

Council of Governors: 18.01.2018

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Chief Executive Report – 18th January 2018

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| Presented by: | Professor Clive Kay, Chief Executive | Author: | Helen Haslam, Executive Officer to Chief Executive |
| Previously considered by: | Not applicable | | |

| Key points | Purpose: |
|---|---------------------|
| 1. Internal Communication <ul style="list-style-type: none"> a. New Year Message to Staff from the Chairman and the Chief Executive. b. Changes at Executive Director level. | To discuss and note |
| 2. Visits and External Communications <ul style="list-style-type: none"> a. Presentation on the Bradford 'Virtual Ward' to the King's Fund on 8th November 2017. b. Visit from Matthew Swindells, National Director of Operations and Information, NHS England on 8th December 2017. c. Visit from Amanda Campbell, Chief Executive of the Parliamentary and Health Service Ombudsman on 14th November 2017. d. Visit from Nic Fox, Director of Provider Digitisation and Programmes at NHS Digital on 14th November 2017. e. Operational Management of Winter Briefing from NHS Improvement. f. Department of Health Safer Maternity Care: The National Maternity Safety Strategy – Progress and Next Steps. g. NHS Providers 2017/18 Q2 Finance and Performance Briefing. h. Home Office letter regarding European Union citizens living in the United Kingdom. i. Communication from NHS Improvement/NHS England - Operational Updates from the NHS National Emergency Pressures Panel – 21st December 2017 and 2nd January 2018. | To discuss and note |
| 3. Quality, Investment and Development <ul style="list-style-type: none"> a. Opening of a new Clinical Decisions Unit. b. Renovations to the Women's and Newborn Unit. c. First Birthday for the Fragility Fracture Service. d. Launch of the Virtual Children's Ward. | To discuss and note |
| 4. Workforce <ul style="list-style-type: none"> a. New Consultants in Post. b. University of Leeds Undergraduate Medical Education Placement Evaluation. | To discuss and note |
| 5. Celebrating Success <ul style="list-style-type: none"> a. Staff Awards Ceremony. b. Volunteer Awards Ceremony. c. 30 Year Anniversary of the Academic Unit of Elderly Care and Rehabilitation. | To discuss and note |
| 6. Research <ul style="list-style-type: none"> a. New £3m Research Centre at Bradford Royal Infirmary. b. Respiratory Research Team. | To discuss and note |

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Executive Summary:

Report from the Chief Executive on the Trust's performance of its functions and the Directors' performance of their duties.

The report provides the Council of Governors with items of interest and details of recent events, achievements and important external correspondence received throughout the months of November and December 2017 and early January 2018.

Financial implications:

No

Regulatory relevance:

Monitor:

Risk Assessment Framework

Quality Governance Framework

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

Report from the Chief Executive 18th January 2018

1. Internal Communication

a) New Year Message to Staff from the Chairman and the Chief Executive

2018 marks the 70th anniversary of the National Health Service and, for all of us who work across Bradford's family of hospitals, it is poised to be one of the most important years in our history.

Thanks to the efforts of every single one of you, we once again enter a new year – and the challenges it will undoubtedly bring – in a stronger position than we were 12 months ago.

We are very much aware that we ask a great deal of you, and we are incredibly proud of the way in which you have all responded. Not just individually, but more importantly by pooling all your different skills and working together as one team.

More than once during the past year, we have been told that this is something that should be bottled and shared with the wider NHS!

Both of us would like to take this opportunity to pay tribute to your dedication to our patients, who depend on the first-class services you provide.

We have witnessed this first-hand when meeting you while out and about on our ward and departmental visits, and listening to – and acting on – your experiences which you have shared at our growing programme of *Let's Talk Live* events.

Your contribution remains key to our future success as we build on the progress we achieved together in 2017.

These are your achievements. You all really do make a difference. And we would like to say thank you for living our refreshed **values – We Care; We Value People; We Are One Team** – and translating them into action.

This week does not just signal the start of 2018 and a New Year. It also marks the beginning of a critical period, in which we face a twin challenge.

First, we have to deliver our financial and performance challenges to the end of March and beyond. Like many parts of the NHS we have some ground to make up, but we are confident that with the right ambition and commitment, we can maintain the incredible momentum that's been generated. We are in no doubt we can do this. It will require a real team effort - it's been described as "the new EPR" - and it will be a great achievement given the scale and pace of change we have all faced. Meeting our finance and performance targets will allow us to unlock more freedoms: so-called "earned autonomy".

Second, we can look forward to one or more visits from the CQC, to review the progress we have made, and determine whether we are safe, caring, responsive, effective and well-led. CQC will be looking for evidence that we are continuously working to improve the quality of our care. In the last year we have shown we are willing to try many different approaches, from preventing pressure ulcers and caring for the deteriorating patient, through to improving the efficiency of our theatres and outpatients. The common thread is that we are ready to challenge current practice if we think that there may be a better way to deliver care. We are dedicated to continual improvement, but not dependent on any one method; instead we believe we will improve the work that we do by testing simple ideas, measuring the change, and repeating the process until we've achieved our aim.

We very much welcome the CQC's review as, like us, their focus is on the quality of care. Their visits allow us to shine a light on the improvements and success stories we are proud of here in Bradford, and demonstrate how we learn and share lessons to improve the service for our patients. Our vision is to be outstanding in all that we do, and the CQC's visit is our opportunity to demonstrate this. And

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getting a “Good” (or even “Outstanding”) rating from the CQC will cement our position as one of the leading groups of hospitals in the NHS, and ensure we retain control of our own future.

These things are important not as ends in themselves, but because greater autonomy will enable us to spend more time focusing on quality of care for our patients. This really matters in Bradford where the communities we serve still have some of the poorest health in UK. We want to be outstanding to properly reflect the fantastic work of all our colleagues, but also because that's what the people of Bradford need and deserve. As an organisation that is succeeding in a difficult climate, we will be in a stronger position to recruit and retain staff, develop our services, invest in the future, and collaborate effectively with our partners in health and care.

In turn, this autonomy will help us to achieve:

Our vision

- To be an outstanding provider of healthcare, research and education; and a great place to work

Our 5 strategic objectives

- 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

Wherever we work, whatever our role, we all have a part to play in meeting these challenges and giving our patients the best possible care.

For this, we would like to thank you once again for your continued hard work. We think you perform your roles brilliantly, and should be justifiably proud of your outstanding achievements, both as individuals and as members of a very successful team. We look forward to working with you all to make 2018 not just a milestone for celebrating our hospitals' past achievements but, more importantly, as a launch pad for an even more successful future as well.

We would like to send our very best wishes to you and your families, for a happy and healthy 2018.

Clive Kay
Chief Executive

Bill McCarthy
Chairman

b) Changes at Executive Director level

Donna Thompson, our current Director of Governance and Operations retires at the end of March 2018.

From 1st April 2018, the role will be divided back into Chief Operating Officer, and Director of Governance and Corporate Affairs.

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Tanya Claridge will take up the substantive post of Director of Governance and Corporate Affairs on 1st April.

As we have not yet appointed to the substantive Chief Operating Officer post, I have decided to appoint Sandra Shannon, our current Interim Assistant Director of Operations (Elective) who has been working with us since August, as Acting Chief Operating Officer.

In order to ensure a smooth transition, Sandra will take up post on 8th January 2018. Sandra will be responsible for all elements of the Chief Operating Officer portfolio: operational management; operational performance delivery; service transformation; site management (including the winter room); estates and facilities; resilience and business continuity.

Between 8th January and 31st March 2018, Donna will revert to Director of Governance and Corporate Affairs with responsibility for clinical and corporate governance; regulatory assurance/compliance; clinical effectiveness; risk management; health and safety; legal services; inquests and corporate affairs.

I look forward to working with Donna, Sandra and Tanya in their new roles.

2. Visits and External Communications

a) Presentation on the Bradford 'Virtual Ward' to the King's Fund on 8th November 2017.

At his visit to the Foundation Trust in June 2017, Matthew Swindells, NHS England's National Director: Operations and Information, was impressed by the Foundation Trust's 'hospital at home' virtual ward service for elderly people.

As a consequence, Matthew invited myself and Dr Maj Pushpangadan, Consultant Geriatrician and Clinical Lead for the Virtual Ward Service, to share the Bradford experience with a number of individuals, including Professor Chris Ham, Chief Executive of the King's Fund, Professor Don Berwick, President Emeritus and Senior Fellow of the Institute for Healthcare Improvement, and an international visiting Fellow at the King's Fund, and Matthew himself. The discussion was very much focussed on how the Bradford Virtual Ward model could be extended to other parts of the country in an attempt to keep patients independent and out of hospital.

Following the roundtable discussion, further collaborative working will take place in an attempt to share best practice.

I would like to take this opportunity to thank Maj and all his colleagues involved in the successful development and implementation of the Bradford Virtual Ward.

b) Visit from Matthew Swindells, National Director of Operations and Information, NHS England on 8th December 2017.

On 8th December 2017 I was very pleased to welcome Matthew Swindells, NHS England's National Director Operations and Information, to the Foundation Trust.

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Matthew was taken on a brief tour of the Bradford Royal Infirmary, and met with several members of staff, including those in Orthopaedics, Paediatrics and the Intensive Care Unit.

Matthew observed a number of 'virtual clinical services', including the 'Virtual Fracture Clinic' and the 'Virtual Children's Ward'. As Matthew was also very much well-aware of the success of our 'Virtual Ward', he was extremely complementary regarding the extent to which the Foundation Trust has embraced 'Virtual Clinical Care' and is now very much at the forefront of such provision in the UK.

c) Visit from Amanda Campbell, Chief Executive of the Parliamentary and Health Service Ombudsman on 14th November 2017.

On 14th November 2017 the Trust hosted Amanda Campbell, Chief Executive of the Parliamentary and Health Service Ombudsman (PHSO). The PHSO was set up by Parliament to provide an independent handling service for complaints that have not been resolved by the NHS in England and UK government departments.

Whilst at the Trust, Amanda met with myself, Donna Thompson, Director of Governance and Operations, and Tanya Claridge, Assistant Director of Governance and Risk. We discussed the measures that the Trust takes to handle complaints and manage risk, and demonstrated one of the 'safety huddles' the team undertake on a regular basis to address safety issues. Amanda was also given a tour of our Simulation Centre by Karen Dawber, Chief Nurse.

It was a pleasure to host Amanda at the Trust and share with her the outstanding work the Trust does to improve both our management of risk and patients' experience

d) Visit from Nic Fox, Director of Provider Digitisation and Programmes at NHS Digital on 14th November 2017.

On the 14th November 2017 the Foundation Trust also hosted Nic Fox, Director of Provider Digitisation and Programmes at NHS Digital, to allow him the opportunity to see our EPR system in operation.

Nic joined NHS Digital in February 2015, and has a large portfolio at NHS Digital looking at ways to improve patient care using digital processes, offering patients better self-care through online services, and work towards a paper free NHS. This was a valuable opportunity for the Trust to demonstrate its own journey from a paper to an electronic system, and how this was leading to improvement in patient care.

During his visit, Nic was taken on a tour of the Trust led by Cindy Fedell, Director of Informatics and Dr Paul Southern, Associate Medical Director of Informatics, where he met with staff using the EPR system and listened to their experiences.

Nic was extremely impressed by the positive approach that the teams had taken to ensure that the implementation of EPR was a success, and the impact this had on the services the Trust provides.

It was a pleasure to host Nic at the Trust, and allow him the opportunity to see the EPR system in operation.

e) Operational Management of Winter Briefing from NHS Improvement.

I received the Operational Management of Winter Briefing from Pauline Philip, National Urgent and Emergency Care Director at NHS Improvement.

The briefing details 3 key areas that NHSI are working on with Trusts to address the challenging winter period. These are described briefly below:

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1. Winter Operating Model

NHSI are developing a new winter operating model this year, focused on continuous monitoring, and supporting improvement with a national, regional and local presence. The winter operations infrastructure is being built on a series of principles, which include:

- Ensuring patient flow in the Urgent and Emergency Care (UEC) pathway is maintained seven days per week.
- Proactively managing the risks to Accident and Emergency performance, delivery and patient safety through support, collaboration and transparency.
- Greater emphasis on continuous monitoring and support using information, with more emphasis on forecasting measures to help prevent deterioration in performance.
- Having a dedicated team and supporting infrastructure, with teams jointly led across NHS England/NHS Improvement, with representatives from key partner agencies and functions: the Association of Directors of Adult Social Services (ADASS), Local Government Association (LGA), Public Health England (PHE) and Primary Care.

2. Local Winter Teams

NHSI propose, if not in place already, that Local Delivery Boards ensure that local operational models have the following:

- A hospital doctor, nurse and operating manager who are accountable for the management of urgent and emergency care and who have a direct relationship with the CEO of each Trust.
- A local cross-system winter operations team, with sufficient capacity released to operate the joint local arrangements and at a level of seniority sufficient to commit organisational resources. This team should include the following roles:
 - A senior manager responsible for Urgent and Emergency Care in the Clinical Commissioning Groups.
 - Local Authority Social Care Director – nominated by the Local Authorities.
 - Community Provider Senior Operational Lead.

3. Local Escalation Plans

NHSI set out the need to develop clinical escalation plans that detail the actions local systems will take in anticipation and response to times of pressure. Clinical escalation plans will need to take actions to ensure that:

- All patients who are to be admitted have a timely 'Decision to Admit' to ensure they do not need to remain in the Emergency Department for any longer than is clinically necessary.
- Patients are not cared for on hospital corridors.
- Escalations beds have the necessary staffing and equipment to ensure safe care.
- 12 hour trolley waits in the Emergency Department never happen.
- Patients do not wait more than 15 minutes in ambulances before being handed over to the hospital.
- The hospital can manage increasing demand because of flu, norovirus, etc.

A copy of the letter from Pauline Philip is attached for information at **Appendix 1**.

f) Department of Health *Safer Maternity Care: The National Maternity Safety Strategy – Progress and Next Steps*.

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I recently received the Department of Health's *Safer Maternity Care: The National Maternity Safety Strategy – Progress and Next Steps* publication.

Two years ago the Department of Health (DoH) set an ambition to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth by 2030. To make sure progress is quickly made, they also set out an expectation of a 20% reduction by 2020. In October 2016, the DoH published an action plan outlining a number of initiatives at national level and local level to support this ambition.

This document reports on progress against that initial action plan. It also proposes a number of steps to make sure the DoH are doing all they can to prevent serious incidents in maternity services. The document also explains how all the elements of the Maternity Safety Strategy are designed to form a coherent and aligned system-wide approach to improving safety in maternity care.

A copy of the Safer Maternity Care publication is attached at **Appendix 2**.

g) NHS Providers 2017/18 Q2 Finance and Performance Briefing.

On the 16th November 2017 NHSI released the Q2 Financial and Operational Performance figures for the provider sector. These figures cover the six-month period ending 30th September 2017, the briefing summarises the key headlines from those figures:

- The Q2 net deficit forecast for the sector is now £623m, compared to the £791m 2016/17 year end position and the £2.45bn 2015/16 position. This is a deterioration from £523 million forecast deficit reported at Q1.
- At Q2, providers reported a year to date deficit of £1.15bn. This compares to a deficit of £648m in Q2 2016/17 and a deficit of £1.61bn in Q2 2015/16.
- Within the overall sector position there remains £292m worth of uncommitted sustainability and
- 90.2% of emergency patients were seen within 4 hours
- The elective waiting list stood at a record 4.1m.

A full copy of the briefing is attached at **Appendix 3**.

h) Home Office letter regarding European Union (EU) citizens living in the United Kingdom.

I received a letter from The Home Office confirming that EU citizens living lawfully here before the UK's exit from the EU will be able to stay.

I am delighted that this will give our EU staff the assurance and peace of mind that I know they have been requiring for some time. We all, as NHS colleagues and patients, rely heavily on their knowledge, skills and compassion, and they have always made, and now will continue to make, a huge positive impact on this country's healthcare services.

The letter highlights a new process which will enable our EU staff and their families to apply, from the second half of 2018, for 'Settled Status' in the UK and this process will remain open for at least two years after the UK leaves the EU.

A copy of the letter is attached at **Appendix 4**.

i) Communication from NHS Improvement/NHS England - Operational Updates from the NHS National Emergency Pressures Panel - 21st December 2017 and 2nd January 2018.

I received a letter from Pauline Philip, National Urgent and Emergency Care Director at NHS Improvement making me aware of guidance issued from the National Emergency Pressures Panel.

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The National Emergency Pressures Panel is a group of senior clinicians, established in October 2017, to advise the NHS on the clinical risk in the system, and potential actions that could be taken to ease pressure.

The guidance issued on 21st December 2017, regarding reviewing elective activity to deal with non-elective pressures, ensures that resources are directed to our sickest patients, and asks that we review elective plans to consider where the Foundation Trust can free up further capacity to support non-elective care.

These changes are in addition to our detailed winter plans, which already focus on areas such as improving flow and discharges in the hospital, and enhancing capacity outside of the hospital.

In addition to the letter on 21st December 2017, I received a further update of the Operational Update from the NHS National Emergency Pressures Panel on 2nd January 2018.

This further guidance issued to support the Foundation Trust as part of NHS Improvement's NHS Winter Pressures Protocol, includes additions to the recommendations made by the panel on 21st December 2017 to support frontline staff, and are mainly based around recommendations within the Emergency Department to help improve flow.

The Foundation Trust is taking relevant actions based on the recommendations.

A copy of the covering letters from Pauline Philip, and Operational Updates are attached at ***Appendices 5a and 5b.***

3. Quality, Investment and Development

a) Opening of a new Clinical Decisions Unit.

I am pleased to inform you that our new Clinical Decisions Unit (CDU) opened on Monday 6th November 2017. The unit is part of our Emergency Department, and is sited in a specially-adapted area.

The CDU has capacity for 13 patients and is a designated area where patient conditions can be managed as an adjunct to the main ED. These patients are unlikely to require admission to an inpatient bed and will remain under the care of the ED Consultant while they are in the CDU, with the unit primarily using criteria-led discharge.

The new unit is a really positive step, and a great asset which can only further enhance our ED services and therefore patient care. I would like to take this opportunity to thank all those involved in the establishment of this service.

b) Renovations to the Women's and Newborn Unit.

I would like to inform you of the planned £1.8m renovation of the Women's and Newborn Unit. This work will improve the unit's patient comfort, energy efficiency and the aesthetics of the building itself.

The refit will include better-insulated windows, refurbishment of the roof and weatherproof insulated cladding panels fixed to the outside of the building. The cladding – Rockpanel FS-Xtra, is made from the latest ultimate fireproof materials and go beyond all the latest British regulatory standards and checks for fire safety. It also meets European fire safety standards.

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The work started in November 2017, and is expected to last approximately 40 weeks. During this time the unit will continue to operate as normal; at times there may be some reduced capacity but this will be planned carefully so that there is no disruption to mothers and their babies.

c) First birthday for our Fragility Fracture Service.

The first week in December saw our innovative Fracture Liaison Service celebrate its first birthday. The service is co-ordinated by Fragility Fracture Liaison Sister, Janine Connor who is supported by a wider multidisciplinary team.

Based at Bradford Royal Infirmary, the service works to identify patients at risk of fracture and of the bone disease osteoporosis and hopes, by starting them on treatments and providing them with lifestyle and dietary advice, to prevent them from suffering further broken bones. In the first 10 months alone, approximately 1,000 patients have been assisted by this service.

Fewer than half of trusts countrywide have this service, so I believe it reflects extremely well on the Foundation Trust that we are delivering this advanced area of care.

I would like to congratulate the team on an excellent first year, and wish them continued success in the future.

d) Launch of the Virtual Children's Ward.

On the 4th December 2017 our Children's Service launched their new 'virtual ward'. This will be a year-long, Clinical Commissioning Groups (CCGs) funded pilot, believed to be the first of its kind in the country. The new scheme aims to deliver a more efficient service to our patients, reduce emergency admissions and readmissions to our hospitals, empower families to manage common medical problems better and enhance collaborative working with our CCGs and GP colleagues across the district.

The new scheme will work along similar lines to our ambulatory care service and the elderly care virtual ward. Our community nursing team will treat children aged up to 16 years-old in the comfort of their own home, under the expert supervision of our Consultant Paediatricians through the use of regular telephone clinical huddles, and telemedicine. The virtual ward will offer an alternative outcome to a hospital admission for unwell children and will operate from 9 am to 9 pm, seven days per week.

Bringing all these elements together and using telemedicine in decision support is the first of its kind in the UK, so it's a hugely exciting development for us here in Bradford.

I wish the team the very best with the service and look forward to seeing the outcomes of the pilot.

4. Workforce

a) New Consultants in Post.

Dr Nicolas Rabb joined the Trust on 1st November 2017 as a Consultant Gastroenterologist, and was previously a Specialty Registrar in Leeds Teaching Hospitals NHS Trust. Nicolas is particularly skilled in the endoscopic management of patients with bleeding of the upper gastrointestinal tract.

Dr Praveen Karajgi joined the Trust on 13th November 2017 as a Consultant in Acute Medicine, and was previously a Specialty Registrar in Calderdale and Huddersfield NHS Foundation Trust.

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Praveen has experience in acute & general medicine, with sub-specialty clinical experience and knowledge.

Dr Nicola Lee joined the Trust on 4th December 2017 as a Consultant in Uroradiology, previously working as a Specialty Registrar in Leeds Teaching Hospitals NHS Trust. Nicola is now one of two specialist consultant uroradiologists in the Trust, alongside Dr Harry Bardgett.

Dr Jivendra Gosai joined the Trust on 11th December 2017 as a Consultant in Device Cardiology, previously working as a Specialty Registrar at Sheffield Teaching Hospitals NHS Foundation Trust.

I am sure the Council of Governors will join me in welcoming all our new consultants to the Foundation Trust.

b) University of Leeds Undergraduate Medical Education Placement Evaluation.

I recently received a letter from Professor Trudie Roberts, Director at Leeds Institute of Medical Education and Professor Richard Fuller, Director of Medical Education and Programmes at the University of Leeds congratulating Trust staff on their support of Leeds Medical undergraduate education.

The school evaluates student feedback on the experiences they have at their placements, and the Foundation Trust scored over 80% in all areas, which is an exceptional achievement.

It was pleasing to see that undergraduate students feel their placements are of value and they enjoy the experience here at Bradford Teaching Hospitals Foundation Trust.

The letter from University of Leeds is attached at **Appendix 6a**, and the report itself attached at **Appendix 6b**.

5. Celebrating Success

a) Staff Awards Ceremony.

On Thursday 7th December 2017, the Foundation Trust held our *Brilliant Bradford Staff Awards Ceremony*.

The staff awards ceremony is a great opportunity for the Foundation Trust to thank our staff for their continued dedication and support to all our patients.

All of the Executive Team were delighted by the response to our staff awards; the quality and quantity of entries submitted by staff was unprecedented. I know our judging panels had a difficult task choosing winners due to the high standards of people shortlisted.

There were three prizes for Team of the Year and single winners for the other awards, which are for outstanding individuals, both clinical and non-clinical. There were also awards handed out to two of our “unsung heroes” as well as a richly deserved Lifetime Achievement honour.

The list of winners is detailed below:

Team of the Year Award - Ward 28 (Orthopaedic, Breast and Trauma)

Finance and Performance Excellence Award - Corinne Wood, Temporary Staffing Manager

Excellence in Collaboration Award – Mr Chris Bem, Consultant ENT Surgeon and lead for *Well Bradford*

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Excellence in Care Award - Sara Dixon, Extended Scope Practitioner, Physiotherapy
Learning Excellence Award – Joint first place, Wendy Milner, Senior Sister, ICU, and Jacqui Smith, Sister, Ward 29.
Valuing People Award - Malik Latif, Medical Records Team Co-ordinator
Chief Executive's Unsung Hero Award - Ben Martin, Informatics Team
Deputy Chief Executive's Unsung Heroes Award - Directorate Managers
Lifetime Achievement Award – Shirley Hannan

I would like to sincerely congratulate all the winners and the nominees, and take the opportunity to thank all the staff at Bradford for their hard work throughout 2017, which has been a tremendous year for the Trust.

b) Volunteer Awards Ceremony.

Our volunteers were honoured at a special ceremony held at Bradford City Football Club, on Thursday 7th December 2017, and I am grateful to our Deputy Chairman, Trevor Higgins, for presenting the certificates and awards at the ceremony.

The ceremony was an opportunity to present almost 80 volunteers with certificates and commemorative plaques for long service as well as to crown the "Volunteer of the Year 2017".

The judging panel for this year's 'Volunteer of the Year' was Knowledge, Library and Information Services Manager, Abbas Bismillah; Senior Infection Prevention and Control Clinical Nurse Specialist, Robina Fayyaz and Directorate Manager, Louise Lacey.

This year, 17 volunteers were nominated for the top prize and after a very tough job, Phlebotomy Volunteer and Play Assistant, Liz Austin was crowned "Volunteer of the Year 2017". Liz is a former staff nurse at BRI, and after retiring, she decided she wanted to become a volunteer. She began

volunteering four years ago and now helps out two days a week, splitting her time as a phlebotomy guide at St Luke's Hospital, and a play assistant on the children's ward (ward 30) at BRI.

Taking the runner-up prize this year was Bradford Radio Royal Volunteer and Chaplaincy Volunteer, Christopher Fisher, and in joint third place were Play Assistants, Mary Darrington and Katarzyna Piotrowska.

A total of 37 dedicated volunteers were rewarded for long service.

I really could not have been more delighted to be part of our annual Volunteer Awards ceremony - honouring people who give up their free time to improve the experience of our patients.

c) 30 Year Anniversary of the Academic Unit of Elderly Care and Rehabilitation.

It is 30 years since the successful Academic Unit of Elderly Care and Rehabilitation was founded, and over the decades the unit has grown to become an international leader in healthcare innovation, playing a leading role in stroke and elderly care research, and is still led by its original founders, Professor Anne Forster who leads the stroke programme, and Professor John Young, who leads the elderly care research programme.

The unit is based in the Bradford Institute for Health Research (BIHR) building on the Bradford Royal Infirmary site, and is part of the University of Leeds, administratively located within the Leeds Institute of Health Sciences. It has built up a large portfolio of applied health research relevant to older

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people and people with stroke, and has a long track record of addressing key clinical questions through evaluation by randomised trials.

The anniversary was marked by a celebration dinner at Bradford City Hall, attended by staff, patients and those who have supported and helped the unit in its work over the years.

I would like to congratulate them on their many years of service and wish them continued success for the future.

6. Research

a) New £3m Research Centre at Bradford Royal Infirmary.

I am delighted to inform you of the latest stage in the development of a new Yorkshire research centre to be based on the Bradford Royal Infirmary site, which will improve the health and wellbeing of children and the elderly, and the safety of patients in hospitals and clinics.

A decision on the final planning approach is expected to be made by Bradford Council within the next few weeks, with work on the centre due to start in March 2018. The centre has been made possible thanks to a £1m award from national charity the Wolfson Foundation. The Wolfson Foundation is a charity awarding grants to support and promote excellence in the fields of science, medicine, the Arts and humanities, education and health and disability.

The centre will bring together researchers from Bradford Teaching Hospitals NHS Foundation Trust, as well as the Universities of Leeds and Bradford. The three areas it will address have been identified as key health priorities for the county - Healthy Childhood, Healthy Ageing, and High Quality and Safe Care.

By combining the expertise of health researchers with clinicians who have daily contact with patients, the centre will ensure that its findings are put rapidly into practice, resulting in better health and social care for those who need it in Yorkshire.

b) Respiratory Research Team.

I would like to pass on my congratulations to our talented respiratory research team following an amazing achievement which has seen them recruit global first patients into research trials.

As a result of a renowned international reputation in respiratory medicine, GlaxoSmithKline (GSK) chose the Bradford Institute for Health Research (BIHR) to launch their worldwide vaccine study in Chronic Obstructive Pulmonary Disease (COPD). The trial aims to assess whether the vaccine offers protection against a bacteria which commonly causes a worsening in the condition of patients with COPD.

Our respiratory research team has a patient, a 69-year-old from Shipley who has suffered from COPD for 10 years, who will be the first patient in the world to undergo this trial.

The wider trial will see two doses of the vaccine administered intramuscularly in COPD patients aged 40 to 80 years old with a previous history of acute exacerbation COPD. This will then be followed after 390 days with a second dose of the vaccine.

I wish the team the very best with their research and look forward to their results.

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The Council of Governors is asked to receive and note this report.



7 November 2017

To: Trust Chief Executives
CCG Accountable Officers
Local A&E Delivery Board Chairs

Cc: Regional ADASS Chairs
LGA CHIA
PHE Regional Director

Winter briefing 1

Operational management of winter – expectations and communication

We are aware that in recent weeks you have received a number of communications with regards to the management of winter. Over the next few months clarity of communication will be vital, so Pauline has agreed with NHS England, NHS Improvement and other key stakeholders that working with your Regional Director (for Urgent and Emergency Care), Pauline will provide you with regular winter briefings. If you would like to raise any questions related to these briefings, or make any comments and suggestions, then we ask that you email your Regional Director and Pauline directly at nhsi.uecdirector@nhs.net.

This briefing sets out further detail of the implementation of this year's winter operating model, as well as expectations of local clinical escalation planning and local winter teams.

1. Winter operating model

As we have talked about previously, we are developing a new winter operating model this year, focused on continuous monitoring and supporting improvement with a national, regional and local presence. The winter operations infrastructure is being built on a series of principles, based on learning from previous winters both through experience and formal reviews. These are:

- We need to ensure that patient flow in the UEC pathway is maintained 7 days per week.
- We will be more proactive in managing the risks to A&E performance, delivery and patient safety through support, collaboration and transparency.

- There will be a greater emphasis on continuous monitoring and support using information shared at all levels and an emphasis on forecast measures, looking ahead to deploy 'levers' to prevent deterioration in performance or risks to safety.
- There will be a step change in the levels of cover and period of response that matches local expectations and adds value in terms of support to local systems, maintaining safety and improving performance.
- A dedicated team and supporting infrastructure, that are separate from Emergency Preparedness, will be in place to operate this model.
- These teams will be jointly led across NHSE/I with representatives from key partner agencies and functions: ADASS, LGA, PHE, primary care.

The national and regional infrastructure to deliver this operating model is currently being put in place and should be in contact with you in the coming weeks, if not already. In our next briefing we will provide more details on how we see the model working at a local, regional and national level.

2. Local winter teams

We believe that at the heart of the winter operating model should be a supportive interaction with local teams, for this reason we are asking you to establish under the auspices of the Local Delivery Board, if not in place already, a local operational model with the following features:

- A hospital doctor, nurse & operating manager who are accountable for the management of urgent and emergency care and who have a direct relationship with the CEO of the Trust.
- A local cross-system winter operations team, consisting of the following roles, with sufficient capacity released to operate the joint local arrangements and at a level of seniority sufficient to commit organisational resources:
 - A senior manager responsible for UEC in the CCG.
 - Local Authority Social Care Director – nominated by the Local Authorities.
 - Community Provider Senior Operational Lead.

This team will need to be supported to ensure that rapid decisions can be made to meet operational pressures based on a shared set of data and agreed triggers for escalation.

Your Regional Directors and/or Winter Operations Directors will ask you to give assurance that these arrangements are place as we enter the winter period.

3. Local escalation plans

We recognise that local system planning is already well underway to manage the pressures of winter. Further, we have in recent letters, set out the need to develop clinical escalation plans that detail the actions your local system will take in anticipation and response to times of pressure.

Our expectation is that this clinical component is a core part of your local winter escalation plan and that they set out the actions that will need to be taken to consistently ensure that safety is maintained during times of significant pressure. Clinical escalation will need to ensure that:

- All patients who are to be admitted have a timely 'Decision to Admit' to ensure they do not need to remain in the ED for any longer than is clinically necessary.
- Patients are not cared for on hospital corridors.
- Escalations beds have the necessary staffing and equipment to ensure safe care.
- 12 hour trolley waits in the ED never happen.
- Patients do not wait more than 15 minutes in ambulances before being handed over to the hospital.
- The hospital can manage increasing demand because of flu, norovirus, etc.

We are asking that every acute trust with a Type 1 A&E department have a real dialogue with all of their clinical staff in order to develop this element of the plan and that they are signed off by your Boards. This should also be shared across your system given that managing escalation is a system-wide responsibility.

We would like you to share your plans with your Regional Director by the 20th November. Finally, as in previous years, we will be collecting additional information about the availability of services (particularly out of hospital) during the holiday period. This collection will be launched next week.

In terms of the North, we intend having regular dialogue with A&E Delivery Board Chairs, both as individuals and as a community. We had a productive discussion on 30 October which covered:

- how the winter operations room will function;
- current regional performance;
- expectations of group 3 and 4 systems;
- DToCs;
- primary care;
- 'flu immunisation;
- Clinical escalation; and
- regional support for challenges systems.

We are following up with a meeting in Leeds on 13 November where we shall work through our operating model and how we intend to work closely with you going forward. There is also an Action on A&E event on 9 November at Elland Road football ground and we are pleased that all the places have been taken up.

Over the next few weeks there will be specific focus on DToC reductions and primary care provision over pressured periods and we be looking to ensure your plans are as robust as they can be.

We hope that this briefing is helpful and please do provide feedback. Once again thanks for all of the efforts underway to prepare for and manage the pressures of winter.

Yours Sincerely

A handwritten signature in black ink, appearing to read 'Pauline Philip'.

Pauline Philip
National Urgent and Emergency Care Director

A handwritten signature in black ink, appearing to read 'L. Simpson'.

Lyn Simpson
Executive Regional Managing Director
(North)
NHS Improvement

A handwritten signature in black ink, appearing to read 'Richard Barker'.

Richard Barker
Regional Director (North)
NHS England



Department
of Health

Safer Maternity Care

The National Maternity Safety Strategy - Progress and Next Steps

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Foreword from the Secretary of State for Health



Giving birth is the most common reason for admission to hospital in England. Thanks to the dedication and skill of NHS maternity teams, the vast majority of the roughly 700,000 babies born each year are delivered safely with high levels of satisfaction by parents.

Since 2010, the Government has invested nearly £40m in capital funding for maternity services and last year we invested just over £9m of additional funding to support safety training for multi-disciplinary maternity teams, innovative new approaches to improving safety and to create a national safety and quality improvement movement through the Maternity and Neonatal Health Safety Collaborative. We also made maternal mental health a priority through our investment of £365 million from

2015/16 to 2020/21 to perinatal mental health services.

Two years ago the Department set a challenging ambition to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth by 2030. To make sure progress is quickly made, we also set out an expectation of a 20% reduction by 2020.

Last year we published an action plan outlining a number of initiatives at national level as well as practical action to build leadership at local level to champion maternity services and support local teams. I am inspired by how maternity and neonatal professionals and services are working to improve safe outcomes under the leadership of our national maternity champions, Matthew Jolly and Jacqueline Dunkley-Bent, and through the work of the Maternity Transformation Programme.

Local Maternity Systems have formed across England and are working with women locally on proposals to make maternity services safer and more personal. More than 90% of Trusts have a named Board level maternity safety champion. So far this year, around 12,000 more staff have taken part in multi-disciplinary training in leadership, communication, situational awareness and emergency skills and drills compared to last year. The Maternal and Neonatal Health Safety Collaborative was launched and is providing quality improvement education and support for local safety improvement projects; and 25 services are taking forward innovative safety improvement projects thanks to the Maternity Innovation Fund.

Maternity care in England is being transformed for the better; however on average, two litigation claims for brain injured babies are settled every week. The Royal College of Obstetricians and Gynaecologists recently reported that 76% of the 727 cases of birth-related deaths or brain injuries they reviewed might have had a different outcome with different care. We must continue to do everything we can to prevent such avoidable tragedies from occurring in the future.

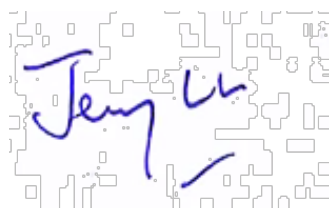
This refreshed Maternity Safety strategy sets out additional measures to drive improvement further and faster. We are going to focus on improving the rigour and quality of investigations into term stillbirths, neonatal and maternal deaths and serious brain injuries under the auspices of the Healthcare Safety Investigations Branch. There will be more support for maternity and neonatal training, measures to facilitate the dissemination of learning from investigations and improving local care practices to improve safety. We are also going to continue to focus on improving women's health by developing expertise in maternal medicine and improving care for

women with pre-existing conditions such as cardiac disease or diabetes, as well as supporting maternity services to develop expertise in smoking cessation.

I believe that safe care is personalised care. There is good evidence that women who have 'continuity of carer' throughout pregnancy and one-to-one support in labour have safer outcomes for themselves and their babies. We need to provide women with the resources and support to make informed decisions and train clinicians to have individualised care planning conversations which uphold women's autonomy and meet their individual needs (including during labour where this can become more challenging when circumstances change quickly). Our plans to improve safety form the golden thread of an overarching vision to improve maternity services – led by the Maternity Transformation Programme – which is looking to make services safer, kinder and more personalised.

We won't achieve our ambitions without also focusing on reducing the number of babies born pre-term each year. To encourage additional focus on reducing preterm births, the Department is extending the national ambition to include reducing the national rate of pre-term births from 8% to 6%. There are already 30 specialist pre-term birth clinics across the country that can provide a mechanism around which change can be focussed and delivered.

Based on the early progress so far and this additional support, I believe that we can bring forward the date for achieving our national ambition to 2025. The Department will be working closely with NHS England, NHS Improvement, the Royal Colleges and other national partner organisations to implement the measures set out in this refreshed maternity safety strategy. I urge local maternity champions to seize the opportunities presented by these initiatives and drive real change locally. Together we can make England's maternity services even safer.



Jeremy Hunt

Secretary of State for Health

As leaders of the professional bodies for midwives and obstetricians, we welcome this refreshed Maternity Safety Strategy and the additional targets and commitments it contains. Much has been done already through an array of initiatives to improve the safety of maternity care, and this revised strategy will give everyone involved in maternity care the opportunity to reflect on past successes and focus on key areas where more still needs to be done.

The healthcare professionals who care for women, their babies and their families need to be at the heart of any initiative to improve maternity care. The RCOG and RCM are committed to speaking with one, united voice on maternity safety and ensuring every woman has a good birth, with the best possible experience and outcomes for her and her baby; and to providing a shared vision of a modern maternity team whose common purpose is supporting best practice, respectful relationships, strong leadership and putting women at the centre of care. Midwives are in a unique position to help achieve this, as they are the one healthcare professional whom all women will see during their pregnancy and birth, and therefore have a clear role in ensuring care is coordinated, safe and, most importantly, personal.

We therefore welcome the opportunities set out in this strategy to build on the experience and knowledge we already hold to improve maternity care still further. We are committed to sharing the expertise we have gained from Each Baby Counts, and our understanding of the complex interplay of factors that lead to stillbirths, neonatal deaths and brain damage during term labour, to work with partners such as NHS Improvement to expand the work and reach of the Maternal and Neonatal Safety Collaborative and the Healthcare Safety Investigation Branch as they undertake their investigations. Expansion of the national strategy to include a focus on preterm birth and brain injury will likewise help provide a more complete picture of maternity safety, strengthening our evidence base to help us deliver ever more effective care.

Achieving the ambition set out in this strategy will require ongoing support to align the multiple initiatives, with all of us invested in improving maternity care working collaboratively across the system. The RCM and RCOG believe that we can build on the trust and buy-in we already have from frontline clinical staff for initiatives such as Each Baby Counts and the National Maternity and Perinatal Audit, by providing them with the support they need to translate lessons learned into improvements in everyday care. The Maternity Transformation Programme provides a once-in-a-generation opportunity to harness the enthusiasm and commitment of all of us to drive change and we strongly encourage all members of the maternity team, and those responsible for managing and commissioning maternity services, to use this Strategy to deliver even safer care for women and their families.

As local implementation of the Maternity Transformation Programme begins via the development of Local Maternity Systems, we are committed to working together to ensure the ambition set out in this strategy is translated in every unit across the country, continuing to learn from each other, share best practice and ensure the safety of women and babies is at the heart of everything we do.



Professor Lesley Regan, President, Royal College of Obstetricians and Gynaecologists



Royal College of
Obstetricians &
Gynaecologists



Gill Walton, CEO, Royal College of Midwives



A message from the National Maternity Safety Champions

Firstly we would like to thank and congratulate all those who have provided so much over the past 12 months to make maternity care safer. The diversity of achievements reflects a system wide approach to improving maternity safety and some are described in this report. We feel that it is important to acknowledge the excellent work going on in other parts of the Maternity Transformation Programme, and across the whole Maternity system by front line doctors, midwives, commissioners, managers, the Royal Colleges, charities and most importantly the contribution made by women who use our maternity services. We thank you all and look forward to supporting you to make maternity care safer than it has ever been before.

Progress is already taking shape across the country, a result of the innovation and commitment of all those involved in maternity care to provide more personal and safer care to the women and the babies they care for. One of the highlights this year has been the launch of the Maternity and Neonatal Health Safety Collaborative by NHS Improvement with midwives and doctors attending from every Local Maternity System across the country.

We would like to thank all those involved in developing the policy and supporting the maternity safety agenda. This includes the series of ministerial round table meetings with ten national charities and other key stakeholders on the subject of maternity safety and pre-term birth reduction respectively. These meetings have led to the development of new initiatives, described in this document that will lead to further improvements in maternity outcomes across the country.

We currently have the greatest opportunity to change maternity services for the better. The wide scope of what is being implemented reflects the fact that there are very few easy big gains and overall improvement will be through the aggregation of marginal gains. The overall strategy is to identify as many possible opportunities to improve outcomes by combining system thinking with a life course approach. We are developing better pathways to provide best practice with improved surveillance to identify where there is unwarranted variation in outcomes. We are confident that improved investigations when things go wrong, combined with shared learning, support for staff and national training in quality improvement methodology, will deliver better care.



Matthew Jolly

***National Clinical Director for Maternity
and Women's Health, NHS England***

National Champion for Maternity Safety



Jacqueline Dunkley-Bent

***Head of Maternity, Children and Young
People, NHS England***

National Champion for Maternity Safety

Executive summary

Two years ago the Department set a challenging ambition to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth by 2030. To make sure progress is quickly made, we also set out an expectation of a 20% reduction by 2020.

In October 2016, we published an action plan outlining a number of initiatives at national level as well as practical action to build leadership at local level to champion maternity services and support local teams.

This document reports on progress against that initial action plan. It also proposes a number of steps to make sure we are doing all we can to prevent serious incidents in maternity services. These include:

More support for better, safer care

- NHS Improvement is developing a central platform within the NHS Improvement Hub to foster a cohesive community of Maternity Safety Champions, other system leaders and experts to help spread learning and best practice across the system.
- To support local providers and commissioners to meet this aim and to assist with implementation of Saving Babies Lives, new funding to train midwives to have the knowledge, skills and confidence to give very brief advice to women during antenatal appointments and upskilling practitioners (e.g. maternity support workers) to deliver evidence based smoking cessation interventions.
- New funding over three years to train 12 consultant physicians as 'Obstetric Physicians' to be able to establish networked maternal medicine across England. The Obstetric Physician together with an Obstetrician trained as a Sub-Specialist in Maternal Medicine will provide expert care for pregnant women with complex medical problems. They will also provide region-wide leadership and expertise across the whole network to help ensure there is early recognition of problems and access to best practice care.
- A new Atain e-learning programme to support healthcare professionals to improve outcomes for babies, mothers and families through the delivery of safer care with a focus on four clinical areas: respiratory conditions; hypoglycaemia; jaundice; and asphyxia (perinatal hypoxia-ischaemia). An additional module also raises awareness of the importance of keeping mother and baby together.

Measures to improve the quality of reviews and investigations:

- The Department of Health is committed to improving the standards and quality of investigations and learning from serious incidents leading to stillbirth, early neonatal death or serious brain injury in term babies and all maternal deaths from direct or indirect causes related to pregnancy.
- The new Healthcare Safety Investigation Branch (HSIB) will be funded to develop investigation standards and conduct independent investigations into all cases that meet the

criteria for notification from the RCOG's Each Baby Counts Programme and all maternal deaths from direct or indirect causes related to pregnancy.

NHS England, working with NHS Improvement, the Department of Health and HSIB will publish, by Quarter 2 of 2018, information and guidance on the standards for maternity investigations to deliver the Morecambe Bay and Better Births recommendations.

- The Government will consider with interested parties how coroners could carry out an investigation into those babies who are stillborn at 37 weeks gestation and over.
- Following a consultation earlier this year, the Department will look to develop a Rapid Redress and Resolution scheme ideally from 2019

More support for learning and quality improvement

- Funding for the Royal College of Obstetricians and Gynaecologists and the Royal Colleges of Midwives to launch 'Each Baby Counts Learn and Support' - a programme of work to enable greater collaboration between the Royal Colleges and the NHS via the Maternal and Neonatal Health Safety Collaborative - the aim is to align quality and safety improvement, multi-professional learning and clinical leadership into a consistent and sustainable safety strategy across the system.

An incentive to further support the implementation of best practice to improve safety

- NHS Resolution will launch a new scheme to incentivise local services for taking steps to improve delivery of best practices in maternity and neonatal services. NHS Resolution has built provision for an incentive fund into its pricing for 2018/19. Trusts that are able to demonstrate compliance with 10 criteria agreed by the National Maternity Champions will be entitled to at least a 10% reduction in their CNST maternity contribution.

Around 55,000 babies are born pre-term (i.e. 24 - 36 weeks gestation) each year. This represents a national pre-term birth rate of 7.9% in England and Wales. We need to focus efforts on reducing the pre-term birth rate if we are going to achieve the national Maternity Safety Ambition.

To encourage this additional focus, the Department of Health is setting an additional ambition to reduce the national rate of pre-term births from 8% to 6% by 2025.

We are currently on track to meet our ambition to reduce stillbirths, neonatal and maternal deaths by 20% by 2020. The range of additional funding and support should enable maternity and neonatal services to go farther and faster.

We have, therefore, decided to re-set the national Maternity Safety Ambition to halve the rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth to 2025.

The Department will be working closely with NHS England, NHS Improvement, the Royal Colleges and other national partner organisations through the Maternity Transformation Programme to implement the measures set out in this refreshed Maternity Safety Strategy.

1. Introduction

Maternity services are unique in healthcare in that they support mostly healthy women and their families through a momentous life event. England is a safe place to have a baby, and the vast majority of women using NHS services have good outcomes and report a positive experience of care. When we compare our outcomes to other high-income countries, however, we can see that too many babies in England are stillbornⁱ and die soon after birthⁱⁱ. Furthermore, around 50 women in England die each year from direct or indirect causes related to pregnancyⁱⁱⁱ.

The impact to the families who lose a much loved baby or mother or those caring for a child with a birth-related brain injury is devastating, especially when the outcome could have been prevented. Through the efforts of skilled midwives, obstetricians, neonatologists, neonatal nurses, support staff and other health professionals, the outcomes and experiences of care for pregnant women, their babies and families are improving. There is still more we must do, however, to ensure England is one of the safest places in the world to have a baby.

The national maternity safety ambition and action plan

In October 2016, the Department of Health published **Safer Maternity Care - Next steps towards the national maternity ambition**. It set out our vision and an action plan to achieve the national ambition to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth by 2030. To stimulate rapid progress, we also set out an expectation of a 20% reduction in these rates by 2020.

The action plan was structured around the five key drivers for delivering safer maternity care:

- **Focus on leadership:** creating strong leadership for maternity systems at every level.
- **Focus on learning and best practice:** identifying and sharing best practice, and learning from investigations.
- **Focus on teams:** prioritising and investing in the capability and skills of the maternity workforce and promoting effective multi-professional team working.
- **Focus on data:** improving data collection and linkages between maternity and other clinical data sets to enable benchmarking and to drive a continuous focus on prevention and quality.
- **Focus on innovation:** creating space for accelerating improvement and innovation at local level.

The Maternity Transformation Programme in summary

Following the launch of the **National Maternity Review Report, Better Births**, in February 2016, NHS England established the **Maternity Transformation Programme (MTP)** with leadership from across the system to ensure all women get high quality maternity care regardless of their circumstances or where they live. The MTP brings together clinicians, national bodies, charities and service user representatives to deliver change. The implementation of *Better Births* will ensure that women receive greater control and more choice, as well as making care safer, by providing information and care based around the needs and circumstances of mothers and their babies.

Forty-four Local Maternity Systems (LMS) across England are developing Better Births Implementation Plans, setting out how they will deliver safer and more personalised maternity care by the end of 2020/21. This means maternity services will ensure that:

- All pregnant women have a personalised care plan. They are able to make well-informed decisions about their maternity care during pregnancy, labour, birth and postnatally.
- Most women receive 'continuity of carer' during pregnancy, labour, birth and postnatally.
- More women are able to give birth in midwifery settings (at home and in midwifery units).
- The rates of stillbirth, neonatal and maternal death, and brain injury occurring during or soon after birth will have reduced by at least 20% and they are on track to halve these rates.
- Multi-disciplinary teams are thoroughly investigating safety incidents to understand the causes of every stillbirth and other adverse maternity outcomes, learning from these incidents, testing and implementing system improvements and sharing this knowledge through their Local Maternity Systems and other networks.
- Healthcare professionals have a greater understanding of situational awareness and the systematic factors that can cause avoidable safety incidents. They feel free to raise concerns.
- Multi-disciplinary teams have developed knowledge and skills in quality improvement science through the **Maternal and Neonatal Health Safety Collaborative**. The culture in all maternity and neonatal units is visibly one of continuous learning and quality improvement.

The 'golden thread'

Safety is the 'golden thread' that runs through the MTP. Safer care will be achieved when the entire vision of the *Maternity Safety Strategy* and *Better Births* is implemented across the country.

MTP system partners, including the Royal Colleges, MBRRACE¹ and NHS Resolution have contributed significantly by reviewing maternity mortality and morbidity cases, recommending where and how services and the wider system can focus efforts for improvement and raising national awareness.

This document:

- reports on progress with implementation of the **Safer Maternity Care Action Plan**;
- sets out new support and actions focussed on better care, better investigations, better learning and improvement and better outcomes for mothers and their babies; and
- explains how all the elements of the Maternity Safety Strategy link and contribute to form a coherent and aligned system-wide approach to improving safety in maternity care.

¹ Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK - the national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths.

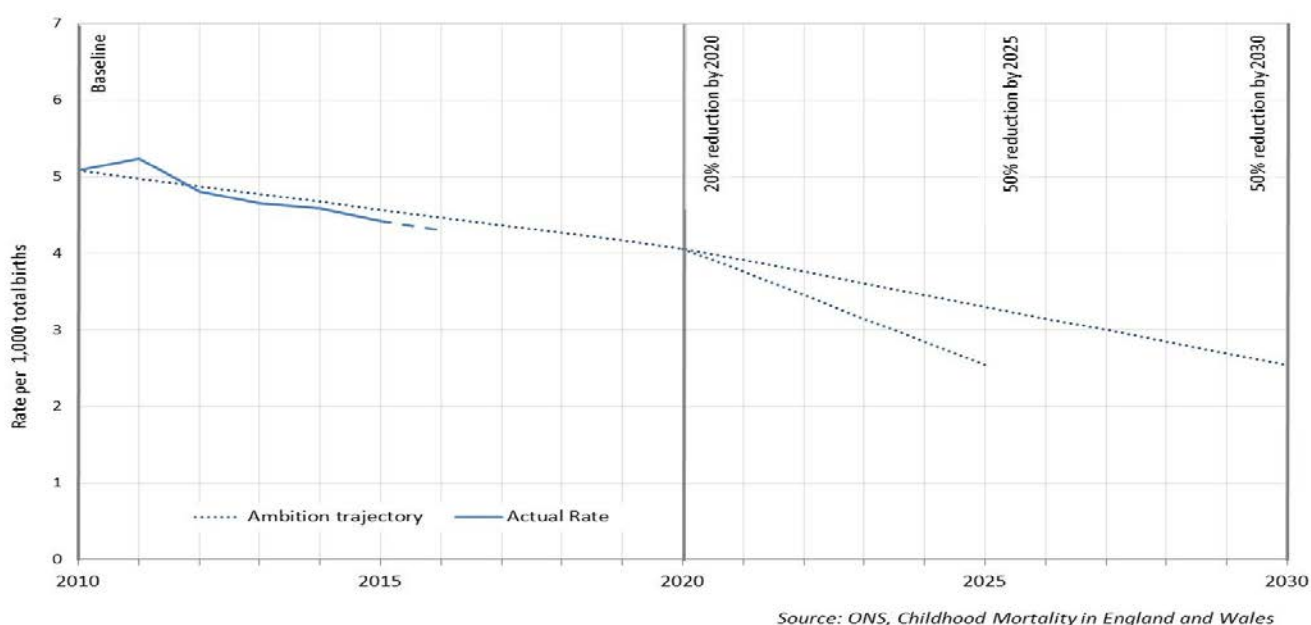
2. Progress on national ambition outcomes

The response to the National Maternity Safety Ambition by multi-disciplinary teams working in maternity and neonatal units across England has been inspirational, and outcome data suggests that their actions are having a positive impact on health outcomes.

Stillbirths

There were 2,952 stillbirths in England in 2015^{iv}. Since 2010, the stillbirth rate has fallen 16% from 5.1 stillbirths per 1,000 births in 2010 to 4.3 stillbirths per 1,000 births in 2016 (Figure 1). Comparing the 'Actual rate' to the 'Plan to meet ambition' shows we are making progress towards meeting the ambition for 2020, but we must not become complacent.

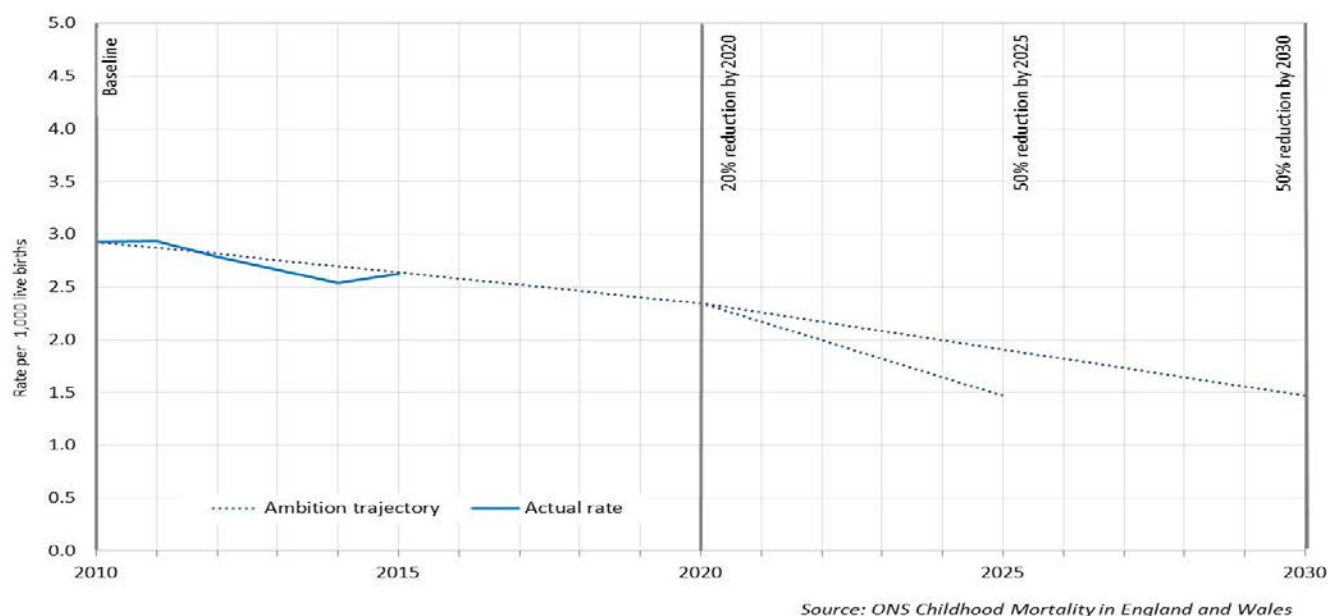
Figure1: Stillbirth rate per 1,000 births in England



Neonatal deaths

There were 1,745 neonatal deaths in England in 2015^v. The neonatal death rate has fallen 10% from 2.9 neonatal deaths per 1,000 live births in 2010 to 2.6 neonatal deaths per 1,000 live births in 2015 (Figure 2). Comparing the 'actual rate' to the 'plan to meet ambition' suggests that progress has been made; however, a recently published analysis of World Health Organisation and Office for National Statistics data, shows that the UK ranks 19th out of 28 European countries for neonatal mortality - a drop of 12 places since 1990^{vi}. The analysis also found that the UK made less progress in the 25 years from 1990 to 2015 than all of the other 28 European countries, apart from Germany and France. This data together with the increase in the neonatal mortality rate in 2015 suggests there is a need to re-focus efforts on sustaining the overall decreasing trend.

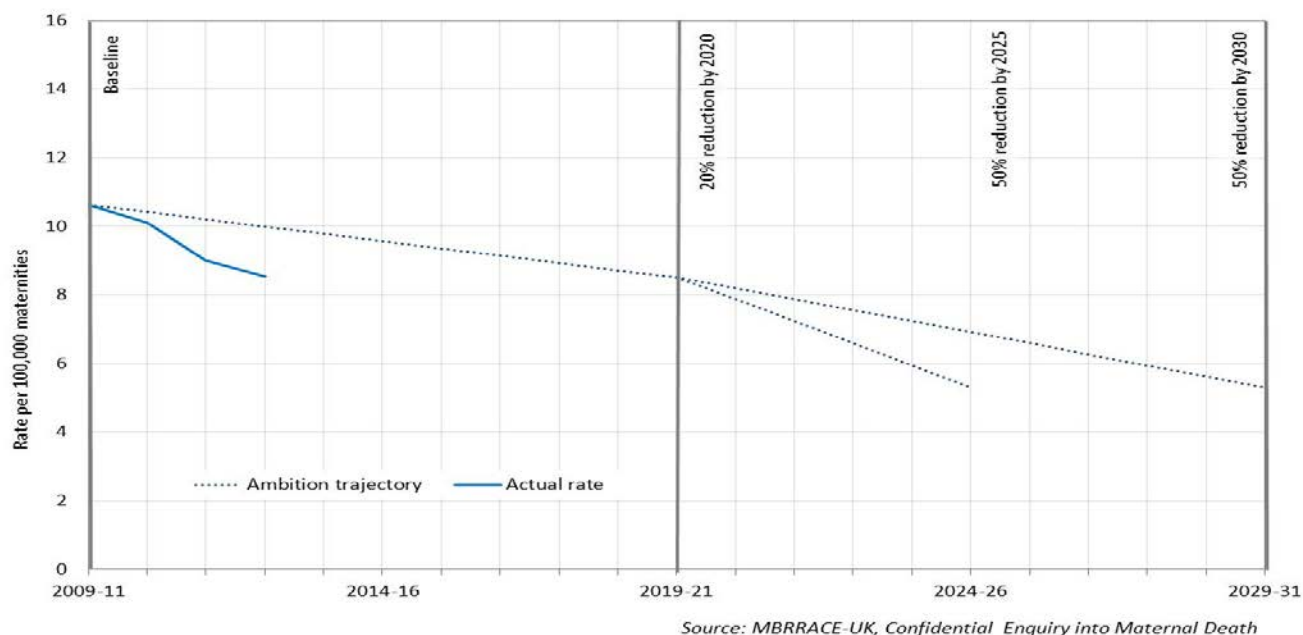
Figure 2: Neonatal mortality rate per 1,000 births in England



Maternal deaths

There were 200 maternal deaths in the UK during the period from 2012 to 2014, equivalent to 8.5 deaths per 100,000 maternities^{vii}. Around 50 women in England die each year from causes related to pregnancy. The UK maternal mortality rate has fallen 20% compared to the 2009-11 period (Figure 3). Comparing the 'actual rate' to the 'plan to reach the ambition' suggests that progress is on track to meet the national ambition for 2020. However, MBRRACE-UK cautions that the decrease in the rates from 2009-11 to 2011-2014 is not statistically significant and, for this reason, achieving the aspiration to halve the maternal mortality rate will be a challenge for UK health services.

Figure 3: Maternal mortality per 100,000 maternities in the UK



Brain injuries occurring during or soon after birth - a new definition

Until now, there has been no agreed definition for 'brain injury occurring during or soon after birth', with which progress against the national ambition could be tracked. In early 2017, the Department of Health convened an expert consensus group led by Matthew Jolly (Consultant Obstetrician and National Champion for Maternity Safety) and Professor Neena Modi (President of the Royal College of Paediatrics and Child Health and Director of the Neonatal Data Analysis Unit at Imperial College London). The objective for the group was to agree on a working definition that could be used to measure the national rate of 'brain injuries that occur during or soon after birth' (See Box 1).

Box1: Definition for 'brain injuries occurring during or soon after birth'

Any infant admitted to a neonatal unit who presents with any of the following signs or conditions, at any point during their stay on the neonatal unit:

- Seizures, all infants;
- A diagnosis of intracranial haemorrhage, perinatal stroke, hypoxic ischaemic encephalopathy (HIE), central nervous system infection, and kernicterus (bilirubin encephalopathy): all infants;
- A diagnosis of preterm white matter disease (periventricular leukomalacia): preterm infants only.

This definition includes a broader range of causes of brain injury than that used by the Royal College of Obstetricians and Gynaecologists' **Each Baby Counts Programme**². It captures indicators of potential brain injury that could occur in pre-term as well as term births and injury that occurs soon after birth. This measure also provides more timely data for tracking progress against the national maternity ambition because it can take many years for an actual sustained brain injury to be confirmed.

According to this new definition, the rate of brain injuries occurring during or soon after birth in England was 5.2 per 1,000 live births in 2015. More information about the development of this definition and the calculation of a birth-related brain injury rate is published by C. Gale et al on behalf of the Brain Injuries Expert Working Group in the *Archives of Disease in Childhood* (November 2017)³. The research also shows that the rate of brain injury in babies born pre-term (under 37 weeks) is around seven times greater than the rate of brain injury in babies born at term.

Variation in perinatal mortality rates

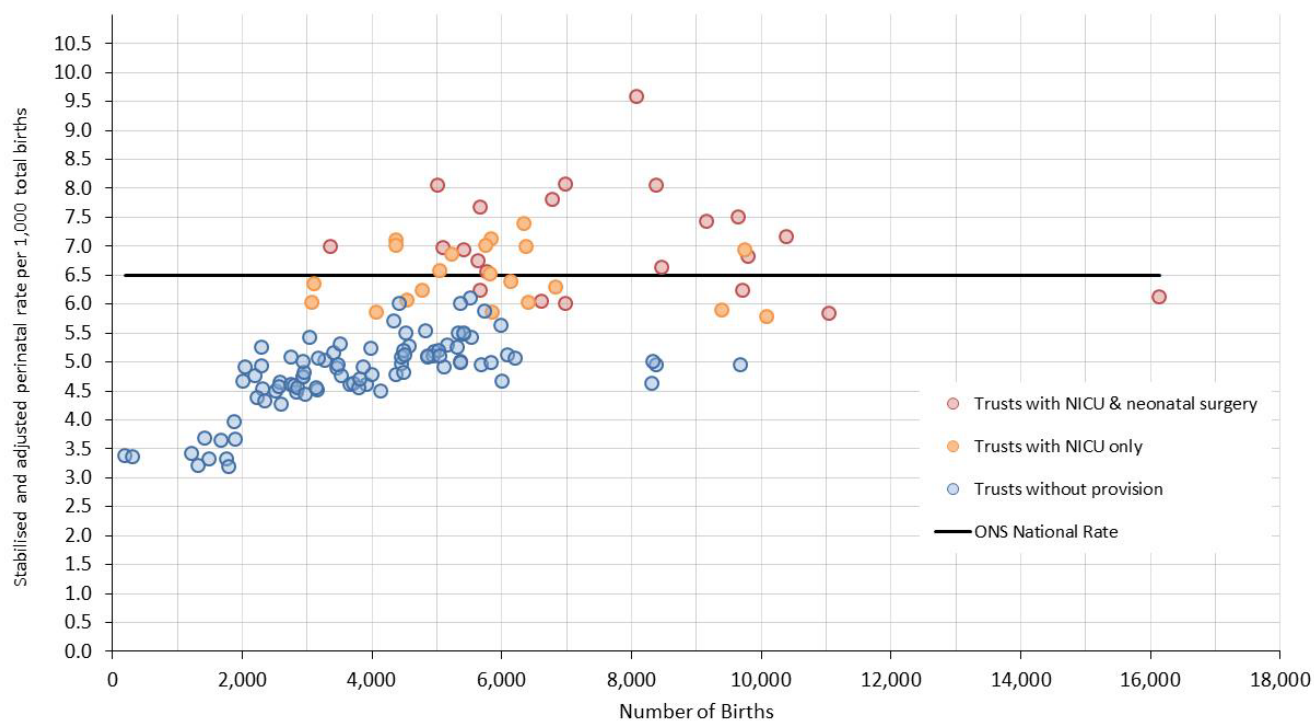
Perinatal mortality rates vary considerably across the country even when we adjust for known risk factors and the size of the trust. In 2015, NHS Trust-level perinatal (stillbirth + neonatal) mortality rates in England ranged from 3.2 to 9.6 per 1,000 births (Figure 4). Some variation observed in perinatal mortality rates is random and arises because each patient is different

² <https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/information-for-trusts-health-boards/frequently-asked-questions/>

³ Neonatal brain injuries in England: population-based incidence derived from routinely recorded clinical data held in the National Neonatal Research Database.

(known as 'patient mix'). However, some variation results from differences in the uptake and implementation of national guidance and best practice⁴. Reducing unwarranted variation between services will contribute significantly to achieving the national ambition.

Figure 4: 2015 Stabilised and adjusted perinatal mortality rates by NHS trust in England



Source: MBRRACE, Perinatal Mortality Surveillance Report

⁴ <https://www.england.nhs.uk/rightcare/2017/01/04/matthew-cripps-3/>

3. Better, safer care

Safe care is personalised care. Maternity is unlike most other healthcare specialities because pregnancy is not an illness. Pregnancy, labour and birth are natural physiological states, and most healthy women remain at low risk of developing complications. For some women, however, including those initially considered to be 'low-risk', circumstances can change dramatically and rapidly putting both the woman's and the baby's lives at risk.

Mothers and the health professional teams caring for women both need information and support throughout pregnancy, labour and at the postnatal stage so that women can make truly informed decisions and clinicians know how to support women effectively to do this about care. Getting to know a woman throughout her maternity journey enables healthcare professionals to be more aware of a woman's background, attitude to certain interventions and decisions about what actions might be taken should circumstances change quickly.

There is good evidence that women who have 'continuity of carer' throughout pregnancy and labour, including one-to-one support at this time, have safer outcomes for themselves and their babies. Women who receive continuity of midwife-led care are 16% less likely to lose their baby and 19% less likely to lose their baby before 24 weeks. They are also 24% less likely to experience pre-term birth^{viii}.

Clinicians also need to know when, how and to whom they should refer women to other care providers, when appropriate, to maximise their potential for the safest possible outcomes regardless of how services are commissioned. From the women's point of view, the experience of engaging with multiple services and clinicians should feel 'seamless'.

Local Maternity Systems

The 44 LMS are uniquely placed to bring people together across organisational boundaries and adopt a whole system approach to improving maternity services. Through the MTP, NHS England asked the 44 LMS to draw up local maternity transformation plans by the end of October 2017 and set out how they will implement the vision set out in *Better Births* by 2020/21. This includes improving choice and personalisation in maternity services so that, for example, most women receive continuity of the person caring for them. It also includes improving the safety of maternity care, with local areas asked to set out their contribution towards delivering the Maternity Safety Ambition.

A focus on leadership

The Safer Maternity Care Action Plan made the case for strong leaders at every level of the system; working across regional, organisational or service boundaries to promote the professional cultures needed to deliver better care. It set out specific actions for NHS trusts to strengthen leadership. In response, **more than 90% of trusts have appointed a named board-level Maternity Safety Champion as well as obstetric and midwifery Maternity Safety Champions.**

As the first step of a strategy to support these nominated champions, NHS Improvement is developing a central platform within the NHS Improvement Hub to foster a cohesive community of champions and other stakeholders and experts, and help spread learning and best practice across the system.

Other leadership roles are also in place across the system to support one or more of the many safety projects underway in maternity and neonatal services; notably, **the board-level Executive Sponsors and Improvement Managers that have been identified for the Maternal and Neonatal Health Safety Collaborative (MNHSC)**. Taken together, these leadership roles can make a significant contribution to maternity and neonatal safety and improvement especially where the links between these leaders and the board level maternity safety champion are strongly established and maintained. This will enable local safety information; recommendations from national reports relating to maternity safety; and agreed action plans and issues to be raised at trust board level as part of an informed, coordinated and streamlined process.

Saving Babies Lives Care Bundle

Developing better care pathways starts with a greater focus on surveillance and working with women to prevent ill health. The **Saving Babies' Lives care bundle** is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

The majority of maternity care providers are now implementing improvement activities across all four elements of the Care Bundle. The Maternity Transformation Programme has partnered with the University of Manchester, who are conducting an evaluation of the implementation of the Saving Babies' Lives Care Bundle (SPiRE – Saving babies lives Project Impact and Results Evaluation). This study aims to determine how services are applying the care bundle to maternity care and how it may affect the pregnancy and birthing experiences of women and service delivery by staff. The study began in April 2017 and will run until December 2017. It will report on pregnancy outcomes and stillbirth rates in approximately 100,000 deliveries from 20 NHS maternity units in England who are currently implementing the care bundle.

Reducing smoking in pregnancy

Supporting women to be smoke-free is a key part of helping them to have a safe and healthy pregnancy. Smoking during pregnancy increases the risk of stillbirth, and babies born to mothers who smoke are more likely to be born pre-term and in poor health.

Smoking during pregnancy is also a major health inequality, with prevalence varying significantly across communities and social groups. Smoking prevalence among pregnant women in more disadvantaged groups and those aged under 20 remains considerably higher than in older and more affluent groups. Mothers in routine and manual occupations are five times more likely to have smoked throughout pregnancy compared to women in managerial and professional occupations, meaning those from lower socio-economic groups are at a much greater risk of complications during and after pregnancy

Smoking is the single biggest modifiable risk factor for poor birth outcomes, and NICE Guidance on smoking amongst pregnant women contains a range of evidenced-based recommendations for maternity providers and local authority commissioners of smoking cessation services. Element 1 of the Saving Babies Lives care bundle includes action to monitor exposure to Carbon Monoxide (a key toxin in tobacco smoke) in all pregnant women and refer people who smoke for specialist support.

Towards a Smoke-free Generation - A Tobacco Control Plan for England (July 2017) set out an aim to reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less by 2022.

To support local providers and commissioners to meet this aim and to assist with implementation of Saving Babies Lives, the Government is providing funding to train midwives to have the knowledge, skills and confidence to give very brief advice to women during antenatal appointments and upskilling practitioners (e.g. maternity support workers) to deliver evidence based smoking cessation interventions.

Roles for specialist midwives should be considered and specialist midwifery advice provided in the design of local services. Local authorities should work with partners in Local Maternity Systems and maternity services to ensure that there is specialist stop smoking support available for pregnant women who smoke and effective pathways to accessing this.

Immunisation against influenza and pertussis

In the period from 2009-12, MBRRACE-UK identified that 36 maternal deaths in the UK were due to influenza. Influenza was an important cause of death during this period (equivalent to 1 in every 11 maternal deaths); half of the associated deaths occurred after a vaccine became available and can therefore be considered preventable.

The relatively rapid decline in maternal mortality rates seen in Figure 3 are due in large part to a reduction in maternal deaths caused by Influenza. There was one death from influenza in 2014 and no deaths in 2012 and 2013^{ix}.

Immunisation against future influenza strains, therefore, remains a vital public health initiative to prevent both mothers and babies from dying.

Pertussis (whooping cough) is a highly infectious, serious illness that can lead to pneumonia and brain damage, particularly in young babies. Most babies with whooping cough will need hospital treatment, and when whooping cough is very severe they may die. Babies who are too young to start their vaccinations are at greatest risk. Research from the vaccination programme in England, however, shows that vaccinating pregnant women against whooping cough has been highly effective in protecting young babies until they can receive their own vaccinations from two months of age.

Public Health England continues to support immunisation against flu and pertussis in pregnancy through the production of immunisation training materials for healthcare professionals, public facing communication materials and professional engagement with midwives, nurses, GPs and obstetricians.

A focus on teams - training and skills

Pregnant women receive care from a multidisciplinary team, whose expertise may include sonographers, obstetricians, neonatologists, maternity support workers, GPs, anaesthetists and fetal medicine consultants, coordinated by her midwife. The most effective teams are those in which every highly-trained individual understands the roles of their colleagues and the value they bring to the women and newborn they care for. They train together, communicate easily and are prepared to raise concerns.

A major element of the Safer Maternity Care Action Plan was the distribution of the £8.1m Maternity Safety Training Fund by Health Education England (HEE) to 136 Trusts throughout England, including all 134 NHS trusts with maternity units. The funding is supporting multi-disciplinary teams to train together and further develop skills and experience in leadership, multi-professional team communication, human factors and situational awareness, cardiotocography (CTG), as well as midwifery and obstetric emergency skills and drills. Details of the funding awards is available at:

<https://www.hee.nhs.uk/sites/default/files/documents/MSTF%20NHS%20trust%20funding%20awards%20and%20training%20focus%20areas%20March%202017%20FINAL.pdf>

Responses from 112 trusts indicate that as of June 2017, over 12,800 more staff have been trained through the Maternity Safety Training Fund, compared to the previous year. Training programmes are due to be completed by March 2018 and HEE will commission an independent evaluation to assess how NHS trusts have improved quality and safety within maternity services and the wider impact for mothers and babies, families, and the maternity workforce.

Networked maternal medicine

MBRRACE-UK found that in 2012-14^x, 51 women in the UK, equivalent to more than a quarter of women who died during pregnancy or up to six weeks after pregnancy, died from a cardiovascular cause. This represents the leading cause of maternal death in the UK and there has been no decrease over the last four reporting periods. Similarly, there has been no decrease in the numbers of women dying from cancer. Preventing these women from dying is essential in order to continue to reduce the maternal mortality rate. A clear message that emerges from MBRRACE's confidential enquiries into maternal deaths is the importance of multi-disciplinary care for these women cross many medical specialties in addition to obstetrics, midwifery, anaesthetics and critical care.

With a view to improving maternal outcomes, NHS England has been working with the Women's Health Clinical Reference Group and others to develop a plan to introduce a network of maternal medicine specialists across the country to care for pregnant women with significant health conditions.

The Department of Health will provide funding over three years to train 12 consultant physicians as 'Obstetric Physicians' to be able to establish networked maternal medicine across England.

The Obstetric Physician together with an Obstetrician trained as a Sub-Specialist in Maternal Medicine will provide expert care for pregnant women with complex medical problems. They will also provide region-wide leadership and expertise across the whole network to help ensure there is early recognition of problems and access to best practice care.

Reducing the number of babies born pre-term

Around 55,000 babies are born pre-term (i.e. 24 - 36 weeks gestation) each year. This represents a national pre-term birth rate of 7.9% in England and Wales. Twins and multiple births are particularly at risk of being born pre-term.

Pre-term birth is a major health inequality with mothers in the most deprived 10% income group twice as likely to have preterm births compared to those from the least deprived decile. The

proportion of preterm births also varies by ethnicity, with infants of Black Caribbean parents more likely to experience preterm birth. Research [ref] suggests around 14% of babies born before 27 weeks will have cerebral palsy.

There are also significant financial costs surrounding pre-term births, both for interventions in the short term, and the longer term financial impacts on health services, education services, and the family involved in caring for a baby born pre-term.

It is clear that we will not achieve the national Maternity Safety Ambition unless the rate of pre-term births is reduced. To encourage additional focus on reducing preterm births, the Department of Health is setting an additional ambition to reduce the national rate of pre-term births from 8% to 6%.

In addition, to improve outcomes for babies born pre-term it is important to ensure that they are born and cared for in the right place. Local Maternity Systems need to ensure clear transfer pathways and protocols for services that need to transfer mothers at risk of delivering pre-term to appropriate tertiary care settings. There is inconsistency in the availability and quality of pre-term services nationally. There are, however, 30 specialist pre-term birth clinics across England comprised of clinicians and academics whose focus is the reduction of pre-term birth and the clinical management of these cases. They provide a mechanism around which change can be focussed and delivered.

Better Mental Health Care for New and Expectant Mothers

The MBRRACE-UK reports on maternal deaths have also shown that direct deaths from psychiatric causes (suicide) have more than doubled from 6 deaths 2009-11 to 14 in 2012-14; while indirect deaths from psychiatric causes (drugs/alcohol/other) have remained relatively steady since 2009-11^{xi}.

NHS England and its partners are working on an ambitious programme to increase capacity and capability in specialist perinatal mental health services across England. This will mean that, **by 2020/21, 30,000 more women will be able to access appropriate, high-quality specialist mental health care, closer to home, both in the community and in inpatient Mother and Baby Units. This transformation is backed by £365 million investment between 2015/16 and 2020/21.** Four new mental health Mother Health and Baby units will open in the next two years and bed numbers in the existing 15 units will increase so that overall capacity is increased by 49% in 2018/19.

NHS England has also allocated £40m to date to support development of specialist perinatal mental health community services across England with 20 new or expanded specialist perinatal mental health community teams now in operation. A further wave of investment totalling £20million is planned in 2018/19 enabling care and treatment to be provided to at least 2,000 more women with severe mental health problems in 2017/18 and 8,000 more women in 2018/19.

NHS England has also established 12 regional multidisciplinary perinatal mental health clinical networks (including maternity services) that are driving change by working collaboratively across the local health and care system to develop local, integrated pathways which support early identification of those at risk of mental illness in the perinatal period. Both the networks and specialist community services continue to support workforce development including offering training to midwives in perinatal mental health care. Further information on next steps has been

published in implementing the [Five Year Forward View for Mental Health](#) and associated [One Year On](#) reports.

Improving neonatal care

Better Births highlighted concerns linked to the safe and sustainable provision of specialist neonatal care. In response, NHS England commissioned **the Neonatal Critical Care Transformation Review**. The Review's initial work identified significant variation in mortality rates across the country and led to establishment of a parallel programme, **Action on Neonatal Mortality** to examine the reasons underpinning this variation and potential solutions to reduce it.

The Review has already asked Local Maternity Systems to take forward two key actions to reduce neonatal mortality:

1. To ensure that all women who deliver at less than 27 weeks do so in centres with a neonatal intensive care unit, and
2. To ensure that all neonatal deaths are investigated at a local level using a standardised framework. Trusts should review all neonatal deaths in line with the new Child death Review Statutory Guidance. This guidance is out to public consultation until 31 December 2017, and a final version will be published in the Spring.

Avoiding term admissions to neonatal care (Atain)

The 'Atain' programme, led by NHS Improvement in collaboration with clinical experts, focused on reducing avoidable causes of harm that can lead to infants born at term (ie $\geq 37+0$ weeks gestation) being admitted to a neonatal unit. Drawing on data from safety reports, hospital admissions and litigation claims the programme focused on addressing the factors leading to these admissions.

The programme identified that over 20% of admissions of full term babies to neonatal units could be avoided. Separation of mother and baby after birth contributes significantly to postnatal mental health morbidity and should be avoided where possible.

A resource pack to support trusts to tackle avoidable term admissions was issued to all trusts in February 2017 as part of a Patient Safety Resource Alert. Every trust in England has begun to implement the Alert and the resource pack. The NHS Improvement Hub now includes an 'Atain platform' that helps the system to share the resources that continue to emerge from the Atain programme.

NHS Improvement has also worked closely with the British Association of Perinatal Medicine and UNICEF Baby Friendly Initiative to develop a standardised Framework for Practice to detect and manage hypoglycaemia in term babies. The Framework has been well received as a means of reducing variation in practice and avoiding unnecessary term admissions which lead to separation of mother and baby. Implementation of the framework is being supported through the Maternal and Neonatal Health Safety Collaborative.

Atain is a key programme of the Maternity Safety Strategy contributing to reduce neonatal mortality and brain injuries. A new Atain e-learning programme for healthcare professionals is being launched in parallel with this strategy document. The e-learning programme will support healthcare professionals to improve outcomes for babies, mothers and families through the delivery of safer care with a focus on four clinical areas:

1. Respiratory conditions
2. Hypoglycaemia
3. Jaundice
4. Asphyxia (perinatal hypoxia-ischaemia)

An additional module also raises awareness of the importance of keeping mother and baby together.

To register to access this free resource, go to <https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/>

4. Improving the quality of reviews and investigations

Despite improvements in maternity safety in recent decades, sadly sometimes things go wrong. There is significant scope to improve reviews and investigations into the circumstances that led to avoidable harm occurring. Repeated reports from MBRRACE-UK, the RCOG's Each Baby Counts Programme, NHS Resolution's reviews of litigation claims and other audit programmes have identified that different care could have led to different outcomes in many cases of perinatal or maternal mortality or morbidity, and that the same types of errors or omissions in care occur in services across the health and care system. It is clear that we will not achieve the National Maternity Safety Ambition if we do not improve the quality and rigour of reviews and investigations when things go wrong, and crucially, improve the way we learn and improve care to prevent such tragic incidents from happening again.

The Perinatal Mortality Review Tool

The Safer Maternity Care Action Plan announced £500,000 of funding from the Department of Health in England for the development of a Standardised Perinatal Mortality Review Tool. A collaboration led by MBRRACE-UK was appointed by the Healthcare Quality Improvement Partnership (HQIP) in early 2017 to develop and establish a national standardised Perinatal Mortality Review Tool (PMRT) building on the work of the Department of Health / Sands Perinatal Mortality Review 'Task and Finish Group'.

The tool, which will be rolled out at the end of 2017, will support:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death ensuring that the care of babies who die in the post-neonatal period in neonatal units can also be reviewed using the PMRT;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;

More information about the PMRT is available at: <https://www.npeu.ox.ac.uk/pmrt/programme>

Healthcare Safety Investigation Branch - a standardised approach to investigating term stillbirths, neonatal and maternal deaths and serious brain injuries

The Morecambe Bay Investigation Report called for;

'clear standards to be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths.'

The review concluded that;

'there is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff.'

Better Births also recommended that;

'There should be a national standardised investigation process when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence.'

The Department of Health is committed to improving the standards and quality of investigations and learning from serious incidents leading to stillbirth, early neonatal death or serious brain injury in term babies and all maternal deaths from direct or indirect causes related to pregnancy.

The new Healthcare Safety Investigation Branch (HSIB) will be funded to develop investigation standards and conduct independent investigations into all cases that meet the criteria for notification from the RCOG's Each Baby Counts Programme and all maternal deaths from direct or indirect causes related to pregnancy.

NHSE, working with NHS Improvement, the Department of Health and HSIB will publish, by Quarter 2 2018, information and guidance on the standards for maternity investigations to deliver the Morecambe Bay and Better Births recommendations.

In April 2017, HSIB became a fully operational and independent branch of NHS Improvement to investigate serious incidents in the NHS, with a strong focus on the learning from such incidents. It undertakes professionalised independent investigations with a comprehensive approach that seeks to understand the system and human factors contributing to harm, as well as the individual actions and events.

HSIB will apply its independent, professionalised investigative approach to the investigations of early neonatal deaths, term stillbirths and cases of severe brain injury in babies ('Each Baby Counts' cases), as well as all cases of maternal death. Like HSIB's national-level investigations, these maternity investigations will be about understanding the facts of what went wrong, rather than assigning blame or liability and will focus on the human and system factors that may be contributory causes.

However, this group of maternity investigations will differ from HSIB's national investigations in important ways. They will have a dual purpose. To provide the family of the baby or mother who was harmed with a full account of what happened in the individual case; and, by finding out what went wrong, to extract the maximum learning for the individual Trust in question and for the wider healthcare system.

This should mean that HSIB maternity investigations will be shorter allowing families to know what happened more quickly and ensure that all relevant information is passed to the family. Each HSIB maternity investigation will take a clinically appropriate approach, working

with families, clinicians with neonatal, paediatric and obstetric expertise and with local teams to establish what happened.

These investigations will be the primary and, as far as possible, the only investigation of the individual case and may be informed if appropriate by tools that local providers will be using such as the Standardised Perinatal Mortality Review Tool for perinatal deaths. This will ensure consistency for all 'Each Baby Counts' cases nationally, and avoid duplication and unnecessary complexity for families. At the same time, for learning purposes and to ensure the spread of good investigative practice in the NHS, local staff will be involved as observers.

Finally, as well as providing comprehensive final reports for each case it investigates, HSIB will publish themed reports drawing together overarching themes and points of learning from multiple investigations and making appropriate recommendations for system bodies to act on these findings.

The new investigative approach will begin in a single region from April 2018 and will continue to roll out to all areas of England by April 2019. When fully rolled out, we expect HSIB to investigate around 1,000 cases a year, with the expectation that the learning from investigations will spur system improvements leading to fewer deaths and injuries in the future.

Support for bereaved families

The quality of care that bereaved families receive when their baby dies can have long-lasting effects. Good care cannot remove parents' pain and grief, but it can help parents through this devastating time. All bereaved parents should be offered the same high standard of parent-centred, empathic and safe care when a baby dies.

The Department of Health has funded SANDS to develop a **National Bereavement Care Pathway (NBCP)** to help professionals support families in their bereavement after any pregnancy or baby loss, be that Miscarriage, Termination of Pregnancy for Fetal Anomaly (ToPFA), Stillbirth, Neonatal Death or Sudden Unexpected Death in Infancy (SUDI). Draft guidance was published in October and is currently being implemented by 11 pilot sites with a view to publishing the final guidance next year.

Rapid resolution and redress

Better Births called for a non-litigious route to early support and redress for children with serious birth-related brain injuries. **The Department of Health consulted on a proposed Rapid Resolution and Redress scheme earlier in 2017 to improve safety, patient experience and cost-effectiveness.** A summary of the consultation responses has now been published. Work is continuing to design and refine the details of how the scheme could operate with a view to establishing the scheme from April 2019.

A new **Early Notification scheme launched by NHS Resolution** in April 2017 provides a new route for families to access compensation which is based on the current principles of liability, but outside the usual litigation process. This new route includes support for immediate needs such as counselling or respite care in eligible cases. It is now a requirement for trusts to report all maternity incidents occurring on or after 1 April 2017 which have the potential to result in severe long-term brain injury.

Coroners' investigations into stillbirths

Currently there are no powers for coroners to conduct investigations into stillbirths as they only have jurisdiction to investigate deaths (including neonatal deaths). Some parents and charities have expressed concern that this is the case. **As part of the work to improve the investigation of and learning from stillbirths and neonatal deaths, the Government will**

consider with interested parties how coroners could carry out an investigation into those babies who are stillborn at term i.e. at 37 weeks' gestation and over. In doing so we will engage with Welsh colleagues on how this would impact the Devolved Administration in Wales.

5. Better learning and quality improvement

Research, national policy reviews, epidemiologic studies, national audits, case record reviews and investigations conducted in recent years have produced a wealth of information on the causes of perinatal and maternal mortality and morbidity. We will not make any progress with the National Maternity Safety Ambition, however, unless that learning is systematically applied to improvements in care in maternity and neonatal services across the country.

The Maternal and Neonatal Health Safety Collaborative

The NHS Improvement-led National Maternal and Neonatal Health Safety Collaborative was launched on 28th February 2017. A key Maternity Safety Strategy programme - the Collaborative aims to help every maternity and neonatal care provider in England to improve safety and outcomes by reducing unwarranted variation and providing a high quality healthcare experience for all women, babies and families.

This three-year programme is building local capability in quality improvement science and providing structured support for local teams to assess their service and develop innovative plans for measurable improvements. Every NHS trust with a maternity service is taking part in this national programme with 44 Trusts recruited for Wave 1 (2017/18), 45 Trusts recruited for Wave 2 (2018/19) and 45 Trusts recruited for Wave 3 (2019/20). During each wave, local maternity service improvement leads receive training and coaching to build their knowledge of improvement theory and share ideas and approaches for applying the learning within their own organisations. The four areas of improvement focus are:

- Human factors;
- Systems and processes;
- Clinical excellence; and
- Person-centred care.

Each Baby Counts Learn and Support

The Department of Health provided the initial start-up funding for the RCOG's Each Baby Counts (EBC) programme which began collecting and analysing data from all UK units in 2015 to identify lessons from stillbirths, neonatal deaths or intrapartum brain injury in term-babies. Since then, EBC has been successful in securing the trust of midwives, obstetricians, neonatologists and other professionals involved in the delivery of maternity care with 100% of Trusts engaging in the programme. This represents valuable frontline clinical expertise committed to improving safety in their local services and supporting improvement initiatives based on the national quality improvement framework set out by the Maternal and Neonatal Health Safety Collaborative.

The Department of Health will, therefore, provide additional funding over the next three years to provide support for the Royal College of Obstetricians and Gynaecologists and the Royal Colleges of Midwives to launch 'Each Baby Counts Learn and Support' - a programme of work to enable greater collaboration between the Royal Colleges and the NHS via the Maternal and Neonatal Health Safety Collaborative - this aims to align quality and safety improvement, multi-professional learning and clinical leadership into a consistent and sustainable safety strategy across the system.

Safer Maternity Care

Other potential benefits expected to arise from the programme include:

- The potential to use data and evidence to identify and stratify support for units at risk, before they become worse;
- A focus on the welfare of the workforce to engage and support maternity staff when things go wrong; and
- Support to capture impact and disseminate best practice.

Focus on innovation

The Safer Maternity Care Action Plan provided a £250,000 fund to which maternity and neonatal services could apply to support and promote the adoption of innovation and the spread of best practice across the NHS. 25 Trusts were successful in their bids for a share of the £250,000 Maternity Safety Innovation Fund to develop innovative ideas (Table 1). Project reports will be collated by April 2018 and shared via the Maternity Safety Champions.

Table 1: Maternity Safety Innovation Fund Projects

| Name of Trust | Innovation |
|---|---|
| Barts Health NHS Trust | A new neonatal jaundice pathway that equips community midwives with transcutaneous bilirubin monitors and an app to communicate with clinical colleagues. |
| Chelsea and Westminster NHSFT | Introduction of neonatal jaundice champion role and a new multi-service neonatal jaundice pathway. |
| City Hospital Sunderland NHSFT | Adoption of Pregnancy CaPI (CAre Plan), a digital maternity network using in-built algorithms to automatically plan maternity care based on UK guidelines. |
| Croydon University Hospital Croydon Health Services NHS Trust | To develop a multi-disciplinary (maternity and neonatal) approach to prevent hypothermia in newborns and reduce avoidable admissions to neonatal units. |
| East Kent Hospitals University NHSFT | Implementation of a personalised digital platform that will automatically risk screen for 'Small for Gestational Age (SGA) babies, Venous Thrombosis Embolism (VTE), and Perinatal Mental Illness; support pregnant women to make positive health choices; support staff to educate and provide personalised care for women and enhance women's experience of care. |
| Great Western Hospitals NHSFT | Introduce 'Flo' technology for remote monitoring of blood pressure for women with raised blood pressure in early/mid pregnancy or the postnatal period. |
| Hinchingbrooke NHS Trust | Development of a dedicated midwifery led service for women requiring complex care, particularly women with: mild to moderate anxiety and depression; previous birth trauma; previous baby loss; tocophobia (fear of childbirth); previous caesarean section or requesting CS without an identified medical need; and women requesting care outside of standard care guidelines. |

The National Maternity Safety Strategy - Progress and Next Steps

| Name of Trust | Innovation |
|--|---|
| Lewisham and Greenwich NHS Trust | Development of an app through which: clinical services will enter and access information on to an electronic record via a portal; referrals for care will be made and women will access their electronic care record, up-to-date clinical advice and other personalised care information. |
| Maidstone and Tunbridge Wells NHS Trust | Development of a link between two electronic maternity record systems to: improve data capture efficiency, manage booking of elective activities such as induction of labour and caesarean sections; populate incident reports with maternity record data and provide data for learning, monitoring safety indicators, highlighting trends and identifying areas for improvement. |
| Medway NHSFT | Diffusion and adoption of 'LABOUR', a new communication tool for maternity and neonatal teams who wish to escalate mothers who are at risk of deterioration. |
| Norfolk and Norwich University Hospital NHS FT | Use of interactive CTG technology for delivery suite simulation training on the human factors surrounding CTG interpretation and management. |
| Northampton General Hospital NHS Trust | Implement a pathway whereby all women with a Carbon Monoxide breath test result of ≥ 11 ppm (designated as a major risk factor) are referred for serial ultrasound measurements carried out by midwife ultrasonographers at a midwife-led clinic. Detection of 'Small for Gestational Age' or 'Fetal Growth Restriction' will enable referral to Fetal/Maternal Medicine specialists for ongoing management in determining the timing and mode of birth. |
| Nottingham University Hospitals Trust | To apply a Human Factor and Ergonomic (HFE) approach to analyse stillbirth incidents in order to explore contributory themes and identify opportunities for intervention. |
| Royal Devon & Exeter NHS Foundation Trust | To develop a package of measures to evaluate blood loss prospectively at Caesarean Section which include: design and testing of new Obstetric Anaesthesia Caesarean Charts incorporating a bespoke Post-Partum Haemorrhage record; design and testing of surgical drapes that will allow rapid identification of blood loss per vaginum and design and testing of a bespoke intra-operative blood loss board to be placed on the operating theatre wall. |
| Royal Wolverhampton NHS Trust | Development and implementation of an interactive Parent Education Package for pregnant women and new mothers on how to minimise the common risks of neonatal and infant deaths in a region with one of the highest infant mortality rates nationally. |
| Saint Mary's Hospital, Central Manchester Foundation Trust | Introduction of a specialised midwife-led clinic for women with a raised BMI of 35-39.9 who have no other risk factors and a new service promoting positive healthy lifestyle education with dietetic support for any pregnant woman with a BMI of 30 or above. |

Safer Maternity Care

| Name of Trust | Innovation |
|--|--|
| Sheffield Teaching Hospitals NHSFT | Development and embedding of a clinical pathway and clinician education package to improve care for women who present with reduced fetal movements using the 'forum theatre' methodology. |
| The Hillingdon Hospitals NHSFT | Development of E-learning training package in Perinatal Mental Health for all midwives, health visitors and doctors working in acute and community services that will be an element of the Trust's mandatory training. |
| University Hospitals Coventry and Warwickshire NHS Trust | Development of a new approach to multidisciplinary team skills training simulations of obstetric emergencies using video for constructive and immediate performance feedback. |
| Dorset County Hospital NHSFT | Provision of a new app to communicate with and provide information to fathers whose infants are resident in a Special Care Baby Unit. |
| Leeds Teaching Hospitals Trust | <ol style="list-style-type: none"> 1. To implement a user interface into the electronic patient record, so that women can have access to their electronic patient record and write in their notes, make comments, and provide feedback regarding care. 2. To link a new sepsis screening tool to the electronic patient record that will enable practitioners in the multi-disciplinary team to quickly respond to suspected sepsis based on established criteria. |
| North Bristol NHS Trust | To introduce a 'Wellbeing Buddy' from a voluntary sector support organisation (Bluebell Care) on maternity wards/units to support women at risk of or experiencing perinatal mental health problems. |
| Northern Lincolnshire and Goole NHS FT | To create a new specialist multidisciplinary clinic that encourages and supports women with a BMI of 35 or greater to make lifestyle and behavioural changes in the antenatal period that will be sustainable after they have given birth. |
| Southend University Hospitals NHSFT | Introduction of high fidelity simulation training throughout Maternity, Neonatal and Emergency Department as part of the mandatory study days. |
| Taunton and Somerset NHSFT | Development of a "one stop" multidisciplinary preconception care clinic for women with diabetes, hypertension, morbid obesity and epilepsy. |

6. Accelerating the pace of improvement

In 2015, the Department launched an ambition to halve the rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths, by 2030. Halving our stillbirth and neonatal mortality rates to 2.6 stillbirths per 1,000 births and 1.5 neonatal deaths per 1,000 lives respectively, would result in the UK ranking in the top 10 countries for perinatal mortality globally; making England one of the safest places in the world to have a baby.

Considerable efforts have been made across the NHS to deliver early progress. New funding and initiatives launched last year through the **Safer Maternity Care Action Plan** to improve leadership and training, the implementation of best practice and a national quality improvement programme as well as support for innovation is rolling out and already having an impact on service improvements.

Through the Maternity Transformation Programme, Local Maternity Systems are developing and Early Adopter and Pioneer services are beginning to increase continuity of carer and the use of Personal Maternity Care Budgets. Services are also improving the amount and quality of data submitted to the Maternity Services Data Set. A national indicators dashboard, offering a range of metrics that trusts will be able to select to focus attention on, will be established by 2018. The dashboard will enable multi-professional teams in local maternity and neonatal services to make better use of routinely collected data in order to track their outcomes, benchmark their performance, and improve the quality of their services.

We are currently on track to meet our ambition to reduce stillbirths, neonatal and maternal deaths by 20% by 2020.

The range of funding and support should enable maternity and neonatal services to go farther and faster.

We have, therefore, decided to re-set the national Maternity Safety Ambition to halve the rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth to 2025.

Incentivising the delivery of best practice to improve safety

Our vision is for a step change in maternity safety in the NHS. Making change happen at pace is a whole system effort and our plans, including the new measures we will take to speed up progress are intended to galvanise efforts across the system, to improve maternity investigations, spread best practice and learning and provide the tools and the expertise to bring about real and sustainable improvements to maternity care.

At the same time we want to send a clear message to the system that this goal is a priority that can be achieved with concerted effort. To encourage local teams to take further steps to improve safety, NHS Resolution will launch a new incentive scheme in 2018.

The scheme will provide a discount on Clinical Negligence Scheme for Trusts (CNST) maternity premia to incentivise local services for taking steps to improve the delivery of best practices linked to safety in maternity and neonatal services. NHS Resolution has built provision for an incentive fund into its pricing for 2018/19.

Trusts that are able to demonstrate compliance with 10 criteria agreed by the National Maternity Champions will be entitled to at least a 10% reduction in their CNST maternity contribution.

The aim of the scheme is to incentivise the implementation of good practice across all maternity units. The agreed criteria are set out in Box 2. By meeting the 10 criteria, Trusts are likely to deliver safer maternity services and may be expected to have fewer cases of brain injuries or other harm which can lead to negligence claims. Trusts' compliance with the criteria will be assessed through a verification process that will be completed by the end of June 2018. Discounts for successful trusts will be confirmed by NHS Resolution.

Trusts not yet able to demonstrate full compliance with the criteria will be eligible for a smaller discount, providing they agree to use the funds to take action towards meeting the criteria, which may include an offer to 'buddy' with a qualifying trust that will provide support. The incentive scheme will apply to acute trusts only in 2018/19 and will be evaluated during the year to determine whether and how it should be developed in future years.

Box 2: Criteria for the Maternity Safety Strategy CNST discount

| | |
|----|---|
| 1 | Are you using the National Perinatal Mortality Review Tool to review perinatal deaths? (Y/N) |
| 2 | Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? (Y/N) |
| 3 | Can you demonstrate that you have transitional care facilities in place and operational to support the implementation of the ATAIN Programme? (Y/N) |
| 4 | Can you demonstrate an effective system of medical workforce planning? (Y/N) |
| 5 | Can you demonstrate an effective system of midwifery workforce planning? (Y/N) |
| 6 | Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives care bundle? (Y/N) |
| 7 | Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback? (Y/N) |
| 8 | Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year? (Y/N) |
| 9 | Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues? (Y/N) |
| 10 | Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme? |

7. The National Maternity Safety Strategy

Maternity is different from other clinical specialities. Most users of acute health services have a specific health problem (such as an illness or a broken bone) that requires treatment in order to be 'cured' and restored to a state of good health.

The expectations in maternity are different because most pregnant women are healthy and pregnancy is a natural physiological process that usually culminates in the birth of a healthy baby. Pregnant women are 'supported' by maternity professionals through this physiological process rather than 'treated' for a pathological condition. The vast majority of deaths and injuries in maternity care are, in the vast majority of cases, unexpected. Consequently, the impact on families can be particularly devastating especially when a death or injury could have been avoided.

This is why maternity safety is the 'golden thread' running through every workstream of the Maternity Transformation Programme. This is also why clinical leaders and innovative thinkers in maternity and neonatal services across the country, supported by national, regional and local organisations, are working to develop leadership, participating in multi-disciplinary team training, examining their own care practices with a critical eye and developing rigorous quality improvement plans. They are implementing evidence-based practices through the Saving Babies Lives care bundle and Atain programmes and are continuously improving the quantity and quality of data they provide to the Maternity Services Dataset and national audit and review programmes.

The aims of this document are to:

- report on progress with implementation of the Safer Maternity Care Action Plan;
- set out new support and actions focussed on better care, better investigations, better learning and improvement and better outcomes for mothers and their babies; and
- explain how all the elements of the Maternity Safety Strategy link and contribute to form a coherent and aligned system-wide approach to improving safety in maternity care.

Every national, regional and local NHS organisation and every member of a maternity or neonatal care team has a role in the Maternity Safety Strategy by:

Providing Better, Safer Care

- With strong leaders working across system boundaries working across system boundaries, promoting professional cultures that support teamwork, continuous improvement and service user engagement; including:

| | | |
|---|---|-------------------|
| Named national, regional and local Maternity Safety Champions - from January 2017 | Every national, regional and local NHS organisation involved with delivering safe maternity and neonatal care | From January 2017 |
| A central platform within the NHS Improvement Hub in development to foster a cohesive community of Maternity Safety Champions, other system leaders | NHS Improvement | From early 2018 |

Safer Maternity Care

| | | |
|--|--|--|
| and experts to help spread learning and best practice across the system. | | |
|--|--|--|

- With the implementation of evidence-based best practice; including:

| | | |
|--|--|----------|
| Continuity of carer throughout pregnancy and labour, including one-to-one support at this time | Maternity Transformation Programme | By 2020 |
| The Saving Babies Lives Care Bundle | NHS England / Maternity Transformation Programme | On-going |
| The Atain Programme | NHS Improvement and clinical experts | On-going |

- With care provided by clinical professionals with expertise in safe care practices; including

| | | |
|---|--|--|
| The Maternity Safety Training Fund | Health Education England | 2017/18 |
| Practitioners with knowledge, skills and confidence to give very brief advice to women during antenatal appointments and upskilling practitioners (e.g. maternity support workers) to deliver evidence based smoking cessation interventions. | Tobacco Control Plan Public Health England | Aim to reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less by 2022. |
| New funding over three years to train 12 consultant physicians as 'Obstetric Physicians' to be able to establish networked maternal medicine across England. | NHS England / Maternity Transformation Programme | Beginning 2018/19 |
| The Atain e-learning programme to support the delivery of safer care with a focus on respiratory conditions; hypoglycaemia; jaundice; and asphyxia (perinatal hypoxia-ischaemia). An additional module also raises awareness of the importance of keeping mother and baby together. | NHS Improvement and clinical experts | From November 2017 |

Improving the quality of information, reviews and investigations

- With standardised approaches to reviews and investigations

| | | |
|---|--|--------------------|
| The Perinatal Mortality Review Tool | A consortium led by the National Perinatal Epidemiology Unit and linked to the MBRRACE data entry system | From December 2017 |
| Regular surveillance and confidential enquiries | MBRRACE-UK | On-going |
| Each Baby Counts | RCOG | On-going from 2015 |
| The National Maternity and Perinatal Audit | RCOG | On-going from 2017 |
| Healthcare Safety Investigation Branch (HSIB) conducting independent investigations into all cases that meet the criteria for notification from the RCOG's Each Baby Counts Programme and all maternal deaths from direct or indirect causes related to pregnancy | HSIB | From 2018/19 |
| Published guidance on the standards for maternity investigations to deliver the Morecambe Bay and Better Births recommendations. | NHS England, working with NHS Improvement, the Department of Health and HSIB | Quarter 2 2018 |
| Development of proposals for coroners to investigate stillbirths. | Department of Health and Ministry of Justice | From 2017 |

- With timely, good quality data

| | | |
|--|------------------------------------|--------------------|
| Maternity Services Dataset | NHS Digital | On-going |
| An agreed definition for brain injuries occurring during or soon after birth | National Neonatal Data Base | From November 2018 |
| Clinical quality indicators and a national data viewer | Maternity Transformation Programme | 2018 |

Improving learning and quality improvement

- With local capability in improvement science and structured support for local teams

| | | |
|---|---|-----------------|
| Maternal and Neonatal Health Safety Collaborative | NHS Improvement | From March 2017 |
| Each Baby Counts Learn and Support | RCOG, RCM and the Maternal and Neonatal Health Safety Collaborative | From 2018/19 |
| Maternity Safety Innovation Fund | Department of Health | 2017/18 |
| | | |

- With better support for bereaved families or children with serious brain injuries

| | | |
|-----------------------------------|----------------------|--|
| National Bereavement Care Pathway | Sands | Wave 1 pilots launched October 2017 |
| Rapid Resolution and Redress | Department of Health | Summary of consultation responses published November 2017 Work continuing to design and refine the details of how the scheme could operate with a view to establishing the scheme from April 2019 |
| Early Notification Scheme | NHS Resolution | From April 2017 |

Accelerating the pace of change

- With a renewed focus on reducing pre-term births
- With a new ambition to halve the rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth
- With a new incentive scheme

| | | |
|--|----------------|--------------|
| A discount on Clinical Negligence Scheme for Trusts (CNST) maternity premia to incentivise local services for taking steps to improve the delivery of best practices linked to safety in maternity and neonatal services | NHS Resolution | From 2018/19 |
|--|----------------|--------------|

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- ⁱ The Lancet, Ending preventable stillbirths, 2016.
 - ⁱⁱ World Health Organisation (WHO), Global Health Observatory - Child Mortality, 2017.
 - ⁱⁱⁱ MBRRACE-UK. Saving Lives, Improving Mothers' Care 2016.
 - ^{iv} Office of National Statistics (ONS), Childhood mortality in England and Wales, 2015.
 - ^v Office of National Statistics (ONS), Childhood mortality in England and Wales, 2015.
 - ^{vi} World Health Organisation (WHO), Global Health Observatory - Child Mortality, 2017.
 - ^{vii} MBRRACE-UK. Saving Lives, Improving Mothers' Care 2016.
 - ^{viii} Cochrane, Midwife-led continuity models of care compared with other models of care for women during pregnancy, birth and early parenting, 2016.
 - ^{ix} MBRRACE-UK. Saving Lives, Improving Mothers' Care 2016.
 - ^x MBRRACE-UK. Saving Lives, Improving Mothers' Care 2016.
 - ^{xi} MBRRACE-UK. Saving Lives, Improving Mothers' Care 2016.

2017/18 QUARTER 2 FINANCES AND PERFORMANCE

Today NHS Improvement (NHSI) released the quarter two (Q2) **finance and operational performance figures** for the provider sector. These figures cover the six month period ending 30 September 2017. This briefing summarises the key headlines from those figures, our view on what they mean, and our media response.

If you have any feedback or questions regarding any of the content in this briefing please contact:

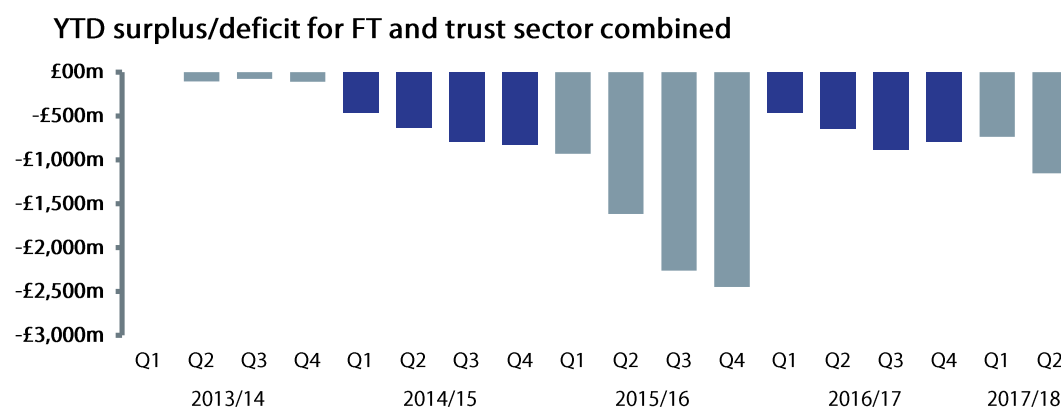
Adam.Wright@nhsproviders.org

KEY HEADLINES

- The Q2 net deficit forecast for the sector is now £623m, compared to the £791m 2016/17 year end position and the £2.45bn 2015/16 position. This is a £100m deterioration from £523 million forecast deficit reported at Q1.
- At Q2, providers reported a year to date deficit of £1.15bn. This compares to a deficit of £648m in Q2 2016/17 and a deficit of £1.61bn in Q2 2015/16.
- Within the overall sector position there remains £292m worth of uncommitted sustainability and transformation funding (STF) which is yet to be received by providers.

FIGURE 1

Year to date surplus/deficit for the NHS provider sector (£m)



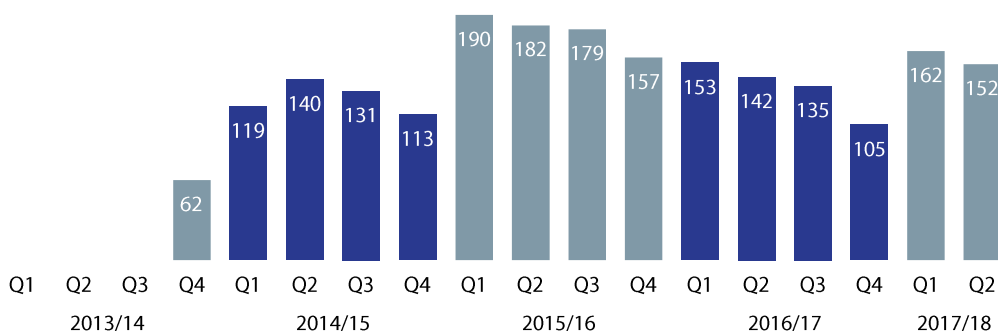
- The forecast deficit position is £127m over plan. The sector ended last year over plan by £211m. 87 providers are now reporting an adverse variance against plan at Q2, up from 67 at Q1. This includes 26 trusts with an adverse variance of more than £5m. The overall net adverse variance was largely driven by:
 - Under delivery of planned efficiency savings. Providers delivered £1.26bn worth of cost improvement plans (CIPs) in the first six months of the year, however these are still £169m or 12% behind plan. Within these CIPs, providers are struggling to make savings on pay. Pay costs alone are £134m or 20% behind plan. The sector currently remains reliant on non-recurrent savings, which are £185m or 167% over plan.
 - Continued growth in A&E attendance, which are up 1.7% during the same period last year. Emergency admissions were up 3.4% at around 1.08m required admitted care after attending A&E.

- Overspend on employee costs. Year to date there has been a £256m overspend against employee costs, broken down to overspends on medical (£217m) and nursing staff (£66m). All regions across England have reported overspends on staff costs. Although there has been a £320m reduction in agency staffing compared to the same period last year, there is a significant overspend of £407m in bank staff.
- Overspend in non-pay costs. Year to date there has been a £70m overspend in non-pay cost pressures. Within this figure there has been a £89m or 11% overspend in purchasing healthcare from other providers, indicating significant capacity constraints. There were also overspends on clinical supplies (£61m), premises (£37m) and consultancy (£35m).
- There has been recovery reduction in elective income, which is £124m behind plan. The waiting list continues to grow, and has now reached 4.1 million at the end of Q2 2017/8, up from 3.64m in Q1.
- 152 (64%) of 238 providers are reporting a deficit, compared to 142 (60%) that reported a deficit in Q2 2016/17.
 - Overall, 111 providers are forecasting a year-end deficit.
 - At Q2, 206 trusts accepted their 2017/18 control totals, given them access to STF. 27 trusts are not signed up. This indicates that no more trusts have signed up to a control total since Q1.
 - Based on year to date performance, trusts have included £338m of STF in their reported year-to-date positions, although the overall sector position includes £292m of uncommitted STF, against a plan of £160m.

FIGURE 2

Number of providers in deficit

Number of providers in deficit



Other key finance data at Q2

- Capital expenditure (capex) was £1,079m at month 6, £806m below plan. The current forecast capex for year end is £3.9bn which represents an underspend of £392m.
- Total CIP delivery was £1,257m. Total savings were £169m behind plan. The forecast shortfall is currently £210m and NHSI has asked providers to identify a further £178m worth of CIP schemes in the remainder of the year to bridge this gap. In 2016/17, 61% of savings were delivered in the last two quarters.

- **Agency spend equalled £1.2bn.** This is due to the immense efforts of trusts to lower agency spend. At the same time, bank spend has been increasing. In Q2 the overall total spend for temporary staff (both bank and agency) was £2.6bn, which represents a decrease of £119m or 4.3% on the same period last year.
- **Financial sanctions continue to fall with providers forecasting fines worth £61m.** This is a significant reduction on the £99m received last year and is a result of the continuing of the STF arrangement whereby providers do not face penalties if they accept control totals.

FIGURE 3

Forecast CIP savings against plan

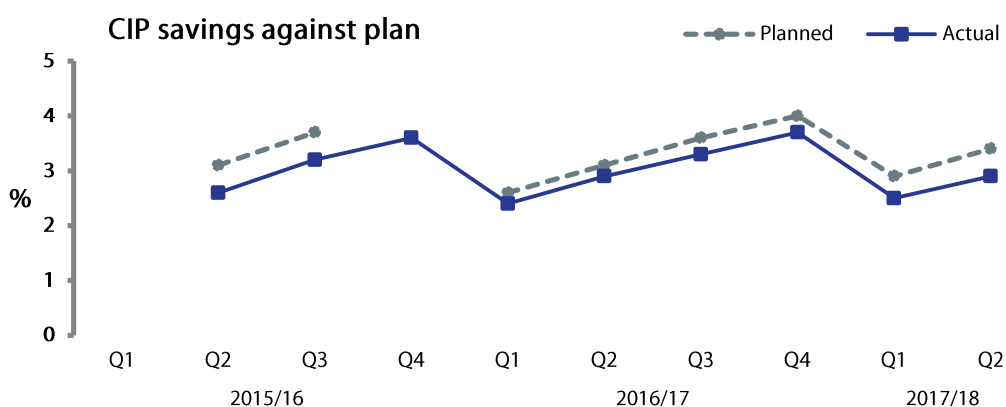
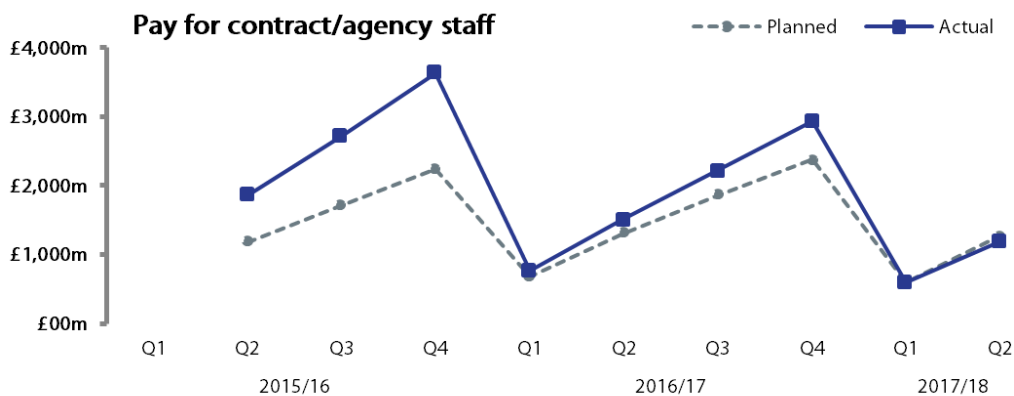


FIGURE 4

Year to date agency staff spend



Key non-finance information

The figures published today also include the latest on operational performance, within Q2:

- 5.44m patients attended A&E departments, which is a small decrease of 0.04% (like-for-like) since Q2 2016/17. NHS England data shows trusts managed to treat, admit and discharge 90.11% of A&E patients within four hours, although NHS Improvement's data shows performance at 89.24%.
- The elective waiting list reached a record 4.1m at the end of the quarter, a 17% increase compared to a year ago. Referral-to-treatment (RTT) performance was 89.10% for the quarter, which represents a drop of 1.49% compared to the same period last year.

- Ambulance services continue to be under pressure, missing the Red 1, Red 2 and 19 minutes response-time targets for Category A ambulance calls (those that are considered life threatening). Performance was 67.96%, 60.30% and 89.49% respectively.

The report notes the significant risks to delivery for the remainder of the year. Compared to this point last year, NHS Improvement accept much of the improvement was “highly dependent” on non-recurrent items, with fewer available this year. The report points to more detailed winter resilience preparations and a more detailed understanding of the winter risks this year.

PRESS RELEASE ON Q2 FIGURES

Q2 FIGURES REFLECT DIFFICULT ENVIRONMENT FOR TRUSTS NHS Improvement release financial performance data for Q1 of 2017/18

- NHS Improvement publishes performance data for the second quarter of 2017/18.
- Figures show 90.2 per cent of emergency patients were seen in four hours, while 3.5% September DTOC target is not met.
- We say sustaining that progress in order to meet the 95 per cent national standard by the end of next year will be extremely difficult against high bed occupancy rates and delayed transfers of care (DTOCs).

NHS Improvement has published performance data for the second quarter of 2017/18, showing that admissions to hospital continue to rise as the demand for emergency and planned care continues to increase.

It shows that 90.2 per cent of emergency patients were seen within four hours.

There were around 168,000 delayed discharges, accounting for five per cent of NHS beds, meaning the service fell short of its 3.5 per cent target this September.

Financially, at this point trusts are collectively predicting a full-year deficit of around £623 million - £127 million higher than planned.

Responding to the Q2 figures published by NHS Improvement, the chief executive of NHS Providers, Chris Hopson, said:

"These figures underline the extremely difficult conditions trusts face in providing safe, timely, high quality care for patients. It is to their enormous credit that in the midst of a prolonged and severe financial squeeze and workforce shortages they have responded to growing demand by treating more patients than ever.

"It is particularly encouraging to see the improvement in A & E response times. However sustaining that progress in order to meet the 95 per cent national standard by the end of next year will be extremely difficult, particularly given the continuing difficulties with high bed occupancy rates and delayed transfers of care (DTOCs) for patients who are ready to move on. The additional £1 billion allocated for social care in the spring budget has not had the effect on DTOCs that we had hoped to see.

"It is concerning to see the year-end deficit forecast has risen to £623 million – which is £127 million worse than planned. Despite great efforts, trusts are slipping behind on the savings required of them. However they are still on track to reduce the provider sector deficit compared to last year. Given the overall NHS financial settlement this year, that would be a great achievement. It is worth noting too that trusts have continued to reduce spending on agency staff.

"There is a long way to go. Last year we saw a significant jump in the deficit figures in Q3. As we head into winter – with the particular challenges and potential for disruption that presents - we will be watching closely to see what happens this time."



Home Secretary
2 Marsham Street
London SW1P 4DF
www.gov.uk/home-office

21 December 2017

Dear Chief Executive,

I am writing to update you following last week's agreement at the European Council for negotiations between the UK and the EU to move to a discussion about our future relationship.

This is good news for the EU citizens working in the NHS and for its many contractors and suppliers. It will also be welcomed by the millions of people in this country who rely on the outstanding care and professional support they provide.

The Prime Minister has consistently said that protecting EU citizens' rights - together with the rights of UK nationals living in EU countries - has been her first priority. EU citizens made a decision to live here without any expectation that the UK would leave the EU. The UK Government wants them to be able to carry on living their lives as before.

We have taken a big step forward. EU citizens living lawfully here before the UK's exit from the EU will be able to stay. The deal will respect the rights that individuals are exercising and the benefits they currently have. This will help EU citizens and organisations like yours plan for the future.

The agreement will not only enable families who have built their lives in the EU and UK to stay together, it also gives certainty about healthcare, pensions and other benefits. It includes reciprocal rules to protect existing decisions to recognise professional qualifications, for example for doctors and architects.

These commitments will be locked into a binding and reciprocal agreement with the EU. You can read the agreement here:

https://ec.europa.eu/commission/sites/beta-political/files/joint_report.pdf. All EU citizens will need to apply to obtain status in UK law. A new, transparent, smooth and streamlined process to enable them to apply for settled status will start during the second half of 2018 and remain open for at least two years after the UK leaves the EU.

Communicating with EU citizens about the scheme will be a top priority for my department to ensure people are aware of the scheme and what they need to do to secure their rights. My officials are working closely with a range of organisations in the design of the scheme. It will be vital that you are kept up to date and feel equipped to pass on information to your staff and partners. This page will be updated with the latest position:

<https://eucitizensrights.campaign.gov.uk/>.

As we move from withdrawal issues to discussing our future relationship with the EU, I shall shortly be publishing proposals for the UK's future immigration system, and bringing forward an Immigration Bill as announced in the Queen's Speech. My officials and I will continue to engage with healthcare providers and as many sectors as possible as part of this process.

I hope this email provides reassurance to you and your teams. I would encourage you to share the links to further information above with anyone in your team who will find it useful. Your staff can also sign up for regular official email updates on citizens' rights from the government here:

<https://www.gov.uk/guidance/status-of-eu-nationals-in-the-uk-what-you-need-to-know>.

I look forward to sharing further progress with you over the coming months.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Amber Rudd', is centered on the page.

The Rt Hon Amber Rudd MP



Pauline Philip
National Urgent and Emergency Care Director
Wellington House
133-155 Waterloo Road
London, SE1 8UG

21 December 2017

NHS Provider Trust CEOs
CCG Accountable Officers

Trust CEOs and CCG AOs

I am writing to make you aware of guidance (Annex A) that the National Emergency Pressures Panel^[1] has today issued regarding reviewing elective activity to deal with non-elective pressures ensure our resources are directed to our sickest patients.

We have already asked that you plan to deliver 85% occupancy from December 22 through to January 8 and that you submit your elective plans for Q4 to your regional teams.

In light of this guidance we are now asking that you review these elective plans to consider where you can free up further capacity to support non-elective care. In doing so we ask that you work with your Regional Director(s) after the Christmas break to agree necessary changes which should then be kept under regular review. These changes should be in addition to your detailed winter plans which focus on areas such as improving flow and discharge in hospitals across the week and enhancing capacity outside of hospital.

I am very grateful for the hard work of you and your teams to manage to the pressures we face. Throughout the coming months our collective priority is to deliver safe patient care and we hope that this guidance acts to support this and reduce the pressures you and your staff face.

Yours,

A handwritten signature in black ink, appearing to read 'Pauline Philip', written in a cursive style.

Pauline Philip
National Urgent and Emergency Care Director

^[1] The National Emergency Pressures Panel is a group of senior clinicians, chaired by Sir Bruce Keogh, established in October to advise the NHS on the clinical risk in the system and potential actions that could be taken to ease pressure.

ANNEX A

OPERATIONAL UPDATE FROM THE NHS NATIONAL EMERGENCY PRESSURES PANEL

The new National Emergency Pressures Panel (NEPP) met yesterday chaired by Professor Sir Bruce Keogh.

The panel was set up earlier this year to advise Pauline Philip, NHS National Director for Urgent and Emergency Care, on pressure and clinical risk. It brings together clinical leaders and experts from organisations including the Royal College of Surgeons, the Royal College of Physicians, the Royal College of GPs, the Royal College of Nursing, Public Health England and the CQC.

In reviewing current and expected demand over the holiday period, the NEPP is making the following operational recommendations to hospitals experiencing high levels of operational pressures, in line with usual practice in previous years:

- The expectation is that non-urgent inpatient elective care should be deferred until mid-January to ensure beds and staff are available for the sickest patients. By acting early Trusts can avoid last minute cancellations that can be costly and inconvenient for patients.
- Day-case facilities should be used flexibly. Many could be used to provide inpatient care to help with the expected surge. Where this is not possible, day case procedures should be ramped up to take pressure off in-patient beds.
- Routine follow-up clinics could be converted into 'hot clinics' providing specialist care to patients referred by GPs to take pressure off of A&E units, for example, for respiratory conditions which peak in winter.
- Individual organisations should move as quickly as possible to use the additional money from the Budget and allocated last Friday to open extra beds and services.
- Urgent GP appointments will, as planned, be available over the holiday period.
- The panel would expect to review the situation in mid-January and make further recommendations on elective activity as needed.

However, the panel advised that cancer operations and time-critical procedures needed to prevent rapid deterioration in a patient's condition should go ahead as planned.

Sir Bruce said: "NHS staff are working flat out to cope with seasonal pressures and ensure patients receive the best possible care. However, given the scale of the challenge, hospitals should be planning for the surge that comes in the New Year by freeing up beds and staff where they can to care for our sickest patients.

"This will also reduce last minute cancellations which are unfair to patients and their families. Patients deserve as much notice as possible if their non-urgent treatment is delayed and I hope that they will bear with us during this testing time for the health service."

Pauline Philip said: "We know that the NHS is about to enter into the most challenging part of the year with spikes in demand likely after the Christmas and New Year breaks.

"Hospitals will, as usual at this time of year, now be prioritising the increased numbers of emergency patients over non-urgent planned services. Additional services and beds will be coming online over the next few weeks funded by the winter Budget cash released by the Government to the local NHS last Friday. Staff are working hard to ensure ambulance handovers are as smooth as possible. There is still time for this public to play their part by ensuring they have their flu jab and by using local pharmacies and NHS 111 for medical advice, alongside other services."

To

CCG Accountable Officers and Clinical
Leads
NHS Foundation Trust Chief Executives
NHS Trust Chief Executives
CC:
NHS Foundation Trust Medical Directors
NHS Trust Medical Directors
NHS Foundation Trust Directors of
Nursing
NHS Trust Directors of Nursing

NHS England
Skipton House
80 London Road
London
SE1 6LH

2 January 2017

Publications Gateway Reference: 07578

Dear Colleague

I am writing to make you aware of further guidance (Annex A) that the National Emergency Pressures Panel has today issued to support you as part of a new NHS Winter Pressures Protocol. This is in addition to the recommendations made by the panel on 21 December, the additional capacity that you are putting in place with the funding announced in the November Budget and your existing winter plans.

I am very grateful for the hard work and commitment of all your staff during the Christmas period. I hope that these recommendations provide further support to help with the pressures that you face. Your Regional Directors will be in contact to provide further support in operationalising these recommendations and please do provide feedback either through them or directly to me if there is further support we can provide.

Yours,



Pauline Philip

National Director, Urgent and Emergency Care,
NHS England and NHS Improvement

Annex A

OPERATIONAL UPDATE FROM THE NHS NATIONAL EMERGENCY PRESSURES PANEL

The National Emergency Pressures Panel (NEPP) met for the second time today (2 January 2018) chaired by Professor Sir Bruce Keogh.

The panel was set up earlier this year to advise Pauline Philip, NHS National Director for Urgent and Emergency Care, on pressure and clinical risk. It brings together clinical leaders and experts from organisations including the Royal College of Surgeons, the Royal College of Physicians, the Royal College of GPs, the Royal College of Nursing, Public Health England and the CQC.

The panel noted that the NHS has been under sustained pressure over the Christmas period with high levels of respiratory illness, bed occupancy levels meaning there is limited capacity to deal with demand surges, early indicators of increasing flu prevalence and some reports suggesting a rise in the severity of illness among patients arriving at A&Es.

The panel discussed the excellent work they have seen and heard about in recent weeks from frontline staff and in hospitals across the country. They formally recorded their thanks for the hard work of staff and discussed the further support that could be given.

Today NEPP are issuing further recommendations, that they believe will support hard-working frontline staff, thereby activating the new NHS Winter Pressures Protocol. These include:

- extending the operational recommendations, made on 21 December, to 31 January This includes the deferral of all non-urgent inpatient elective care to free up capacity for our sickest patients. As previously the panel has reiterated that cancer operations and time-critical procedures needed to prevent rapid deterioration in a patient's condition should go ahead as planned;
- over and above this, day-case procedures and routine follow-up and outpatient appointments should also be deferred or dealt with in different ways, e.g. telephone consultation, where this will release clinical time for non-elective care;
- the clinical time released from the above actions should be re-prioritised to:
 - implement consultant triage at the front-door so patients are seen by a senior decision maker on arrival to the hospital;
 - ensure consultant availability for phone advice for GPs;
 - maximise the usage of ambulatory care and hot clinic appointments as an alternative to Emergency Department attendance and/or hospital admissions;
 - staff additional inpatient beds;
 - provide additional Allied Health Professional input into rehabilitation and discharge; and,
 - ensure twice daily senior review of all patients to facilitate discharge.

- to ensure patient safety comes first CCGs should temporarily suspend sanctions for mixed sex accommodation breaches;
- whilst overall the NHS is doing better than ever before in vaccinating health care workers there is significant variation between organisations¹. There should be an immediate prioritisation of the vaccination of all front line staff over the next two weeks.

The Panel will meet again before the end of January to review the pressures on the system and the impact of the recommendations above.

These recommendations are made in light of the actions that are already being taken to increase capacity in the NHS following the announcement of additional funds in The Budget on 22 November. A significant proportion of the additional capacity funded through November's Budget is due to open in the next fortnight.

The NHS is taking these steps to ensure patients receive the best possible care over this challenging period. Calling 111 is often a quicker and more convenient way of obtaining clinical assessment and advice in non-emergencies and allows staff in A&E to focus on the sickest patients. The Royal College of GPs has already set out three basic steps that all patients should consider before seeking an appointment with their GP for an acute illness, including self-care, using online guidance from NHS Choices and consulting with a pharmacist.

¹ <https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-healthcare-workers-monthly-data-2017-to-2018>

Professor Clive Kay
Chief Executive
Bradford Teaching Hospitals NHS Foundation Trust
Bradford Royal Infirmary
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Bradford BD9 6RJ

30th November 2017

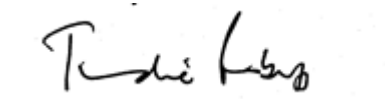
Dear Professor Kay

Undergraduate medical education – placement evaluation


I am writing to both thank and congratulate your Trust staff on their support of Leeds medical undergraduate education. As you know the Trust takes a number of 4th Year students on Acute & Critical Care and Paediatrics placements. The School evaluates student feedback on the experience they have on placement. This is a complex process and the School then uses the feedback to work with placement providers on improvements. We use both quantitative and qualitative data and I am very pleased to tell you that in 2016/17 these placements you provide have scored 80% or above on every aspect. This is an exceptional achievement and across the Leeds placement plan we only have three placements which have achieved this score. I have attached the “RAG” scores achieved by the Acute & Critical Care and Paediatrics placements.

I am delighted that the placement scores so highly with students and that they appreciate the work of all those involved. Please pass on our thanks to all the staff involved.

Yours sincerely



Professor Trudie E. Roberts
BSc, MBChB, PhD, FRCP, FHEA, NTF, Hon FAcadMED
Director, Leeds Institute of Medical Education



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enc

cc: Dr Alex Brown – Undergraduate Clinical Lead
Ms Amanda Hudson – Medical Education Manager
Dr Andrew Baker - Clinical Lead, Acute & Critical Care
Dr Beccy Bardgett - Clinical Lead, Paediatrics

Ms Sharon Walker - Clinical Education Lead
Dr Bryan Gill - Medical Director
Dr Jill Stewart - Clinical Lead, Emergency Medicine



Professor Trudie E Roberts
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Appendix d

**Summary of Student Clinical Placement Evaluation Data
September 2016 to June 2017**

**Bradford Teaching Hospitals NHS Foundation Trust Report
(Acute & Critical Care and Paediatrics only)**

Bradford Teaching Hospital NHS Foundation Trust

Placement Report Overview All Data 2016-2017

| BTHT Clinical Placement Evaluation Questions 2016-17 Data Years 1-2 All rotation data Years 3-5 Based on data from 3 sampled Rotations | Yr1 C2C | Yr2 C2C | Yr3 C2C | Yr3 C2C Sp Senses | Yr4 ACC | Yr4 CCC | Yr4 GOSH Gynae | Yr4 GOSH Obs | Yr4 Paeds | Yr 5 Int | Bradford Trust Overall | All Trusts Average |
|--|---------------------------------------|----------|-----------|-------------------|----------|----------|----------------|--------------|-----------|-----------|------------------------|--------------------|
| Domain 1 Orientation and induction | 91% | | | | | | | | | | 91% | 89% |
| 1. There was comprehensive orientation and induction at the placement (e.g. covering local infection control procedures, | ↓ 84% | 90% | ↓ 88% | ↓ 59% | ↑ 95% | ↑ 80% | ↑ 100% | ↑ 100% | ↑ 98% | ↑ 93% | 89% | 86% |
| 2. I was given information on how to access clinical areas | ↑ 84% | ↓ 86% | ↓ 90% | ↓ 77% | ↓ 95% | ↑ 85% | ↑ 100% | ↑ 100% | ↓ 100% | ↑ 97% | 91% | 90% |
| 3. At the start of the placement the aims of the placement and the anticipated learning outcomes were shared | ↓ 85% | ↓ 89% | ↑ 79% | ↑ 63% | ↑ 95% | ↑ 95% | ↑ 97% | ↑ 100% | ↑ 100% | ↑ 93% | 90% | 87% |
| 4. Administrative staff were approachable, helpful and directed me to my placement | ↓ 81% | ↓ 93% | ↓ 93% | ↑ 90% | ↓ 91% | ↑ 90% | ↑ 100% | ↑ 100% | ↓ 100% | ↑ 98% | 94% | 93% |
| Domain 2 Facilities | 87% | | | | | | | | | | 87% | 85% |
| 5. There was access to a safe area for personal belongings | ↑ 89% | ↓ 84% | ↑ 95% | 78% | ↑ 82% | ↑ 90% | ↑ 90% | ↑ 90% | ↑ 96% | ↑ 88% | 88% | 81% |
| 6. Good quality space for teaching was available | ↑ 86% | ↓ 94% | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 90% | 86% |
| 7. Learning facilities were available and appropriate to my needs | n/a | n/a | ↑ 99% | ↑ 85% | ↓ 95% | ↑ 85% | ↑ 86% | ↑ 93% | ↓ 98% | ↓ 95% | 92% | 90% |
| 8. There was sufficient access to internet IT facilities | n/a | n/a | ↓ 85% | ↓ 49% | ↓ 77% | ↓ 70% | ↑ 81% | ↑ 83% | ↓ 89% | ↑ 95% | 79% | 81% |
| Domain 3 Learning environment and support | 87% | | | | | | | | | | 87% | 86% |
| 9. The staff in the clinical area were friendly, helpful and supportive | ↑ 77% | ↓ 81% | ↓ 95% | ↑ 94% | ↓ 95% | ↑ 95% | ↑ 95% | ↑ 98% | ↓ 98% | ↓ 90% | 92% | 93% |
| 10. I knew who to contact if teachers did not arrive as scheduled | ↑ 82% | ↑ 78% | ↑ 78% | ↑ 66% | ↑ 91% | 70% | ↑ 88% | ↑ 93% | ↑ 94% | ↓ 83% | 82% | 78% |
| 11. I felt appropriately supervised in clinical areas | ↓ 55% | ↓ 69% | ↓ 91% | ↑ 98% | 100% | ↑ 95% | ↑ 97% | ↑ 97% | 98% | ↓ 93% | 89% | 91% |
| 12. The majority of scheduled teaching took place | ↓ 81% | ↓ 83% | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 82% | 85% |
| Domain 4 Delivery of scheduled teaching | 86% | | | | | | | | | | 86% | 90% |
| 13. Tutors showed enthusiasm and commitment to teaching | ↑ 77% | ↓ 92% | ↓ 90% | ↑ 88% | 100% | ↑ 80% | ↓ 95% | ↑ 95% | 98% | ↓ 88% | 90% | 90% |
| 14. The learning opportunities were good and helped me embed concepts into clinical practice | ↓ 70% | ↓ 84% | ↓ 90% | ↑ 87% | 100% | ↑ 90% | ↓ 93% | ↑ 100% | 100% | ↓ 88% | 90% | 91% |
| 15. The placement helped me develop confidence in my clinical skills | ↑ 78% | ↓ 90% | ↑ 94% | ↑ 78% | 100% | ↑ 80% | ↑ 97% | ↑ 98% | 93% | ↓ 83% | 89% | 87% |
| 16. a/b/c Management/prescribing medicines - wording relevant to year - <u>see report</u> | ↑ 70% | ↓ 56% | ↑ 88% | ↑ 57% | ↑ 95% | ↑ 85% | ↑ 71% | ↓ 64% | ↑ 96% | ↑ 76% | 76% | 76% |
| Domain 5 Opportunities for learning and clinical experience | 84% | | | | | | | | | | 84% | 82% |
| 17. The placement was designed to help me to work with patients at the expected level | ↑ 77% | ↑ 83% | ↑ 94% | ↓ 71% | 100% | ↑ 90% | ↑ 91% | ↑ 95% | 100% | ↑ 88% | 89% | 88% |
| 18. The placement gave me the opportunity to achieve the expected outcomes | ↑ 85% | ↓ 81% | ↓ 84% | ↑ 80% | 100% | ↑ 95% | ↑ 97% | ↑ 100% | 100% | ↓ 88% | 91% | 87% |
| 19. The teaching allowed me to address my individual learning needs | ↑ 69% | ↓ 72% | ↓ 86% | ↑ 74% | 100% | ↓ 75% | ↑ 95% | ↑ 93% | 98% | ↓ 83% | 85% | 85% |
| 20. There was opportunity to be observed performing practical procedures in clinical practice | ↑ 91% | ↓ 53% | ↑ 93% | ↑ 77% | ↓ 91% | ↓ 50% | ↑ 95% | ↑ 95% | ↓ 80% | ↓ 81% | 80% | 79% |
| 21. I had opportunity to be observed developing my consultation skills | n/a | ↓ 63% | ↑ 77% | ↑ 53% | ↑ 91% | ↑ 50% | ↑ 84% | ↑ 80% | ↑ 93% | ↑ 68% | 73% | 72% |
| Domain 6 Feedback and Assessment | 79% | | | | | | | | | | 79% | 79% |
| 22. My final assessment focussed on feedback about my performance across the whole placement | ↑ 81% | ↑ 51% | ↓ 72% | ↑ 56% | ↑ 77% | ↓ 80% | ↑ 90% | ↑ 92% | ↑ 95% | ↑ 81% | 77% | 75% |
| 23. I had opportunity to get feedback throughout the placement (e.g. via completion of WPBA/feedback on clinical | ↑ 62% | ↓ 65% | ↓ 77% | ↑ 59% | ↑ 95% | ↑ 75% | ↑ 91% | ↑ 90% | ↑ 98% | 84% | 80% | 82% |
| 24. The feedback I received on my performance was useful and addressed my learning needs | ↑ 62% | ↑ 62% | ↑ 78% | ↑ 58% | ↑ 95% | ↓ 70% | ↑ 88% | ↑ 90% | ↑ 100% | ↑ 87% | 79% | 80% |
| Domain 7 Overall rating of attachment | 85% | | | | | | | | | | 85% | 84% |
| 25. Overall the placement was well co-ordinated and organised | ↑ 74% | ↓ 78% | ↓ 81% | ↑ 72% | 100% | ↑ 80% | ↑ 91% | ↑ 93% | 100% | ↓ 78% | 85% | 85% |
| 26. Overall I would recommend this placement to another student | ↓ 73% | ↓ 78% | ↑ 88% | ↑ 69% | 100% | ↑ 80% | ↑ 91% | ↑ 93% | 100% | ↓ 79% | 85% | 84% |
| STUDENT RESPONSE | 74(77 %) | 67(87 %) | 81(100 %) | 93(100 %) | 22(92 %) | 20(95 %) | 58(97 %) | 59(98 %) | 55(92 %) | 121(98 %) | 750(95 %) | 2502(92 %) |
| Data presenting using the National Student Survey % bands: | Green >= 80% Yellow 65-79.9% Red <65% | | | | | | | | | | | |
| | Small numbers - refer to report | | | | | | | | | | | |

Arrows show comparison with previous year's data (fall or rise in percentage of agreement, no arrow - no change in data)