Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	13.9.18	Agenda item	Bo.9.18.12

Care Quality Commission review of maternity services: Request for information

Presented by	Tanya Claridge, Director of Governance and Corporate Affairs	
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Lead Director	Tanya Claridge, Director of Governance and Corporate Affairs	
Purpose of the paper	This paper has been written to inform the Board that the CQC have notified the Trust that they are reviewing the Trust's maternity services and have made an information request that has been responded to.	
Key control	This paper is a key control for strategic objective 1: to provide outstanding care for patients	
Action required	To note and gain assurance	
Previously discussed at/ informed by	Developed from evidence portfolio submitted by the Trust's maternity service, response to CQC co-authored by Chief operating Officer, Chief Nurse, Medical Director and Director of Governance and Corporate Affairs	
Previously approved at:	**Committee/Group**	**Date**

Key Options, Issues and Risks

The Trust received notification from the CQC that they are reviewing the Trust's maternity services on the 17th August 2018. The notification states that the review has been initiated as the CQC's routine intelligence monitoring has identified a number of incidents reported by the Trust in relation to maternity services.

Analysis

In the letter of notification the CQC requested a range of further information to provide assurance that on-going risks to patient safety are being managed within the maternity services, a response was required by the 31st August 2018.

Recommendation

The Trust submitted a comprehensive response to the request as required on the 31st August 2018. The Board of Directors is asked to note the content of the request and the response made
The Board of Directors should be informed of the outcome of the CQC's review of the service when this information is made available to the Trust.

Risk assessment

Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients		g				
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers			g			
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)	The content of this paper has been risk assessed in relation to the objective to provide outstanding care to patients. The review of a service by the CQC in relation to the safety of care provided is a high risk to achieving the objective					

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Risk Implications (see section 4 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	▪	
Quality implications	▪	
Resource implications		▪
Legal/regulatory implications	▪	
Diversity and Inclusion implications		▪

Regulation, Legislation and Compliance relevance
NHS Improvement: Risk assessment framework, quality governance framework, code of governance , annual reporting manual
Care Quality Commission Domain: *Safe*
Care Quality Commission Fundamental Standard: Regulation 12
Other (please state):

Relevance to other Board of Director's Committee:					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
	▪				

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1 PURPOSE/ AIM

This paper has been written to inform the Board that the CQC have notified the Trust that they are reviewing the Trust's maternity services and have made an information request that has been responded to.

2 BACKGROUND/CONTEXT

The Trust received notification from the CQC that they are reviewing the Trust's maternity services on the 17th August 2018. The notification states that the review has been initiated as the CQC's routine intelligence monitoring has identified a number of incidents reported by the Trust in relation to maternity services. In the letter of notification the CQC requested a range of further information to provide assurance that on-going risks to patient safety are being managed within the maternity services, a response was required by the 31st August 2018.

The CQC requested the following information

- *Following the CQC inspection of the trust in January and February 2018, the trust submitted a post inspection action plan on 13 July 2018. We require you to provide us with an update detailing the progress made on actions identified in relation to the maternity services. Where planned actions have been completed, we require you to provide supporting evidence to demonstrate these actions have been completed effectively.*

- *We require you to provide details of any additional actions or improvements you have taken to minimise patient risks in the maternity services since the CQC inspection. Where applicable, provide evidence to demonstrate these actions have been completed effectively.*

- *We require you to confirm whether the trust has completed a review or trend analysis in relation to incidents and patient deaths in the maternity services. If so, provide details of this, including the scope of the review / analysis, the outcome of the review and what improvement actions have resulted from this analysis.*

3 PROPOSAL

The Trust responded with the following description of how the service is addressing the compliance actions identified during the CQC's unannounced inspection in January 2018, additional actions being taken to minimise patient risks and a description of how the Trust reviews trends and themes in incidents in the service.

Evidence and assurance that the service is addressing the compliance actions identified during the CQC inspection in January 2018.

The maternity element of the Trust's response to the CQC inspection was provided to the CQC this included the plan specific to the compliance actions identified with a description of the current progress being made, together with associated evidence.

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Additional actions and/or improvements

In addition to the Trust's response to the outcome of the inspection, the following additional improvements within the Trust's maternity services were described.

- The service was able to demonstrate compliance with all ten safer maternity care standards identified by NHS Resolution (NHSR). This was approved by the Board of Directors. The full details of the submission and associated evidence were provided The Trust was notified on the 30th July 2018 by NHSR that they were satisfied that we had fully met the 10 standards.
- The service has developed a 'Be the Best' quality initiative which has executive leadership from the Chief Operating Officer. This is designed to support sustainable improvement in patient care and patient experience across the entirety of the maternity services. The group provides an additional function of strengthened executive oversight and governance. The governance and details of the scheme were provided to the CQC.
- As part of the services ongoing work to improve patient safety they have significantly increased compliance with "PROMPT – Making childbirth safer, together" training and this is now embedded in practice for all staff across the clinical disciplines.
- In response to the ANNB Screening Serious Incident, the service have appointed a Failsafe Officer to support the ANNB Screening Co-ordinator, they start in September 2018
- The service has strengthened the existing Maternity Risk Management structure by appointing an additional senior midwife with specific responsibility for risk and governance. The expected start date is October 2018
- Two multidisciplinary engagement events were held in July 2018, focusing on innovative ways to meet the March 2019 national target of 20% of women booked on a continuity of care pathway.
    - A number of pilot schemes are in development including: improving the continuity of carer for women having elective LSCS; joint working within the Homebirth team and continuity of care between Birth Centre and Community Midwifery
- The service has engaged with the local Sands (Still Birth and Neonatal Death Charity) group and is working in partnership to review services for bereaved parents.
- The services has engaged with the Yorkshire and Humber Academic Health Science Network (YHAHSN) Improvement Academy to look at innovative ways to improve staff experience, this includes training a member of staff in the "Joy" training package, and this will enable staff to have a suite of theories and principals to support staff in the workplace.
- The Trust has appointed an experienced and senior consultant obstetrician to work in the capacity as a clinical mentor to the maternity service. Professor Steven Thornton, an eminent Professor of Obstetrics is expected to start in October.

Review of trends

The Trust responded to this request for information by confirming that it continuously reviews trends in incidents/complaints/claims/inquests and risks for all our specialties, including maternity, using the Trust's Quality Oversight System. This system has previously been demonstrated to the CQC inspectors.

In addition, with respect to maternity services the continuous review of trends and themes over the past two years was highlighted, with the following examples provided:

- In 2016 the Trust oversight system (a recent example of an output report was provided), via our weekly quality panel, identified a cluster of intrapartum events and undertook a comprehensive review including commissioning of the RCOG. This has been the whole basis of the maternity improvement programme outlined above.
- All incidents within this service are subjected to a standardised approach to assess the severity, the response required and the learning.
- The recent alert around puerperal sepsis was reported to our Quality Committee in August 2018. A paper which outlined the early findings from the review of this alert was provided. This paper has also been received by the Board of Directors (September 2018). A full report is due to be submitted at the end of September 2018.
- The CQC were provided with an analysis of the routine incident screening reports for the Maternity service (April 2016 – July 2018 (27 months). The highlights were
    - There is evidence of an increasingly positive reporting culture
    - There is a reduction in the number of labour/delivery incidents over this period
    - Overall The incident profile is demonstrating a fall in incidents where harm is identified
- The regional maternity dashboard is reviewed monthly. This has consistently demonstrated good performance in a number of areas compared to peers with positively lower caesarean section rates and reduced perinatal mortality rates.

4 RISK ASSESSMENT

Risk 3262 is an existing risk which is being managed on the corporate risk register states *'There is a risk that the Trust could suffer reputational damage which could impact on patients and staff choosing to come and be treated or to work at BTHFT. This is due to a number of concerns raised by CQC regarding basic care standards, a CQC rating of requires improvement and 2 subsequent never events'.* The current risk is described as moderate and this and the associated mitigation will be reviewed at the Integrated Governance and Risk Committee.

Risk 3273 is an existing risk which is being managed on the Divisional risk register states '*There is a risk that women in maternity will receive unsatisfactory care due to non-compliance with a number of CQC standards. This was identified in the CQC inspection and a rating of needs improvement given. There have also been two never events where non-compliance with safety standards were identified'.* The current risk is also described as moderate and this and the associated mitigation will be reviewed in the context of the notification from the CQC at the Divisional Governance Meeting and any concerns in relation to the effectiveness of the mitigation escalated as required.

5 RECOMMENDATIONS

The Trust submitted a comprehensive response to the request as required on the 31st August 2018. The Board of Directors is asked to note the content of the request and the response made

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