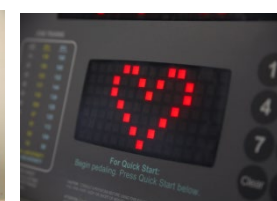


Maternity and Neonatal Services Update including the Three Year Delivery Plan

Sara Hollins, Director of Midwifery, 11 May 2023



- Quality and Patient Safety Academy, as a committee of the Board with delegated authority, received and approved the Maternity and Neonatal Services Update papers, relating to activity in February and March 2023.
- Key highlights presented and discussed:
 - The number of harms occurring in February and March, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of HSIB and SI cases.
 - Completed HSIB and internal investigations/SI reports closed in February and March including learning and progress on actions.
 - Details of 5 neonatal deaths occurring in February and assurance that there are no emerging themes and trends.
 - The Perinatal Mortality Review Tool (PMRT) quarterly report including learning, required to demonstrate compliance with safety action 1 of the Maternity Incentive Scheme.

Closed HSIB/SI Investigations

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February

3 completed investigations

1 internal SI

2 HSIB

Appendices 1a, 1b and 1c available for
closed Board information including
learning

March

1 completed HSIB investigation

Appendix 2a available for closed
Board information including learning

Recommendations for May Board

- Trust Board to approve that they are assured that QPSA have reviewed and discussed the contents of the February and March Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority.
- Trust Board to approve that they are assured that QPSA have reviewed the March PMRT quarterly report including learning, required to demonstrate compliance with safety action 1 of the Maternity Incentive Scheme as a committee of the Board with delegated authority.
- Closed Trust Board to note appendices 1 and 2 describing the stillbirths, HIE and neonatal deaths occurring in January 2023 and both newly reported and ongoing investigations.
- Closed Trust Board to note the completed HSIB/SI reports including recommendations.

Three Year Delivery Plan

- The NHS England 'Three Year Delivery Plan for Maternity and Neonatal Services' was published on 30 March 2023.
- The 'single delivery' plan sets out a series of actions for Trusts, Integrated Care Boards (ICBs) and NHS England in order to improve the safety and quality of maternity and neonatal services.
- It follows several national plans and reports, including the reports by Donna Ockenden and Dr Bill Kirkup, and brings together the key objectives services are asked to deliver against over the next three years.
- The report sets out the 12 priority actions for Trusts and systems for the next three years, across four themes:
 - **Listening to women and families with compassion**
 - **Supporting the workforce**
 - **Developing and sustaining a culture of safety**
 - **Meeting and improving standards and structures**

Listening to women and families with compassion

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- Midwifery Continuity of Carer (MCoC) remains high on the medium to long term agenda, with a continued focus on providing MCoC to our most vulnerable women and pregnant people.
- Digital solutions including personalised care plans which to date we have not found a solution for. This currently prevents us from undertaking the regular audits recommended and acting on the findings.
- Digital solutions to enable women to access their records and interact with their digital plans by 2024. As above.
- Achieving Baby Friendly status by 2027. The service is currently working towards Baby Friendly re-accreditation, but without additional short term investment achieving this by 2027 will be a challenge.
- Provide services that meet the needs of their local populations, paying particular attention to health inequalities, including ensuring access to interpreter services. Good progress has been made in this domain but it is anticipated that ongoing improvements regarding access to interpreting services will carry some financial risk.

Great work already in progress within midwifery and neonatal nursing including International Recruitment, strong focus on pastoral support and development. System working with Local Maternity and Neonatal System (LMNS) including focus on improving medical workforce recruitment

- Provide administrative support to free up pressured clinical time requires exploration and consideration.
- Developing a mentorship programme for newly appointed Band 7 and 8 midwives requires progression.
- Creating an anti-racist workplace will require support and guidance from the Trust Equity and Diversity leads.

Developing and sustaining a culture of safety

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Positive progress already made. Trust rollout of PSIRF, well embedded executive and non-executive safety champion processes, Director of Midwifery attendance at every Board. Good relationships and evidence of co-production with Maternity and Neonatal Voices Partnership (MNVP).

- More oversight and information regarding neonatal services at Board level.
- Involve the MNVP in developing the trust's complaints process- this will need development.

Standards and structures that underpin safer, more equitable care

Full implementation of Saving Babies' Lives Care Bundle version 2.

Maternity Cerner has improved some elements of data recording and collection.

- Implementation of Saving Babies' Lives Care Bundle version 3 by March 2024- scanning capacity is already a major challenge.
- Implementation of the new national maternity and neonatal early warning scores by 2025, is a potential Cerner digital risk.
- Ability for women to access their clinical records and interact with their digital plans to support informed decision making is an existing risk.

Recommendations to Board

- Discussion to be held with the Chief Digital and Information Officer to agree a plan regarding the digital risks described.
- Digital maternity risk entry to be updated accordingly following discussion above.
- The monthly Maternity and Neonatal Services update paper presented to Quality and Patient Safety Academy will be used to update on progress against the plan, and any challenges or risks requiring escalation to Board.
- Any actions requiring financial investment will be brought to Executive Team Meeting, for discussion and decision regarding any next steps.



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Questions?