APPENDIX 1

Maternity Services Annual Report 2018/19: A Year of Achievements

Introduction:

The Maternity Service at Bradford Teaching Hospitals NHS Foundation Trust has experienced a challenging, yet highly successful year during 2018/19.
Since the Quality Summit of 2016, declared following a cluster of Serious Incidents, the service has worked tirelessly to achieve the actions and recommendations of both the Care Quality Commission (CQC) and of the Royal College of Obstetricians and Gynaecologists (RCOG), ensuring that lessons learned and subsequent changes to the provision of care are embedded firmly in practice.

Whilst changes in practice and the need to deliver some elements of the service in a different way were identified and agreed during the preceding year, 2018/19 has proven to be the year when the required changes were achieved.

The positive impact of changes implemented during 2018/19 are described within the report, and our improvement journey has been recognised and acknowledged throughout the year by the Board, commissioners, regulators, service users and staff.

The maternity team are incredibly proud of this year's achievements and whilst we have taken a moment to reflect and celebrate our successes, we recognise that this is the start of the journey and we have more to achieve in the coming years.

The Maternity Workforce:

The midwifery and nursing staffing position at the end of 2018/19 saw the service achieve the 2017 Birth Rate Plus recommended increase to the midwifery establishment, following investment and support from the Trust Board. The increase to establishment has had a positive impact on quality and safety, enabling the 24/7 opening of MAC, 24/7 emergency obstetric theatre cover which in turn has increased the ability to provide 1:1 care to women in labour and an improved management of flow throughout the unit.

A positive recruitment drive in June 2018 resulted in 22 newly qualified midwives choosing Bradford Maternity services to start their midwifery careers. The opportunity to offer up to an additional 10 whole time equivalent (WTE) posts to newly qualified midwives, has enabled us to successfully manage attrition rates over the year and avoid a significant deficit in the spring as seen in previous years. This exercise will be repeated in June for students due to qualify in the autumn.

Recruitment to meet the 2017 approved obstetric theatre staffing paper continued into 2018 with some challenge due to the unique nature of the role, however the end of year position was significantly improved and only a very small proportion of scrub nurse/midwife hours are outstanding. As a result of this we are able to provide a scrub practitioner for emergency cases on the majority of shifts, this reduces the frequency of which a midwife is 'pulled' to scrub and has increased the opportunity to provide 1:1 care in labour.

During 2018/19 we recruited an additional 0.8 WTE Consultant Anaesthetist to ensure dedicated consultant cover for elective caesarean section lists. This appointment has enabled us to be compliant with OAA, RCOA and ACSA guidance, and improves patient safety.

In early 2019 the service welcomed a new Consultant Obstetrician, Amy Hufton, who will lead on perinatal mortality and has a special interest in intrapartum care and maternal medicine.

During 2018/19 there were a number of changes to specialist midwifery roles to reflect the needs of the service and to strengthen the existing maternity risk and governance structure. The Consultant Midwife role was removed from the structure and was replaced by an 8a Risk and Governance Lead Midwife, who leads a small governance team comprising of:

- Specialist Risk and Governance Midwife
- Specialist Midwife for Quality Midwifery Practice (new role)
- Clinical Governance Support Officer

The Specialist Midwife for Quality Midwifery Practice, leads the debrief and birth choice service for women who have had a previous traumatic birth, or women who are requesting care outside of usual guidance (previously facilitated by the Consultant Midwife). The other core element of this role is to support midwives in embedding lessons learned from incidents including any changes to practice in a timely manner.

In March 2019 the service appointed a Specialist Midwife for Continuity of Carer Pathways. This is a 12 month, fixed term secondment funded by the West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS), to develop and support the redesign of services to achieve the Better Births National Maternity Team mandate of 'the majority of women' booked on a Continuity of Carer (CoC) pathway by 2021.

In response to the Antenatal Newborn (ANNB) screening serious incident occurring during 2018, the service has successfully appointed an ANNB Screening Failsafe Officer to support the multiple screening programmes. This development was extremely well received and highlighted as an area of good practice during a recent Public Health England Quality Assurance peer review.

Service Developments:

2018/19 has seen the fruition of a number of developments to improve the quality and safety of the maternity service.

24/7 Maternity Assessment Centre (MAC)

Prior to November 2018, BTHFT provided a 12 hour MAC service between 10.00-22.00h, 7 days a week. Achieving the staffing recommendations of the 2017 Birth Rate Plus acuity tool, has enabled the provision of a 24/7 service. This has had a significant positive impact on service delivery, quality and safety, and also staff and service user satisfaction including:

- Marked increase in the ability to provide 1:1 care in labour.
- Improved flow and reduction in 'bed blocking' on labour ward by non-labouring women out of hours.
- Increase in the timely presentation and assessment of women experiencing reduced fetal movements out of hours.
- 24 hour service has improved staff ability to go home on time at the end of their contracted shift, improving wellbeing and staff morale.

Induction of Labour Suite

At the end of 2018/19, ward M3 opened 2 x 4 bedded bays dedicated to women undergoing induction of labour. Women undergoing induction are cared for on a 1:4 ratio, by midwives

who have expertise in induction and an interest in improving women's experience. This model has additional benefits including:

- Fewer women are induced on labour ward which improves the ability to achieve 1:1 care in labour.
- 'Co-horting' women in 1 area improves surveillance and the ability to monitor in accordance with guidelines and best practice, thus reducing the risk of incidents/poor outcomes during the induction process.
- Improved flow across the unit.

Transformation in antenatal diabetes clinic:

In response to 2 similar serious incidents (SI's) involving women with gestational diabetes in 2017/18, and also as an identified need to improve the experience of women attending antenatal diabetes clinics, a piece of transformational work was undertaken during 2018/19. Working collaboratively with the antenatal clinic multi-disciplinary team (MDT) and service users, the transformation team have introduced a number of changes to improve the quality and safety of the diabetic clinic including:

- Improved system to ensure that women are seen by the appropriate member of the MDT at each appointment.
- Improvements to ensure that women do not leave their appointment without the relevant follow-up in place.
- Significant reduction in clinic waiting times, which has been positively received by women using the service.

Next steps for 2019/20 are to continue the transformation work across other specialist antenatal clinics and maternity ambulatory care services as a whole.

Continuity of carer pathways:

In February 2018, Refreshing NHS Plans 18/19 published corrections to the maternity deliverables. The original deliverable was to increase the number of women receiving **continuity** of the person caring for them during pregnancy so that by March 2019, 20% of women booking receive continuity. The correction is now to increase the number of women receiving **continuity** of the person caring for them during pregnancy, birth and postnatally so that by March 2019, 20% of women booking receive continuity. This is a staged approach, increasing to 35% by March 2020 and the majority of women (nationally defined as 51%) by March 2021.

In April 2018 it was reported to EMT that the BTHFT Continuity of Carer (CoC) trajectory was expected to be 9.2% of women booked on a CoC pathway in March 2019. The maternity service is delighted to report that the actual figure submitted to the National Maternity Team was 18.6%, far exceeding the predicted figure and close to the 20% national expectation.

The service is now working towards achieving the expected 35% by March 2020, progressing to the majority of women (51%) by March 2021.

The newly appointed Specialist Midwife for CoC pathways is leading this mandated work, engaging with midwives, obstetricians and women to develop pathways which increase the likelihood of women receiving care from a known midwife throughout the pregnancy and birth continuum.

Pathways in place include:

- Better Start Bradford funded personalised midwifery 'Clover Team', a case loading team providing care to some of Bradford's most vulnerable and socially deprived women and families.
- Bradford Home Birth Team. Since the team commenced the service has seen a significant increase in the number of women selecting home as the chosen place for birth.
- Gold Star Pathway, providing continuity of carer to women who are HIV positive.

In an attempt to improve CoC for the majority of women, Community Midwifery teams have been reconfigured into 10 teams of 6-8 midwives, which evidence has shown increases the likelihood of being cared for by a known midwife. The next step towards achieving CoC for a larger number of women, is to integrate Community Midwifery teams with the Bradford Birth Centre, which is currently the place of birth for around 25% of women. Pathways developed to date have been delivered cost neutral, however it is anticipated that the requirement for midwives to work differently in order to achieve continuity will require additional resource.

The service is also exploring CoC pathways which specifically improve outcomes for women and babies from Black, Asian, Minority Ethnicity (BAME) backgrounds, in line with the 2018 MBRRACE-UK Saving Lives, Improving Mothers' Care report, which highlighted that BAME women are more likely to die during and immediately following pregnancy, than Caucasian women.

Maternity Communication Team:

One of the great success stories of 2018/19 is the development of the Maternity Communication Team. The team was created in response to feedback from front line staff that communication within the unit was lacking, leading to poor engagement and contributing towards low morale.

A small team of 5 front line staff liaise with the Senior Midwifery team on a monthly basis for updates on local, regional and national maternity issues which are then disseminated to the wider team in a number of ways including:

- Bi-monthly newsletter.
- 'Friday Fives' weekly team member profile ranging from Student Midwives to the Medical Director, published on the closed Facebook group page.
- Monthly birth stats info graphics.

These publications have been extremely well received, with staff commenting that they now feel more included and up to date. The birth stats info graphics are also shared with the general public and have received positive feedback and enquiries from service users. The info graphics were highlighted as an example of good practice during a recent CQC engagement visit.

Quality Improvement:

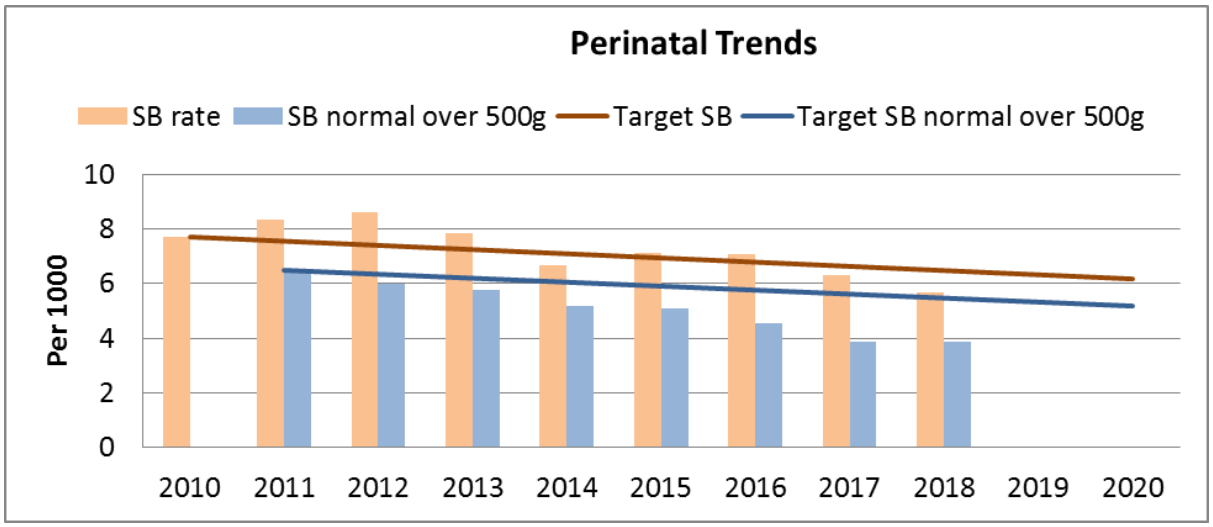
During 2018/19 the service has worked alongside the Trust's wider QI and Informatics teams, to develop a suite of metrics with which to monitor progress and inform quality and service improvements. The metrics are closely aligned to those known to be of interest to the CQC and used as a measure of quality. Further work in this area continues into 2019/20.

The Maternity Safety Agenda:

In 2018/19 the Maternity service worked hard to deliver a high standard of safe, quality care, providing continued assurance of lessons learned from the series of clinical incidents which triggered the 2016 Quality Summit, whilst simultaneously working towards meeting the recommendations of the multiple, nationally driven maternity safety agenda.

Stillbirth Reduction including Saving Babies Lives:

Bradford continues to be a regional and national outlier for stillbirth and perinatal death, however as in 2017/18, 2018/19 has continued to see a downward trajectory in stillbirths of normally formed fetuses.



The Saving Babies Lives care bundle, launched in 2016 as part of the Secretary of State's national ambition to halve stillbirths by 2030, comprised of 4 key elements:

- Reducing smoking in pregnancy
- Risk assessment and surveillance for fetal growth restriction
- Raising awareness of reduced fetal movements
- Effective fetal monitoring during labour

During 2018/19, BTHFT were fully compliant with the implementation of all 4 elements of the care bundle and associated interventions (Appendix 1). A 'deep dive' was undertaken and submitted at the request of the Strategic Clinical Network, in order to identify any gaps, good practice and areas requiring support from the network. The collated information will be returned via WY&H LMS in the form of a highlight report, and is still awaited. (Appendix 2) Saving Babies Lives version 1 was superseded in March 2019 by Saving Babies Lives version 2, and the Trust is expected to be compliant with the recommendations and have implemented additional interventions by March 2020. Quality Committee will be updated on progress against version 2 in December 2019.

Perinatal Mortality Review Tool

The Perinatal Mortality Review Tool (PMRT) was developed with input from bereaved parents, and is designed to support the standardised review of perinatal deaths, using a

systematic, multi-disciplinary approach. Completion of the PMRT results in the production of a report for parents, which includes a meaningful, plain English explanation of why their baby died.

Safety Action 1 of the Maternity Incentive Scheme, requires organisations to demonstrate that the PMRT has been commenced for 90% of eligible deaths from 12 December 2018 to submission of the MIS on 15 August 2019, and that 50% of all eligible deaths are completed to the point of production of a draft report within 4 months of the death.

Appendix 3 is a summary report for Quarter 4 2018/19, of all eligible deaths requiring completion of the PMRT. Subsequent reports will be included within the quarterly maternity services update provided to Quality Committee.

K2 Cardiotocograph (CTG) training and PROMPT (Emergency Skills training)

One of the elements of Saving Babies Lives version 1 relates to effective fetal monitoring during labour. Likewise, the 2016 Quality Summit also highlighted the need for improvement in the interpretation of CTG's to improve outcomes.

For the 2nd consecutive year the service can report that all staff required to interpret CTG's as part of their role, completed the mandatory K2 training package within the expected time frame. In addition to this, we are on target to achieve the Maternity Incentive Scheme requirement of 90% of all staff groups completing an annual multidisciplinary emergency training day, of which CTG interpretation is a component.

Maternal and Neonatal health safety collaborative

BTHFT maternity services participated in wave 1 of the 3 year NHS Improvement 'MatNeo' collaborative, introduced to make measurable improvements in safety outcomes for women, their babies and families. 4 projects linked to national drivers and identified priorities within the service were selected and QI methodology applied. One of the greatest successes emerging from the collaborative work was improving the barriers preventing women presenting with reduced fetal movements in a timely manner, which has been recognised at national level. The WY&H LMS has also used BTHFT's improvement success in this area as a bench mark for good practice within the system. A summary of the MatNeo QI journey will be presented to Quality Committee in June as a standalone item.

1:1 care in labour

As a direct consequence of service developments and improvements including 24/7 MAC opening and the opening of the Induction of Labour Suite, there has been a marked improvement in the ability to provide 1:1 care in labour on labour ward towards the end of 2018/19 and continuing into 2019/20. Prior to these improvements, the 1:1 care in labour rate was frequently between 55-65%, which has now improved to 70%. Further improvements are required to achieve our ambition of 90-100%, and the introduction of capturing failure to achieve 1:1 care as a 'red flag' incident will support the bi-annual review of midwifery staffing, and inform any changes required to existing staffing models.

Maternity Incentive Scheme (MIS) and Maternity Safety Champions

BTHFT successfully achieved the full benefit of year 1 of the MIS in 2018. The service is currently working towards providing Trust Board with the evidence and assurance required to provide sign off before submission to NHSI on 15 August 2019.
One of the 10 safety actions relates to the role of Board level safety champions and organisations providing a mechanism for front line staff to escalate safety concerns. During

2018/19, the 2 Maternity Safety Champions (Head of Midwifery and Clinical Lead for Obstetrics) have worked alongside the Board Level Maternity Safety Champion, Karen Dawber, to create a positive culture wherein maternity safety concerns are high on the Trust's agenda, and where frontline staff are empowered and supported to raise concerns. Although this is a requirement of the MIS, the processes in place including:

- Bi-monthly safety champion meetings.
- Monthly safety meetings and feedback sessions for frontline staff, including neonatal unit.

These measures have been very well received within the unit, with staff appreciating direct access to a member of the Board and the assurance that their concerns are listened to and acted upon where necessary.

Health Safety Investigation Branch (HSIB)

HSIB is part of a national action plan to improve maternity care, and provide an independent, standardised approach to maternity investigations without attributing blame or liability. HSIB 'went live' in the region on 3 December 2018, and 3 cases met the reporting criteria between 3 December and the end of financial year 2018/19.

The service remain responsible for conducting an initial 72 hour review of eligible cases, escalating to Quality Of Care Committee, declaring any Serious Incident cases and reporting on STEISS, and addressing any lessons learned immediately identified. The full investigation and subsequent written report is then completed by HSIB. None of the 3 cases occurring in 2018/19 are as yet completed to draft report stage, however all immediate actions and learning have been addressed and shared with staff.

Service User Engagement and feedback:

During 2018/19 the maternity service has improved engagement with the women and families who choose maternity care at Bradford. Our ambition is to improve this even further and to design and develop services for Bradford women, with Bradford women.

Maternity Voices Partnership (MVP)

Bradford MVP launched in early 2018/19, as a platform for local women, providers and other partners including primary care and community organisations, to shape maternity services and work together to meet the needs of the diverse childbearing population.

The format and structure of the main MVP meetings held quarterly, and the associated sub meetings is still evolving. BTHFT maternity services are well represented by the Head of Midwifery and a variety of clinical staff including obstetricians and specialist midwives. The partnership gives providers the opportunity to share service developments and improvements, provide assurance of quality and safety and ask for the opinions of the women and families using the service. During 2018/19, the MVP did not report any areas requiring action or response, however this is the agreed mechanism to receive and respond to both positive and negative feedback.

Stillbirth and Neonatal Death Society (SANDS)

Positive engagement with bereaved parents can often be challenging, and although the local Bradford SANDS group are well established the maternity service has not consistently engaged with this valuable group of service users. During 2018/19, a member of the maternity service has attended a number of monthly committee meetings, and has actively

sought both positive and negative feedback which has resulted in some positive service changes to bereavement care.

Social Media:

Bradford antenatal, birth and beyond, is the maternity services Facebook page and provides women and families with information about pregnancy, birth and the early postnatal period. It is also an opportunity to share important public health information, such as safe sleeping advice and smoke free homes. During 2018/19, we saw an increase in the number of people accessing the page, and have expanded the page to share birth stories and experiences. The responses have been 100% positive and are highly complementary of the care provided.

Next steps:

A maternity services open day is planned for August 2019, and will not only show case the services we already provide, but provide an opportunity to receive feedback and to understand the needs of Bradford women.

During 2019/20, we are hoping to recruit a number of service users to a number of our key groups including Maternity Services Forum and Antenatal Newborn Screening Group, so that the views and opinions of our women are better represented.

Forward Plan and key priorities for 2019/20:

Many of the safety and quality improvements described within this report continue into 2019/20 and beyond, including a continuation of the transformational work commenced in antenatal clinic.

Continuity of Carer is another national priority which we continue to work towards. Whilst meeting the 35% requirement for 2020 is a key objective, we are keen that achieving continuity for some groups of women does not disrupt the existing high levels of antenatal and postnatal continuity we already achieve for the majority of women. Evidence suggests that providing CoC significantly improves both maternal and neonatal outcomes, however we will also be focusing on improving the experiences of women who either choose or clinically require more traditional pathways of care.

A key priority for 2019/20, which in part will be influenced by anticipated changes to how neonatal services are provided at both local and national level, is the maternity work stream of the Airedale and Bradford Acute Provider Collaboration. We acknowledge that whilst this is the long term vision of both organisations, maternity, neonatal and paediatric services have urgent pressures which require our full engagement, participation and collaboration to ensure that maternity services at both Airedale and Bradford are realistic, accessible and achievable.

Our ultimate ambition is to provide a quality and safe maternity service, listening to our women and families, being responsive to their needs and most importantly, continuing to learn from our mistakes. By employing this approach to how we deliver care, we are optimistic that our regulators will rate us as ‘Good’ at our next inspection and that we then continue our journey to being an ‘Outstanding’ maternity service.

Appendices:

1. Copy of Saving Babies Lives Survey 12 (Maternity Incentive Scheme evidence)
2. Copy of Saving Babies Lives 'Deep Dive' submitted to the Strategic Clinical Network
3. Perinatal Mortality Review Tool, Quarter 4 report to follow