Meeting title:	Public Trust Board **Paper E1**					
Date of the meeting:	08 August 2024					
Title:	Maternity Assurance Committee (MAC) Chairs Highlight Report					
Report presented by:	Julie Hogg, Chief Nurse					
Report written by:	Danni Burnett, Director of Midwifery					
Action – this paper is for:	Decision/Approval		Assurance	X	Update	X
Where this report has been discussed previously	Perinatal Scorecard Board of Directors (July 2024) Quality Committee (25 July 2024)					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
Current Clinical Management Group (CMG) risks indicate challenges around workforce and culture, please read this report alongside corporate risks to consider any additional actions and mitigations
Impact assessment
• N/A

Purpose of the Report

The purpose of this paper is to provide a summary to the Trust Board on the key discussions at the UHL Maternity Assurance Committee (MAC) which met on 3 July 2024.

Summary

MAC members were presented with several papers which intended to share insights into perinatal surveillance and highlighting areas of progress and risks to delivery of the key national and regional drivers for change and improvement.

MAC received progress reports on the implementation of the actions in relation to the Perinatal Safety Improvement Programme (PSIP) and wider perinatal assurance which included UHL's response to:

- CQC action plans and recent published report
- Saving Babies Lives Care Bundle
- NHS Resolution Maternity Incentive Scheme Year 6
- Initial Feedback from the Neonatal Operational Delivery Network (ODN) Peer Review visit
- Feedback and response following the NHS England Workforce, Training, and education (WTE) Quality Assurance visit (pre-registration)

MAC members received in-depth updates on two of the PSIP workstreams:

- Workstream 1 - Growing, retaining, and supporting our workforce which was also subject to the monthly Quality Review Meeting facilitated by the ICB (1 July 2024); and
- Workstream 2 - Listening to and working with women and families, with compassion.

A new Perinatal Insight Dashboard is being created to monitor outcomes to demonstrate improvements and identify areas for additional focus. It is envisaged that this will complement current reporting with a plan to utilise new dashboards by the end of Quarter 2. This has been delayed due to resource issues in the development team.

MAC were briefed on the new request as part of the national Respiratory Syncytial Virus (RSV) immunisation programme. A bipartite letter was published on 23 June 2024 requested that providers should plan for delivery of the new programme from 1 September 2024, with this to be offered to older adults and to pregnant women. A readiness plan was shared with MAC ahead of submission to NHS England indicating concerns regarding the pace required and the absence of any financial or infrastructure guidance. UHL are engaging with ICB and NHS England colleagues to respond to the request.

Recommendation

The Trust Board are asked to:

1. Receive and note the update from Maternity Assurance Committee.
2. Note concerns about the new RSV vaccination programme and request for providers to deliver from 1 September 2024
3. Note that UHL must submit NHSR MIS declaration before 3 March 2025.

University Hospitals of Leicester NHS
NHS Trust

Maternity Assurance Committee (MAC) Chair's Highlight Report to Board of Directors

Subject:	Maternity Assurance Committee (MAC) Highlight Report	**Meeting Date:** 8 August 2024
Prepared By:	Danni Burnett, Director of Midwifery	
Approved By:	Julie Hogg, Chief Nurse	
Presented By:	Julie Hogg, Chief Nurse/Danni Burnett, Director of Midwifery	

Purpose		
To brief the UHL Board of Directors on the key discussions at the Maternity Assurance Committee (MAC) on Wednesday 3 July 2024 and subsequent updates on the new RSV programme.	**Assurance**	Board of Directors are asked to receive and note the update from MAC Board of Directors are asked to note that UHL must submit NHSR MIS declaration before 3 March 2025 Board of Directors are asked to note our concerns about the request to deliver a new RSV vaccination programme from 1 September 2024

Matters of Concern or Key Risks to Escalate	**Major Actions Commissioned / Work Underway**
• **MIS Safety Action 8** requires 90% compliance in each relevant staff group by the end of the 12-month assessment period, due to vacancies in the education team and appropriate requisite qualification to deliver training this standard is at risk. A forecast plan and mitigation is in place which anticipates the standard to be complaint however this is reliant on successful recruitment and seeking additional support to deliver the comprehensive training programme. • An exploratory learner education meeting took place on 19 April 2024 by **NHS England Midlands Workforce, Training, and Education (WTE)** team which has resulted in a decision to implement an intensive support framework (category 2). This is due to several standards not being met. The requirement is for UHL to submit an improvement plan by 9 July 2024 has been submitted, mapped against mandatory requirements. Learners reported a variable experience of learning within the maternity departments of the trust.	• The monthly **Perinatal Scorecard** report for May 2024 highlighted that the workforce position continues to improve across midwifery, obstetrics, and anaesthetists with an ambition of zero vacancies for midwifery by end of Quarter 3. Neonatal ODN support is in place to support the achievement of the British Association of Perinatal Medicine (BAPM) standards specifically for increasing the number of nurses 'qualified in speciality' (QIS). Focus continues improving the response and promoter for Family & Friends Test, and there is a sustained improvement in the number of complaints and concerns in month. Engaging with communities as part of improving access and experience of care was showcased at a recent Health Equality Summit. A new Perinatal Insights Dashboard is in development which is expected to be phased as part of the 2024/2025 reporting, the dashboard will be focusing on impact and outcomes. • **Perinatal Monthly (May 2024) Safety Report** was presented noting

Learners shared positive feedback in relation to their training experience including support from practice assessors, support from the teams on community placements, and in the ward areas at both sites of the trust, and all learners were aware of the mechanisms for raising concerns with the trust and were able to describe who they would approach and the process for doing so. Concerns were raised by learners in relation to induction, timely allocation of practice supervisors, variation in support across the sites, multi-disciplinary learning opportunities, access to clinical systems, and placement capacity.

- Following guidance from the Joint Committee on Vaccination and Immunisation, NHS England (NHSE) and the UK Health Security Agency (UKHSA) has written to systems to set out next steps for delivery of two new **Respiratory Syncytial Virus (RSV) vaccination programmes** from 1 September 2024. The programmes are for 1) older adults and 2) maternal vaccination for infant protection. UKHSA have indicated that the programme will be implemented with Abrysvo® supplied by Pfizer, and delivered through a maternal vaccination programme which will be a year round delivery offer. MAC were informed that a deployment letter is anticipated which will provide confirmation of specific details (finances, training etc) linked to implementation. A readiness planning template was shared with MAC and since submitted to NHS England. Concerns are being worked through NHS England and LLR System teams in relation to funding, clinical governance, communication to the public and pace required to implement the programme in an already operationally challenged situation.
- *Update post MAC on the RSV programme: Currently UHL and the LLR system believe that the optimum delivery model would be a hybrid of high-risk women and birthing people receiving RSV when attending UHL sites for antenatal appointments and low risk women being offer RSV during antenatal appointments in the community. However, due to capacity constraints and workforce resilience in the community midwifery service, this is not felt to be feasible in the short*

zero reportable Patient Safety Incident Investigations (PSIIs) and 2 new Maternity and Newborn Safety Investigations (MNSI) reported as per criteria (1 early neonatal death and 1 stillbirth at 37 weeks), no immediate escalation following initial review. One of the MNSI cases was accepted with the second withdrawing consent. This case will be reviewed as per UHL Perinatal Mortality Review Team (PMRT) process. 7 cases remain open with the MNSI team, and zero safety recommendations (SR) have been issued during the month. Since February 7 MNSI cases have been closed with 5 cases with no SR. Action Plans and Learning Bulletins are in place with learning informing the PSIP. 6 new maternity related complaints / concerns were opened in month relating to communication, attitude, and care management.

- MAC were informed of the recent publication of the Birth Trauma Enquiry APPG Official Report, a response plan is being formulated with system partners and an update will be presented at the next MAC.
- UHL is participant of the Clinical Negligence Scheme for trusts (CNST) **Maternity Incentive Scheme** (MIS) which is operated by NHS Resolution (NHSR) supporting the delivery of safer care. The 10 Safety Standards for the Year 6 scheme were released on 2 April 2024 and MAC received a summary update on the progress. The compliance period for all actions (except safety actions 1, 8, and 10) is 2 April – 30 November 2024.
- MAC received an update on the **Perinatal Safety Improvement Programme (PSIP) Delivery & Progress.** Firstly, feedback was shared following the NHS England Midlands facilitated Maternity Rapid Quality Review Meeting with UHL and key stakeholders on 15 May 2024. The improvement programme was presented alongside the evidence relating to the CQC report and actions. Progress was acknowledged by the CQC, NHS England, and the LLR ICS and it was agreed that LLR System Oversight will continue via the Quality Review Group chaired by the ICB Chief Nurse. MAC then received a brief update on PSIP focusing on 2 of the workstreams.

to medium term. It was therefore agreed that the hybrid model would be pursued, however the community element should be delivered using the Roving Healthcare Units that will locate in areas that enable good access for pregnant women, close to the location of their community antenatal appointments. Women and birthing people that have their antenatal care in their GP surgery, will be able to access the vaccine via their GP practice. The community model would be underpinned by the midwives, who will have the initial discussion re RSV, answer questions and provide supportable encouragement of uptake during existing antenatal appointments – this will include signposting women and birthing people to the RHU clinics or their GP. Super vaccinators will be used to staff the RHU clinics and the system will aim to use those SV's that have some prior midwifery experience if possible.	• **PSIP Workstream 1** priorities: ICON (preventing shaken baby) awareness and audits, new translation service tender exercise, AccurX go live for the Induction of Labour process (text messaging service), launch of DadPad and Co-Parent Pad (essential guides to provide knowledge and practical skills, a support resource), continue to roll out of Mental Health Support Packs to staff, commence the Life Workforce Pilot (volunteer peer breastfeeding support), and collaboration with Stoneygate Centre for Empathic Healthcare as part of a programme of work on empathy. Work is also underway to capture service user feedback as part of the single point of contact development, utilisation of Surrey's Maternity Passport for additional nurses (learning disability and neurodiversity), and continuing to deliver on the Empowering Voices programme of work. • **PSIP Workstream 2** priorities: Maternity Support Worker (MSW) recruitment and the implementation of the MSW competency Framework, review of Professional Nursing & Midwifery Advocate model, launch of the NHS England Safe Learning Environment Charter, biannual workforce assessment (due Q3) which will monitor BirthRate Plus® recommendations, continue to roll out self-rostering, and work to achieve Pathway to Excellence® standards at Leicester General plus community (2025) and Leicester Royal (2026). A refreshed workforce plan is to be presented at MAC capturing actions and monitoring impact. • A progress report was presented detailing the progress on the response plan to **CQC** and alignment to the PSIP and associated workstreams. Since the previous MAC the total number of actions and sub-actions continue to be closed. 87.1% of the section 29a actions have been completed with 83.1% assured. Further audit, survey or other testing is required before the actions can be accepted as fully embedded. A brief update was provided on the recently published CQC report (published 14 June 2024) follow-up visit conducted 10/11 January 2024 where the safety domain improved from inadequate to 'requires improvement'. 3 Must and 2 Should Do's were included within the report surrounding staffing, strengthening adoption of

	Maternity Early Obstetric Warning System (MEOWS), incident reporting, separation of data and clean clutter free environments during internal works. MAC were informed of the oversight and monitoring arrangements in addition to the engagement plans. A further detailed report is to be shared at MAC and Board of Directors in the coming month. • Verbal feedback was provided following the **Neonatal Operational Delivery Network (ODN) Peer Review** of Neonatal Service (9 May 2024). Formal feedback is expected however actions underway in response focusing on workforce plans, escalation process, and estates and facilities.
Positive Assurances to Provide	**Decisions Made**
• **PSIP Workstream 1 – Listening to and Working with Women and Families with Compassion** recent achievements described: the ongoing development of the 'My Maternity Journey Booklet' as part of strengthening personalised care and support plans. Updates were also provided on: the development of the pelvic health service, work to strengthen the bereavement and birth reflections offer, evolvement and ambition for telephone triage / single point of contact, primary care collaboration, and response to improving experience with a lithotomy / theatre challenge and increasing visiting options. MAC also received insight into the 'Best Start to Life' pilot (breastfeeding support), positive feedback from the mental health clinic known as MINT, universal roll out of Vitamin D, and the new website. There has been considerable focus on communication with a new Language and Interpretation Operational Group established with new communication cards launched, training being explored, the introduction of MAMA wallets which have been designed to give key health messages for safer pregnancies, establishment of the EDI Shared Decision Making Council, and increased infrastructure to support pregnant Afghan citizens for Garats Hay. Call the Midwife campaign has now reached into the Community Services and Primary Care, antenatal classes for women in the county is being explored, and referrals to Heads Up charity 1:1 session for 'bumps to babies at home' session has been	• MAC supported oversight and monitoring arrangements as part of the response to the CQC findings, approving of the CMG's intention to work with operational staff to cocreate the response to recently published CQC report • Practice Learning Team and Heads of Midwifery to take the lead on monitoring and oversight of the WTE learner experience improvement plan with regular updates informing the established meetings with the Academic Education Institutions (AEIs). An update on this improvement plan will be shared with MAC During Quarter 3 2024/2025

launched for the City.

- MAC received a progress report on **PSIP Workstream 2 - Growing, retaining, and supporting our workforce**. A briefing pack was presented both at MAC and formulated the UHL response as part of the monthly Quality Review Meeting facilitated by the ICB (1 July 2024). Headlines included:
    - 71 Band 5 new midwives commenced since January 2023 with a further 49 offered posts and 5 new Band 6 midwives due to commence by September 2024: a reduction of midwifery vacancies by over 10%. Turnover rates reducing to below the national and regional rate. Sickness rates for the whole service reducing with an average of 5.7%. Improving student conversion rate. An increase of 9wte Band 7 Midwifery / Maternity Coordinators to strengthen out of hours leadership and support.
    - Response to the latest BirthRate Plus® workforce assessment which will increase wte by 20.6 (nb. This is likely to have a short-term impact on vacancy rate however pipeline indicates a swift recovery.
    - Recruitment of 9 additional speciality doctors plus 3 new Consultants.
    - Provider Workforce reconciliation exercise to work towards one version of the truth.
    - Reducing redeployment, unexpected absence, red acuity reporting, and reportable red flags
    - Investment in culture and wrap around support, such as: 6 shared decision-making councils, safety champion programme, empowering voices, collaboration with UoL and Stoney Gate as part of the empathetic care programme, implementation of the RCOG ‘Team of the Shift’, 48 team / ward leads and coordinators attending the Connect Programme, launch of strengths and values-based recruitment, and a wide range of leadership and support offers.

Comments on Effectiveness of the Meeting
The Perinatal Safety Improvement Programme (PSIP) continues to embed. Monitoring impact of the PSIP will be underpinned by a new Perinatal Insight Dashboard which will have a set of Key Performance Indicators for MAC, UHL Board of Directors and key partners. MAC also received an update from the **Maternity Safety Champions** and **Maternity Digital** programme, both standing items as part of a refreshed workplan.