have an identified safeguarding need. Smoking rates are high, which contributes to high infant mortality and stillbirth rates.

The service maintains a good working relationship with our maternity commissioners at the CCG, who share many of our concerns and are very supportive of the service. Specific roles to address public health issues have been received funding from the CCG, Public Health and the Local Authority:

- Smoking Cessation Midwife: This is a 3 year post which is externally funded and is due to end in early 2019 with no plans to re-commission. There has been significant progress with how this role is delivered in the last 12 months, but unfortunately there has been little reduction in the amount of women smoking at the time of delivery (SATOD), and we have no influence over the high number of women who are smoking at the time of booking. Without this post, it is highly unlikely that SATOD numbers will reduce.
- Public Health Infant Feeding post has now ended and transferred to another provider. BTHFT still has a substantive Infant Feeding Co-ordinator post with a number of support midwives working on a seconded basis.
- Vulnerable Women's Pathways Midwife: Unfortunately the 'One Stop Midwifery service for women with drug and alcohol dependencies was decommissioned in 2016. A midwife has been in a funded post for almost 12 months to develop pathways for vulnerable women. During her role she has also provided care to a small, but exceptionally complex group of women, delivering care in shop doorways on occasions. This group of women would undoubtedly have 'slipped through the net', had this midwife not been in a position to provide care. The role ceases at the end of April 2018, and whilst the pathways developed will support community midwives in sign posting women to relevant services, there are a number of complex, vulnerable women, who need case loading by a specialist midwife.

Other concerns include the impact that changes to the provision of contraceptive services across the city are having on the Lilac service and teenage pregnancy rates. Over the last six months we have seen an increase in women accessing Lilac for termination of pregnancy, and our Teenage

Pregnancy Specialist midwife has noted an increase in the number of young, pregnant teenagers booking for maternity care.

In order to further reduce the stillbirth and infant mortality rates and to improve maternal outcomes, it is essential that we continue to work closely with our commissioners and public health colleagues to address the provision of specialist services for vulnerable women.

The Head of Midwifery is a core member of the Child Death Overview Panel (CDOP), chaired by the local Public Health Consultant, which ensures that key public health messages and learning such as safe sleeping for infants, which have the potential to influence and reduce infant deaths are shared with all Health Care Professionals caring for babies and new families.

9.0 Community Midwifery

Community Midwifery is currently configured into 6 teams plus the Better Start Bradford, Opal team project. The teams vary in size with caseloads of approximately 420 – 650 women. The smallest team was developed in line with the Better Births agenda to offer enhanced continuity of care and a more personalised experience for women and their families. In part the last year has shown this to be successful with the midwives from this team being able to provide much better levels of antenatal and postnatal continuity for the women on their caseloads.

In autumn 2017 a new day on call system was introduced in response to both the challenge of providing better continuity of care. This has been extremely successful in ensuring that midwives are available to cover their own clinics, and alleviating the pressures relating to staffing and workload pressures. It has also facilitated the option for the day call midwives to pursue their own personal development and ensure they are up to date with training if not required elsewhere.

The team have started looking at a more streamlined system for referrals into maternity care including an online referral system, as a direct response to feedback from women who reported frustrations when trying to self-refer via the telephone. This will give women an alternative referral route which they can access at their own convenience. The team encourage GP services to refer women electronically through the NHS email account to the teams, as a quicker and more robust system than the current paper based and faxed system we have in place.

The Community Managers are actively involved in engaging with other Trusts and agencies to share ideas and visions for the future of maternity services, and how community midwifery fits within that in line with Better Births. We are actively encouraging our workforce to think about ways of improving continuity within our service, and to consider how the service can change or adapt to meet the needs of women and their families.

Community antenatal clinics are currently held in around 60 different venues across the city, and as part of the Better Births agenda and also as part of the local council review of buildings, we will be looking at stream lining where services are provided ensuring that they are delivered in the right locations, and are accessible to the women who need them. Consideration is being given as to how we can develop community hubs, enabling one stop access to services to improve engagement and uptake of care, which will include linking named Consultant Obstetricians to teams.

9.1 Better Start Bradford Maternity Project

This is a three year pilot of personalised midwifery care in Bradford, funded for 3 years by the Big Lottery, due to end in October 2018. Opal team consists of six midwives, a team leader, a midwifery support worker and two admin workers provide care for 400 women in one of the most deprived areas of the city. The focus is on enhanced antenatal and postnatal care. The team works in a paired 'buddy' system with the aim of each woman seeing their named midwife or buddy a minimum of 90% of the time during the antenatal and postnatal period thus providing good continuity of care.

A final evaluation of the project is expected in June 2018, and Better Start Bradford (BSB) is currently in discussions with the Head of Midwifery to look at the development of future projects when the pilot ends. With the challenge ahead that 20% of women will have continuity of carer by 2020/21 as mentioned earlier, the focus of discussions has been how BSB can support us in achieving this, and early consideration is being given to the development of a homebirth team.

10.0 National Reports and Recommendations and Regional Networking

Report recommendations from bodies such as the National Institute for Clinical Excellence (NICE), Royal College of Obstetricians and Gynaecologists (RCOG), and Royal College of Midwives (RCM), NHS England and Public Health England are discussed within the service and benchmarked against current practice. Discussion takes place at relevant forums and any changes are implemented as appropriate. This is also reported and escalated through the Divisional and Trust risk and governance structures.

10.1 National Maternity Review - 2 years on.

The vision set out in the February 2016 National Maternity Review was that maternity services in England must become safer, more personalised, kinder, professional and more family friendly by 2021. During 2017/18, the maternity service has continued to work towards how we can achieve the ambitions set out in the document. Achieving continuity of carer, including during the intra-partum period, for 20% of women by 2020/21, is one of the key priorities for the service.

Some elements of Better Births are slightly easier to achieve, for example we have considered how we can enhance the care of vulnerable women by adding to existing services in the community setting, and essentially taking the service to the women who are the most difficult to reach with some of the poorest outcomes.

10.2 Yorkshire and Humber Strategic Clinical Network

The maternity service is represented at regional level both at the Yorkshire and Humber Strategic Clinical Network and the Clinical Expert Group, and at a wealth of other regional maternity and neonatal steering groups and working groups. This ensures that the service contributes to, participates in, and influences key regional and national work such as prevention of stillbirth, improving perinatal mental health, benchmarking practice and policy and regional dashboard development.

In 2017, representatives from BTHFT Maternity have led the way by chairing steering groups such as Maternal Enhanced and Critical Care (MEaCC), and used good practice already in existence at BTHFT to shape training in this subject at regional level.

The Yorkshire and Humber Maternity Safety Learning Network was launched in 2017, and is attended by the Head of Midwifery and/or Divisional Clinical Director on a quarterly basis. Anonymised case studies of clinical incidents are submitted to the panel by individual Trusts, reviewed for relevance and examples of shared learning before being presented at the safety learning network. This is proving to be an excellent forum for maternity providers in the region to share serious incidents and near misses, any lessons learned and examples of good practice, which have the potential to happen in any maternity unit. The safety learning network cases are expanding to include anaesthetic and neonatal issues, and the relevant multi-disciplinary team members will be invited to attend those discussions.

10.3 West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS)

Throughout 2017/18, the Head of Midwifery and several Senior Midwives have been engaged with the WY&H LMS and its associated work streams which include:

- Safer Maternity Care Task & Finish Group
- Maternity Voices Partnership Task & Finish Group
- Choice & Personalisation Task & Finish Group
- Perinatal Mental Health Task & Finish Group
- STP Maternity Workforce Task & Finish Group

11.0 Specialist Services

There are a number of specialist services within Maternity, some of these are described in more detail within this section.

11.1 Teenage pregnancy service

Many teenage mothers suffer social and economic deprivation and the impact of teenage pregnancy on the health of mothers and their babies is well documented. Babies born to teenage mothers are at an increased risk of prematurity and are 25 % more likely than average to have a low birth weight. There is a 60% higher than average infant mortality rate in babies born to this group of mothers.

Young women aged 16 and under at booking are automatically cared for by the Specialist Midwife, those between 17 and 19 can be referred into the service depending upon need, i.e. care leavers, homelessness, learning difficulties. All other women in this age group are cared for by their local midwives. Midwives across the Trust can access support when caring for these women from the specialist midwife.

We are aware of a recent increase in access to abortion services within the Trust since the reduction in contraceptive services across the district, and so it would therefore be reasonable to assume that the rate of births may also increase. In light of the data provided for Q1 of this year and the concurrent increase in access to abortion for <18's, and the change to the post holder now would be a good time to evaluate the services provided to young parents across maternity services.

Following training in 2017, the SMTP commenced a service offering the fitting of sub dermal contraceptive implants to teenage mothers in the early postnatal period. The aim of the service is to support young women to take control of their fertility, and avoid a repeat pregnancy within a short timescale. A number of other vulnerable women using the service have also benefited from having the necessary counselling and insertion before discharge from hospital.

11.2 Maternity Safeguarding

Midwives are the primary health professionals likely to be working with and supporting women and their families throughout pregnancy and are ideally placed to recognise the need for additional safeguarding support. However, other health professionals including maternity support workers, obstetricians and their team and, where applicable, specialist key workers may also be directly engaged in providing support. By signposting and referral to the many initiatives and agencies available during pregnancy, many families who utilise these services fall below the threshold for assessment and intervention by Children's Social Care (CSC). A joint working Safeguarding Families Document facilitates information sharing and care planning for families who have a

heightened level of need during the antenatal, intra-partum and or postnatal period. It enables all professionals to keep contemporaneous records which are shared with everyone involved in safeguarding the family.

In the year April 2017 to March 2018 the maternity services supported 578 women / families with a heightened level of need leading to potential safeguarding and /or child protection issues. This represents 10.4% of the total births for the year and an increase of 9.6% on the 522 women identified in 2016 – 2017. The majority of women were managed with safeguarding support from universal services, mental health services, children's centres, Family Nurse Partnership, NSPCC, and domestic abuse services. A "Safeguarding Families" document was available for each woman and a plan of care and an outcome for the pregnancy documented.

During the reporting period 365 referrals were made to Children's Social Care for unborn babies and new-born children from the 578 women and families identified with a heightened level of need. This is 36.8% of the total of vulnerable families. 149 of these referrals were made by maternity service staff, 39 by the police, 54 by other agencies and 123 were already known to CSC.

There was a plan for 58 babies to be discharged home with mother or parents subject to a child protection plan. In which there is a midwife to attend the child protection conference and subsequent meetings. 38 babies went home with their mother subject to a child in need plan. 50 babies were removed from their parents in the reporting period; the majority were removed to foster care following court proceedings to acquire an Interim Care Order (ICO).

In recognition of the increase in safeguarding and child protection concerns identified within maternity services, the Head of Midwifery and the management team have increased the hours of the Safeguarding Support Midwife from 16 to 30 hours per week, in addition to 37.5 hours Named Midwife post.

11.2 Antenatal and New-born Screening Services

Care and support is provided to all the high risk women identified by all the screening programmes.

The following screening is offered in Bradford:

- Antenatal screening:
    - Sickle Cell and Thalassemia
    - Fetal Anomaly (Down's, Edwards' and Patau's syndrome & fetal anomaly)
    - Infectious Diseases (Hepatitis B, HIV and Syphilis)

New-born screening:

- New-born Blood Spot (Phenylketonuria, Medium Chain Acyl CoA Dehydrogenase Deficiency (MCADD), Cystic Fibrosis, Congenital Hypothyroidism, Sickle Cell) including extended screening
- New-born and Infant Physical Examination (NIPE Smart)
- New-born Hearing

11.2.1 Serious Incidents

There have been two serious incidents involving screening.

11.2.1.1 Infectious diseases screening programme

On 1 March 2017, as part of the Joint Venture (JV) between Airedale NHS Foundation Trust (ANHSFT) and BTHFT, the provision of antenatal microbiology screening for BTHFT was transferred from Leeds Teaching Hospitals NHS Foundation Trust to the Joint Venture. A Level 2 comprehensive investigation was commissioned on the 12th April 17 following raised concerns regarding the Infectious Diseases Screening Programme. 153 women who had infectious diseases screening bloods taken during their booking appointment in March 17 were identified as not having results and not processed correctly.

The investigation team conducted a physical walk through both laboratories which enabled the identification of specific problems and interventions required. The different systems in place for the handling and management of the antenatal screening samples between the two sites created a situation whereby samples were not assessed and tested correctly. With the transfer to the JV there appears to have been no clear process in place for the handover and the roles and responsibilities of the various personnel involved.

The root cause was poor communication and preparation prior to the transfer to identify the key differences in the provision of the screening service before the go-live of the Joint Venture.

11.2.1.2 Sickle Cell and Thalassaemia screening programme

On the 9th March 2018 the Trust declared a serious incident in relation to the Sickle Cell and Thalassaemia Programme. A cohort of 22 women, were identified as having missed screening for sickle cell and thalassaemia when collating data for the quarterly KPI data submission. The women were of advanced gestation or postnatal when identified. The main concerns were around the availability of the local FOQ form, non-compliance of the test tracking process and dual reporting of systems. Additionally a major concern is the lack of a consistent failsafe process to identify and escalate missed screening whereby reducing the risk of recurrence and harm. This investigation is still in progress.

11.3 Parent Education

The Bradford Antenatal Birth and Beyond service offers a variety of group and individual antenatal education classes to prepare women and partners for pregnancy, labour, birth and beyond. Topics covered include active pregnancy, labour, birth, and active birth, breastfeeding, building a positive relationship with baby, responding to baby, caring for baby and becoming a family. Classes are developed in line with Department of Health guidance from the 'Pregnancy, Birth and Beyond' document and are regularly reviewed and updated to include the best current evidence, public health and safety messages.

The service also offers specialised one to one sessions for women with complexities such as multiple pregnancies, epilepsy, or learning/physical disabilities.

Evaluation of the service is ongoing. The feedback we receive from women and their partners is positive, attendance at most classes remains high and women and their partners report that they value and enjoy the sessions they attend. Women report that they feel less anxious after attending the classes.

11.4 Bereavement Support

The Bereavement Support Midwife (BSM) post is responsible for the delivery of a high quality service and provides leadership to staff, is responsible for the co-ordination of all aspects of care for parents who have suffered the death of a baby following first or second trimester pregnancy loss, termination of pregnancy for foetal abnormality, stillbirth or neonatal death.

The BSM provides specialist advice and guidance to midwives, and other staff, and liaises with other professional groups and agencies in hospital and in the community. As well as providing appropriate, responsive education and training to all members of staff who come into contact with bereaved families.

To encourage the use of a supportive network of midwifery, nursing, medical and other staff involved in bereavement care.

11.5 Infant Feeding

Bradford Women's & New-born Unit were accredited as a Baby Friendly hospital in May 2004. The unit was last reaccredited in March 2015 and our next reassessment was due in March 2018, however, due to the amount of time invested in working towards the neonatal unit accreditation, a decision was made to delay the reassessment until the end of 2018 (up to a nine month delay is allowed).

On the 12th- 14th December 2017 we undertook a rigorous external assessment for stage 2 and stage 3 of the UNICEF Baby Friendly accreditation for neonatal units and were delighted achieve

the full accreditation, making Bradford the first level 3 neonatal unit in the UK to achieve the award. The report praised staff for excellent work in achieving this prestigious award. The focus between now and December 2018 is on preparing staff for reaccreditation and baseline audits of practice are currently being undertaken.

11.6 Vulnerable Women's Pathways

In April 2017 the CCG commissioned a Specialist Midwife to develop a series of pathways for vulnerable pregnant women. The role was funded for 12 months, ending on the 31st May 2018 with a final report and recommendations being presented to the CCG in June 2018.

The aim of the role was to identify ways in which outcomes for the vulnerable women and her unborn can be improved within the Bradford area, and focused on the needs of women who misuse substances, migrants, asylum seekers, victims of domestic abuse and others with complex social needs. A series of maternity pathways have been developed with the intention of enabling health care professionals to provide appropriate, relevant and comprehensive care packages, which consider both the social and emotional needs of the mother alongside the health needs of her and the unborn baby.

Key findings include identifying that there are no specialist midwifery services for women:

- who misuse substances
- who are recent migrants, asylum seekers or refugees
- who have difficulty reading or speaking English
- who have experienced domestic abuse
- who have experienced FGM
- who have learning difficulties
- who have mental health issues

The main recommendation resulting from the 12 month role is the strong need to establish a Vulnerable Woman's Team (VWT) for women with complex needs which would help to facilitate closer working with other agencies but more importantly it would facilitate better opportunities for engagement by the pregnant woman. The VWT would offer an enhanced package of community midwifery care with and direct access to a named midwife.

The final report findings and recommendations will be shared wider following review by the CCG

12.0 Summary and Key priorities

2017/18 has been a challenging year for maternity services at BTHFT, but has also included exceptionally positive progress on the Maternity Improvement Plan. It is very clear that lessons

have been learned from the Serious Incidents which resulted in the 2016 Maternity Quality Summit, and that changes in practice have been accepted by staff and embedded in practice.
Of most significance for the service is the reduction of stillbirths, particularly those considered to be potentially avoidable. Whilst we celebrate this achievement, we are not complacent and fully at acknowledge that the preventative work to date needs to be sustained, and that further work is needed to further reduce the rate, particularly around smoking cessation and raising awareness of reduced foetal movements in certain hard to engage groups.

12.1 Priorities for 2018/19

- The reviews and risk assessments of high priority areas listed on the Maternity Improvement Plan are to be added to the maternity action tracker and be subject to regular assurance checks, monitored through Women's Core Governance Group.
- Perform regular assurance checks to ensure that actions from Serious Incidents are truly embedded in practice
- Ensure that any changes to practice, new ways of working are evaluated and embedded in practice
- To replicate the success achieving CTG training compliance year on year, and not become complacent in our approach to training.
- Ongoing focus on midwifery staffing
- Completion of mandatary training
- Achieve required staffing to provide 24/7 obstetric theatre cover
- Achieve required staffing to open MAC 24/7
- Review antenatal services
- More integrated working for antenatal care to see if we can achieve greater continuity of care for women seeing both midwife and obstetrician,
- Address some of our ambulatory care challenges-increasing numbers of women attending hospital for reduced FM and having growth scans.
- Review community based clinic locations and consider creating hubs to modernise and improve access for women from more deprived areas or backgrounds.
- Work with interpreting services and community members/schemes/doulas e.g. to help us integrate care /inform community groups re antenatal care in some European migrant groups who often arrive in the UK advanced in their pregnancies.
- Continue to work with the WY & H LMS and local commissioners to achieve the Better Births recommendations, prioritising continuity of care.
- Continue to develop service user engagement and partnership working

Despite all of the challenges presented in 2017/18 staff have shown a high level of commitment to the service and are genuinely proud to work within the Maternity Service at Bradford, striving to provide high quality care to women and babies in the area.

12.2 Recommendations:

- The Committee is asked to note the content of the report and the actions taken and progress made.
- Quarterly reports to the Quality Committee to provide oversight of maternity performance, including key performance indicators
- The Maternity team to present to Board
- Copies of the report to be made available to the CCG, CQC and other stakeholders