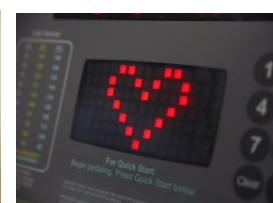
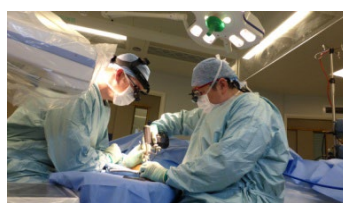


Maternity and Neonatal (Perinatal) Services Update June/July 2023 and Maternity Incentive Scheme Year 5 position

Sara Hollins, Director of Midwifery
Board of Directors, 21 September 2023



June/July Highlights



Bradford Teaching Hospitals
NHS Foundation Trust

- The June and July perinatal update papers were presented to July and August Quality and Patient Safety Academy respectively.
- As a delegated authority of Trust Board, Academy received and approved the papers, appendices and recommendations.
- Details of harms, including stillbirths, neonatal deaths and hypoxic ischaemic encephalopathy, and completed investigation reports including learning, were shared and are also available to Trust Closed Board for information.
- In July, Executive Team Meeting (ETM), received a presentation regarding the predicted position of the Maternity Incentive Scheme, Year 5.

Discussion Points



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- The number of harms occurring in June and July, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of HSIB and SI cases were discussed.
- June QPSA were informed that there was to be a 'Deep Dive' of HIE cases occurring in 2022/23 as we have identified ourselves as a possible outlier. This will have been deferred from July due to holidays and a multidisciplinary review arranged for September.
- Completed HSIB and internal investigations/SI reports closed in June and July were discussed including learning and progress on actions.
- The PMRT quarterly report including learning, required to demonstrate compliance with safety action 1 of the Maternity Incentive Scheme presented to July QPSA.
- The ATAIN/TCU quarterly report, required to demonstrate compliance with safety action 3 of the Maternity Incentive Scheme presented to August Academy.
- June and July Maternity Training Compliance was presented and discussed respectively at July and August QPSA.
- July QPSA were informed that the CSU has an emerging concern regarding the Core Competency Framework training requirements and the significant increase required for each midwife to meet compliance.

MIS Year 5 position



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- 10 Safety Actions remain unchanged although some alterations to the action descriptors.
- Additional Board level evidence required for some actions.
- First MIS submission since publication of Saving Babies Lives version 3. Uncertain if we will meet the standard if there is a further increase to scan recommendations- Benchmarking exercise is in progress.
- The Core Competency Framework training requirements have significantly increased the number of mandatory training hours required by every midwife (headcount not whole time equivalent).
- Trajectory to meet 90% anaesthetic and obstetric compliance with PROMPT is fragile and potentially at greater risk if industrial action persists.
- ICB funding of the MNVP is at risk of being insufficient to meet the MIS and 3 year plan requirements for both Bradford and Airedale- Funding arrangements have been amended, but there has been little activity from the MNVP to provide robust evidence of compliance.

Summary and anticipated position



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Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Y
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Y
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Y
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Y
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Y
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle version three?	
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Y
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Y

Together, putting patients first

- High level of confidence that compliance will be declared for Safety Actions, 1-5, 9 and 10.
- Moderate to High risk that Safety Action 7 will not meet the standard.
- High risk that Safety Actions 6 and 8 will not meet the standard.

- Financial: Trust will not receive the total premium.
- Reputational: The MIS exists to provide assurance and evidence of safe services. Declaring non-compliance may attract external scrutiny in the absence of mitigation and robust action plans for the standards not achieved.
- Trust Board sign off of action plans will be required in January prior to self-declaration in February 2024.

Request of September Board



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- Trust Board to approve that they are assured that QPSA have reviewed and discussed the contents of the June and July Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority. Appendices 1 and 2.
- Trust Board to note that a multidisciplinary team review of the 2022/23 HIE cases will take place in September and findings presented to October QPSA.
- Trust Board to approve that they are assured that QPSA have reviewed the June Perinatal Mortality Review Tool (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.
- Trust Board to approve that they are assured that QPSA have reviewed the July ATAIN/TCU quarterly report including learning, required to demonstrate compliance with safety action 3 of the Maternity Incentive Scheme as a committee of the Board with delegated authority.
- Closed Trust Board to note appendices 3 and 4 describing the stillbirths, HIE and neonatal deaths occurring in June and July 2023 and both newly reported and ongoing investigations.
- Closed Trust Board to note appendices 3a, 3b and 4a completed HSIB/SI reports including recommendations.
- Trust Board to note that concerns regarding meeting the Core Competency Framework training requirements was reported to June QPSA and subsequently presented to Executive Team Meeting as part of the Maternity Incentive Scheme, Year 5 update.
- Trust Board to note appendix 5, Maternity Incentive Scheme, Year 5, position presentation, discussed at Executive Team Meeting on 7 August, and the current prediction that the Trust may not be in a position to declare full compliance in February 2024.