East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Perinatal Mortality Review Tool (PMRT) Quarterly Report – Q1 2023/24**

Meeting date: **7 September 2023**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO): Maternity and Neonatal Board Safety Champion**

Paper Author: **Interim Matron for Quality Governance**

Appendices:

NONE

Executive summary:

Action required:	Assurance
Purpose of the Report:	• The purpose of this report is to assure that all stillbirths and neonatal deaths are reviewed using the national electronic Perinatal Mortality Review Tool (PMRT). • This is in accordance with the standards set out in NHS Resolutions Maternity Incentive Scheme which aim to continue to support the delivery of safer maternity care.
Summary of key issues:	• The report confirms that during the Quarter 1 reporting period the service has used the tool to the required standard as set out in NHS Resolution, Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 5, and identifies learning to improve. • CNST year 5 commenced on 30 May 2023, therefore, this report running from 1 April to 30 June extends beyond CNST Year 5 reporting. • During Quarter 1, there have been a total of 5 cases reported, 3 of the cases were not supported and of which 1 was a stillbirth and 2 were neonatal deaths. • A PMRT generated Case List, pulled from the PMRT, shows the cases to date and their reporting stage. This has been shared with the Board Safety Champion but because it includes patient information it is not appended to this report. • Within the last quarter the Trust reported all cases to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) within 7 days of the death. • Within the last quarter the Trust had a100% compliance with surveillance being completed. • Within the last quarter the Trust had a 100% compliance rate of commencing the review within the allocated time scales. • The PMRT lead Midwife role commenced in post on 19 June 2023. The Bereavement Lead Midwife for William Harvey Hospital (WHH) and the Patient Safety Matron are handing over the work to the new lead. • The new Integrated Bereavement Pathway has been

	implemented at EKHUFT and the new team are working closely with the Multidisciplinary team to establish their new roles and ways of working. Implementation of the pathway will aide with the resolution of some of the reoccurring themes identified through the PMRT review. • In line with Ockenden recommendations, organisations should provide a 7-day specialist bereavement service for maternity and neonatal services. The transformation work led by the Head of Midwifery will address this and a band 4 post to support administration and coordination processes has recently been recruited, along with 2 x band 6 Midwives and 1 x Whole Time Equivalent (WTE) band 7 Bereavement Lead Midwife. • There is a 100% compliance with external reviewers at PMRT meetings, however this is as a result of the bereavement and governance midwives from neighbouring trusts supporting one another. There is a plan being discussed to potentially hold one Local Maternity and Neonatal System (LMNS) wide PMRT meeting where all Trusts join to review and discuss their cases. • The Board generated report shows the cases that have been reviewed within this quarter at the Multidisciplinary PMRT meeting. All cases are on schedule to be completed in the time frame and adhering to the time frames set by the national framework.
Key recommendations:	The Board of Directors is invited to receive **ASSURANCE** that a Quarterly Perinatal Mortality Review Tool paper has been received for Q1 2023/24 demonstrating full compliance in line with CNST standard requirements.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate. **Children's Care Group RR 2742:** There is a risk that the Trust will not be able to provide responsive post bereavement care to bereaved parents in neonatal areas.
Resource:	N
Legal and regulatory:	Y – NHS Resolution, CNST, Ockenden.
Subsidiary:	N

Assurance route:

Previously considered by: MNAG

East Kent Hospitals University NHS Foundation Trust

PERINATAL MORTALITY REVIEW TOOL QUARTERLY REPORT - Q4 2022/23

1. The purpose of report

1.1. The purpose of this report is to assure that all stillbirths and neonatal deaths are reviewed using the national electronic Perinatal Mortality Review Tool (PMRT).

1.2. This is in accordance with the standards set out in NHS Resolutions Maternity Incentive Scheme which aim to continue to support the delivery of safer maternity care.

2. Executive summary

2.1. The report confirms that the service is using the tool to the required standard, set out in NHS Resolutions, CNST Maternity Incentive Scheme Year 5, Safety Action One, and also identifies learning to improve.

2.2. A report was last received by this Group for Quarter 4 in May 2023 for the reporting period of January – March 2023.

2.3. The time period, for this quarterly reporting to trust board, is from 1 April to 30 June 2023 and includes 3 cases.

2.4. A PMRT Generated Board Report provides a summary of all reviews carried out using the tool during this reporting period.

2.5. As cases are reported through the PMRT tool, reports are generated and presented using the PMRT Tool.

2.6. A PMRT generated Case List, pulled from the PMRT, shows the cases to date and their reporting stage. This has been shared with the Board Safety Champion but because of patient information is not appended to this report.
This detail is captured against each standard below and shows100% compliance.

2.7. The current standard as received from NHSR May 2023 relaunch of CNST Year 5 is detailed below:

NB - this data includes cases before CNST Year 5 re-commenced:

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		
No	**Standard**	**Current Compliance for Q1 reporting period**
a)	All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	Met
b)	For 95% of all the deaths of babies in the Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.	Met
c)	For deaths of babies who were born and died in the Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of	

	the death, and a minimum of 60 % of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.	Met
d)	Quarterly reports will have been submitted to the Trust Executive Board from 30 May 2023.	Met

3. Safety Action 1 Quarterly Report Covering period April, May and June 2023

3.1. The time period, for this quarterly reporting to trust board, is from 1 April 2023 to 31 May 2023 and includes 1 stillbirths and 2 neonatal deaths.

3.2. All cases are reported through the PMRT tool, reports are generated using the PMRT Tool and learning disseminated through the monthly perinatal mortality meetings.

3.3. A PMRT generated Case List, pulled from the PMRT, shows the cases to date and their reporting stage. This has been shared with the Board Safety Champion but because of patient information is not appended to this report.
This detail is captured against each standard below and shows compliance in all areas with the exception of Standard a).

4. Compliance against standards required

4.1. **Standard a)** All eligible perinatal deaths should be notified to MBRRACE-UK must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one calendar month of the death. There were 5 cases reported, 3 cases the reviews were not supported as they didn't meet the criteria. Of the supported cases 1 was a stillbirth and 2 neonatal deaths and all cases that the Trust were responsible for reporting were reported to MBRRACE and the notification was reported within 7 days and surveillance within 1 month.

4.2. **Standard b)** For 95% of all the deaths of babies in the Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.

Reporting period 01 April 2023 to 30 June 2023	Number of Cases	Number of PMRT Started	% Compliance within standard timeframe
Stillbirths	1	1	100%
Neonatal Deaths	1	1	100%

4.3. **Standard c)** For deaths of babies who were born and died in the Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60 % of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.

Reporting period 01 April 2023 to 30 June 2023	%of reviews started within two months of the death	% Draft Report Stage within four months of the death	% Published within six months
Stillbirths	100%	N/A	100%
Neonatal Deaths	100%	N/A	100%

Overall 100% compliant against this standard

- All deaths have had an initial review by a multi-disciplinary team.
- 1 death has had a final multi-disciplinary review with an external auditor at the PMRT monthly meeting. The outstanding 2 are scheduled for 02/08/2023 Multi-disciplinary Team (MDT) meeting.
- The learning from the review is disseminated to the wider team at the monthly perinatal mortality and morbidity meetings in the usual way, and themes reported through to the monthly Women's Health Governance Meeting.

4.3.1. **Opportunities for improvement**

- Overall perinatal review attendance numbers are good and the team have taken on board the feedback around ensuring all team members names and job roles are documented on the review tool to give assurance of the quoracy of the meetings.
- Now the Trust has recruited into the role of PMRT Lead Midwife there will be a period of notice that the successful applicant will have to give and then a robust induction period which ensures the National standards are continually met.
- Within EKHUFT there is a challenge to offer the debrief service at 6 week postnatal due to Obstetric Consultant availability and clinic capacity. The Obstetric Consultant job plans are being reviewed with this consideration.
- It remains challenging for the Bereavement Midwives, who are required clinicians identified by MBRRACE, to attend the review meetings. The Bereavement Lead Midwife at The William Harvey Hospital attends and leads every PMRT meeting with support from the Governance team and the MDT panel but is currently handing over to the new PMRT Lead Midwife.
- A wider MDT group of clinicians willing to support with action planning would be valuable as the actions which would make lasting change require group ownership.
- Administrative support is currently being established within the governance team to aide with the preparation recording all discussions and documenting. In addition, an administrator dedicated for bereavement services has been identified and appointed.
- The PMRT role has a lead Obstetrician with an allocated PA for the Queen Elizabeth the Queen Mother Hospital (QEQM) but does not have one for the WHH.
- Following a recent Serious Incident there is are concerns around management of the Pre Eclamptic woman and the management of fluid balances.

4.4. Standard d) Quarterly reports will have been submitted to the Trust Executive Board from 30 May 2023.

4.4.1. We are 100% compliant against this standard.
Quarterly reports have been submitted to the Trust Board that include details of all deaths reviewed and consequent action plans – completed to date.

4.4.2. **Opportunities for improvement**

- MBRRACE advise that parents should be informed of the review prior to discharge from the hospital. With the appointment of the new bereavement

midwives, this does happen consistently for all families. Streamlining the PMRT process to ensure parents are aware of the review and anticipating a call would be better received by families. Having one key contact as advised by MBRRACE, particularly when there are multiple investigations and different clinicians collecting parents' questions, is essential for families. This now sits with the Bereavement Lead Midwives.

- Where families have agreed to be visited at home as part of the review process, their engagement has been more comprehensive and has offered more learning opportunities for the Trust. Opportunity to provide this more widely or offer the 6 weeks follow up across both sites with a bereavement midwife/ PMRT midwife attendance would offer more opportunity for parental involvement, answer their questions, offer support and may enhance learning.

5 PMRT Issues themes Extract for East Kent Hospitals University NHS Foundation Trust from reviews of deaths completed between 01/04/2023 and 31/05/2023

5.1 There are currently no running themes relating to PMRT within EKHUFT. The issues relevant at the moment relate to management of the Pre-Eclamptic Woman, communication between other Trust's where the family have received care between Trust's and the incorrect labelling of placentas to the mortuary. The Better together team have created Lunch and Learns which involved the teaching of the fluid balance and the Trust have agreed a National team to come to EKHUFT to teach management of the pre eclamptic Woman.

6. Next Steps

a. To induct new PMRT midwife into the role.
b. With the recruitment to the new bereavement posts, establish the team to support the implementation of the new pathway across 7 days a week.
c. Implement the approved PMRT process to ensure follow up arrangements are clear and consistent across both sites.
d. Have a broader MDT review on the action plans once the reviews are pre-published.
e. Review documentation options for bereaved families.
f. Review the options of the interpretation services that the service offers and potentially consider having face to face service for bereaved families.
g. Scope the potential to offer the routine 6 week de brief appointment so it is performed in a timely manner.
h. Ensure the PMRT reviews align to other investigations within the Trust i.e.: ongoing Serious Incidents (SIs) so actions are the same in both reviews and parents are involved.
i. Improve parental involvement in the review process by ensuring parents are informed of the review prior to discharge from the hospital, and a key contact is identified to support parents through the review process.

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme Year 5 Safety Action 3: Transitional Care Services to Minimise Separation of Mothers and their Babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal Units (ATAIN) Programme – Quarterly Report Q4 and Q1 2023**

Meeting date: **7 September 2023**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO): Maternity and Neonatal Board Safety Champion**

Paper Author: **Maternity Matrons – ATAIN/Transitional Care Lead & Post-Natal Ward Manager – Queen Elizabeth the Queen Mother Hospital (QEQM)**

Appendices:

APPENDIX 1 and 2: Transitional Care (TC) and ATAIN Action Plan

Executive summary:

Action required:	Information
Purpose of the Report:	• The purpose of this report is to update the Maternity and Neonatal Assurance Group and Trust Board on East Kent Maternity's progress in implementing **Safety Action 3** and provide a **quarter 4&1 2023** update on the audits required against the standards. • Raise awareness of risks in achieving CNST Standards and actions developed in response to case reviews and the action plans in place to improve (see Appendix 2): • ATAIN and Transitional Care Action Plan to highlight recommendations for future service development that would support the principles of **Avoiding Term Admissions to Neonatal** Unit and **keep mothers and babies together** in a fully functioning Transitional Care Environment.
Summary of key issues:	• The paediatric and maternity teams are supported jointly by the 'neonatal care co-ordinator' who oversees administrative aspects of the service. ***Gap identified– vacant post for neonatal care co-ordinators Trust wide**. • Whilst the current staffing model explicitly rosters an NTC midwife each shift, in real terms they are unable to fully dedicate themselves to the position due to high acuity, sickness and staff shortages. Therefore, the midwifery team will divide the ward workload according to activity. NTC families are always cared

	for by a midwife and not a support worker. ***Gap – lack of sustainable staffing model to support the NTC model** • The Trust NTC guidelines has been embedded fully and there is an audit programme supervised by the Trust audit lead midwife. However, **data has not been captured consistently at WHH** (see Appendix 1 for breakdown of data). • **To develop the service into a fully functioning NTC**, Neonatal and Midwifery staffing, training, equipment and estates resource investment is required. Elements of the estate's requirements are captured within the maternity estates workstream. • Weekly cross-site meetings to review all term admissions into SCBU/NICU attended by either the LW or PNW manager, senior neonatal nurses from each site and senior clinical leads from each site. However, **irregular attendance at ATAIN meetings** by an obstetric lead due to conflicting work pressures/sickness. • Each admission is reviewed to identify if separation could be avoided. Individualised actions and learning are agreed by MDT leads at the ATAIN meeting. These are used to inform future learning with regards to improving safety outcomes and minimising the separation of mothers and babies. However, **the current model applied cannot fulfil full criteria of BAPM (2017) NTC framework**.
Key recommendations:	The Board of Directors is invited to: 1. **NOTE** and **DISCUSS** the report. 2. Receive Assurance that there is an effective process established of ongoing assessment and that the evidence provided is sufficiently robust. 3. To improve workforce to support NTC by recruiting to vacant positions Trust wide. 4. To achieve Sustainable staffing model to support the NTC model and to explore employing band 5 neonatal nurses. 5. Exception report findings to be shared with maternity staff to create awareness where the criteria haven't been met for further improvements. 6. **NOTE** the receipt and content of this CNST Safety Action 3 Quarterly update report. 7. **SUPPORT** the broader considerations and the development of further improvements as defined within the appended action plan. 8. Require formal agreement that the Transitional Care and ATAIN reviews and action plan findings will also be shared with the Local Maternity and Neonatal System (LMNS), Integrated Care Board (ICB) and Integrated Care System (ICS) quality surveillance meeting

Implications:

Links to Strategic Theme:	• Quality and Safety • Our Patients
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.
Resource:	Y - Staffing and training resource required to develop Transitional Care into a fully functioning service.
Legal and regulatory:	Y – Clinical Negligence Scheme for Trusts (CNST), BAPM standards.
Subsidiary:	N

Assurance route:

Previously considered by: MNAG

East Kent Hospitals University NHS Foundation Trust

CNST Maternity Incentive Scheme Year 5
Safety action 3: Transitional care services to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme
Quarterly Report 2023

1. Purpose of the report

a. The purpose of this report is to update the Maternity and Neonatal Assurance Group and Trust Board on East Kent Maternity's progress in implementing Safety Action 3 and provide a quarter 4 & 1 2023 update on the audits required against the standards.

b. Raise awareness of risks in achieving CNST Standards and actions developed in response to case reviews and the action plans in place to improve (see Appendix 1: ATAIN and Transitional Care Action Plan).

c. Highlight recommendations for future service development that would support the principles of Avoiding Term Admissions to Neonatal Unit and keep mothers and babies together in a fully functioning Transitional Care Environment.

2. Background

It is recognised that Nationally, over 20% of admissions of full-term babies to neonatal units could be avoided. By providing services and staffing models that keep mother and baby together, the harm caused by separation can be reduced.

The Avoiding Term Admissions (ATAIN) campaign encourages maternity and neonatal services to work together to identify babies whose admission to a neonatal unit could be avoided and to promote understanding of the importance of keeping mother and baby together when safe to do so.

2.2. There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child.

2.3. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

2.4. ATAIN focuses on four areas of significant potential harm to babies. It is believed that these areas are where there can be the greatest impact:

- respiratory conditions
- hypoglycaemia
- jaundice
- asphyxia (perinatal hypoxia-ischaemia)

2.5. Transitional Care was developed in partnership with British Association of Perinatal Medicine (BAPM) to enable the safe management of babies with medical conditions, whilst allowing baby to remain with mother.

2.6. Babies suitable for management in a fully equipped TC unit;

- Of at Least 34weeks gestation and at least 1600g birth weight who do not fur fill criteria for High Dependency Care (HDC)/Neonatal Intensive Care Unit (NICU) admission.
- Well babies with Suspected Sepsis requiring Intravenous (IV) Antibiotics.
- Congenital Anomalies requiring Nasogastric (NG) assisted feeding.
- Jaundiced babies requiring phototherapy (Single or Enhanced).
- Babies requiring feeding support with NG assisted feeding.
- Babies under observation or treatment for Neonatal Abstinence Syndrome.
- Babies who require assistance with thermoregulation.

2.6. Transitional Care services were launched on each acute site at East Kent in 2018.

2.7. The service is provided on the postnatal wards, led by Midwifery staff but with care involvement by the Neonatal team.

The following sections provide East Kent's current position against each of the CNST Safety Action 3 Standards A to C.

3. Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?
Standard A

Standard a) Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care:

3.1 The Trust Neonatal Transitional Care (NTC) Guideline v.3 (2022) is accessible to all staff and due for review in Dec 2025. This guidance has been based upon the principles of the British Association of Perinatal Medicine (BAPM) Neonatal Transitional Care Framework (2017).

3.2 Neonatal/paediatric clinical care planning is a continual process that includes regular discussions at ward rounds and board rounds. Evidence of care is further documented in case notes, electronic record systems and discharge summaries.

3.3 The Trust NTC guideline has been developed by the multi-disciplinary team (MDT) that include maternity and neonatal clinical leads.

3.4 At QEQM, the neonatal/paediatric team have a room based on the postnatal ward (PNW) located adjacent to the NTC allocated side-rooms on the PNW. This provides an easy point of access for joint care planning and escalation.

3.5 The WHH have nursery facilities that are utilised by maternity and neonatal staff. This provides an easy point of access for joint care planning and escalation.

3.6 At the WHH there are milk kitchen facilities that can be used by staff and parents alike. ***GAP** – The QEQM have no milk kitchen facilities.

3.7 Auditable standards are embedded into the Trust guideline and are the basis of continuing audits.

3.8 The paediatric and maternity teams are supported jointly by the 'neonatal care co-ordinator' who oversees administrative aspects of the service. ***GAP** – vacant post for a second neonatal care co-ordinator at the QEQM.

3.9 Care co-ordinator vacated post March 2023, data collection has since been completed by NICU nursing staff however this in unsustainable for them. ***GAP** - Resulting gaps in data entry have been identified as a result of vacancy.

3.10 The 'Bobble Hat' risk assessment tool is used to define at least one element of the HRG XA04 admission criteria.

Evidence of recent improvement:
The 'Bobble Hat' risk assessment tool has recently been updated to include a date and time of risk assessment. This followed quarterly audit review that found there was no evidence to demonstrate the risk assessment was taking place within 60 minutes of birth.

3.11 Whilst the current staffing model explicitly rosters an NTC midwife each shift, in real terms they are unable to fully dedicate themselves to the position due to high acuity, sickness and staff shortages. Therefore, the midwifery team will divide the ward workload according to activity. NTC families are always cared for by a midwife and not a support worker. ***GAP** – lack of sustainable staffing model to support the NTC model.

3.12 The policy has been embedded fully and we have an audit programme supervised by the Trust audit lead midwife who compiles a quarterly report with exceptions being reviewed by ward managers and specialist team members. ***GAP** – Exception report findings demonstrate babies are not always fed within 60 minutes of birth.

Evidence of recent improvement:
It was found during an exception report deep dive that data capture methods were not robust when determining if babies were receiving antibiotics within 60 minutes of prescribing. A review of the audit process and subsequent training for the staff member completing the audit led to us demonstrating that 100% of babies prescribed antibiotics, received them within the 'golden hour' during the last quarter.

3.13 To develop the service into a fully functioning NTC, Neonatal and Midwifery staffing, training, equipment and estates resource investment is required. Elements of the estate's requirements are captured within the maternity estates workstream. ***GAP** – There are alternative ideas to the current estates plan that could expand capacity at the QEQM site.

4. Standard B

Standard b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.

4.1 Weekly cross-site meetings to review all term admissions into Special Care Baby Unit (SCBU)/NICU attended by either the LW or PNW manager, senior neonatal nurses from each site and senior clinical leads from each site. ***GAP** - Irregular attendance at ATAIN meetings by an obstetric lead due to conflicting work pressures/sickness. Currently reliant on a single obstetrician's availability.

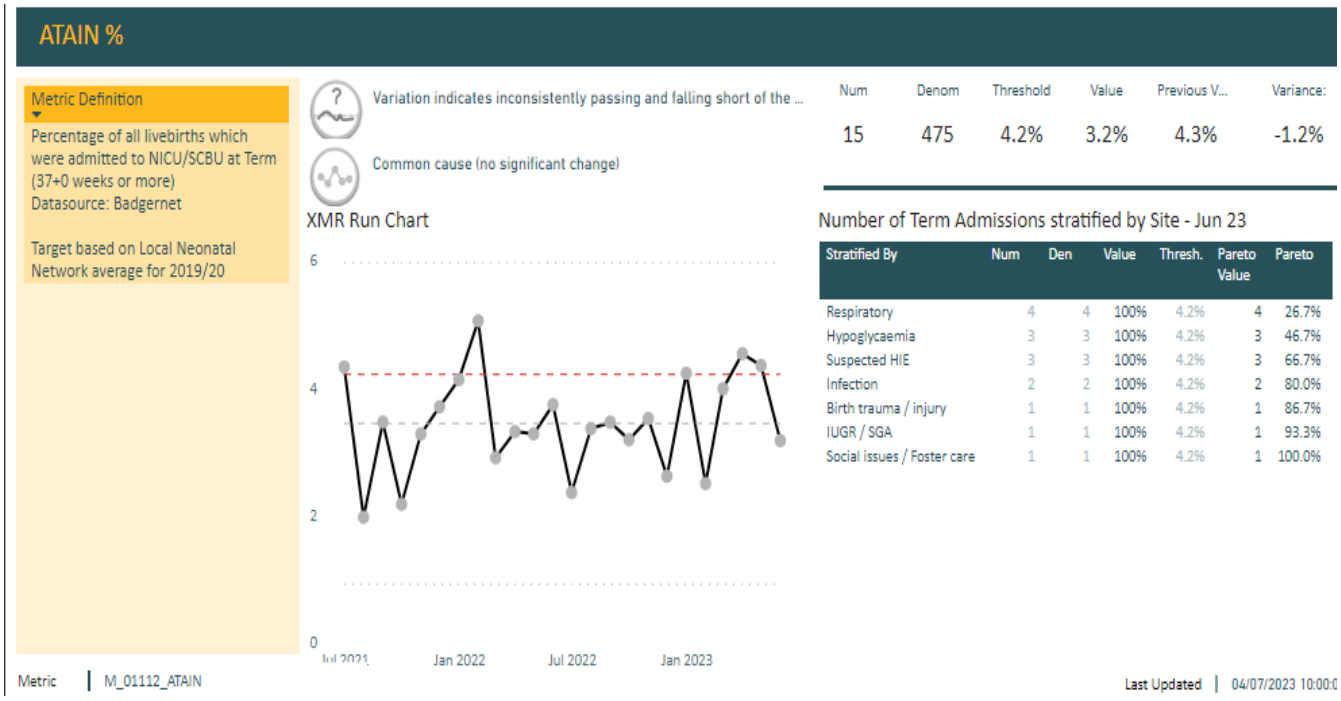
Evidence of recent improvement:
Recent regular attendance by members of the maternity patient safety team have provided an added level of governance and assurance to these meetings.

4.2 Each admission is reviewed to identify if separation could be avoided. Individualised actions and learning are agreed by MDT leads at the ATAIN meeting. These are used to inform future learning with regards to improving safety outcomes and minimising the separation of mothers and babies born at > 37 weeks. There is evidence that data and learning themes are shared amongst the team in the form of a bi-monthly poster and where appropriate, individual support for staff is provided. ***GAP** – cannot fulfil full criteria of BAPM (2017) NTC framework.

ATAIN admissions to SCBU/NICU Q4 &Q1 2023

Threshold 4.2%	**QEQM**	**WHH**	**Trust**
Jan Q4	4.9%	3.9%	4.2%
Feb Q4	4.9%	0.8%	2.5%
Mar Q4	4.0%	4.2%	4.0%
Apr Q1	6.0%	3.6%	4.5%
May Q1	5.0%	4.0%	4.3%
June Q1	2.9%	3.5%	3.2%

Data source Badgernet



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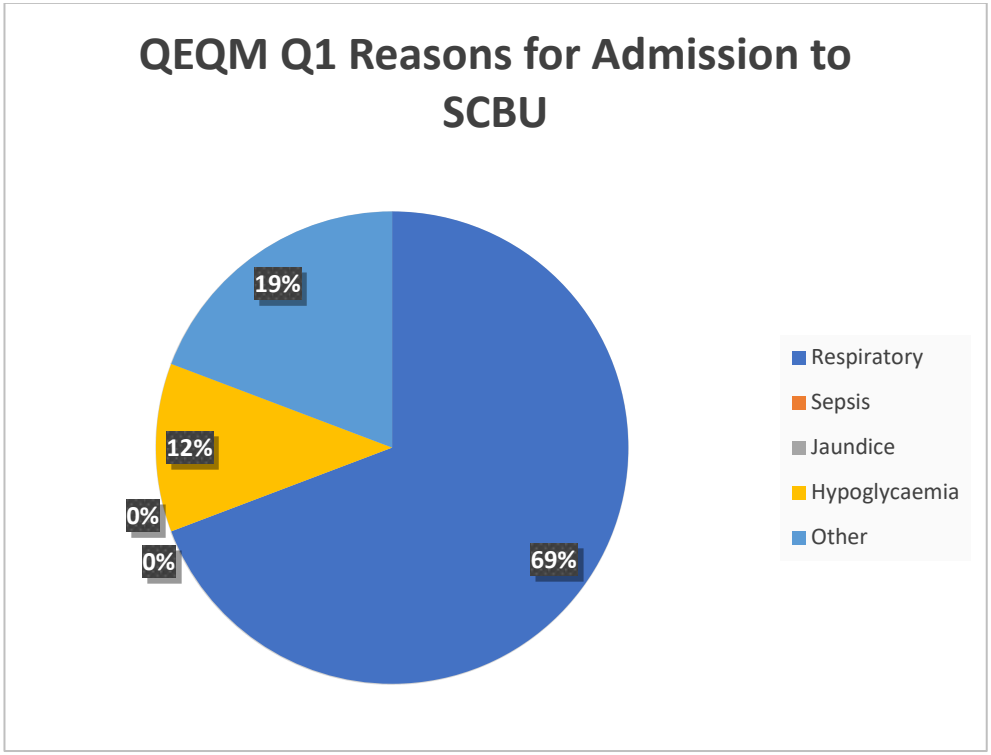
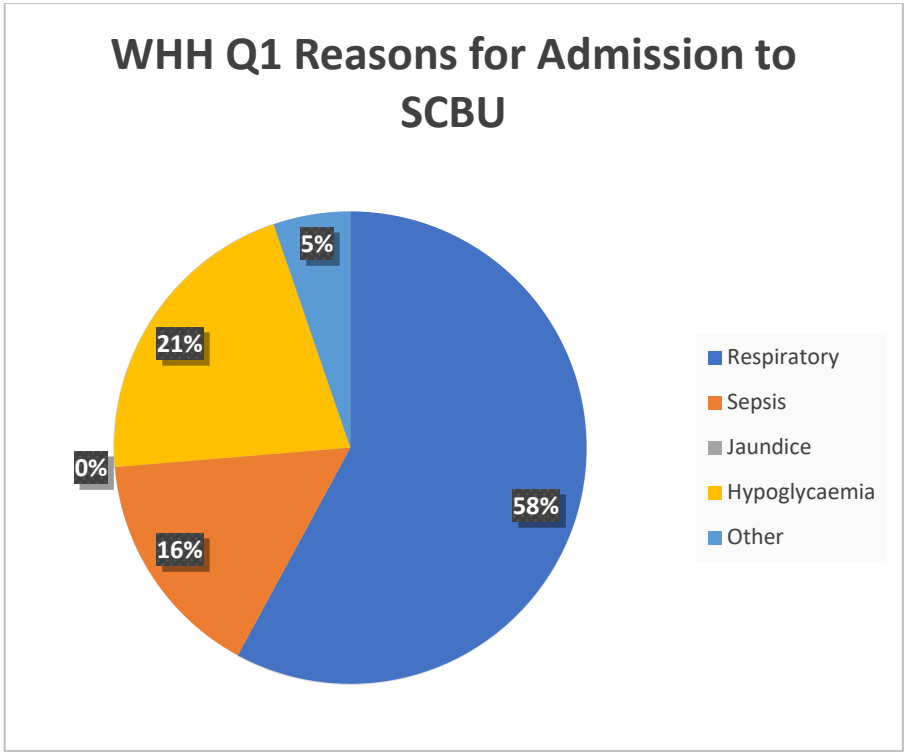
Reasons for Admission to SCBU





Other: Neuro, opioid withdrawal, social place of safety.

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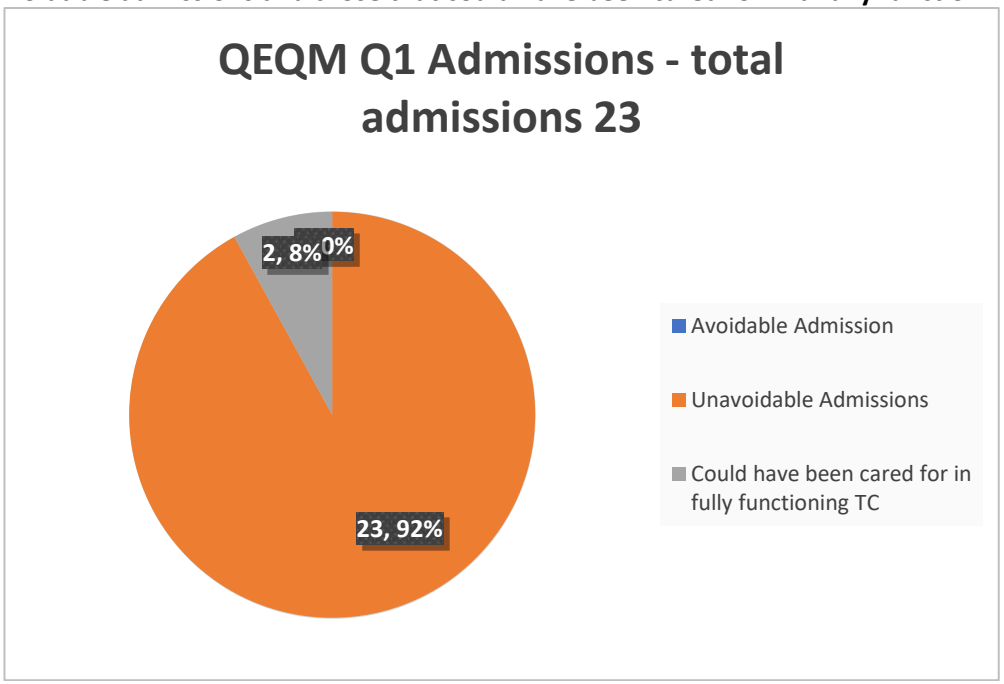
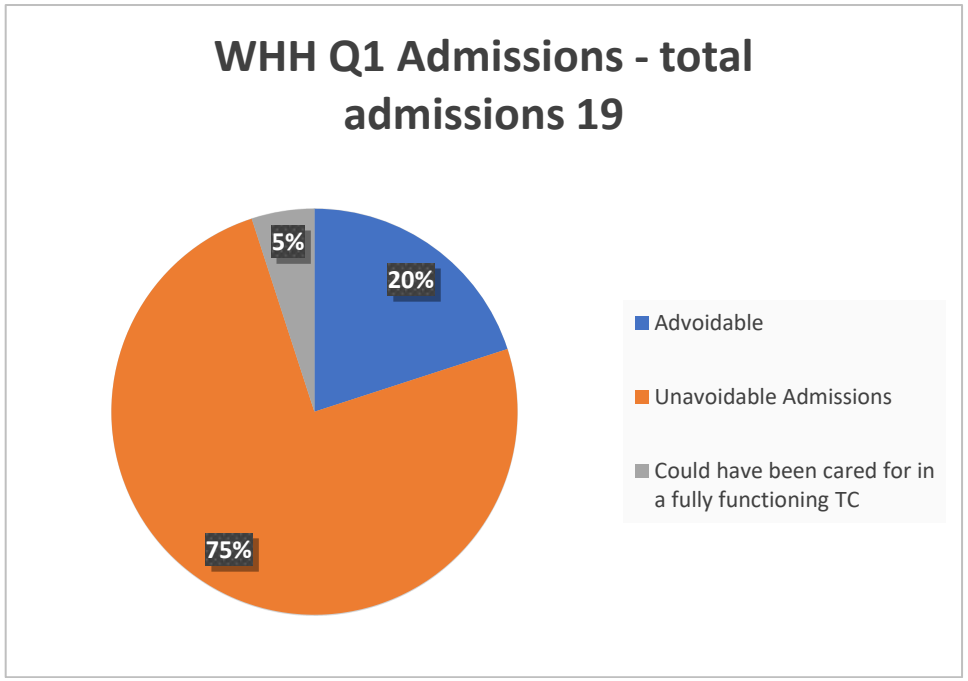
Avoidable admissions and those that could have been cared for in a fully functioning TC





***GAP** Neither site is able to offer a full transitional care service due to gaps in the workforce, estates and training. In quarter 1 both QEQM and the WHH had babies that could have remained with their mother in the Transitional Care areas of their postnatal wards if nasogastric feeding could be offered.

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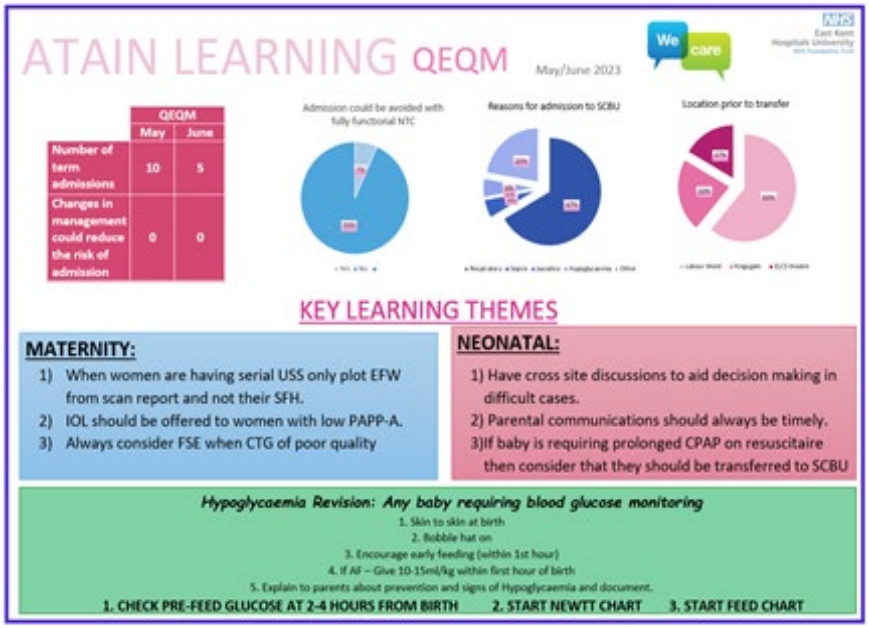
Evidence of recent improvement: QEQM PNW ward manager to develop current bi-monthly posters to reflect both sites to improve cross-site learning.



ATAIN LEARNING QEQM

May/June 2023

We care

	QEQM May	QEQM June
Number of term admissions	10	5
Changes in management could reduce the risk of admission	0	0

Admission could be avoided with fully functional NTC

Reasons for admission to SCBU

Location prior to transfer

KEY LEARNING THEMES

MATERNITY:

1) When women are having serial USS only plot EFW from scan report and not their SFH.
2) IOL should be offered to women with low PAPP-A.
3) Always consider FSE when CTG of poor quality

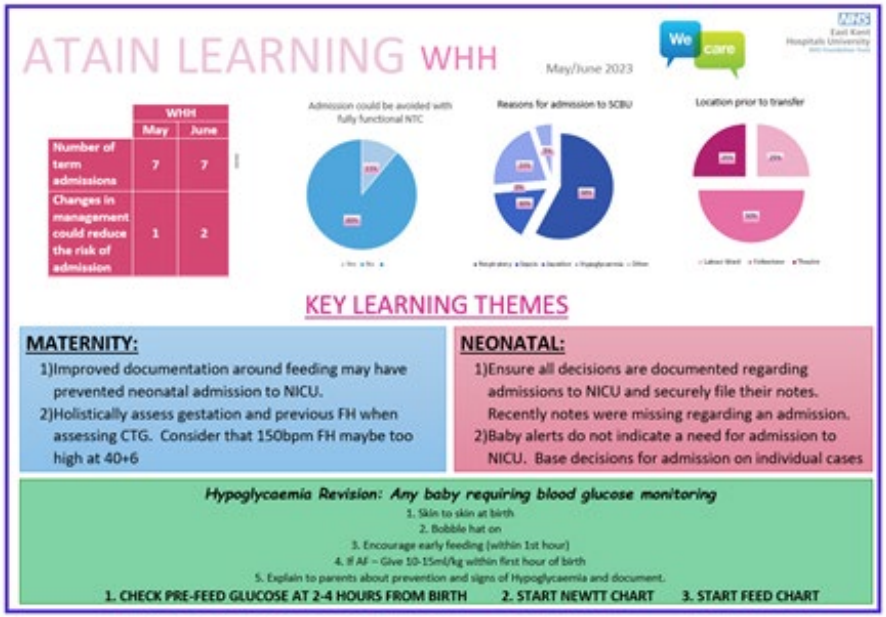
NEONATAL:

1) Have cross site discussions to aid decision making in difficult cases.
2) Parental communications should always be timely.
3) If baby is requiring prolonged CPAP on resuscitaire then consider that they should be transferred to SCBU

Hypoglycaemia Revision: Any baby requiring blood glucose monitoring

1. Skin to skin at birth
2. Bobble hat on
3. Encourage early feeding (within 1st hour)
4. If AF – Give 10-15ml/kg within first hour of birth
5. Explain to parents about prevention and signs of Hypoglycaemia and document.

1. CHECK PRE-FEED GLUCOSE AT 2-4 HOURS FROM BIRTH 2. START NEWTT CHART 3. START FEED CHART



ATAIN LEARNING WHH

May/June 2023

We care

	WHH May	WHH June
Number of term admissions	7	7
Changes in management could reduce the risk of admission	1	2

Admission could be avoided with fully functional NTC

Reasons for admission to SCBU

Location prior to transfer

KEY LEARNING THEMES

MATERNITY:

1) Improved documentation around feeding may have prevented neonatal admission to NICU.
2) Holistically assess gestation and previous FH when assessing CTG. Consider that 150bpm FH maybe too high at 40+6

NEONATAL:

1) Ensure all decisions are documented regarding admissions to NICU and securely file their notes. Recently notes were missing regarding an admission.
2) Baby alerts do not indicate a need for admission to NICU. Base decisions for admission on individual cases

Hypoglycaemia Revision: Any baby requiring blood glucose monitoring

1. Skin to skin at birth
2. Bobble hat on
3. Encourage early feeding (within 1st hour)
4. If AF – Give 10-15ml/kg within first hour of birth
5. Explain to parents about prevention and signs of Hypoglycaemia and document.

1. CHECK PRE-FEED GLUCOSE AT 2-4 HOURS FROM BIRTH 2. START NEWTT CHART 3. START FEED CHART

4.3. Evidence that the action plan has been signed off by the Director of Midwifery (DoM)/Head of Midwifery (HoM), Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan:

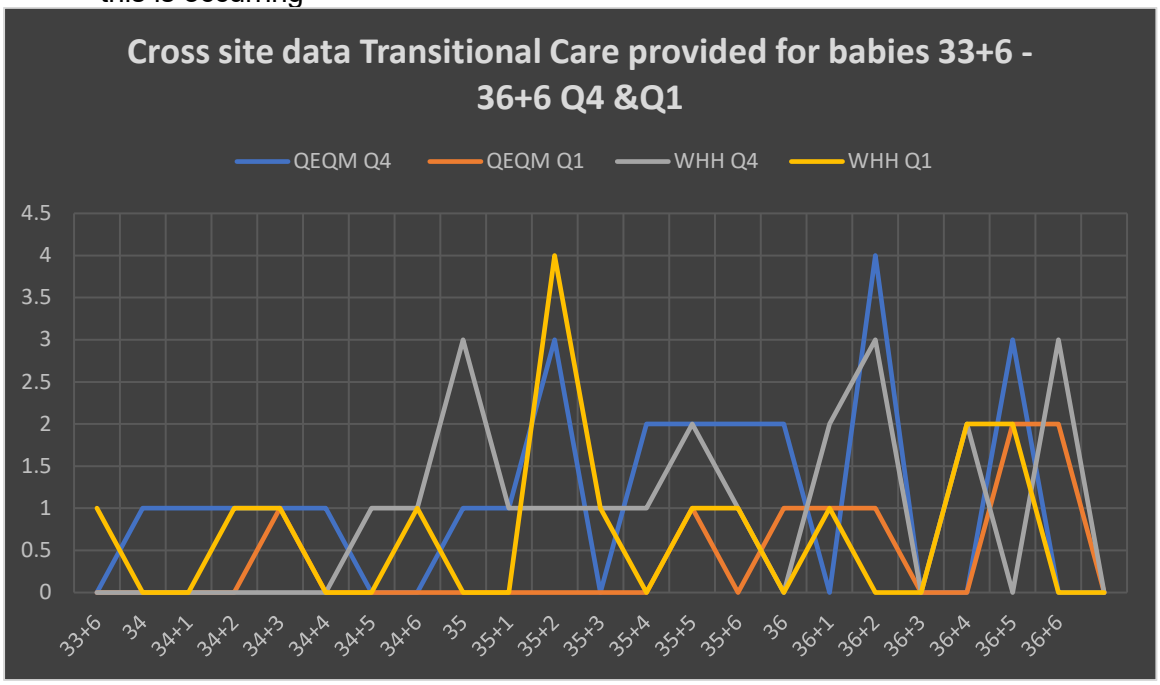
4.4. The Transitional Care and ATAIN action plans have been developed and approved by the Clinical and Midwifery Leads and Neonatal Safety Champion and are shared with the Maternity and Board Safety Champions through the Bi Monthly meetings and MNAG and Board reporting arrangements

4.5. Evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion, LMNS and ICS quality surveillance meeting each quarter is through the agreed Trust Board reporting structure.

5. Standard C

Standard C) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway

Guideline for admission to TC to include babies 34+0 – 36+6 and data to evidence this is occurring



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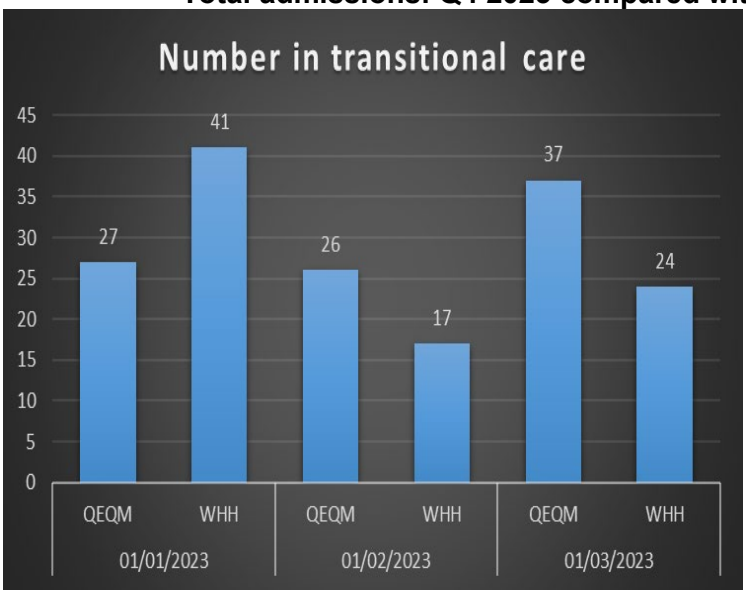
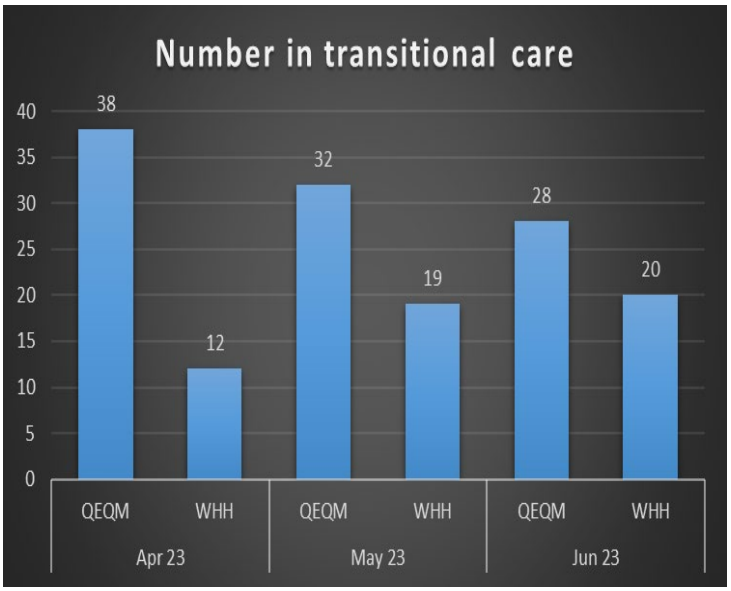
Appendix 1

Breakdown of data

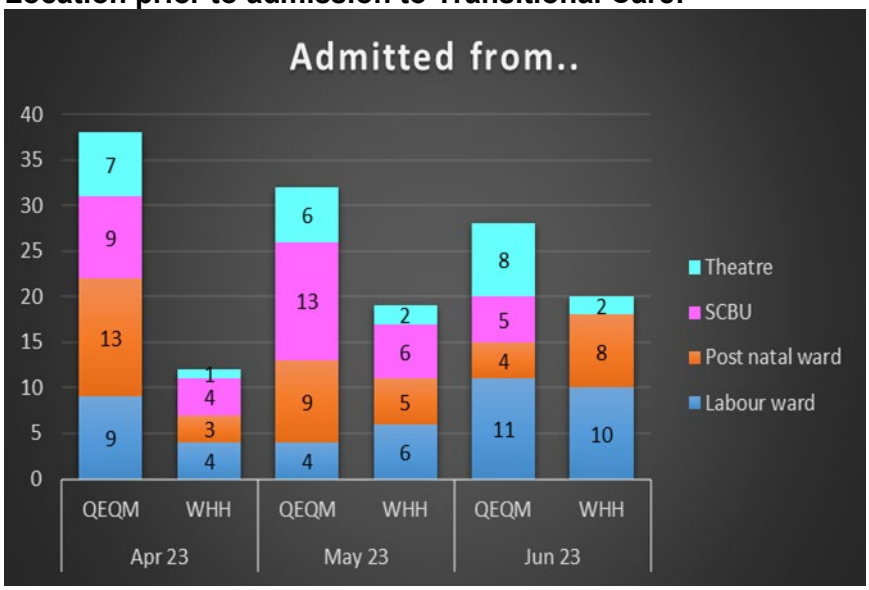
All babies admitted to Transitional Care are included in this audit. A total of 149 babies were admitted to Transitional Care at EKHUFT in Quarter 1 2023/24.
QEQM had a total of 98 babies admitted.
WHH had a total of 51 babies admitted - ***70% of babies admitted to transitional care in June have missing data (27% of total WHH admissions in Q1) therefore data is liable to be skewed. *GAP This is due to a recent staff vacancy.*

Total admissions: Q4 2023 compared with Q1 2023





Location prior to admission to Transitional Care:



QEQM – Admissions to Transitional Care were from the Postnatal Ward (27%), Labour ward (24%), SCBU (28%) and Theatres (21%). There were no readmissions into TC

WHH - Babies were admitted to Transitional Care from the Postnatal Ward (31%), Labour Ward (39%), SBCU (20%), Theatres (10%) with no Re-admission.

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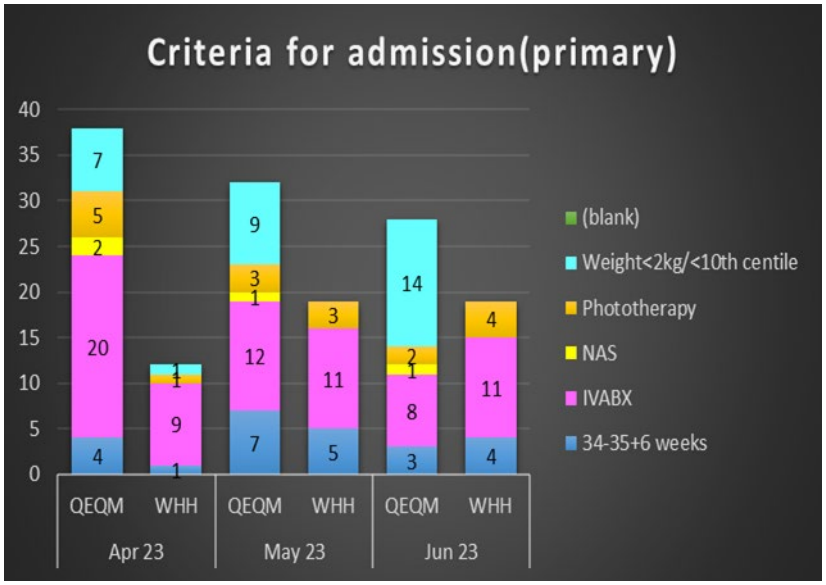
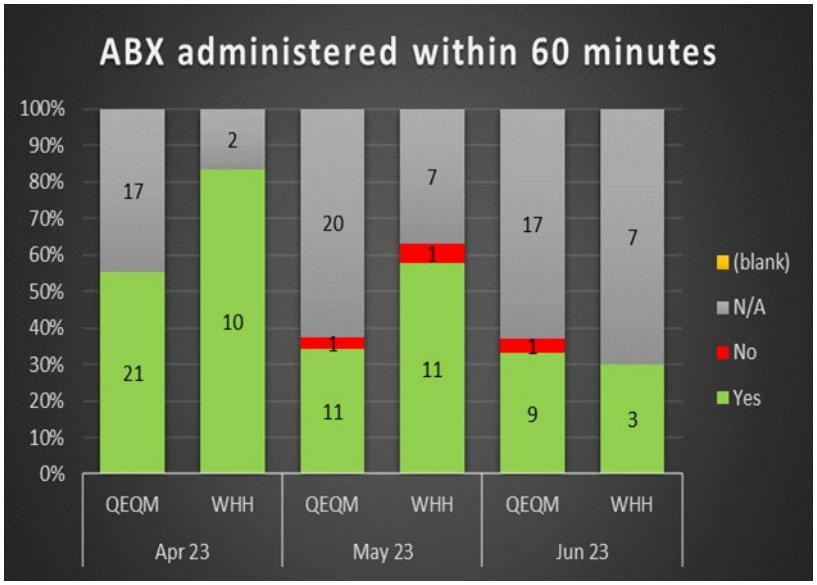
Admission by primary criteria



QEQM – The top criteria for admission into transitional Care during quarter 1 were IVAB (41%) followed by weight (31%). These trends are similar to quarter 4 when IVAB (43%) and weight (29%) were also the top criteria.

WHH - The primary criteria for admission to Transitional Care during quarter 1 were; IVAB (61%), compared with 46% in Q4.

Antibiotics administered within 60 minutes of prescribing



QEQM – 48% of admissions to transitional care were prescribed antibiotics. Of these babies, 95% had their antibiotics administered within 60 minutes of prescribing.

WHH - 40% of babies in Q1 had antibiotics administered within 60 minutes. 60% of babies in Q1 had no data entered.

Ward managers currently perform quarterly exceptions report to review omissions

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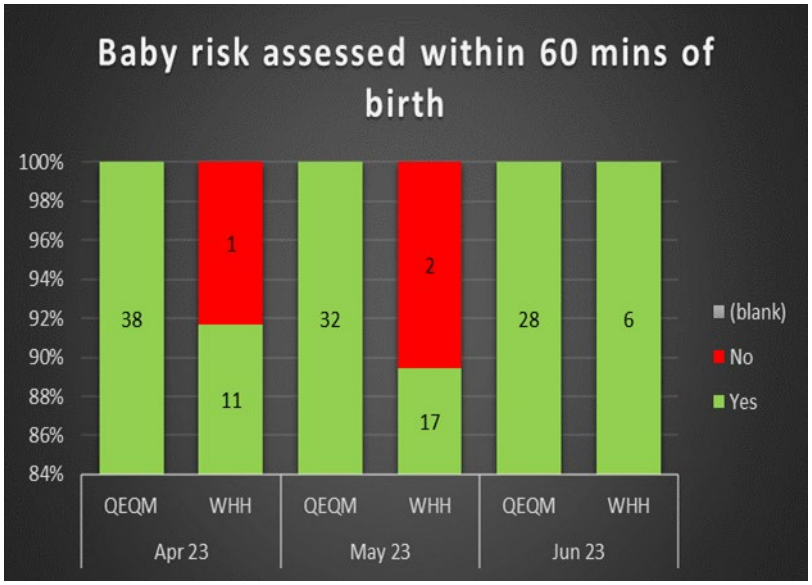
Baby's risk assessed within 60 minutes of birth

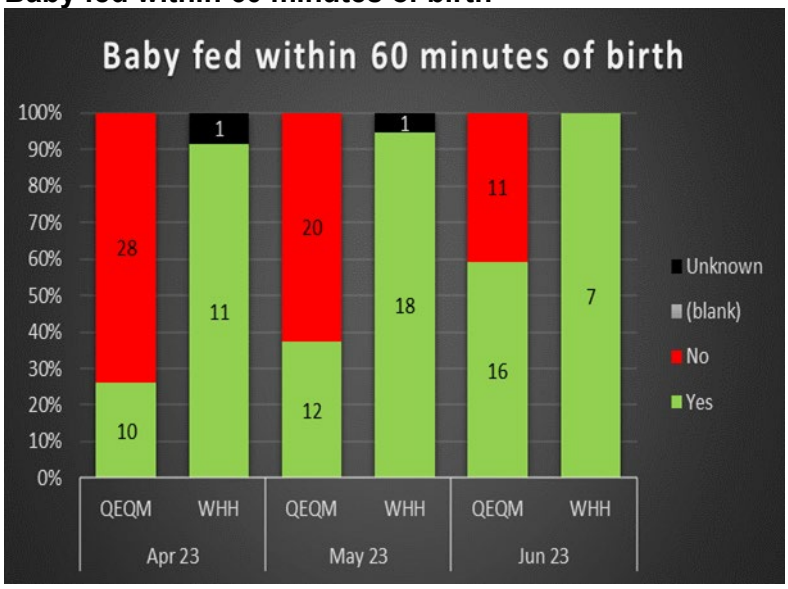


QEQM – 100% of babies were risk assessed within 60 minutes. This is consistent with Q4. ***Watch Metric***
WHH - 67% of babies were risk assessed within 60 minutes of birth in Q1.

Compared to quarter 4 were 74% of babies were risk assessed within 60 minutes of birth.
2% of babies were not risk assessed within 60 minutes of birth in Q1.

**For 27% of babies there is no documentation as to whether they were risk assessed within 60 minutes of birth for Q1.

Baby fed within 60 minutes of birth



QEQM – 39% of babies were fed within 60 minutes of birth in quarter 1. This compares with 38% in quarter 4.
WHH - 71% of babies were fed within 60 minutes of birth in quarter 1. Compared to 77% of babies were fed within the first 60 minutes of birth in Q4.

**4% of babies were documented blank and 29% were documented as unknown

A deep dive is ongoing by the Infant Feeding team to create an understanding of the reasons for these figures.

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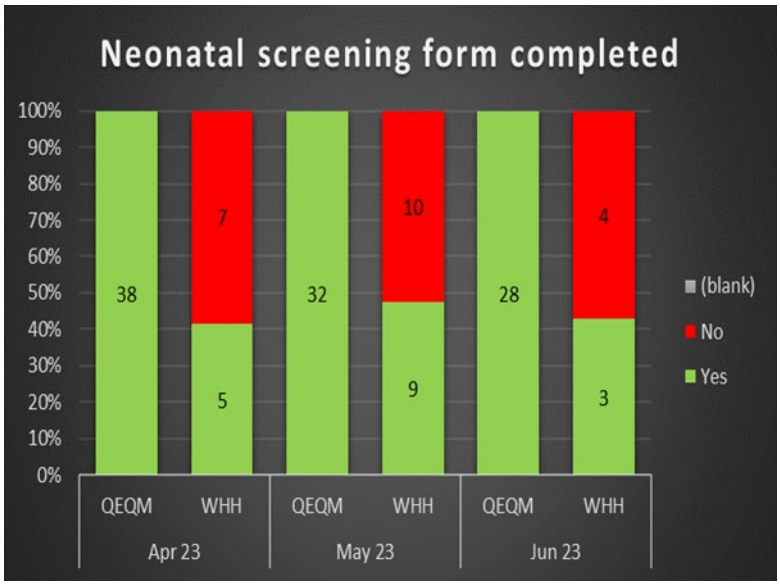
Neonatal Screening Form completed



QEQM – 100% of babies had a neonatal screening form completed in Q1. This is consistent Q4. ***Watch metric***.

WHH - 25% of babies had a screening form completed for Q1 compared to 78% for Q4.
41% of babies did not have a screening form completed for Q1.

**25% of babies the data was not recorded within the audit

Watch Metrics:

Remaining auditable standards:	**QEQM Q1**	**QEQM Q4**	**WHH Q1**	**WHH Q4**
Care plan with daily involvement	100%	100%	100%	100%
Newborn Early Warning Trigger & Track (NEWTT) Chart	100%	100%	100%	100%
Drug Chart	100%	100%	100%	100%
Completed feeding chart	100%	100%	100%	100%

Appendix 2: ATAIN and Transitional Care Action Plan

	*Gaps in current service provision	Immediate measures taken to make service safe	Recommendation Identified following case review	Action plan to achieve compliance with recommendation (SMART)	Lead Responsible	Date for Completion	RAG rating	Progress/Comments	Date Complete
Workforce									
1	**QEQM** 3 day cover Neonatal Care Co-ordinator vacancy	Gaps in roster filled by SCBU ward clerk and other neonatal care co-ordinator.	Recruit to role for 3-day cover		TT	July 2023	Complete	Successful recruitment into the role	Complete - New recruit to commence 6/7/2023
2	**WHH** 7 day cover Neonatal Care Co-ordinator vacancy	Ward manager to hold oversight of audit and robust data collection – neonatal nursing staff to capture data	Recruit to role	Discuss with neonatal matron recruitment plans Review role of neonatal nursing staff Alternatively review maternity establishment	LA/LM/PH/AS	Sept 23		Current state is impacting on data collection methods 10/8/23 – conversation between matron at WHH with NICU Matron to discuss re-establishing neonatal care co-ordinator – to review budget and meet again in 2 weeks	
3	**QEQM** Sustainable staffing model to	Midwife allocated each shift to care for families	Explore employing band 5	Feasibility report	LF/PH/AS	Dec 2023	On track	Feasibility report in progress – aim for August completion.	

	support the TC model		neonatal nurses.	Present to senior team for staff model agreement				Utilizing band 5 nurses will facilitate full compliance with BAPM NTC model	
4	**WHH** Sustainable staffing model to support the TC model	Band 4 nursery nurses also available to support role 4 WTE budgeted	Consider additional Nursery nurses to cover 24/7	Review applicable elements of QEQM feasibility report	LA/LM/JS/PH/LF	Sept 23	Partial	Additional staff required if we want to embed a full TC model Out to advert for further NN to cover 1.8 WTE vacancy	
Quality and Safety									
5	**Cross site** Babies not fed within 60 minutes of birth	Findings of report shared with maternity staff to create awareness	Exception report to investigate why babies are not always fed within 60 minutes of birth	Raise staff awareness of recommendations to feed babies within 60 minutes of birth	MK/SB/PP/KL/RG	Sept 2023		Exception report in progress - Unsure of current state – to liaise with Infant Feeding Team leads (PP/KL) for deep dive update.	
6	**WHH** Babies are not risk assessed within 60 minutes of birth	Findings of report to be shared with maternity staff. To be shared at handover. Labour Ward staff to ensure babies are within 60 minutes of birth.	Review exceptions to look for gaps as to why babies are not always risk assessed within 60 minutes of birth	Raise staff awareness of bobble hat process to ensure/improve compliance.	SB/LM	August 2023	Complete	Message of week out to staff re bobble hat initiative shared January 2023	
7	**Cross site**	Reviews of notes by maternity ward	Create awareness		ZW/JL/NC CA/EK	October 23	Partial	16/8/23 – email sent to clinical	

	Irregular attendance at ATAIN meetings by obstetric lead	managers – seek to obtain obstetric opinion if concerns are evident.	amongst obstetric colleagues that there is a vacancy for ATAIN support					director to request Obstetric lead and attendance from WHH site, QEQM consultant attends	
8	**Cross site DOTS service**	Babies unable to have their care needs met within the current NTC space on the PNW are admitted to SCBU. Babies that can have most of their care provided in the current NTC space are taken to SCBU to have elements fulfilled that cannot be achieved on the PNW.	Explore employing band 5 neonatal nurses.	Feasibility study in progress – aims for completion August 2023	MC/AS/ICB/TT	In progress – Reliant on the availability of neonatal outreach services being available.		Until ICB development of neonatal outreach service this may be unsustainable	
9	**Cross site** Develop the Transitional Care Service to include full care criteria and expand opportunities to keep mums and	Scope opportunities/requirements to support transformation of the TC service to include neonatal outreach service (previously DOTS)	Explore co-production opportunities	Resume working party progress – liaise with LJ for this •Current position •Required standard •What expansion opportunities are there within existing estates footprint •What additional capacity	TC working party/ICB/TT/LJ	March 24		TC working party lead has left Trust 16/8/23 – to recommence working party to explore options e-mail sent to Matron of NICU and maternity to look at dates and party members required	

	babies together			requirements are required •What are the additional staffing requirements to support this expansion •What are the training needs and who/how can these be met •What additional equipment/resource requirements					
Estates									
10	Estates plan	Review current plans for estates to address the possibility of increasing capacity at the QEQM & WHH sites	Review and further consultation of current plan Explore co-production opportunities	Add to Risk Register current lack of ability to fulfil NTC criteria as set by BAPM	KC/MC/AS	TBC		Plans stalled due to financial limitations – aim for works to commence 2024	
11	**QEQM** No Milk Kitchen	Included in estates plans	Release funds to proceed with milk kitchen			TBC		2019 Plans created and approved regarding the development of a milk kitchen 2022 Plans added to estates plans	

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Clinical Negligence Scheme for Trusts (CNST) Year 5, Safety action 6: Compliance with all elements of the Saving Babies' Lives Care Bundle (SBLCB) Version Three**

Meeting date: **7 September 2023**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO): Maternity and Neonatal Board Safety Champion**

Paper Author: **Consultant Midwife**

Appendices:

APPENDIX 1: REPORT

Executive summary:

Action required:	Discussion
Purpose of the Report:	All NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024. CNST safety action 6 requires provision of assurance that the Maternity service is track to fully implement all 6 elements of SBLv3 by March 2024. The purpose of the report is to share mapping of the current situation and steps required to implement in full.
Summary of key issues:	SBLCBv3 was published 31/05/23. This report provides an initial gap analysis. Many of the required interventions have already been implemented. However, there is a substantial amount of work required to achieve implementation in full. Capturing process and outcome indicators to be developed to inform future reports. Access to the national implementation tool will be available on the Maternity Transformation Programme's Future NHS platform. This will facilitate agreement of a local improvement trajectory with their Integrated Care Board (ICB), and track progress locally in accordance with that trajectory.
Key recommendations:	The Board of Directors is asked to **NOTE**: • Focus, dedication and resource to acheive implementation by target date March 2024. • Use of the national implementation tool to assist with planning and tracking progress.

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	• Agreement of a local improvement trajectory with the ICB. • Inclusion of compliance percentage against key recommendations with evidence in future reports.

Implications:

Links to 'We Care' Strategic Objectives:	This report aims to support the following 'We Care' strategic objectives: • Patients • Quality and safety
Link to the Board Assurance Framework (BAF):	N/A
Link to the Corporate Risk Register (CRR):	CRR 77 - There is a risk of failure to provide adequate maternity services to women and their families due to an inability to embed a patient safety culture. CRR 122 - There is a risk of inadequate midwifery staffing levels and skills to meet the needs of women and their families.
Resource:	Y – specialist midwives time to implement required interventions.
Legal and regulatory:	N
Subsidiary:	N

Assurance route:

This paper has not yet been considered at other committees.

23/077 – APPENDIX 3

July 2023

East Kent Hospitals University NHS Foundation Trust

Division	Women's Health
Report Title	CNST Year 5 Safety action 6: Compliance with all elements of the Saving Babies' Lives Care Bundle (SBLCB) Version Three
Purpose	To provide the board with assurance of compliance or actions in place to reach compliance
Frequency	Quarterly
Date	June 2023 (Q1)

Required Standard 1) Provide assurance to the Trust Board and Integrated Care Board (ICB) that you are on track to fully implement all 6 elements of SBLv3 by March 2024. 2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available	
Element 1 – Reducing smoking in pregnancy	
Element 1 - interventions	
1.1 CO testing offered to all pregnant women at the antenatal booking and 36-week antenatal appointment	As per EKHUFT Maternity guideline on smoking in pregnancy. Recorded on E3 and audited monthly. Data available via information portal. May 2023 CO testing at booking - compliance 98.6%. May 2023 Co testing at 36 weeks – compliance 36 weeks 89.6%
1.2 CO testing offered at all other antenatal appointments to groups identified within NICE Guidance NG209.	CO monitoring at every antenatal contact from 01/05/23 to ensure undertaken as per National Institute for Health and Care Excellence (NICE) guidance. EKHUFT Maternity guideline on smoking in pregnancy updated to reflect the changes, available via Policy centre.
1.3 Whenever CO testing is offered, it should be followed up by an enquiry about smoking status with the CO result and smoking status recorded.	Mandatory CO question and smoking status embedded within E3

1.4 Instigate an opt-out referral for all women who have an elevated CO level (4ppm or above), who identify themselves as smokers or have quit in the last 2 weeks for treatment by a trained tobacco dependence treatment adviser (TDA) within an in-house tobacco dependence treatment service.	Opt out referral process in place with referrals being made via E3. Data available via Information portal. May 2023 - 77.4% of smokers were referred at booking.
1.5 Nicotine replacement therapy (NRT) should be offered to all smokers and provision ensured as soon as possible.	NRT is offered to smokers when they accept smoking cessation support with One You Kent. NRT can also be offered to women when they attend or are admitted to hospital but not mandatory. Embedded within training. NRT Standard Operating Procedure (SOP) in draft awaiting final ratification, this will enable suitably trained midwives to provide direct supply of NRT e.g. in Triage.
1.6 The tobacco dependence treatment includes behavioural support and NRT, initially 4 weekly sessions following the setting of the quit date then regularly (as required, however as a minimum monthly) throughout pregnancy to support the woman to remain smokefree.	This level of service is currently provided by One You Kent. Plans for phased introduction of an EKHUFT in-house Maternity stop smoking service are underway. Once established the new in-house will provide this level of behavioural support and NRT.
1.7 Feedback is provided to the pregnant woman's named maternity health care professional regarding the treatment plan and progress with their quit attempt (including relapse). Where a woman does not book or attend appointments there should immediate notification back to the named maternity health care professional.	A weekly spreadsheet detailing engagement and treatment plans is provided by One You Kent to the Smoking in Pregnancy Specialist Midwife and the community midwives. However, this does not provided feedback on an individual basis to the woman's named midwife.
1.8 Any staff member using a CO monitor, should have appropriate training on its use and discussion of the result.	Staff receive practical and theoretical instruction about the use of CO monitors during the annual mandatory training week. 1:1 sessions can also be provided on request.
1.9 All staff providing maternity care to pregnant women should receive training in the delivery of Very Brief Advice (VBA) about smoking, making an opt-out referral and the processes within their maternity pathway (e.g., referral, feedback, data collection).	Included in smoking cessation session in annual mandatory training week.
1.10 Individuals delivering tobacco dependence treatment interventions should be fully trained to NCSCT standards	One You Kent Staff are trained to NCSCT standards. This training is being arranged for staff who will be using the new NRT protocol.
Element 1 - continuous learning	
1.11 When analysing patient safety incidents, maternity care providers should review smoking status throughout pregnancy and determine whether the appropriate pathway of care for this was followed.	The Patient Safety / PMRT Midwives inform the Smoking Cessation Specialist Midwife of relevant cases for her review and input into investigation. However, reporting processes require strengthening to ensure that this always happens. The Smoking Cessation Midwife emails the Patient Safety / PMRT Midwives on a weekly basis as a prompt to ensure that no cases are missed.
1.12 Maternity providers should regularly review (a minimum of quarterly) their smoking-related data to understand performance and develop improvement plans (this list is designed to provide a steer and is not exhaustive): A. Identification of women who smoke – Determine any factors that would optimise CO testing rates and enquiry about smoking status, from both the provider/pathway and service-user perspective and make changes to pathways and processes as appropriate. B. Training of staff – Ensure all staff involved in identification, referral and treatment of women who smoke, and provision of VBA are appropriately trained.	The Smoking in Pregnancy Specialist Midwife reviews available data on a monthly basis. A – E3 data related to CO monitoring is reviewed monthly, any gaps are identified and plans made to address, for example low compliance by a particular team or individual or at a particular type of appointment B – All obstetricians, midwives, maternity support workers and maternity care assistants receive training with mandatory update

C. Engagement – Determine and address any barriers to engagement with treatment services or compliance with treatment interventions from both the provider/pathway and service-user perspective. D. Referral – Determine and address any factors that are influencing opt-out referral, from both the provider/pathway perspective and service-user perspective. E. Quit rates – Consider the pathway holistically to determine which steps can be optimised to facilitate quit attempts and successful quits. F. Relapse – Determine factors that are contributing to relapse and whether additional support or changes to pathways may address these. G. Inequalities – Consider all the above by protected characteristics and other variables influencing inequalities, such as factors related to deprivation. Make changes to pathways and processes, or carry out additional supportive activity, to address any inequity or inequalities identified.	C – Engagement may be influenced by quality of VBA at appointments, the Smoking Cessation Midwife is working alongside staff to strengthen. Scope to gain service user input to shed further light on engagement / lack of D – A robust referral system in place, but service user perspective to be sought E – Multi agency review of pathway to determine steps to optimise quits is required. Once EKHUFT in-house service is established there will be greater opportunity to review the entire pathway F – this will be more easily achieved once the EKHUFT in-house service is established. Currently One You Kent are providing the stop smoking service and will have a better understanding of factors contributing to relapse. G – Data to be explored from perspective of protected characteristics and deprivation. Advice has been sought from Business Intelligence Lead
1.13 In order to monitor quality and effectiveness of pathways, maternity services should set ambitions for their pathway with regular review (a minimum of quarterly) of data and targeted quality improvement work to ensure they are being achieved.	To date effectiveness measures have been related to referral rates, CO monitoring and smoking at time of delivery. These are monitored monthly. Further ambitions to be identified in relation to EKHUFT in-house service and regular review to take place
1.14 Based on highly performing areas, stretching ambitions to achieve effective implementation of the full Element may include: A. 95% of women where CO measurement and smoking status is recorded at their booking appointment. B. 95% of women where CO measurement and smoking status is recorded at their 36-week appointment. C. 95% of smokers have an opt-out referral at booking for treatment by a TDA within an in-house service. D. 85% of all women referred for tobacco dependence treatment engage with the programme (have at least one session and receive a treatment plan). E. 60% of those referred for tobacco dependence treatment set a quit date. F. 60% of those setting a quit date successfully quit at 4 weeks. G. At least 85% of quitters should be CO verified.	A – This target is being exceeded, during May 2023 98.6% pregnant women had CO and smoking status recorded at booking B – Achieving CO measurement and smoking status at 36 weeks for 95% of women requires some further work, during May 2023 this took place for 89.6% of women C – The in-house service for EKHUFT is not yet established, however recruitment of the first in-house Maternity smokefree advisor has taken place and her start date is currently awaited D/E/F/G – Data on engagement, quit dates and verified quits to be sought from One You Kent
1.15 Individual providers should examine their outcomes in relation to other providers or systems with similar smoking prevalence or populations. National benchmarking is available through the Maternity Services Dashboard and will be available to ICS/LMS as the Tobacco dependence patient level collection is established.	Benchmarking review to take place

Element 1 - process indicators	
APRIL 23 – JUNE 23 1a. Percentage of women where there is a record of 1.a.i. CO measurement at booking appointment 1.a.ii. CO measurement at 36-week appointment 1.a.iii. Smoking status** at booking appointment 1.a.iv. Smoking status** at 36-week appointment1a.	Recorded on E3 and available via information portal, audited monthly CO measurement at booking – 97.9% CO measurement at 36 week appointment – 91.4% Smoking status at booking – 11.8% Smoking status at 36 week appointment – 99.4% Smoking at time of Delivery 10.76%
1b. Percentage of smokers* that have an opt-out referral at booking to an in-house tobacco dependence treatment service.	Referral to One You Kent recorded on E3 and available via information portal under the 'smoking data' tab, audited monthly Referals to One You Kent at booking 75.6% (June 2022 – May 2023) In-house tobacco dependence treatment service not yet available
1c. Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date.	Data to be obtained from One You Kent
Element 1 - outcome indicators	
1d. Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks.	39.5% of smokers quit in the past 12 months
1e. Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks.	Data to be obtained from One You Kent
Element 2 - Fetal growth - risk assessment, surveillance, and management	
Element 2 - interventions	
2.1 Assess all women at booking to determine if prescription of Aspirin is needed using an appropriate algorithm agreed with the local ICSs.	Euroking: Risk Assessment for Aspirin at booking Guidelines: Assessment of Fetal Growth This is already included within guideline 'Assessment of Fetal Growth V10 02/12/2022'

2.2 Recommend vitamin D supplementation to all pregnant women using an appropriate algorithm agreed with the local ICS.	This is already included within guideline 'Antenatal Care V5 2021'
2.3 Assess smoking status and manage findings as per Element 1.	As above
2.4 Perform a risk assessment for FGR by 14 weeks gestation using an agreed pathway (for example, Appendix D). In multiparous women risk assessment should include the calculation of previous birthweight centiles. The pathway and centile calculator used should be agreed by both the local ICSs and the regional maternity team.	Guideline 'Assessment of Fetal Growth V10 02/12/22' states GROW App Birthweight centile calculator to be used at booking to calculate prev. babies birthweight. Appendix D changes commenced Dashboard collection of FGR Risk Assessment at booking. Unknown gestations for collection. Guidance awaited.
2.5 During risk assessment trusts are encouraged to use information technology platforms to facilitate accurate recording and correct classification of risk by staff. No single provider is recommended, but technology platforms should not prevent compliance with Element 2 guidance and should follow national recommendations on the use of fundal height and fetal growth charts.	Risk assessment recorded at booking on Euroking: Questionnaire states FGR Risks. This requires amending according to Appendix D updates. No current classification of risk. Potential requirement for risk assessment classification question on E3 at booking & every AN contact. Awaiting implementation guidance
2.6 As part of the risk assessment for FGR blood pressure should be recorded using a digital monitor that has been validated for use in pregnancy	Amendments required to the following guidelines, not yet commenced. 'Assessment of Fetal Growth' 'Hypertension in Pregnancy'
2.7 Women who are designated as high risk for FGR (for example see Appendix D) should undergo uterine artery Doppler assessment between 18+0 to 23+6 weeks gestation.	Amendments required to guidelines: 'Assessment of Fetal Growth' 'Obstetric Ultrasound' Data collection and audit to be confirmed
2.8 The risk of FGR should be reviewed throughout pregnancy and maternity providers should ensure that processes are in place to enable the movement of women between risk pathways dependent on current risk.	Euroking: Questionnaire states FGR Risks This requires amending according to Appendix D updates. No current classification of risk. Potential requirement for risk assessment classification question on E3 at booking & every AN contact.
2.9 When an ultrasound-based assessment of fetal growth is performed Trusts should ensure that robust processes are in place to review which risk pathway a woman is on and agree a plan of ongoing care.	Questionnaire states FGR Risks on Booking questionnaire only. This requires amending according to Appendix D updates. No current classification of risk. Potential requirement for risk assessment classification question on E3 at booking & every AN contact.
2.10 Women who are at low risk of FGR following risk assessment should have surveillance using antenatal fundal height (FH) measurement before 28+6 weeks gestation. Measurements should be plotted or recorded on charts by clinicians trained in their use.	Guidelines: 'Assessment of Fetal Growth' already states Fundal Height measurements should be commenced from 26/40

	'Antenatal Care' states symphysis–fundal height should be measured and recorded at each antenatal appointment from 28 weeks,25 weeks for primiparous.
2.11 Staff who perform FH measurement should be competent in measuring, plotting (or recording), interpreting appropriately and referring when indicated. Only staff who perform FH measurement need to undergo training in FH measurement.	Annual mandatory training to be developed to encompass FH measurement. Changes required to training needs analysis, lesson plan and assessment method. To be discussed at Multi Professional Faculty of Maternity Education. Training attendance to be monitored via dashboard.
2.12 Women who are undergoing planned serial scan surveillance should cease FH measurement after serial surveillance begins. FH measurement should also cease if women are moved onto a scan surveillance pathway in later pregnancy for a developing pregnancy risk (e.g. recurrent reduced fetal movements).	Message of the week (MOW) included to cease SFH once serial scanning Guideline 'Assessment of Fetal Growth' requires amendment to emphasise
2.13 Women who are at increased risk of FGR should have ultrasound surveillance of fetal growth at 3-4 weekly intervals until delivery (see RCOG guidance and Appendix D)	Amendments required to guideline 'Assessment of Fetal Growth' Now included in annual mandatory training, TNIA updated to reflect this
2.14 When FGR is suspected an assessment of fetal wellbeing should be made including a discussion regarding fetal movements (see Element 3) and if required computerised CTG (cCTG). A maternal assessment should be performed at each contact this should include blood pressure measurement using a digital monitor that has been validated for use in pregnancy and a urine dipstick assessment for proteinuria. In the presence of hypertension NICE guidance on the use of PlGF/sflt1 testing should be followed.	Amendments required to the following guidelines: 'Assessment of Fetal Growth' 'Fetal Medicine Unit' 'Reduced Fetal Movements'
2.15 Umbilical artery Doppler is the primary surveillance tool for FGR identified prior to 34+0 weeks and should be performed as a minimum every 2 weeks. Maternity care providers caring for women with early FGR identified prior to 34+0 weeks should have an agreed pathway for management which includes fetal medicine network input (for example, through referral or case discussion by phone). Further information is provided in Appendix D.	FMU Lead involvement required Amendments required to the following guidelines: 'Assessment of Fetal Growth' 'Fetal Medicine Unit' 'Obstetric Ultrasound'
2.16 When FGR is suspected, the frequency of review of estimated fetal weight (EFW) should follow the guidance in Appendix D or an alternative which has been agreed with local ICSs following advice from the provider's Clinical Network and/or regional team.	Amendments required to guideline 'Assessment of Fetal Growth' Now included in annual mandatory training, TNIA updated to reflect this
2.17 Risk assessment and management of growth disorders in multiple pregnancy should comply with NICE guidance or a variant that has been agreed with local ICSs following advice from the provider's Clinical Network	Cross reference multiple pregnancy guidance with NICE guidance required
2.18 All management decisions regarding the timing of FGR infants and the relative risks and benefits of iatrogenic delivery should be discussed and agreed with the mother. When the estimated fetal weight (EFW) is <3rd centile and there are no other risk factors (see 2.20), initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation.	FMU Lead involvement required Amendments required to the following guidelines: 'Assessment of Fetal Growth' 'Fetal Medicine Unit'

2.19 In fetuses with an EFW between the 3rd and <10th centile, delivery should be considered at 39+0 weeks. Birth should be achieved by 39+6 weeks. Other risk factors should be present for birth to be recommended prior to 39 weeks (see 2.20)	FMU Lead involvement required Amendments required to the following guidelines: 'Assessment of Fetal Growth' 'Fetal Medicine Unit'
2.20 Fetuses who demonstrate declining growth velocity from 32 weeks' gestation are at increased risk of stillbirth from late onset FGR. Declining growth velocity can occur in fetuses with an EFW >10th centile. Evidence to guide practise is limited and guidance (see Appendix D) is currently based on consensus opinion. In fetuses with declining growth velocity and EFW >10th centile the risk of stillbirth from late onset FGR should be balanced against the risk of late preterm delivery. In infants where declining growth velocity meets criteria (see Appendix D) delivery should be planned from 37+0 weeks unless other risk factors are present. Risk factors that should trigger review of timing of birth are: reduced fetal movements, any umbilical artery or middle cerebral artery Doppler abnormality, cCTG that does not meet criteria, maternal hypertensive disease, abnormal sFlt1: PlGF ratio/free PlGF or reduced liquor volume. Opinion on timing of birth for these infants should be made in consultation with specialist fetal growth services or fetal medicine services depending on Trust availability.	FMU Lead involvement required Amendments to guidelines: Assessment of Fetal Growth FMU
2.21 Trusts should determine and act upon all themes related to FGR that are identified from investigation of incidents, perinatal reviews, and examples of excellence.	Extra tab to be added on PMRT Audit Data to include incidences and excellence Add relevant case studies to TNIA for inclusion in annual mandatory training
2.22 Trusts should provide data to their Boards and share this with their ICS in relation to the following: a) Percentage of babies born <3rd birthweight centile >37+6 weeks' gestation. b) Ongoing case-note audit of <3rd birthweight centile babies not detected antenatally and born after 38+0 weeks, to identify areas for future improvement (at least 20 cases per year, or all cases if less than 20 occur). c) Percentage of babies born >39+6 and <10th birthweight centile to provide an indication of detection rates and management of SGA babies. d) Percentage of babies >3rd birthweight centile born <39+0 weeks gestation	a) Data collected on Dashboard Data collected Quarterly from PI b) Continuous audit completed Q1 Data collected, report started - to present in July 23 Q2 Data to be commenced 01.07.23 c) Dashboard data currently collects <10th centile >37+6 To change to >39+6 d) Data not currently collected. To explore getting data onto Dashboard
2.23 Use the PMRT to calculate the percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue. Trusts should review their annual MBRRACE perinatal mortality report and report to their ICS on actions taken to address any deficiencies identified.	Notification for all obstetric incidents with related fetal growth issues in place PMRT audit being undertaken

2.24 Individual Trusts should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements.	Contact made with ICB
2.25 Individual Trusts should provide data on the distribution of FGR outcomes with relation to maternal reported ethnicity.	To await implementation guide to inform technical guidance To explore potential to provide ethnicity to FGR rates (gestation unknown) on Dashboard
2.26 Maternity providers are encouraged to focus improvement in the following areas: a) Appropriate risk assessment for FGR and other conditions associated with placental dysfunction and robust referral processes to appropriate care pathways following this. b) Appropriate prescribing of aspirin in line with this risk assessment in women at risk of placental dysfunction. c) Review of ultrasound measurement quality control. Trusts are encouraged to comply with BMUS guidance on audit and continuous learning with relation third trimester assessment of fetal wellbeing d) Trusts will share evidence of these improvements with their Trust Board and ICS and demonstrate continuous improvement in relation to process and outcome measures.	a) as per 2.13 b) as per 2.1 c) to be explored further d) awaiting implementation tool that will become available to support providers to baseline current practice against SBLCBv3, agree a local improvement trajectory with their ICB, and track progress locally in accordance with that trajectory
Element 2 - process indicators	
2a. Percentage of pregnancies where a risk status for Fetal Growth Restriction (FGR) is identified and recorded at booking.	tbc
2b. Percentage of pregnancies where a Small for Gestational Age (SGA) fetus is antenatally detected, and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital.	tbc
2c. Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT).	tbc

Element 2 - outcome indicators	
2d. Percentage of babies <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR).	tbc
2e. Percentage of babies >3rd birthweight centile born <39+0 weeks gestation	tbc
Element 3: Raising awareness of reduced fetal movement	
Element 3 - interventions	
3.1 Information from practitioners, accompanied by an advice leaflet (for example, RCOG or Tommy's leaflet available in multiple languages) on RFM, based on current evidence, best practice and clinical guidelines, to be available to all pregnant women by 28+0 weeks of pregnancy and FM discussed at every subsequent contact.	Referenced in guidelines: 'Reduced,Altered or Absent fetal movements' Information currently on Dashboard re provision of leaflet for reduced fetal movements by 28 weeks gestation No data on fetal movements discussed at every antenatal contact, to explore presentation on dashboard
3.2 Use provided checklist (on page 33) to manage care of pregnant women who report RFM, in line with national evidence-based guidance (for example, RCOG Green-Top Guideline 57).	New proforma included within guideline 'Reduced, Altered or Absent fetal movements' sent out for comment and presented at the guideline group meeting on 23.06.23 - not approved, changes required which have now been made and the revised document has been sent out for comment
Element 3 - continuous learning	
3.3 Maternity care providers should examine their outcomes in relation to the interventions and trends and themes within their own incidents where the presentation and/or management of RFM is felt to have been a contributory factor.	Data currently collected by PMRT Audit Tracker 23.06.23 Incidence & Excellence Tracker commenced to track all incidences and reporting in relation to reduced fetal movements To present data in newsletters and at audit day To update TNIA based on findings monthly, to enable inclusion in annual mandatory training session
3.4 Maternity care providers should ensure whether inequalities (particularly relating to ethnicity and deprivation) are being adequately addressed when there are incidents relating to presentation with or management of RFM.	To add to PMRT audit data a new column for tracking ethnicity To present findings on audit day To update TNIA on service users case reviews when relevant, for inclusion in annual mandatory training
3.5 Individual trusts should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements.	ICB contacted Awaiting implementation tool that will become available to support providers to baseline current practice against SBLCBv3, agree a local improvement

	trajectory with their ICB, and track progress locally in accordance with that trajectory
3.6 Maternity providers are encouraged to focus improvement in the following areas: a) Signposting to information regarding RFM to pregnant women by 28+0 weeks of pregnancy. b) Appropriate care according to local guidance in relation to risk stratification and ongoing care for women presenting with RFM. c) Ensuring appropriate use of induction of labour when RFM is the only indication (for example, induction of labour for RFM alone is not recommended prior to 39+0 weeks).	a) On dashboard b) As per 3.2 c) On dashboard
Element 3 - process indicators	
3a. Percentage of women who attend with RFM who have a computerised CTG.	tbc
3b. Proportion of women who attend with recurrent RFM* who had an ultrasound scan to assess fetal growth.	tbc
Element 3 - outcome indicators	
3c. Percentage of stillbirths which had issues associated with RFM management identified using PMRT	tbc
3d. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation.	tbc
Element 4: Effective fetal monitoring during labour	
Element 4 - interventions	

4.1 All staff who care for women in labour are required to undertake annual training and competency assessment on knowledge and skills required for effective fetal monitoring via Intermittent auscultation (IA) [Midwives] and electronic fetal monitoring [Midwives and Obstetricians].	Current compliance is at 95.7% Current compliance figures inlcude NHSP staff but do not include agency staff as they do not currently receive training within the Trust - process for assurance of agency midwifery staff fetal monitoring training to be formalised and align with process for locum doctors Current passmark 75% procedure agreed with ICB in 2020. Updated competency assessment process to go to ICB for approval Passmark to increase TO 85% for Year 2 training 2023/2024 fetal monitoring training programme Stretch target passmark of 95% to be reviewed with current competency process 
4.2 At the onset of every labour, there is a structured risk assessment undertaken which informs the clinicians recommendation of the most appropriate fetal monitoring method at the start of labour. This risk assessment should be revisited throughout labour as part of a holistic review.	Guidelines: Fetal Heart Monitoring (Including Dawes Redman and STAN monitoring) version 3 (2022) To await release of ABC risk assessment tool
4.3 Regular (at least hourly) systematic review of maternal and fetal wellbeing should be agreed and implemented. This should be accompanied by a clear guideline for escalation if concerns are raised using this structured process. All staff to be trained in the review system and escalation protocol.	Guidelines: Fetal Heart Monitoring (Including Dawes Redman and STAN monitoring) version 3 (2022)

4.4 A buddy system should be used to help provide an objective holistic review for example 'Fresh Eyes' – this should be undertaken at least hourly when CTG monitoring is used and at least four hourly when IA is utilised, unless there is a trigger to provide a holistic review earlier. 4.5 Identify a dedicated lead midwife (minimum of 0.4 WTE) and lead obstetrician (minimum 0.1WTE) with demonstrated fetal monitoring expertise to focus on and champion best practice in fetal monitoring.	This is included within the Fetal Heart Monitoring (Including Dawes Redman and STAN monitoring) version 3 (2022) Data for audit of Fresh eyes and Fresh Care to be presented at Women's Health Audit Day 18.7.23
4.5 Identify a dedicated lead midwife (minimum of 0.4 WTE) and lead obstetrician (minimum 0.1WTE) with demonstrated fetal monitoring expertise to focus on and champion best practice in fetal monitoring. (Some Trusts may choose to extend the remit of the Practice Development Midwife to fulfil the role of Fetal Monitoring Lead, whereas others may wish to appoint a separate clinician. The critical principle is that the Fetal Monitoring Leads have dedicated time within their remit to support staff working in intrapartum care to provide high quality intrapartum risk assessments and accurate fetal heart rate interpretation using either IA or CTG. The role should contribute to building and sustaining a safety culture in intrapartum care with all staff committed to continuous Improvement).	1 WTE Fetal Monitoring Midwife for each site (QEQM and WHH) Obstetric lead for each site 0.1 WTE (QEQM and WHH)
Element 4 - continuous learning	
4.6 Maternity care providers should examine their outcomes in relation to the interventions, trends and themes within their own incidents where fetal monitoring was likely to have been a contributory factor.	Currently the FM team have a criteria for reviewing all cases that meet a set criteria for review. This is not embedded in the governance process
4.7 Individual Trusts should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements.	Need to ascertain how this will be achieved Awaiting implementation tool that will become available to support providers to baseline current practice against SBLCBv3, agree a local improvement trajectory with their ICB, and track progress locally in accordance with that trajectory
4.8 Maternity providers are encouraged to focus improvement in the following areas: a) Risk assessment of the woman/fetus at the beginning and regularly during labour. b) Interpretation and escalation of concerns over fetal wellbeing in labour.	Guidelines: Fetal Heart Monitoring (Including Dawes Redman and STAN monitoring) version 3 (2022) Also covered in full day training and weekly CTG teaching

Element 4 - process indicators	
4a. Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors and situational awareness.	Retrospective monthly compliance does not currently inlcude agency midwifery staff. Human factors is currently in the lesson plan for fetal monitoring training to be approved by MFME 17.7.23 TNIA updated to reflect lesson plan changes for human factors within fetal monitoring
4b. Percentage of staff who have successfully completed mandatory annual competency assessment.	This data is available through classmarker but is not on the maternity dashboard
4c.Fetal monitoring lead roles appointed	All roles appointed to
Element 4 – outcome indicators	
4d. The percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. *Using the severe brain injury definition as used in Gale et al. 201825.	To ensure that there is a clear process for identification of cases that meet this crietria and assess if fetal monitoring was a contributory factor To ensure a robust process is embedded for the review of all cases meeting this criterion To explore whether this can be added to the Maternity Dashboard as a metric
Element 5: Reducing preterm births and optimising perinatal care	
Element 5 - interventions	
5.1 Each provider trust should have. a) An Obstetric Consultant lead for preterm birth, delivering care through a specific preterm birth clinic, or within an existing fetal medicine service. b) An identified local preterm birth/perinatal optimisation Midwife Lead c) A Neonatal Consultant lead for preterm perinatal optimisation	Perinatal Optimisation Task Group already in progress Monthly meetings - to commence minute taking

d) An identified Neonatal Nursing lead for preterm perinatal optimisation	
5.2 Each Preterm Birth Lead team should have clear audit and QI pathways for preterm birth prevention, prediction and perinatal optimisation, and should engage in shared learning and QI with local preterm birth clinical networks, LMNSs and neonatal ODNs.	Register Perinatal Optimisation audit and Preterm Clinic audit (prediction/prevention) Monthly Perinatal Optimisation Meetings to share data Await LMNS Meetings Access to ODN Network required
5.3 Assessment of all women at booking for their risk of preterm birth and stratification to low, intermediate and high-risk pathways using the criteria in Appendix F. It is recognised that there are imperfections in the predictability of preterm birth on the basis of history; the use of digital algorithms & tools (for example the Tommy's app) may also be useful to support assessment.	In 'Preterm Labour and Birth guidelines'
5.4 In the assessment of women presenting in suspected preterm labour, evaluated digital tools are now available (QUIDS, QUiPP) to improve predictive accuracy of triage and enable collaborative decision making.	To launch Ffn & QUiPP App Awaiting stock issue resolution by Hologic, hoping to launch in August
5.5 Networked Trusts should agree on the use of these tools within their ICS/LMNS.	As above - already agreed and awaiting launch
5.6 Multiple pregnancy – risk assessment and management in multiple pregnancy should comply with NICE guidance or a variant that has been agreed with the local network or ICS following advice from the provider's clinical network.	Compliant with NICE: In Antenatal Guidleine In Multiple Pregnancy guideline
5.7 Assess smoking status (see Element 1) and implement appropriate intervention to ensure the pregnancy is smoke free before 15 weeks.	As above
5.8 Assess all women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C or an alternative which has been agreed with the local network or ICS following advice from the provider's clinical network.	See 2.1
5.9 Symptomatic women require assessment using quantitative fetal fibronectin (qfFN) measurements (and use of decision-assist tools such as the QUiPP and QUIDS apps). The use of TVCS may also be used with or without qfFN. Further advice may be sought from UK Preterm Clinical Network, BAPM, or NICE guidance55).	See 5.4
5.10 Assess each woman with a history of preterm birth to determine whether this was associated with placental disease and discuss prescribing aspirin with her.	To include into preterm birth guideline
5.11 Test for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking. Following any positive culture and treatment, a repeat MSU to confirm clearance is recommended54.	In Antenatal Guideline

5.12 Asymptomatic women should have access to transvaginal cervix scanning (TVCS) to assess the need for further interventions such as cervical cerclage and progesterone supplementation (Appendix F).	To include in Preterm birth guideline
5.13 Every provider should have referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories. This should include access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage. These procedures are performed relatively infrequently and therefore are best provided on a supra-regional basis in order to maintain expertise.	To produce SOP for referral to Tertiary Clinic To include within Preterm Birth guidelines
5.14 Midwifery Continuity of Carer (CoC) models, with a focus on individualised risk assessment and care pathways, may prevent preterm birth and save babies' lives. Ref B0961_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf (england.nhs.uk). Local implementation plans for midwifery CoC models should ensure prioritisation of women from the most deprived groups in line with Core20+5. However, Midwifery CoC must be supported by safe staffing levels to preserve the safety of all pregnant women and families https://www.gov.uk/government/publications/final-report-of-the-ockenden-review	Will require team of Midwives, Preterm Lead B7 Post or FWB B7 additional post
5.15 Women identified to be at increased risk of preterm birth should be made aware of the signs/symptoms of preterm labour and encouraged to attend their local maternity unit early if these occur.	To include in Preterm Labour & Birth guidelines PIL being created to include signs and symptoms to provide at PBSC
5.16 Ensure the neonatal team are involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with parents prior to birth. This is especially important at earlier gestational ages. In the case of extreme prematurity where complex decision making is required (active survival focused care or comfort care), management should be as outlined in the 2019 BAPM Framework for Practice regarding Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation: "Conversations with parents should be clearly documented and care taken to ensure that the agreed management plan is communicated between perinatal professionals and staff shifts. Decisions and management should be regularly reviewed before and after birth in conjunction with the parents; plans may be reconsidered if the risk for the fetus/baby changes, or if parental wishes change." https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019	Already included in Preterm Labour and Birth guidelines Wording amendments required
5.17 Women identified to be potentially at increased risk of imminent preterm birth, where active survival focused care is planned, should be made aware of optimisation interventions that may be offered. Families should also be offered information and support for families from charities such as Bliss.	JT to set up D/C pack containing BLISS Leaflet and PIL on signs/symptoms and PO. Information of D/C pack to be included in Preterm Birth guidelines
5.18 Acute tocolysis may be used when short term delay is desirable i.e., in utero transfer, and probably to ensure adequate antenatal exposure to corticosteroid/magnesium sulphate (i.e. no longer than 48 hours). There is no evidence that maintenance tocolysis is beneficial	To amend Preterm Birth guidelines to include this information

when compared with no tocolysis treatment, oxytocin antagonist and calcium channel blockers appear effective in delaying birth for more than 48 hours. In the absence of any contraindications nifedipine is the preferred agent for tocolysis2.	
5.19 Place of birth – Women who have symptoms suggestive of preterm labour or who are having a planned preterm birth: a) less than 27 weeks gestational age (in a singleton pregnancy) b) less than 28 weeks gestational age (in a multiple pregnancy) c) any gestation with an estimated fetal weight of less than 800g should be managed in a maternity service on the same site as a neonatal intensive care unit (NICU). Maternity services must operate in close perinatal collaboration with neonatal networks to ensure that babies predicted to require a higher level of neonatal care than can be provided in the local delivery unit are moved in utero whenever possible. https://www.bapm.org/pages/194-antenatal-optimisation-toolkit	a) & b) both included on Information Portal (Dashboard) c) to explore data collection and inclusion on dashboard
5.20 Antenatal corticosteroids should be offered to women between 22+0 (where active management is agreed) and 33+6 weeks of pregnancy, optimally at 48 hours prior to birth. A steroid-to-birth interval of greater than seven days should be avoided if possible. and repeat courses of steroids should be avoided where possible. https://www.bapm.org/pages/194-antenatal-optimisation-toolkit	Amendments of wording required with Preterm Labour & Birth guidelines Data collected on Dashboard currently
5.21 Magnesium sulphate to be offered to women between 22+0 (where active management is agreed) and 29+6 weeks of pregnancy – and considered for women between 30+0 and 33+6 weeks of pregnancy – who are in established labour or are having a planned preterm birth within 24 hours. https://www.bapm.org/pages/194-antenatal-optimisation-toolkit	Amendments of wording required with Preterm Labour & Birth guidelines Data collected on Dashboard currently
5.22 Intrapartum antibiotics All women in preterm labour at less than 37 weeks of gestation should receive intravenous intrapartum antibiotic prophylaxis (Benzylpenicillin, where not contraindicated) to prevent early onset neonatal Group B Streptococcal (GBS) infection irrespective of whether they have ruptured amniotic membranes. This excludes planned caesarean births without labour. NB – this intervention should be considered up to 36+6 weeks.	Amendments of wording required with Preterm Labour & Birth guidelines Data collected on Dashboard currently To make IVABx mandatory field on Badgernet
5.23 Cord Management Babies born at less than 37 weeks gestational age should have their umbilical cord clamped at or after one minute after birth – this can have benefits for all babies. Perinatal multidisciplinary teams should work together to ensure this can reliably be delivered at all births. https://www.bapm.org/pages/197-optimal-cord-management-toolkit	Data currently collected on Dashboard

5.24 Normothermia Babies born at less than 37 weeks gestational age should have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. Neonatal normothermia can have benefits for all babies. https://www.bapm.org/pages/105-normothermia-toolkit	Data currently collected on Dashboard
5.25 Early maternal breast milk (MBM) Babies born below 37 weeks gestational age should receive their own mother's milk, ideally within 6 hours, but aiming always within 24 hours of birth (except in rare situations where there are contraindications to MBM). Perinatal teams should work together to ensure consistent delivery of antenatal advice about MBM, with support (equipment, education, help) for mothers to express within two hours of birth. https://www.bapm.org/pages/196-maternal-breast-milk-toolkit	Data currently collected on Dashboard Infant Feeding Coordinators working to improve compliance
5.26 Volume-Targeted Ventilation For babies born below 34 weeks' gestation who need invasive ventilation, use volume-targeted ventilation (VTV) in combination with synchronised ventilation as the primary mode of respiratory support. This reduces the chance of death or bronchopulmonary dysplasia by 27% and intraventricular haemorrhage (grades 3–4) by 47% compared with pressure-limited ventilation modes. *NB – For preterm babies who do not need invasive ventilation, consider nasal CPAP or nasal high-flow therapy as the primary mode of respiratory support. NICE guidance: Quality statements Getting it right first time: Neonatal intensive care	Data currently collected on Dashboard
5.27 Caffeine For babies born below 30 weeks' gestation, caffeine reduces the chance of death or disability. Caffeine should be started within 24 hours of birth	Data currently collected on Dashboard
Element 5 - continuous learning and improvement	
5.28 All providers are encouraged to draw upon the learning from the four BAPM toolkits and a range of resources from other successful regional current programmes (e.g., PERIPrem resources, MCQIC) a) https://www.bapm.org/pages/104-qi-toolkits b) https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/	Preterm Labour & Birth guidelines already reference BAPM Toolkits To arrange launch of PREM7+ (Already included in TNIA and Lesson Plans)

c) https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/spsp-programmes-of-work/maternity-and-children-quality-improvement-collaborative-mcqic/neonatal-care/ d) https://www.weahsn.net/our-work/transforming-services-and-systems/periprem/	
5.29 Maternity & Neonatal care providers should determine and act upon all themes related to preterm birth that are identified from investigation of incidents, perinatal reviews and examples of excellence, particularly focusing on prediction, prevention, preparation and perinatal optimisation, including: a) Risk assessment of women in their first pregnancy for the risk of preterm birth and timely triage to the appropriate care pathway. b) Management of women at high risk of preterm birth, including appropriate cervical length surveillance and use of cervical cerclage. c) Implementation of optimisation interventions as a whole preterm perinatal optimisation pathway, including measurement and reporting of overall optimisation pathway compliance	To maintain spreadsheets: - PMRT Audits - Incidents and excellence tracker - Perinatal Optimisation Tracker To present data on audit day and newsletters To update TNIA on findings monthly a) To perform audit (as per MIS Y4) b) Register PBSC Audit c) Perinatal Optimisation audit and action plans
5.30 Maternity & Neonatal care providers should demonstrate continuing improvement by regular reassessment of the process and outcome indicators below. These data can be accessed through a number of national and network level data sources including the National Neonatal Audit Programme (NNAP) and Neonatal ODN data. Data completeness via electronic maternity and neonatal record systems is vitally important, and data quality should be monitored frequently. Provider Trusts should seek to support data quality assurance, including support for data clerk or data manager time.	Data clerk or data manager time required
5.31 Benchmarking: Maternity & Neonatal care providers should examine their process and outcome indicators in relation to similar provider Trusts to understand variation and inform potential improvements.	Advice and tools awaited
5.32 Sharing learning & improvement: The preterm birth teams (see 5.1) within each Maternity & Neonatal care provider setting should: a) Review and share their process and outcome indicator data across the perinatal team on a regular basis (at least quarterly) to drive continual improvement. b) Share process and outcome indicator data, and evidence of improvement with their Maternity & Neonatal Board level safety champions, LMNS (Local Maternity & Neonatal System) and ICS (Integrated Care System) quality surveillance teams on a quarterly basis.	Perinatal Optimisation Task Group in progress. a) Commence minutes for PO Task Group monthly meetings b) Action plans required quarterly from PO Audit

Element 5 - process indicators	
5a. Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU)	tbc
5b. Percentage of women giving birth before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth.	tbc
5c. Percentage of women giving birth before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth.	tbc
5d. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection.	tbc
5e. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth.	tbc
5f. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth.	tbc
5g. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth.	tbc
5h. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (1 to 7 above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation)	tbc
Element 5 - outcome indicators	
5i. Mortality to discharge in very preterm babies (NNAP definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner)	tbc

5j. Preterm Brain Injury (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: a) Germinal matrix/ intraventricular haemorrhage b) Post haemorrhagic ventricular dilatation. c) Cystic periventricular leukomalacia	tbc
5k. Percentage of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	tbc
5l. Maternity care providers will provide outcome data to the Trust Board and share this with the LMNS relating to the incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a) in the late second trimester (from 16+0 to 23+6 weeks). b) preterm (from 24+0 to 36+6 weeks).	tbc
Element 6: Management of pre-existing diabetes in pregnancy	
Element 6 - interventions	
6.1 Women with a diagnosis of pre-existing diabetes in pregnancy should be offered care in a one stop clinic, providing care to pre-existing diabetes only, which routinely offers multidisciplinary review and has the resource and skill set to address all antenatal care requirements. The multidisciplinary team should consist, as a minimum, of: Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife.	
6.2 Women with type 1 diabetes should be offered real time continuous glucose monitoring (CGM) and be provided with appropriate education and support to use this.	Need to check whether wording in guideline requires amendment
6.3 Women with type 2 diabetes should have an objective record of their blood glucose recorded in their hospital records/EPR and be offered alternatives (e.g., intermittently scanned CGM) to blood glucose monitoring if glycaemic targets are not achieved	Guideline to be amended to include this

6.4 Women with diabetes should have an HbA1c measured at the start of the third trimester and those with an HbA1c above 48mmol/mmol should be offered increased surveillance including additional diabetes nurse/dietetic support, more frequent face to face review and input from their named, specialist Consultant to plan ongoing care and timing of birth decisions.	
6.5 Women with diabetes and retinopathy requiring treatment during pregnancy and/or kidney impairment (CKD 2 with significant proteinuria i.e. PCR>30; or CKD 3 or more) should be managed in a regional maternal medicine centre where care can be delivered in a single MDT clinic. In circumstances where regular travel to a tertiary clinic is not possible, ongoing care should be planned via regular (4-6 weekly) MDT discussion with the MMC centre throughout the pregnancy.	Not managed in a regional maternal medicine centre where care can be delivered in a single MDT clinic.
6.6 Recognising the very high risk of fetal death (stillbirth rate 160 per 1,000 births) associated with diabetic ketoacidosis (DKA), all pregnant women presenting to secondary care with DKA should have ongoing multidisciplinary Consultant input and be cared for in line with the jointly agreed trust policy.	Guideline to be updated to reflect this
Element 6 - continuous learning	
6.7 Maternity care providers involved in the care of women with type 1 and type 2 diabetes should examine their outcomes in relation to all themes related to these women. These include risk assessment and management in the antenatal and intrapartum period.	Audit required
6.8 Maternity care providers who look after women with type 1 and type 2 diabetes in pregnancy should submit data to the NPID audit, review their submissions and develop an action plan to address ongoing challenges.	Data submitted but development of an action plan required
6.9 Individual Trusts should examine their outcomes in relation to other Trusts caring for women in pregnancy with type 1 and type 2 diabetes and engage with wider regional and national Diabetes Clinical networks to share examples of good practice and work collaboratively to address challenges.	Some discussion takes place Benchmarking required
6.10 Individual Trusts should actively gather feedback from service users about their care, and co-produce guidance and proposed care pathways with Maternity Voices Partnerships (MVP) members with 'lived experience'.	Greater liaison with MVP required in relation to diabetes Patient experience midwives to support Feedback is obtained via Your Voice is Hear, but not specifically related to diabetes unless the women raise this in the conversation
6.11 All cases of perinatal death in women with diabetes, or where diabetes is considered to be a possible contributory factor, should be reviewed by a multidisciplinary team which includes members with expertise in the care of women with diabetes in pregnancy. Learning from these case reviews should be disseminated as appropriate and an action plan developed to reduce the risk of recurrence.	Formal process to be developed to ensure that this occurs should such a situation arose
6.12 Any pregnancies where CGM or HbA1C was not offered in line with the recommendations should be subject to	All women are offered

	Any incidents occurring would be fully investigated in line with clinical governance processes
Element 6 - process indicators	
6a. Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc).	Guideline requires review and update Current guideline outlines multidisciplinary team approach and joint clinics
6b. Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes.	
6c. Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets.	tbc
6d. Demonstrate compliance with CGM training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes.	tbc
6e. Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with DKA during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities and availability of expertise.	Requires development
Element 6 - outcome indicators	
6f. The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the NPID dashboard (aiming for >95% of women)	tbc
6g.The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the start of the third trimester (aiming for >95% of women)	tbc

Q1 2023-24 Summary

Saving babies' lives version three: a care bundle for reducing perinatal mortality was published by NHS England on 31 May 2023. It provides evidence-based best practice for providers and commissioners of maternity care across England to reduce perinatal mortality. Building on the achievements of previous iterations, Version 3 includes a refresh of all existing elements. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy.

As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

Identified leads within EKHUFT are as follow:

Element 1: reducing smoking in pregnancy - Amy Evans, Smoking Cessation Specialist Midwife
Element 2: Fetal growth - Poppy Corrall, Fetal Wellbeing Midwife
Element 3: Raising awareness of reduced fetal movement - Poppy Corrall, Fetal Wellbeing Midwife
Element 4: Effective fetal monitoring – Becky DuCane and Sian Hancock, Fetal Monitoring Midwives
Element 5: Reducing preterm birth - Poppy Corrall, Fetal Wellbeing Midwife
Element 6: Management of pre-existing diabetes – Hilary Purkess and Laura La Roche, Diabetes Midwives

Although this a report for Q1 2023-24, it is only a few weeks since SBLv3 was published. In that time a gap analysis has been undertaken and required actions identified. Not only do these actions need to be implemented but also work to collate data and evidence to map against process indicators and outcomes. An implementation tool will be available on the Maternity Transformation Programme's Future NHS platform. This tool will support providers to baseline current practice against SBLCBv3, agree a local improvement trajectory with their ICB, and track progress locally in accordance with that trajectory. Trusts will be asked to use the implementation tool in 2 ways to ensure local oversight:

- Track and demonstrate compliance to the Trust Board and ICBs
- Holding quarterly quality improvement discussions with the ICBs

It is hoped that use of the tool will assist future reporting.

23/077 – APPENDIX 4

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Perinatal Quality Surveillance Tool (PQST) Report**

Meeting date: **7 September 2023**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO): Maternity and Neonatal Board Safety Champion**

Paper Author: **Deputy Director of Midwifery and Interim Head of Governance**

Appendices:

NONE

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	The purpose of this report is • To update on East Kent Maternity's services are aligned to the key elements included within the perinatal and assurance framework as defined by NHS England (NHSE). • This is in accordance with the standards set out in NHS Resolutions (NHSR) Maternity Incentive Scheme, Safety Action 9, which aims to continue to support the safer maternity and Ockenden report recommendations. • Provide assurance that the service is using the tool and reporting to the required standard set out in the NHS implementing a Revised Perinatal Quality Surveillance Model Report December 2020, NHS resolution Clinical Negligence Scheme for trusts (CNST) Maternity Incentive Scheme year 4- Safety Action nine and Ockenden 1 Report Immediate and Essential Actions.
Summary of key issues:	• The report confirms that the service is using the tool to the required standard, as set out in the NHS implementing a Revised Perinatal Quality Surveillance Model Report December 2020. **The report includes the following key messages for the group's attention –** • CNST reporting has now begun a new period**. May to December.** • Currently the area of concern remains on standard 8 in relation to PRactical Obstetric Multi-Professional Training (PROMPT) due to anaesthetic workforce challenges. The exact criteria for year 5 have been now released. There are ongoing challenges with the availability of obstetric faculty to facilitate Multi-Disciplinary Team (MDT) PROMPT. • Anaesthetic training compliance for PROMPT has improved to 83% but remains below the national standard of 90%. • There were 3 Healthcare Safety Investigation Branch (HSIB) referrals for the month of June. • Supernumerary status and 1:1 care compliance was not reported at 100%, however, the figures have been validated and records will be updated to confirm 100%. • There were 3 reported serious incidents during June, 1 at Queen Elizabeth the Queen Mother Hospital (QEQM), 1 at William Harvey Hospital (WHH) and 1 at Kent & Canterbury Hospital (K&C). • Friends and Family Test (FFT) received 168 responses which is a 11.9% response rate increase from last month which was 10.9%. The responses show 90.5% extremely likely or likely to recommend which is a slight increase from last month so remains stable.104 comments in total, 84 positive comments= 80.8% increase from 85.6% last month. Positive experiences and Named staff in comments- 24 members of staff named. • The Your Voice is Heard (YVIH) team achieved a response rate of 77.3% which is an increase from May (76.4%). With a Key Performance Indicator (KPI) of a 70% response rate. • Training compliance was met across all maternity staff groups for fetal monitoring PROMPT and Newborn Life Support (NLS). • We Hear You, Team engagement day 28 June.
Key recommendations:	The Board of Directors is asked to **NOTE** the content within the maternity dashboard.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.
Resource:	N
Legal and regulatory:	Y – Clinical Negligence Scheme for Trusts (CNST) NHS Long Term Plan-standard contract.
Subsidiary:	N

Assurance route:

Previously considered by: Maternity and Neonatal Assurance Group (MNAG)

East Kent Hospitals Perinatal Quality Surveillance June 2023

Month: June 2023

East Kent Hospitals Hospital NHS Trust Perinatal Quality Surveillance Reporting

CQC Maternity Ratings WHH

Overall	Safe	Effective	Caring	Well-led	Responsive
Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate

CQC Maternity Ratings QEQM

Overall	Safe	Effective	Caring	Well-led	Responsive
Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Good

Maternity Safety Support Programme: Yes — Support Lead: Mai Buckley

Findings of review of cases eligible for referral to HSIB: During the month of June there were 3 referrals to HSIB (2 accepted)

The number of incidents logged graded as moderate or above and what actions are being taken.

There were 3 reported moderate or above harm incidents during June which is inclusive of the 3 HSIB referrals and 1 SI. Below summarises the Moderate Harms and above:

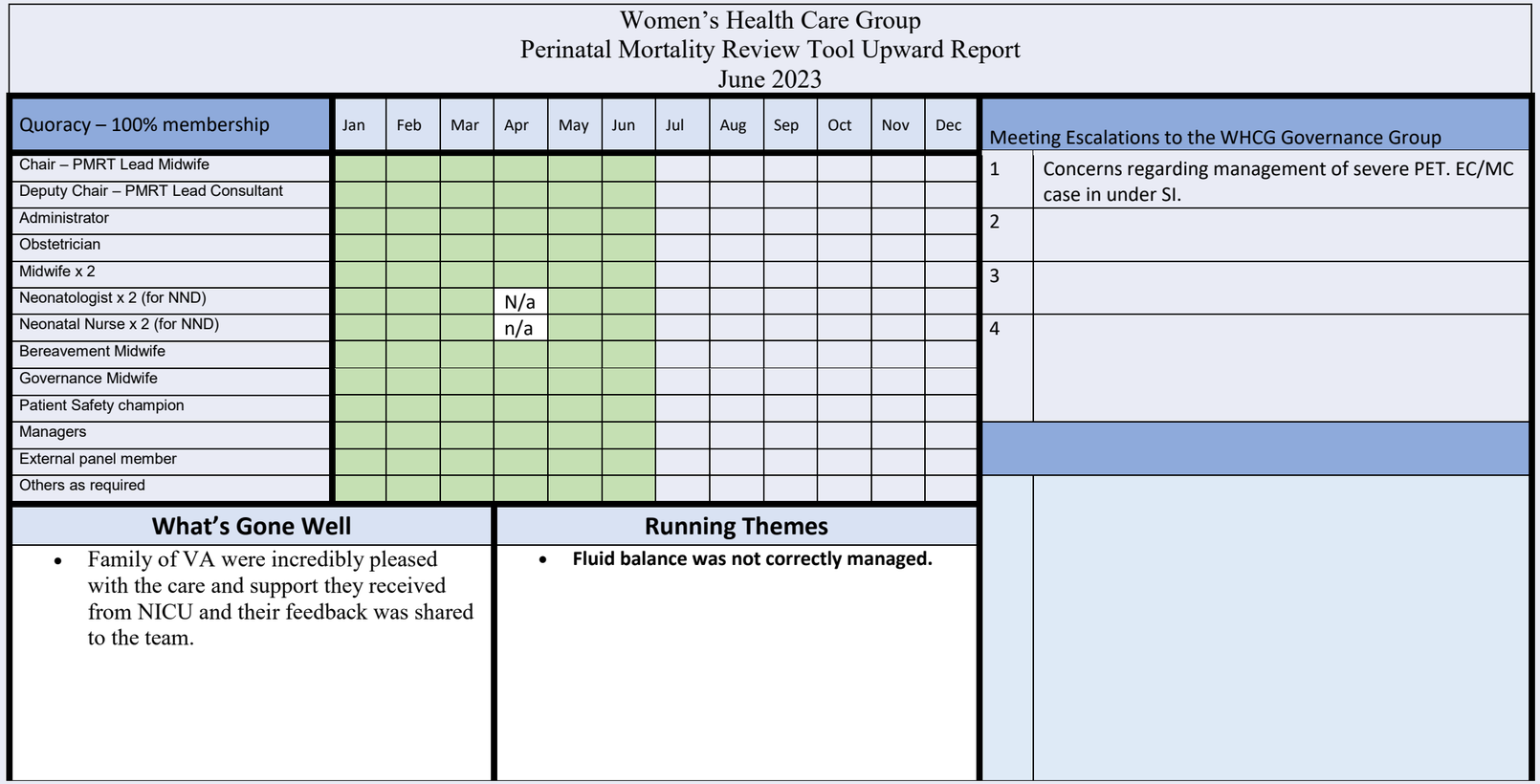
Site	Location	Category	Subcategory	Outcome
QEQM	Labour ward / delivery suite (QEQM)	Women's Health - unexpected problem/outcome for baby	Cord blood gases pH < 7.1 or BE < -10 at birth	SI - HSIB investigation
WHH	Operating theatre (WHH)	Women's Health - unexpected problem/outcome for baby	Neonatal collapse	HSIB referral not accepted
QEQM	Labour ward / delivery suite (QEQM)	Women's Health - unexpected problem/outcome for baby	Unanticipated admission to SCBU	SI (July reporting month) – HSIB investigation

The table below summarises the serious incidents:

Site	Location	Category	Subcategory	Outcome
WHH	Folkestone ward (maternity)	Delay / failure	Failure - to follow up arrangements	SI – internal investigation
KCH	Canterbury birthing centre	Delay / failure	Failure / delay in diagnosis - other	SI – internal investigation (multiple cases)
QEQM	Labour ward / delivery suite (QEQM)	Women's Health - unexpected problem/outcome for baby	Cord blood gases pH < 7.1 or BE < -10 at birth	SI - HSIB investigation (also in table above)

A summary of key actions taken forward with for staff in clinical areas are:

- Communication regarding sepsis screening and documentation via “Message of the Week” and “Lunch and Learn”
- Introduction of Safety Thread sharing immediate lessons learned

Themes from reviews of perinatal deaths	**Themes** 	
100% of perinatal mortality reviews include an external reviewer	As shown in table above	
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training.	**Fetal Monitoring All Maternity Staff**	**Fetal Monitoring Mat Leave and LTS Removed** **Challenges:** • Availability of PROMPT obstetric and anaesthetic faculty to undertake PROMPT. Therefor session have been cancelled. • Ongoing compliance of anaesthetic attendance to training is increasing however still not at the 90% threshold

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	214	227	94.3%
Midwife - Community	99	107	92.5%
Other Obstetric Doctor	40	40	100.0%
Obstetric Consultant	31	31	100.0%
Unknown	1	1	100.0%
Maternity Support Worker	0	0	NaN
Total	**385**	**406**	**94.8%**

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	203	208	97.6%
Midwife - Community	93	94	98.9%
Other Obstetric Doctor	38	38	100.0%
Obstetric Consultant	30	30	100.0%
Unknown	1	1	100.0%
Maternity Support Worker	0	0	NaN
Total	**365**	**371**	**98.4%**

Prompt All Maternity Staff
PROMPT Mat Leave and LTS Removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	215	227	94.7%
Midwife - Community	101	109	92.7%
Maternity Support Worker	79	89	88.8%
Other Obstetric Doctor	39	39	100.0%
Obstetric Consultant	31	31	100.0%
Unknown	4	4	100.0%
Total	**469**	**499**	**94.0%**

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	204	208	98.1%
Midwife - Community	96	96	100.0%
Maternity Support Worker	76	81	93.8%
Other Obstetric Doctor	37	37	100.0%
Obstetric Consultant	30	30	100.0%
Unknown	4	4	100.0%
Total	**447**	**456**	**98.0%**

Anaesthetics covering maternity	Number requiring training	Number of staff trained	Percentage Compliance by staff group
Anaesthetic consultants	**41**	**34**	**83%**
All other anaesthetic Doctors	**40**	**28**	**70%**

NLS All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	209	227	92.1%
Midwife - Community	99	109	90.8%
Maternity Support Worker	75	89	84.3%
Other Obstetric Doctor	38	39	97.4%
Obstetric Consultant	29	32	90.6%
Unknown	4	4	100.0%
Total	**454**	**500**	**90.8%**

NLS Mat Leave and LTS removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	197	208	94.7%
Midwife - Community	95	96	99.0%
Maternity Support Worker	72	81	88.9%
Other Obstetric Doctor	36	37	97.3%
Obstetric Consultant	29	31	93.5%
Unknown	4	4	100.0%
Total	**433**	**457**	**94.7%**

- NLS compliance for MSWs has dropped this is due to an increase in the number of new starters at the WHH.

Minimum safe staffing in maternity services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively		**The medical work force during June remains the same as the picture below-** **Obstetrics-** **QEQM** No incidents of nonattendance escalated. **Consultant Rota** - 2 substantive consultants not undertaking Full on call rota duties due to OH recommendations. - 2 substantive consultants not delivering full on call due to job plan changes (leadership and post retirement) - 2 locum agency consultants providing cover. - 2 Offers for Consultants post **Registrar rota** - One registrar going on maternity leave at the end of April. **WHH** No incidents reported of non-attendance escalated. **Consultant rota** - 1 substantive consultant not doing full on call duties due to OH requirements. **Registrar rota** - 1 SHO GPST gap

Supernumerary Status Maintained		
Month	QEQM	WHH
Jan-23	99.2%	99.6%
Feb-23	99.3%	99.5%
Mar-23	97.9%	100.0%
Apr-23	100.0%	98.9%
May-23	100.0%	99.3%
Jun-23	100.0%	99.3%
Total	99.4%	99.4%

1 to 1 care in Labour		
Month	QEQM	WHH
Jan-23	100.0%	97.9%
Feb-23	99.3%	97.4%
Mar-23	100.0%	97.9%
Apr-23	100.0%	98.5%
May-23	100.0%	99.0%
Jun-23	98.7%	99.4%
Total	99.7%	98.5%

Supernumerary Status
Supernumerary Status: there was 1 incidence of supernumerary status not being met at the WHH

1:1 care in labour:
Compliance of 1:1 in Labour was reported at 99.1% Trust-wide, this related to 2 patients reported as not having received 1:1 care in labour at WHH and 1 at QEQM

Midwifery
The Midwifery workforce numbers remain primarily unchanged in terms of vacancy, sickness and maternity leave.

10 Internationally educated Midwives recruited 2 passed OSCIs and in post 3 due OSCIs week commencing 5th June Remainder commenced in training

FFT Feedback

FFT Main Themes June 2023 (collated on 6/7/23)	Actions
168 responses which is a 11.9% response rate which is an increase from 10.9% from last month. The responses show 90.5% extremely likely or likely to recommend which is an increase from the last 2 months which was 89.4%. 104 comments in total. 84 positive comments= 80.8% decreased from 85.6% last month. Positive experiences and named staff in comments, 24 members of staff named in June.	Reported back to staff via personalised email and new posters on the wards, hard to define good care. Due to changes within the team, and challenges recently with the PEM team providing USS telephone support for women and families, we would like to request that as a team we report on the FFT data a month in arrears, ie July we would report on May's data. This would enable us adequate time to theme and provide a more in-depth report on the data received. Also, the response rate changes throughout the month, with the end of the month showing more responses than at the beginning. There is also a new PTL for the comments for FFT which has come into place for the trust to try and centralise and ensure that the feedback is themed in a similar way and comparable.
Ultrasound scans • Appointments cancelled and hard to get hold of anyone to rebook • Delay in appointments and awaiting contact • Emergency scan not done in timely manner • Inappropriate travel between scan and review • Rude receptionist	Escalated to Operations Manager.
Estates (Reoccurring theme) • Wards too loud • Loud when bringing another patient into the bay • Other patients being loud • Ward small and hot • Room not big enough, too hot, cramped and lacks confidentiality and sound proofing. Facilities need updating.	Limitations due to the estates that PEM have put forward some suggestions from feedback receive about the estates and awaiting estate plans to be agreed and actioned.
Delays in Discharge (Reoccurring theme) • Delays • Discharged without pain relief	There has been a discharge group set up to look at the processes and what could be improved. In speeding up this process. Also, discussions around managing expectations and information around discharge.
Postnatal Care • More support on the PN ward for general baby care • General lack of care • Busy • Overnight care	Escalated to HOM, Matron and Managers
Behaviour and Attitude of Staff (reoccurring theme) • Rude to partner • Rude staff	Escalated with ward managers, Matrons and HOMs at both sites
Delay in Caesarean Section	Have noted the feedback
No recliner chair for partner	Have noted the feedback
Use of language needs to be better so could be better understood by families	Have noted the feedback
Food provision for those that have specialist diet, e.g Diabetes needs improvement	Have noted the feedback

Service user feedback

Service User Feedback Themes	Actions
Your Voice is Heard – June Data	Patient experience midwives are looking at feedback from these conversations and see if themes are re-occurring and how to improve these themes
The service achieved a response rate of 77.3% which is an increase from May (76.4%). With a KPI of a 70% response rate. There have been a few less call this month due to some days the calls being on hold due to helping with the USS call line. Aim to catch up on these in July.	Response rate this month has been our best month to date. There is also a new PTL for the comments for FFT which has come into place for the trust to try and centralise and ensure that the feedback is themed in a similar way and comparable. The use of something similar for YVIH will be discussed in July or August.

Of the families that responded 87.5% said that they would return to East Kent for their maternity care. This is an increase from last month of 84.27%. 5.5% (18 people) were unsure if they would return to EKHUFT, 7.3% (24 people) said no they wouldn't return to EKHUFT for their care. Of the 330 Conversations: • 262 were positive-79.4% ↓ • 46 were neutral-13.9%↑ • 22 were negative- 6.7%↓ • 118 compliment emails sent to staff members	Email address have been gathered from families that gave consent to be involved with a Maternity Participation group (name to be decided) and aim is to get our own Maternity participation group to commence with the MVP co-production in more areas. We will also try and direct people to join MVP as well. Due to changes within the team, and challenges recently with the PEM team providing USS telephone support for women and families, we would like to request that as a team we report on the FFT data a month in arrears, ie July we would report on May's data. This would enable us adequate time to theme and provide a more in-depth report on the data received. The dashboard now shows the themes collated and the trends however this may change if we use the new PTL. Due to the sickness and changes in the teams there is some delay in the theming however the new Patient experience coordinator has started this month and once fully orientated should enable the PEM to complete outstanding theming. We shall set up a meeting this month to talk to HOMs and Matrons about the findings from YVIH and other feedback.
Actions that are completed: • Hot drinks for partners to be offered at same time as birthing parent. • Snack bags to be ordered on request for the partners	Communications have gone out to staff and patients about now offering hot drinks for partners and the availability of snack bags on request. This is currently still a theme in YVIH but is expected to come down in 4 weeks which will be 6 weeks from when it is introduced. The posts on Facebook about this was in the majority positive from families and in feeding back to families in YVIH they are happy about this change.
Actions that are ongoing 1. Pain management meeting 2. Chairs that were trailed at QEQM did not have enough feedback from patients and staff therefore a second retrial is 12th July for 2 weeks. 3. Water coolers installation at WHH 4. The essential rounding 5. Medication/drug rounds 6. Discharge meeting 7. Antenatal co-produced classed TENS machine for Labour ward	1. An email has gone out to the HOMs, matrons and managers to request a new chair for this group. 2. Have emailed the Matron and Postnatal ward manager about supporting the trial of chairs 3. Have emailed the ward managers at WHH about the water coolers (QEQM already have these in situ) 4. Review the effectiveness of essential rounding as similar themes still coming up in feedback, have escalated this to the HOMS and matrons and managers 5. Delay in medication still a theme coming up – escalated to HOMs Matrons and managers 6. Still ongoing- update from meeting today 7. All coproduction events have taken place, feedback to be given back to the community matrons and staff and patent survey to be closed online. We have learnt from these events that they really need to be in the same areas and times that current appointments are occurring to get feedback 8. Awaiting SOP to be produced but also need to look at the NICE intrapartum guideline when they are published.

MVP Feedback

Maternity Voice Partnership feedback (continued themes)	**Actions**
No meeting this month due to meeting was cancelled. New MNVP has been appointed Sarah Hubbard we shall be arranging a meeting with her this month and update next month.	Meeting with Sarah Hubbarb to be arranged

Any other Feedback aquired	**Actions**
PEM meet with various groups throughout the month. BAT • Jaundice not being diagnosed • Care and communication in the latent phase and listening	To continue these meetings and also feedback to appropriate areas.

	• Being in pain when baby in OP Position
Number of Complaints	5 Complaints were logged during June of these 4 related to care at the WHH, and 1 at QEQM (data will need updating as 2 more to be logged).

Site	Location	Category	Subcategory
WHH	FF - WHH FOLKESTONE WARD	Diagnosis	Delay in receiving diagnosis
WHH	FF - WHH FOLKESTONE WARD	Attitude	Problems with nurse's attitude
QEQM	QLAB - QEQM LABOUR WARD (MUMS)	Surgical management	Unexpected outcome / post op complications
WHH	OTH - OTHER	Clinical management	Unhappy with treatment
WHH	FF - WHH FOLKESTONE WARD	Clinical management	Unhappy with treatment

Listening to women engagement activities and evidence of co-production	Co-production events around the antenatal classes were held throughout June. Feedback is being continually gathered through YVIH and FFT.
Staff feedback from frontline safety champions and walk-abouts	Following publication of the CQC report on the 26th May staff forums were held to support the team and be available for any questions Senior Clinicians Day held on 6th June to discuss MTP . All staff engagement event with service users/ MIA/ICB and MatNeo representation on 28 June 2023 New DOM and DDOM have undertaken all engagement sessions during the month of May and continued through June
HSIB/NHSR/CQC or other organisation with a concern or request for action made direct to the Trust	The CQC publication on the 26th May Quality rounds have now been implemented and formalised. The findings reported through the MNAG. Key metrics relate to: • Environmental and infection prevention and control (IPC) weekly rounds. These are now in place and supported by the matron or HOM on each site. These also include hand hygiene and personal protective equipment (PPE) audits. • Fresh Eyes compliance – daily audits are in place to review compliance on both sites • Equipment safety checks, including resuscitaire checks. Daily monitoring in place, 100% now being reported. • Community now included in stop the clock for weekly monitoring of community equipment and safety checks
Coroner Reg 28 made directly to the Trust	N/A

Progress in achievement of CNST 10 Safety Standards

Safety Action	Rational for Red/Green status	BRAG status (not due to deliver until 30 June 2022)
1. Use of the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard	Fully compliant against standards. Quarterly 4 report received by MNAG May 2022 and Board for June. Risk -Need to ensure that the review panel is made up of the right multidisciplinary teams and include Bereavement leads, Neonatal medical staff and external reviewer. Access to an external reviewer frequently causes concern and is an ongoing risk. Ockenden and CNST require 100% compliance. LMNS are setting up a bureau to access external reviewers. Action plan development and completion needs to be completed in a timely way to reduce risk of breeching standard requirements.	
2. Submitting data to the Maternity Services Data Set to the required standard	Risk around Maternity Information System Provider-Euroking, developing system capability to meet data input quality and submission requirements. Data being submitted more accurately bypassing Euroking. Working as a region to find solutions	
3. Demonstrating transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme	Q4 report to MNAG May 2023. Need clarity on process for sharing report and action plan with LMNS, ICS and commissioners. Transitional Care will be included on the audit programme from April which will improve data capture and reporting that is currently completed manually. Areas of risk are around capture of ATAIN actions within a central repository to better understand repeat themes. Template to be developed to allow this to be captured within the weekly ATAIN meetings. Need to have an explicit staffing model in place for TC. This is in place for Midwifery team but not Neonatal. Not built into workforce Business case.	
4. Demonstrating an effective system of clinical* workforce planning to the required standard	Risks around progression of Neonatal Nursing actions from year 3, which require significant investment to increase the workforce. Audits against BAPM standards not yet started but will be led by Dr Munn. Audits against Anaesthetic standards not yet started-Dr Hudsmith and Walters aware of requirements for 6 month audit.	
5. Demonstrating an effective system of midwifery workforce planning to the required standard?	Confident standard can be met. Biannual Midwifery Workforce Paper submitted for May to October reporting period. Supernumerary status and 1:1 care in labour remain under 100%-action plan for year 3 has been incorporated into the workforce workstream.	
6. Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2	A quarterly report including all risks, mitigating actions and escalations is included in February Maternity and Neonatal Assurance Group (MNAG) Reporting.	

Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

5 Elements of SBLCBV2	RAG	Risks
ELEMENT 1: Reducing smoking in pregnancy		CO monitoring at 36 weeks - 88.5% compliance level
ELEMENT 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		Uterine artery Dopplers (UtAD) Implementation 2 February 2022. Appendix G reduced scanning schedule stops on introduction of UtADs
ELEMENT 3: Raising awareness of reduced fetal movement		Compliance 92.1% for women attending with reduced fetal movements. Requirement 8%. Fetal Movements having Computerised CTGs. 99.5% of women have FGR risks recorded at booking (requirement 80%)
ELEMENT 4: Effective fetal monitoring during labour		Compliant for all staff groups
ELEMENT 5: Reducing preterm births		Not meeting Steroid and Magnesium Sulphate standards. National challenge- will not fail if isn't achieved. Action plan and Mat Neo Quality Improvement work in progress to support

	7. Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local services	Work continues with the MVP to coproduce plans to address concerns raised by women	
	8. a. Evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? b. In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, Multiprofessional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4	Severe Risk- Anaesthetic workforce attending multi-professional maternity emergencies training day. Attendance is improving. Working with anaesthetic leads to address gap, supported by CMO.	
	9. Demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues	MatNeoSip Quality Improvement work aligned to the National Driver continue around Perinatal Optimisation bundle of care. Safety Champion Walkabouts and feedback sessions continue monthly on each site. Actioning of concerns are captured in a repository and themes are included in PQST report. Midwifery Continuity of Carer remains on hold as previously reported.	
	10. Reporting 100% of qualifying 2023/2024 incidents under NHS Resolution Early Notification scheme	3 cases reported this year	
Proportion of midwives responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)		Trust wide survey currently in progress Work to start on the focus on three things, that will improve working lives for our teams in line with Trust staff survey action plan. This will be reported at specialty level to the People and Culture Committee, however the idea is that we use this to focus on three things as teams, whether that is physical named departments, or teams as groups of similar people working to the same goal i.e. Care Group Triumvirates.	
Proportion of specialty trainees in obstetrics and gynaecology responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)		Trust wide survey currently in progress Work to start on the focus on three things, that will improve working lives for our teams in line with Trust staff survey action plan. This will be reported at specialty level to the People and Culture Committee, however the idea is that we use this to focus on three things as teams, whether that is physical named departments, or teams as groups of similar people working to the same goal i.e. Care Group Triumvirates.	
Outstanding Ockenden recommendations		Ongoing work around • Training needs analysis (TNA) - update to reflect requirements for 23/24 • LMS reports showing regular review of training data and minutes. Criteria and agreed pathways for referrals to Maternal Medicines Centre (MMC) • Personal Care and Support plans – pilot has commenced • Improving the practice & raising the profile of fetal wellbeing monitoring • Submission from MVP chair rating trust information in terms of: accessibility and quality of info available to service users • An audit of 5% of notes, on women who have specifically requested a care pathway, and also a selection of women who request a caesarean section during labour or induction. • Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan • Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. • Risk assessments required for policies not in date – fetal monitoring is completed	

Glossary

CCG: Care Quality Commission

CNST: Clinical Negligence Scheme for Trusts. An insurance scheme whereby NHS organisations pay an annual premium to mitigate against the cost of clinical negligence claims

CNST: Maternity Incentive Scheme. Aims to support the delivery of safer maternity care through an incentive element to trusts CNST insurance contributions. The maternity pricing is inflated by 10% which trusts are incentivised to recover through the delivery of 10 safety actions.

DATIX: The trusts incident reporting system

ENS: Early Notification Scheme. FFT-Friends and Family Test. A quick anonymous survey for service users to give views after receiving care or treatment and for staff to feedback on whether they would recommend as a place to work or receive treatment.

HSIB: Healthcare Safety Investigation Branch. Independent investigation body tasked with carrying out investigations and reporting using a standardised approach without attributing blame or liability

IEA: Immediate and Essential Actions (in relation to the Ockenden Report Recommendations December 2020)

Kleihhauer test: A test performed to understand if there is any fetal blood in the maternal circulation on Rh-negative mothers. The test should be done and any subsequent Anti D immunoglobulin administered within 72 hours of delivery, sensitising event (i.e. abdominal trauma) or invasive procedure.

MIS: Maternity Information System. At East Kent we use Euroking as our MIS provider

MNAG: Maternity and Neonatal Assurance Group. Governance reporting forum.

MSDS: Maternity Services Data Sets. A patient level data set that captures information about activity carried out by Maternity Services relating to mother and baby(s), from the point of the first booking appointment until discharge from maternity services

MVP: Maternity Voices Partnership. A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.

NLS: Neonatal Life Support Training

NHSR: NHR Resolution

Partogram: A tool used to monitor labour and prevent prolonged and obstructed labour focusing on observations related to maternal, fetal condition and labour progress.

PMRT: Perinatal Mortality Review Tool. Aims to support a standardised process of perinatal mortality reviews, learning reporting and actions to improve care across NHS maternity and neonatal units.

PROMPT: Practical Obstetric Multi-Professional Training. Covers the management of a range of obstetric emergency situations

SBLCBv2: Saving Babies Lives Care Bundle Version 2. A care bundle for reducing perinatal mortality

Uterine artery Doppler screening: An ultrasound scan that uses waveform analysis in the second trimester of pregnancy as a predictive marker for the later development of preeclampsia and fetal growth restriction.

23/077 – APPENDIX 5

East Kent Hospitals University NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS (BoD)

Report title: **Perinatal Quality Surveillance Tool (PQST) Report**

Meeting date: **7 September 2023**

Board sponsor: **Chief Nursing and Midwifery Officer (CNMO): Maternity and Neonatal Board Safety Champion**

Paper Author: **Deputy Director of Midwifery and Interim Head of Governance**

Appendices:

NONE

Executive summary:

Action required:	**Assurance**
Purpose of the Report:	The purpose of this report is • To update on East Kent Maternity's services are aligned to the key elements included within the perinatal and assurance framework as defined by NHS England (NHSE). • This is in accordance with the standards set out in NHS Resolutions (NHSR) Maternity Incentive Scheme, Safety Action 9, which aims to continue to support the safer maternity and Ockenden report recommendations. • Provide assurance that the service is using the tool and reporting to the required standard set out in the NHS implementing a Revised Perinatal Quality Surveillance Model Report December 2020, NHS resolution Clinical Negligence Scheme for trusts (CNST) Maternity Incentive Scheme year 4- Safety Action nine and Ockenden 1 Report Immediate and Essential Actions.
Summary of key issues:	• The report confirms that the service is using the tool to the required standard, as set out in the NHS implementing a Revised Perinatal Quality Surveillance Model Report December 2020. **The report includes the following key messages for the group's attention –** • CNST reporting has now begun a new period**. May to December.** • Currently the area of concern remains on standard 8 in relation to PRactical Obstetric Multi-Professional Training (PROMPT) training due to anaesthetic and obstetric workforce challenges. The exact criteria for year 5 have been now released. There are ongoing challenges with the availability of obstetric faculty to facilitate Multi-Disciplinary Team (MDT) PROMPT. Sessions have been cancelled due to the lack of availability. • Anaesthetic training compliance for PROMPT has improved to 83% but remains below the national standard of 90%. • 1 Healthcare Safety Investigation Branch (HSIB) referral for the month of July. • 2 Serious incidents reported. • Supernumerary status compliance reported at 100% at Queen Elizabeth the Queen Mother Hospital (QEQM) and 99.4% William Harvey Hospital (WHH). • 1:1 care in labour 100%. • There were 4 reported Moderate harm incidents in July 3 were at WHH and 1 at QEQM. • Friends and Family Test (FFT) received 252 responses which is a 12.3% response rate. • The responses show 94.6% extremely likely or likely to recommend which is an increase from last month. • The Your Voice is Heard (YVIH) team achieved a response rate of 75.7% with a Key Performance Indicator (KPI) of a 70% response rate. 88.9% Happy to return. • Matron for Patient Safety and Consultant Midwife for intrapartum care out for advert. • 1 Band 7 Labour Ward coordinator shortlisted awaiting interview. • 13 Internationally educated Midwives currently being supported in the clinical area whilst awaiting OSCIs assessment 3 newly qualified midwives recruited due to commence in October. • Training compliance was met across all maternity staff groups for fetal monitoring PROMPT and Newborn Life Support (NLS).
Key recommendations:	The Board of Directors is asked to **NOTE** the content within the maternity dashboard.

Implications:

Links to Strategic Theme:	• Quality and Safety • Patients
Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.
Resource:	N
Legal and regulatory:	Y – Clinical Negligence Scheme for Trusts (CNST) NHS Long Term Plan-standard contract.
Subsidiary:	N

Assurance route:

Previously considered by: Maternity and Neonatal Assurance Group (MNAG)

East Kent Hospitals Perinatal Quality Surveillance July 2023

Month: July 2023	**East Kent Hospitals Hospital NHS Trust Perinatal Quality Surveillance Reporting**

CQC Maternity Ratings WHH

Overall	Safe	Effective	Caring	Well-led	Responsive
Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate

CQC Maternity Ratings QEQM

Overall	Safe	Effective	Caring	Well-led	Responsive
Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Good

Maternity Safety Support Programme

Yes — Support Lead: Mai Buckley

Findings of review of cases eligible for referral to HSIB

During the month of July there was 1 referral to HSIB

The number of incidents logged graded as moderate or above and what actions are being taken.

There were 4 reported moderate harm incidents during July

Site	Location	Category	Subcategory	Outcome
WHH	Labour ward / delivery suite (WHH)	Women's Health - unexpected problem/outcome for baby	Birth injury to baby	
WHH	NICU/SCBU (WHH)	Women's Health – unexpected problem/outcome for baby	Birth injury to baby	
WHH	Obstetric operating theatre (WHH)	Operations / Procedures	Unplanned return to theatre	
QEQM	Kingsgate Ward	Care / Treatment	Lack of nursing care identified	

The table below summarises the serious incidents:

Site	Location	Category	Subcategory	Outcome
QEQM	Labour ward / delivery suite (QEQM)	Women's Health - unexpected problem/outcome for baby	Unanticipated admission to SCBU	HSIB Referral
WHH	Labour ward / delivery suite (WHH)	Adult protection / Safeguarding of adults	Adult protection other issue	

A summary of key actions taken forward with for staff in clinical areas are:

- Immediate learning shared regarding MDT support for complex care / Case presentation planned following SI review/findings
- Communication regarding sepsis screening and documentation via “Message of the Week” and “Lunch and Learn”

Themes from reviews of perinatal deaths

Themes

Women’s Health Care Group
Perinatal Mortality Review Tool Upward Report
July 2023

Quoracy – 100% membership	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Meeting Escalations to the WHCG Governance Group	
Chair – PMRT Lead Midwife													1	MDT felt staff lost oversight of the woman’s care.

Deputy Chair – PMRT Lead Consultant														
Administrator													2	The 999-operator delayed CPR to establish the baby was not breathing.
Obstetrician														
Midwife x 2													3	This baby was for a coroner's case but memory making was undertaken and the equipment used for resuscitation was removed, this should have been left in situ and the family should have been informed that memory making could be facilitated following the coroners review.
Neonatologist x 2 (for NND)				N/a										
Neonatal Nurse x 2 (for NND)				n/a									4	
Bereavement Midwife														
Governance Midwife														
Patient Safety champion														
Managers													**Cases Discussed in July**	
External panel member														
Others as required													**MH**	**Discussed in July MDT. NND 39+1.**
													AH	**Care was graded C.**

What's Gone Well	Running Themes
• Excellent attendance at the MDT meeting including many staff who had supported the family before and after their loss. Secam were also able to provide the 999 recording of the call for the meeting. Community attended and were able to provide insight into the care given to the family and a deeper understanding into the family background.	

100% of perinatal mortality reviews include an external reviewer	As shown in table above

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training.

Fetal Monitoring All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	214	228	93.9%
Midwife - Community	95	103	92.2%
Other Obstetric Doctor	37	39	94.9%
Obstetric Consultant	30	31	96.8%
Unknown	2	2	100.0%
Maternity Support Worker	0	0	NaN
Total	**378**	**403**	**93.8%**

Fetal Monitoring Mat Leave and LTS Removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	203	205	99.0%
Midwife - Community	89	91	97.8%
Other Obstetric Doctor	35	37	94.6%
Obstetric Consultant	29	30	96.7%
Unknown	2	2	100.0%
Maternity Support Worker	0	0	NaN
Total	**358**	**365**	**98.1%**

Prompt All Maternity Staff

PROMPT Mat Leave and LTS Removed

Challenges:

- Due to the unavailability of PROMPT obstetric and anaesthetic faculty to undertake PROMPT. Therefor session have been cancelled.
- One session was also cancelled due to strikes
- Ongoing compliance remains the same of anaesthetic attendance to training is increasing however still not at the 90% threshold
- There have been no faculty or candidates given from the WHH Anaesthetic due to summer holidays and annual leave.
- NLS compliance for MSWs has increased and plans to be complaint next month.

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	209	228	91.7%
Midwife - Community	97	105	92.4%
Maternity Support Worker	78	90	86.7%
Other Obstetric Doctor	36	38	94.7%
Obstetric Consultant	29	31	93.5%
Unknown	5	5	100.0%
Total	**454**	**497**	**91.3%**

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	198	205	96.6%
Midwife - Community	91	93	97.8%
Maternity Support Worker	76	82	92.7%
Other Obstetric Doctor	34	36	94.4%
Obstetric Consultant	28	30	93.3%
Unknown	5	5	100.0%
Total	**432**	**451**	**95.8%**

Anaesthetics covering maternity	Number requiring training	Number of staff trained	Percentage Compliance by staff group
Anaesthetic consultants	41	34	83%
All other anaesthetic Doctors	40	28	70%

NLS All Maternity Staff

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	207	228	90.8%
Midwife - Community	95	105	90.5%
Maternity Support Worker	75	90	83.3%
Other Obstetric Doctor	36	38	94.7%
Obstetric Consultant	28	31	90.3%
Unknown	5	5	100.0%
Total	**446**	**497**	**89.7%**

NLS Mat Leave and LTS removed

Role Type	Compliant	Total Staff	Compliance %
Midwife - Acute	196	205	95.6%
Midwife - Community	91	93	97.8%
Maternity Support Worker	73	82	89.0%
Other Obstetric Doctor	34	36	94.4%
Obstetric Consultant	28	30	93.3%
Unknown	5	5	100.0%
Total	**427**	**451**	**94.7%**

Minimum safe staffing in maternity services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively

Supernumerary Status Maintained

Month	QEQM	WHH
Feb-23	99.3%	99.5%
Mar-23	97.9%	100.0%
Apr-23	100.0%	98.9%
May-23	100.0%	99.3%
Jun-23	100.0%	99.3%
Jul-23	100.0%	99.4%
Total	99.6%	99.4%

1 to 1 care in Labour

Month	QEQM	WHH
Feb-23	99.3%	97.4%
Mar-23	100.0%	97.9%
Apr-23	100.0%	98.5%
May-23	100.0%	99.0%

The medical work force during July remains the same as the picture below-

Obstetrics-
QEQM
No incidents of nonattendance escalated.
Consultant Rota
- 2 substantive consultants not undertaking Full on call rota duties due to OH recommendations.
- 2 substantive consultants not delivering full on call due to job plan changes (leadership and post retirement)
- 2 locum agency consultants providing cover.
- 2 Offers for Consultants post

Registrar rota
- One registrar going on maternity leave at the end of April.

Jun-23	98.7%	99.4%
Jul-23	99.4%	99.0%
Total	99.6%	98.7%

Supernumerary Status

Supernumerary Status: 99.4 % WHH 100% QEQM

1:1 care in labour:

Compliance of 1:1 in Labour was reported at 100% Trust-wide

Midwifery

The Midwifery workforce numbers remain primarily unchanged in terms of vacancy, sickness and maternity leave.

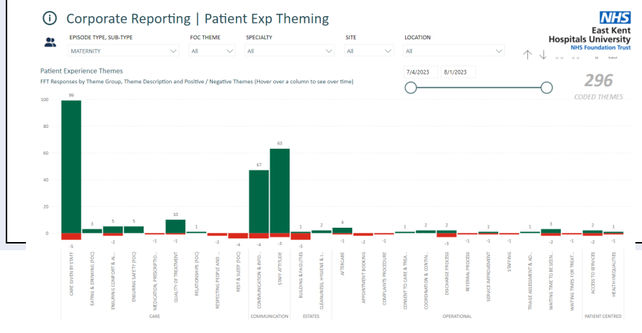
Matron for Patient Safety and Consultant Midwife for intrapartum care out for advert
1 Band 7 Labour Ward coordinator shortlisted awaiting interview

13 Internationally educated Midwives currently being supported in the clinical area whilst awaiting OSCIs assessment 3 newly qualified midwives recruited due to commence in October

WHH
No incidents reported of non-attendance escalated.
Consultant rota
- 1 substantive consultant not doing full on call duties due to OH requirements.

Registrar rota
- 1 SHO GPST gap

FFT Feedback

FFT Main Themes July 2023 (collated on 1/8/23)	Actions
July saw a 12.3% response rate which is a slight increase from 12.2% in June. The responses show 94.6% extremely likely or likely to recommend which is an increase from June 91.7% 296 comments made in total. 252 positive comments= 85.1% an increase from 80.8% last month. 38 members of staff named in July- compared to 24 in June. 	PEM to report back to staff via personalised email and update posters on the wards There is a new PTL for FFT- the aim that FFT feedback is themed in a standardised way and is comparable. The use of something similar for YVIH will be discussed in August. Our current system of coding/theming is time consuming and a more streamline approach is needed. We would like to request that the Pt Experience Team report on FFT data a month in arrears. This would enable us adequate time to theme and provide a more in-depth report on the data received and be more achievable long-term.

• **Care Given by staff** (104 comments- makes up **35%** of all comments) • Caring, went above and beyond • Informative • Made to feel at ease • Built a relationship- funny, supportive, helpful • Rude • Staff not confident	99 positive comments 5 negative comments	Positive feedback to staff Escalate concerns at monthly meeting with Matrons/HOMS/Ward Leads- Next meeting 28/8/23
• **Staff Attitude** (63 comments- makes up **21.2%** of all comments) Recurring theme • Kind, lovely • Professional • Helpful • Compassion • Rude, abrupt	60 positive comments 3 negative comments	Positive feedback to staff Escalate concerns at monthly meeting with Matrons/HOMS/Ward Leads- Next meeting 28/8/23
• **Communication and information** (51 comments- makes up 17.2% of all comments) • Informative • Good communication from staff, clear explanations • Given enough information to make informed decision-making • Given choice • Unclear information • Lack of information	47 positive comments 4 negative comments	Positive feedback to staff Escalate concerns at monthly meeting with Matrons/HOMS/Ward Leads- Next meeting 28/8/23
• **Quality of Treatment** (11 comments- makes up **3.7%** of all comments) • 10 comments positive, 1 negative		
• **Ensuring Comfort and Alleviating pain** (7 comments- makes up **2%** of all comment) • Timely, adequate analgesia • Delayed analgesia	5 positive comments 2 negative comments	Pain Assessment and Management in Maternity Bi-Monthly meetings ongoing Need to review effectiveness of essential rounding as similar themes still apparent in feedback, have escalated this to the HOMS and matrons and managers. Next meeting 28/8/23
• **Building and facilities** (6 comments- makes up **2%** of all comments) Recurring theme • hot, cramped, noisy • Tired, old fashioned	6 negative comments	Limitations due to estates. PEM have put forward some suggestions from feedback received about the estates and awaiting estate plans to be agreed and actioned.
• **Discharge process** (5 comments- makes up **1.7%** of all comments) Recurring theme • Smooth discharge • Delayed discharge	2 positive comments 3 negative comments	Discharge Group set up to look at the processes and identify potential Quality Improvements. Also, discussions around managing expectations and information around discharge.
• **Waiting time to be seen on site** (5 comments- makes up **1.7%** of all comments) • Seen Quickly • Long wait to be seen	3 positive comments 2 negative comments	Have noted feedback

Service user feedback

Service User Feedback Themes	Actions
Your Voice is Heard – July Data	Patient experience midwives are looking at feedback from these conversations and see if themes are re-occurring and how to improve these themes
The service achieved a response rate of 75.7% With a KPI of a 70% response rate. 88.9% were happy to return Of the families that responded 88.9% said that they would return to East Kent for their maternity care. This is an increase from last month of 87.5%. 3.5% (19 people) were unsure if they would return to EKHUFT, 4.5% (24 people) said no they wouldn't return to EKHUFT for their care. Of the 535 Conversations: • 331 were positive • 50 were neutral • 23 were negative • 118 compliment emails sent to staff members	Response rate this month has been our best month to date. Email address have been gathered from families that gave consent to be involved with a Maternity Participation group (name to be decided) and aim is to get our own Maternity participation group to commence with the MVP co-production in more areas. We will also try and direct people to join MVP as well. The increase in call has been due to the team catching up with calls missed from June due to clinical commitments. The dashboard now shows the themes collated and the trends however this may change if we use the new PTL. Due to the sickness and changes in the teams there is some delay in the theming however the new Patient experience coordinator has started this month and once fully orientated should enable the PEM to complete outstanding theming. We plan set up a meeting this month to talk to HOMs and Matrons about the findings from YVIH and other feedback.
Actions that are completed: • Hot drinks for partners to be offered at same time as birthing parent. • Snack bags to be ordered on request for the partners	Communications have gone out to staff and patients about now offering hot drinks for partners and the availability of snack bags on request. This is currently still a theme in YVIH but is expected to come down in 4 weeks which will be 6 weeks from when it is introduced. The posts on Facebook about this was in the majority positive from families and in feeding back to families in YVIH they are happy about this change.
Actions that are ongoing 1. Pain management meeting 2. Chairs that were trailed at QEQM did not have enough feedback from patients and staff therefore a second retrial is 12th July for 2 weeks. 3. Water coolers installation at WHH 4. The essential rounding 5. Medication/drug rounds 6. Discharge meeting 7. Antenatal co-produced classed	1. An email has gone out to the HOMs, matrons and managers to request a new chair for this group. 2. Have emailed the Matron and Postnatal ward manager about supporting the trial of chairs 3. Have emailed the ward managers at WHH about the water coolers (QEQM already have these in situ) 4. Review the effectiveness of essential rounding as similar themes still coming up in feedback, have escalated this to the HOMS and matrons and managers 5. Delay in medication still a theme coming up – escalated to HOMs Matrons and managers 6. Still ongoing- update from meeting today 7. All coproduction events have taken place, feedback to be given back to the community matrons and staff and patent survey to be closed online. We have learnt from these events that they really need to be in the same areas and times that current appointments are occurring to get feedback 8. Awaiting SOP to be produced but also need to look at the NICE intrapartum guideline when they are published.

MVP Feedback

Maternity Voice Partnership feedback (continued themes)	Actions
PEM met with Sarah Hubbard 25/7/23. Agreed to monthly meetings and walk-arounds at alternative sites each month. Aim to discuss MVP feedback collated for the previous month during this time. Date TBC Sarah awaiting completion of HR paperwork. She is keen to increase engagement with the MVP. PEM will introduce her in the next Patient experience newsletter	Meeting with Sarah Hubbard Aug TBC

Any other Feedback aquired	Actions

	BAT (July) - Poor communication - Not being given enough information - Attitude/'throw away' comments - No explanation of position of baby and the impact on labour and pain perception - Not feeling part of the decision-making process - Not reading the Birth Plan Social media via comms (July) - Good support during premature birth - Staff caring	To continue monthly BAT meetings and feedback to appropriate areas. To combine BAT feedback with YVIH feedback themes and feedback to HOMs/Matrons at meeting 28/8/23 Positive messages from families are included in the Monthly newsletter that goes out to all staff in the Care Group.

Number of Complaints

6 Complaints were logged during July of these 4 related to care at the QEQM, and 1 at WHH and 1 at KCH

Site	Location	Category	Subcategory
QEQM	KIN - QEQM KINGSGATE WARD	Diagnosis	Delay in receiving diagnosis
QEQM	KIN - QEQM KINGSGATE WARD	Delays	Delays in receiving treatment
WHH	FF - WHH FOLKESTONE WARD	Communication	Doctor communication issues
K&C	OTH - OTHER	Appointments	Problems with department appointment
QEQM	OTH - OTHER	Attitude	Problems with doctor's attitude
QEQM	OTH - OTHER	Surgical management	Unexpected outcome / post op complications

Listening to women engagement activities and evidence of co-production	Co-production events around the antenatal classes were held throughout June. Feedback is being continually gathered through YVIH and FFT.
Staff feedback from frontline safety champions and walk-abouts	Following publication of the CQC report on the 26th May staff forums were held to support the team and be available for any questions Senior Clinicians Day held on 6th June to discuss MTP . All staff engagement event with service users/ MIA/ICB and MatNeo representation on 28 June 2023 New DOM and DDOM have undertaken all engagement sessions during the month of May and continued through June
HSIB/NHSR/CQC or other organisation with a concern or request for action made direct to the Trust	The CQC publication on the 26th May Quality rounds have now been implemented and formalised. The findings reported through the MNAG. Key metrics relate to: • Environmental and infection prevention and control (IPC) weekly rounds. These are now in place and supported by the matron or HOM on each site. These also include hand hygiene and personal protective equipment (PPE) audits. • Fresh Eyes compliance – daily audits are in place to review compliance on both sites • Equipment safety checks, including resuscitaire checks. Daily monitoring in place, 100% now being reported. • Community now included in stop the clock for weekly monitoring of community equipment and safety checks
Coroner Reg 28 made directly to the Trust	N/A

Progress in achievement of CNST 10 Safety Standards

Safety Action	Rational for Red/Green status	BRAG status (not due to deliver until 30 June 2022)
1. Use of the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard	Fully compliant against standards. Quarterly 4 report received by MNAG May 2022 and Board for June. Risk -Need to ensure that the review panel is made up of the right multidisciplinary teams and include Bereavement leads, Neonatal medical staff and external reviewer. Access to an external reviewer frequently causes concern and is an ongoing risk. Ockenden and CNST require 100% compliance. LMNS are setting up a bureau to access external reviewers. Action plan development and completion needs to be completed in a timely way to reduce risk of breeching standard requirements.	
2. Submitting data to the Maternity Services Data Set to the required standard	Risk around Maternity Information System Provider-Euroking, developing system capability to meet data input quality and submission requirements. Data being submitted more accurately bypassing Euroking. Working as a region to find solutions	
3. Demonstrating transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme	Q4 report to MNAG May 2023. Need clarity on process for sharing report and action plan with LMNS, ICS and commissioners. Transitional Care will be included on the audit programme from April which will improve data capture and reporting that is currently completed manually. Areas of risk are around capture of ATAIN actions within a central repository to better understand repeat themes. Template to be developed to allow this to be captured within the weekly ATAIN meetings. Need to have an explicit staffing model in place for TC. This is in place for Midwifery team but not Neonatal. Not built into workforce Business case.	
4. Demonstrating an effective system of clinical* workforce planning to the required standard	Risks around progression of Neonatal Nursing actions from year 3, which require significant investment to increase the workforce. Audits against BAPM standards not yet started but will be led by Dr Munn. Audits against Anaesthetic standards not yet started-Dr Hudsmith and Walters aware of requirements for 6 month audit.	
5. Demonstrating an effective system of midwifery workforce planning to the required standard?	Confident standard can be met. Biannual Midwifery Workforce Paper submitted for May to October reporting period. Supernumerary status and 1:1 care in labour remain under 100%-action plan for year 3 has been incorporated into the workforce workstream.	
6. Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2	A quarterly report including all risks, mitigating actions and escalations is included in February Maternity and Neonatal Assurance Group (MNAG) Reporting.	

Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

5 Elements of SBLCBV2	RAG	Risks
ELEMENT 1: Reducing smoking in pregnancy		CO monitoring at 36 weeks - 88.5% compliance level
ELEMENT 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		Uterine artery Dopplers (UtAD) Implementation 2 February 2022. Appendix G reduced scanning schedule stops on introduction of UtADs
ELEMENT 3: Raising awareness of reduced fetal movement		Compliance 92.1% for women attending with reduced fetal movements. Requirement 8%. Fetal Movements having Computerised CTGs. 99.5% of women have FGR risks recorded at booking (requirement 80%)
ELEMENT 4: Effective fetal monitoring during labour		Compliant for all staff groups
ELEMENT 5: Reducing preterm births		Not meeting Steroid and Magnesium Sulphate standards. National challenge- will not fail if isn't achieved. Action plan and Mat Neo Quality Improvement work in progress to support

	7. Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local services	Work continues with the MVP to coproduce plans to address concerns raised by women	
	8. a. Evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? b. In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, Multiprofessional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4	Severe Risk- Anaesthetic workforce attending multi-professional maternity emergencies training day. Attendance is improving. Working with anaesthetic leads to address gap, supported by CMO.	
	9. Demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues	MatNeoSip Quality Improvement work aligned to the National Driver continue around Perinatal Optimisation bundle of care. Safety Champion Walkabouts and feedback sessions continue monthly on each site. Actioning of concerns are captured in a repository and themes are included in PQST report. Midwifery Continuity of Carer remains on hold as previously reported.	
	10. Reporting 100% of qualifying 2023/2024 incidents under NHS Resolution Early Notification scheme	3 cases reported this year	
Proportion of midwives responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)		Trust wide survey currently in progress Work to start on the focus on three things, that will improve working lives for our teams in line with Trust staff survey action plan. This will be reported at specialty level to the People and Culture Committee, however the idea is that we use this to focus on three things as teams, whether that is physical named departments, or teams as groups of similar people working to the same goal i.e. Care Group Triumvirates.	
Proportion of specialty trainees in obstetrics and gynaecology responding with AGREE or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment (reported annually)		Trust wide survey currently in progress Work to start on the focus on three things, that will improve working lives for our teams in line with Trust staff survey action plan. This will be reported at specialty level to the People and Culture Committee, however the idea is that we use this to focus on three things as teams, whether that is physical named departments, or teams as groups of similar people working to the same goal i.e. Care Group Triumvirates.	
Outstanding Ockenden recommendations		Ongoing work around • Training needs analysis (TNA) - update to reflect requirements for 23/24 • LMS reports showing regular review of training data and minutes. Criteria and agreed pathways for referrals to Maternal Medicines Centre (MMC) • Personal Care and Support plans – pilot has commenced • Improving the practice & raising the profile of fetal wellbeing monitoring • Submission from MVP chair rating trust information in terms of: accessibility and quality of info available to service users • An audit of 5% of notes, on women who have specifically requested a care pathway, and also a selection of women who request a caesarean section during labour or induction. • Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan • Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. • Risk assessments required for policies not in date – fetal monitoring is completed	

Glossary

CCG: Care Quality Commission

CNST: Clinical Negligence Scheme for Trusts. An insurance scheme whereby NHS organisations pay an annual premium to mitigate against the cost of clinical negligence claims

CNST: Maternity Incentive Scheme. Aims to support the delivery of safer maternity care through an incentive element to trusts CNST insurance contributions. The maternity pricing is inflated by 10% which trusts are incentivised to recover through the delivery of 10 safety actions.

DATIX: The trusts incident reporting system

ENS: Early Notification Scheme. FFT-Friends and Family Test. A quick anonymous survey for service users to give views after receiving care or treatment and for staff to feedback on whether they would recommend as a place to work or receive treatment.

HSIB: Healthcare Safety Investigation Branch. Independent investigation body tasked with carrying out investigations and reporting using a standardised approach without attributing blame or liability

IEA: Immediate and Essential Actions (in relation to the Ockenden Report Recommendations December 2020)

Kleihhauer test: A test performed to understand if there is any fetal blood in the maternal circulation on Rh-negative mothers. The test should be done and any subsequent Anti D immunoglobulin administered within 72 hours of delivery, sensitising event (i.e. abdominal trauma) or invasive procedure.

MIS: Maternity Information System. At East Kent we use Euroking as our MIS provider

MNAG: Maternity and Neonatal Assurance Group. Governance reporting forum.

MSDS: Maternity Services Data Sets. A patient level data set that captures information about activity carried out by Maternity Services relating to mother and baby(s), from the point of the first booking appointment until discharge from maternity services

MVP: Maternity Voices Partnership. A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.

NLS: Neonatal Life Support Training

NHSR: NHR Resolution

Partogram: A tool used to monitor labour and prevent prolonged and obstructed labour focusing on observations related to maternal, fetal condition and labour progress.

PMRT: Perinatal Mortality Review Tool. Aims to support a standardised process of perinatal mortality reviews, learning reporting and actions to improve care across NHS maternity and neonatal units.

PROMPT: Practical Obstetric Multi-Professional Training. Covers the management of a range of obstetric emergency situations

SBLCBv2: Saving Babies Lives Care Bundle Version 2. A care bundle for reducing perinatal mortality

Uterine artery Doppler screening: An ultrasound scan that uses waveform analysis in the second trimester of pregnancy as a predictive marker for the later development of preeclampsia and fetal growth restriction.