

**Women's Service  
Clinical Business Unit**

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**Private and Confidential**

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Dear HSIB,

Following receipt of your escalation of emerging concerns letter, dated 11 May 2022, we have considered each of the concerns raised and have provided a summary of any relevant changes or improvements already in place and any further actions or planned improvements.

- 1. Supporting mothers whose first language is not English:**
  - a. Insufficient provision / usage of interpreting services for antenatal appointments.**
  - b. Family members being used to interpret information for the mother.**

**a) Insufficient provision / usage of interpreting services for antenatal appointments:**

Recent actions taken to address and improve the provision and use of interpreting services:

Appointment of 2 Maternity Support Workers (MSW) with additional language skills in antenatal clinical: December 2021

Provision of Parent Education classes in Urdu and Punjabi

Self-referral for maternity services on-line form can now be converted into any language

Well embedded use of MAMA academy wallets.

Staff survey conducted in July 2021 exploring staff challenges and barriers to using interpreting services. Recommendations:

- Purchase of Smart phones for all clinical areas solely for interpreting purposes- completed
- Purchase of language line I-pads to enable easy access video interpreting. Devices currently in medical electronics and anticipated to be in use by June 2022

Interpreting audit completed in September 2021. Recommendations included:

- Improving documentation of the use of interpreters
- Documenting when a staff member has provided interpreting support
- Consider providing leaflets in different languages regarding common procedures, for example caesarean section, induction of labour.

Further actions required:

- Consider how we can improve the initial identification of women who need an interpreter as women do not always volunteer this information prior to the Booking appointment. This is included on the electronic booking form but is frequently not answered or completed incorrectly
- Following the recent roll-out of Cerner Maternity EPR there needs to be further education and improvement in the documentation of both the offer and any decline of use of an interpreter, and clarification of when an interpreter is used
- Repeat the interpreting audit no earlier than 6 months after the roll out of the video devices to assess if this has had the impact expected
- Roll out of common procedures leaflets in different languages

**b. Family members being used to interpret information for the mother:**

Best practice is to encourage all women whose 1<sup>st</sup> language is not English, to accept the offer of an interpreter (either face to face, by telephone or virtual) at every contact. We are aware that some women decline this offer in preference of using a family member to interpret but this is not always recorded.

Further actions required:

- Improved documentation specifically recording that interpreting services have been offered but declined in preference of a family member
- Improved documentation of when interpreting services have been accepted but have not been used. For example: Interpreter did not attend appointment, devices unavailable, clinical emergency requiring immediate communication.

**2. Fetal growth surveillance:**

**a. Opportunities for growth ultrasound scans to being undertaken following a slowing growth trajectory on symphysis-fundal height measurements.**

Recent actions taken:

- Symphysis Fundal Height competency package developed in May 2020 and was progressively rolled out across the service. Use of this package is included in the maternity training needs analysis and is repeated on a 2 yearly basis.
- The updated guideline: 'Ultrasound surveillance and management of pregnancy with suspected small for gestation (SGA) and fetal growth restriction (FGR) baby' was written in December 2020 and following ratification and education was rolled out in February 2021.
- The clinician involved in the most recent case has completed the SFH competency package.

Further actions required:

- Lessons Learned to be circulated to all staff, with focus on Maternity Assessment Centre staff, reminding that if a woman is referred with a slowing growth trajectory on SFH and is re-measured by a different clinician and a measurement discrepancy is identified, the smaller measurement should still generate a growth scan referral to avoid false reassurance.

3. **Trust audit for missed small or gestational age (SGA) babies:**
  - a. **No audits completed after September 2021.**
  - b. **Uncertainty about the validity and reliability of data provided to the investigation, in relation to missed SGA audits from March 2020 to September 2021.**

**No audits completed after September 2021:**

HSIB have raised that: The trust local guidance 'Guidelines for risk assessment, Ultrasound surveillance and management of pregnancy with suspected small for gestation (SGA) and fetal growth restriction (FGR) baby' (December 2020) indicates an annual 'rolling audit and regional reporting' of the 'percentage of FGR babies <3rd centile born after 37+6 or missed on scan'; it does not specify it should be SBLCB related.

The Trust would like to clarify that the annual rolling audit and the regional reporting, including quarterly audits, are all based on SBLCB recommendations.

The Yorkshire and Humber Regional Maternity Network did not request quarterly SBLCB audits in line with the national pause of the Maternity Incentive Scheme, year 4, in December 2021. In addition, the Maternity Incentive Scheme also supported the non-submission of quarter 3 2021, SBLCB data, in organisations where staffing was critical. Both midwifery and obstetric staffing was at critical levels during this time, reflected on our maternity risk register. To prioritise direct clinical care, supported by the NHS Resolution Maternity Incentive Scheme, further audits were not undertaken after September 2021. However, we continued to monitor our rolling data via our local maternity dashboard.

A submission of up to date rolling data was not requested from the Trust, by the lead HSIB investigator for the most recent case, who instead based her conclusions on data submitted for a previous case in January 2022. This only included data up to September 2021.

For completeness and additional assurance we can provide the local maternity dashboard for this period.

Whilst dashboard data regarding the number of cases identified is available, the patient level detail was not available resulting in an inability to scrutinise individual cases. This was as a result of personnel changes in responsibility of populating the dashboard, further affected by the recent change from Medway to Cerner EPR. This is now resolved.

A further contributory factor to reviewing individual cases, has been significant obstetric and midwifery staffing challenges, resulting in an inability to hold monthly FGR multidisciplinary team review meetings. January to May 2022 cases have been reviewed by the Safer Maternity Care Midwife. An initial MDT meeting was held on 9 May to discuss resuming the monthly review meetings. The next meeting is planned for 1 June 2022.

**Further actions required:**

- Re-instatement of monthly FGR MDT meetings from 1 June 2022
- Retrospective MDT review of the January to May 2022 cases, including collation of any themes and trends to then be included into an overarching annual report of the 12 months May 2021 to May 2022.
- Quality and Safety lead midwife to review what data is collected for the rolling dashboard to ensure that the methodology is still relevant following the change of EPR systems

**Uncertainty about the validity and reliability of data provided to the investigation, in relation to missed SGA audits from March 2020 to September 2021:**

As previously mentioned, the rolling data HSIB are referring to in relation to the most recent case, is data which was provided for an earlier investigation in January 2022.

The Trust can provide rolling data of missed SGA/FGR babies between January 2022 to date.

The snap shot audit provided by the Safer Maternity Care midwife was based on 40 cases of babies over 37+6 weeks born in January 2022. 6 of the 40 babies were found to be undetected SGA/FGR. The auditor used 40 as the denominator giving a rate of 15%. Following HSIB's letter of concern, the Trust have realised that the methodology applied to this audit was incorrect, giving a falsely elevated percentage of babies.

HSIB are correct in their query regarding the validity and reliability of the data and the Trust are addressing and clarifying the methodology used for future snap shot audits, and would like to apologise for the confusion.

**Actions taken:**

- The Safer Maternity Care Midwife identifies all cases of babies less than the 3<sup>rd</sup> centile every month (using the monthly birth rate as the denominator). This should be comparable with the rolling data reflected on the dash board

**Further actions:**

- Following the change from Medway to Cerner EPR, the Maternity Service is working closely with Business Intelligence to ensure that we meet the MSDS reporting elements of the Saving Babies' Lives Care Bundle. Medway did not support the submission of this data previously.

We hope that this provides you with the assurance that significant improvement work has already been undertaken in relation to both the provision of interpreting services and the identification and management of SGA/FGR babies and that further improvements are planned/in progress.

We would also like to confirm that the escalation of emerging concerns letter along with this response has been shared with our Maternity Commissioners and West Yorkshire and Harrogate Local Maternity System and the CQC for transparency.

Yours sincerely

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