

<b>Meeting Title</b>	<b>Board of Directors</b>		
<b>Date</b>	<b>14.07.22</b>	<b>Agenda item</b>	<b>Bo.7.22.18a</b>

## MATERNITY AND NEONATAL SERVICES UPDATE – MAY 2022

<b>Presented by</b>	Karen Dawber, Chief Nurse		
<b>Author</b>	Sara Hollins, Director of Midwifery		
<b>Lead Director</b>	Karen Dawber, Chief Nurse		
<b>Purpose of the paper</b>	To provide the Quality and Patient Safety Academy and Trust Board with a monthly update on progress with the Maternity Improvement Plan, including CQC Action Plan, monthly stillbirth position and continuity of carer. Ensures that key elements of the Perinatal Clinical Quality Surveillance Model are visible and transparent at Trust Board level.		
<b>Key control</b>	N/A		
<b>Action required</b>	To note		
<b>Previously discussed at/ informed by</b>			
<b>Previously approved at:</b>	<b>Academy/Group</b>	<b>Date</b>	
	Quality and Patient Safety Academy QA.6.22.17	29.06.22	

### Key Options, Issues and Risks

The Maternity Service was rated as 'Requires Improvement' following the November 2019 Care Quality Commission (CQC) inspection. The service has acknowledged the findings and recommendations, and is committed to addressing the issues raised and becoming an 'Outstanding' service.

Following Executive approval, the service have embarked on a significant quality improvement and transformation project, intended to improve the stillbirth rate and other outcomes highlighted by the CQC, and ultimately support the journey towards being an outstanding maternity service.

Bradford is a regional and national outlier for stillbirths and concerns were raised by the CQC in November 2019 that the service had failed to identify a rising trend during 2019. The service has improved the monthly review process and will provide the Board of Directors and Quality and Patient Safety Academy with a monthly stillbirth position, in order that they are fully informed and able to scrutinise and challenge as required. The service reported an annual reduction in stillbirths during 2020, with a further reduction in 2021. However, stillbirth reduction remains a key priority for the service as we continue to work towards the national ambition and 'halve it' trajectory.

The monthly maternity and neonatal services report presented to Trust Board and Quality and Patient Safety Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Board has an open and transparent oversight and scrutiny of maternity and neonatal services.

The format of this report supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible and transparent at Trust Board level.

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### Analysis

The service has acknowledged the recommendations of the CQC 2019 report, and has incorporated them into the existing maternity action plan. The 'must, should, could' do actions and recommendations are summarised on the first page of the overarching action plan, with additional tabs providing more detailed descriptions of the actions required to evidence compliance. The overarching improvement plan has been updated to include the Ockenden Assurance action plan. Significant progress and compliance has been achieved with outstanding actions linked to major maternity transformation plans which are not yet complete but nearing finalisation. Recent internal audit of the CQC action plan was assessed as 'Significant Assurance'.

The service presented proposed transformation plans to Board of Directors in May 2020, focusing on key areas of improvement identified as necessary to reduce the stillbirth rate. The Outstanding Maternity Service Programme resumed in March following a 6 week pause to support safe staffing levels during an episode of high sickness and absence.

Monitoring of the monthly stillbirth rate continues, with every case subject to a 72 hour review and discussion with the Executive, Non-Executive and Trust level Maternity Safety Champions. This process is well embedded, including the rapid identification and escalation of in-month 'spikes' in the stillbirth rate which are subject to thematic reviews and reporting of any findings and subsequent learning to Trust Board.

During the last 6 months of 2021, this monthly update paper included Neonatal harms and data, in addition to maternity. This is to ensure that neonatal harms, learning and improvements are visible at Board level.

### Recommendation

Quality and Patient Safety Academy/Board of Directors is asked to note the contents of the Maternity and Neonatal Services Update, May 2022.

Quality and Patient Safety Academy/Board of Directors is asked to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned.

Quality and Patient Safety Academy/Board of Directors is asked to note that there were 4 HSIB reportable Serious Incident (SI) declared in May and 0 internal SIs.

Quality and Patient Safety Academy/Board of Directors is asked to acknowledge appendices 3 to 6: the HSIB escalation of concerns letter and the Trust response and associated action plan.

Quality and Patient Safety Academy/Board of Directors is asked to note appendix 7 the ATAIN Quarter 4 review as a requirement of the Maternity Incentive Scheme, Year 4, Safety Action 3 compliance.

Quality and Patient Safety Academy/Board of Directors is asked to note that there will be a Maternity Digital Quality and Safety Summit in July.

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Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients, delivered with kindness			g			
To deliver our financial plan and key performance targets			g			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					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)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risk Implications (see section 5 for details)	Yes	No	N/A
Corporate Risk register and/or Board Assurance Framework Amendments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diversity and Inclusion implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performance Implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Regulation, Legislation and Compliance relevance			
NHS Improvement: (please tick those that are relevant)			
<input checked="" type="checkbox"/> Risk Assessment Framework		<input checked="" type="checkbox"/> Quality Governance Framework	
<input type="checkbox"/> Code of Governance		<input type="checkbox"/> Annual Reporting Manual	
Care Quality Commission Domain: Choose an item.			
Care Quality Commission Fundamental Standard: Choose an item.			
NHS Improvement Effective Use of Resources: Choose an item.			
Other (please state):			
Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<b>1</b>	<b>PURPOSE/ AIM</b>
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The purpose of this paper is to provide a monthly update on progress with the Maternity Improvement Plan, including the Care Quality Committee (CQC) Action Plan, the monthly stillbirth position and continuity of carer. It also provides an update on the Outstanding Maternity Service quality improvement/transformation programme, intended to improve key areas of the service and support the journey towards being outstanding.

The paper also provides a brief narrative of the maternity outcomes and metrics reported in the monthly maternity dashboard.

Bradford is a regional and national outlier for stillbirths and concerns were raised by the CQC in November 2019 that the service had failed to identify a rising trend during 2019. This failing contributed to the 'Requires Improvement' rating applied to Maternity Services on 9 April. The service reported an annual reduction in stillbirths during 2020, with a further reduction in 2021. However, stillbirth reduction remains a key priority for the service as we continue to work towards the national ambition and 'halve it' trajectory.

The monthly maternity services report presented to Trust Board/Quality and Patient Safety Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Board has an open and transparent oversight and scrutiny of maternity and neonatal services as described in the Perinatal Clinical Quality Surveillance Model.

<b>2</b>	<b>BACKGROUND/CONTEXT</b>
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**Ongoing Impact of Covid-19 pandemic on Maternity Services:**

It is proposed that as Covid numbers have dropped and NHS organisations are returning to a 'business as usual', that this section will be removed from future papers and instead, any concerns or service changes directly related to Covid will be exception reported.

**Ockenden Report of Maternity Services at Shrewsbury and Telford NHS Trust and Ockenden Assurance Plan**

The Ockenden report of Maternity Services at Shrewsbury and Telford NHS Trust was published on 10 December 2020. The report looked at maternal and neonatal harms occurring between 2000-2019 at Shrewsbury and Telford Hospital and resulted in 27 recommendations for the named Trust with a further 7 early recommendations, referred to as immediate and essential actions (IAE's) to be implemented by all NHS Maternity services.

This was followed by the 2nd Ockenden Report on 30 March 2022 which included a further 15 IAE's. The national request is that Trust's continue to focus on embedding the original 7 IAE's and that a national plan will be developed following the publication of the East Kent report later in the year.

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The service is preparing for the Regional Maternity Team assurance visit, which is scheduled for 29 June 2022. The visit is intended to assess compliance and progress with the initial 7 IAE's.

The service has recently responded to the national and regional request to provide a further self-assessment of the Ockenden Assurance Plan, appendix 1. The service has made progress in all areas over the last 2 years and has only one domain which is partially compliant. This is in relation to the audit of the use of the Personalised Care Plan (PCP).

The PCP is currently offered in paper format only and is held by the woman and not the service; this makes it impossible to robustly audit. The service is working towards the use of the Patient Portal, which will give women access to complete their individual PCP on line, and will be accessible to midwives and obstetricians to view and input as required. As yet there is no suggested date as to when this will be available. In the interim the service is exploring other ways to conduct a reliable audit of the use of PCP's.

### **Maternity Staffing**

Safety Action 9 of the Maternity Incentive Scheme, Year 4, requires that there is evidence that discussions regarding safety intelligence, including minimum staffing in maternity services are taking place at Board level.

Current vacancy against the safe staffing establishment is 6.98 WTE which includes the agreed uplift for maternity leave. There are 15 WTE midwives on maternity leave which is contributing to the current staffing pressure.

Despite a relatively small vacancy rate, the service continues to experience daily staffing challenges as a result of sickness and absence and increased rates of maternity leave. This is mitigated on a daily basis with redeployment of staff, use of non-clinical midwives where required, and flexing beds in inpatient areas. This process is managed by the daily Midwifery Bed Manager under the supervision of the Matron team.

### **Obstetric Staffing**

There are currently 22 Consultant Obstetricians and Gynaecologists within the CBU. There are 3 pure Consultant Obstetricians on the Out of hours on call Obstetric rota and 3 pure Consultant Gynaecologists on the Gynaecology rota as well as colleagues who cover both.

There are 2 consultants off at present on long term sick.

We interviewed and appointed one candidate for the Fetal medicine consultant post on 23/5/22. Unfortunately the second candidate pulled out before the interview. We had approval to appoint both as Obstetricians to the unit if they were both appointable on the day. This leaves one funded Obstetric post that will need to be re advertised again in the near future.

A new O+G locum started in post on 21st April 2022. The CBU has achieved approval for a further locum in O+G with an interest in Urogynaecology on 24/5/22 to help reduce the waiting lists and back logs in Urogynaecology. There is a senior registrar within the unit with this interest and subject to her achieving her CCT in June, she is keen to apply for this post.

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Our Gynaecology Oncology Lead consultant has given his notice and will leave the trust on 20th June and has secured another post closer to his home. 2 external candidates have applied and been shortlisted for this post with an interview date on 11th July 2022. They are both strong candidates with a wealth of Gynaecology Oncology experience. It is essential that we ensure senior consultant presence in managing this service to maintain patient safety in this area of Gynaecology.

Labour ward is always covered by a consultant and there are no exceptions to report. Labour ward consultant led ward rounds (4 x daily) are currently being audited.

Through May 2022 and moving forward, all Obstetric consultants have allocated job planned time to deliver Obstetric ward rounds on the antenatal wards. This ensures consultant wards rounds across the 7 days of the week. Consultants are offering days when this fits around other clinical/ admin work as often the ward round takes longer than 1 hour. This has been separated from MAC/ ANDU cover as we just cannot yet deliver this on top of the existing work already delivered within and on top of the consultant job plans. This means we can now provide assurance that Obstetric ward rounds are being consistently delivered every day with consultant presence and will be reviewed in the Ockenden assurance visit in June 2022.

The Acute out of hours Gynaecology on call rota (commenced 1/11/21) is in place ensuring a separate consultant is on call for Obstetrics and Gynaecology 24 hours/ day. Some consultants are delivering this on top of their job plans (claiming extra pay) and some are taking down clinical activity in order to provide it. This is also an extra strain on the consultant body especially as much of the cover is out of hours in the evenings, overnight and across weekends.

#### Registrars:-

Currently we have 12 Registrars (4 of them are only 60%) occupying 10 slots on a 1:11 rota leaving one slot completely empty as a gap (no empty slot at present).

We have 2 ST3 registrars that need senior cover and support with an SR or consultant present on each shift out of hours (to meet entrustability standards set by the RCOG) until they acquire all the necessary skills to be competent on the labour ward.

There are 2 x staff grades + 1 clinical fellow (until September 2022 and their contract will need extending after that), 2 x ST7, 1 x ST6 (only these 5 senior registrars are able to cover ST3 entrustability nights), 2 x ST5, 2 x ST4 and 2 x ST3.

#### SHOs:-

We currently have 13 SHO's working full time. We have a supernumerary FY2 working 60% joining us within the next 2 weeks.

2 of our SHO's are Trust Grades as the GP scheme only gave us 4 trainees instead of 6 in February this year which left us with 2 full time gaps which have now been filled.

Recent success with trust HR in being able to offer escalated locum rates in line with other specialities within the trust has ensured that we have managed to cover many of the immediate gaps in the junior staffing tiers to ensure the shifts are safe. HR have agreed to escalated rates until the end of August 2022 for the registrars and until the end of June 2022 for the SHOS to be reviewed again at these points.

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### **Maternity Action Plan and CQC rating**

Maternity Services received a 'Requires Improvement' rating in the 2019 inspection report published in April 2020. The service has acknowledged the recommendations including monitoring and escalation of stillbirth rates, monitoring and management of infection risks in maternity theatres, and have incorporated 'must, should and could' do's into the existing maternity action plan for immediate attention.

The 2019 CQC action plan is complete with the majority of actions now 'business as usual' or ongoing. For example, the action relating to closely monitoring infection risks in obstetric theatre will be categorised as 'ongoing' until the completion of the planned theatre rebuild. On-going surveillance of all women who have had a caesarean birth remains in place as part of the risk mitigation until the work is complete which is now imminent.

The action plan incorporates the Ockenden assurance actions as described earlier and outstanding actions from Serious Incidents (SI's) and a national benchmarking tab. It is reviewed as a minimum, 4-6 weekly by the Director of Midwifery, Clinical Director and Risk and Governance Lead Midwife.

The CQC action plan was the subject of an internal audit in March and was given a rating of 'Significant Assurance' which is reflective of the robust systems and processes in place within the Foundation Trust. The 'ongoing' status of the escalation guideline review prevented the final rating of 'high' assurance. This piece of work is now in the final stages and has been delayed due to the need to align the local guideline with LMS and Regional maternity escalation guidelines.

### **Stillbirth Position**

There were 2 stillbirths in May. See appendix 2 available to Quality and Patient safety Academy and Closed Board members. Table 1 is the running total of stillbirths in 2022, including the number of cases requiring further detailed investigation, and the number of butterfly babies whose deaths were expected.

Table 1:

Stillbirths 2022			Expected deaths within total number	Further detailed investigation
Month	Number of babies	Running total	Butterfly babies	Number of cases
January	1	1	0	1
February	3	4	2	0
March	3	7	2	0
April	2	9	1	1 (level 1)
May	2	11	0	0



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### **Hypoxic Ischaemic Encephalopathy (HIE)**

There were 3 babies requiring cooling for HIE in May. See appendix 2 available to Quality and Patient safety Academy and Closed Board members. All 3 cases meet the criteria for HSIB referral and have been accepted by the team with parental consent.

The 3 clinical cases were all distinctly different and there are no similarities noted following immediate review. However, 1 case does have similarities with previous incidents relating to maternity telephone triage. This is being addressed with the team.

### **Serious Incidents (SIs) and serious harms**

The December 2020 Ockenden Report, independent review of Maternity services at the Shrewsbury and Telford Hospital NHS Trust, contained 7 immediate and essential actions (IAE) to improve care and safety in maternity services for all Trusts.

IAE 1: Enhanced Safety, recommends that all maternity SI reports and a summary of the key issues, must be sent to the Trust Board and the Local Maternity System (LMS).

There were 4 HSIB reportable cases occurring in May as described in appendix 2 available to Quality and Patient Safety Academy and Closed Board members.

There are 7 ongoing maternity SI's, 5 HSIB 1 Trust level and a maternal death which has yet to be accepted formally by HSIB.

Safety Action 9 of the Maternity Incentive Scheme, Year 4, requires that there is evidence that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues, are taking place at Board level.

Ongoing Maternity SIs:

Information available in Closed Board appendix 2

Appendices 2a, b and c are copies of recently closed/final SI and HSIB reports including recommendations and learning. This is available to Quality and Patient safety Academy and Closed Board members only.

The Ockenden report is clear that neonatal harms should also be visible at Trust Board level. This report already covers monthly neonatal harms regarding care provided during pregnancy and birth, and has not previously featured neonatal harms regarding the care received after birth. This report features a brief description of any neonatal SI's declared in month, including any immediate lessons learned. It must be noted that the responsibility to escalate, investigate and action any learning, sits with the Neonatal Service and not the Maternity Service. The exception will be any case which crosses both specialties.

There were 0 neonatal SI's declared in May and no ongoing neonatal SI's under investigation.



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## **Neonatal Deaths (NND)**

There were 3 NND in May.

Table 2:

NND 2021			Expected deaths within total number	Further detailed investigation
Month	Number of babies	Running total	Extreme preterm/congenital anomalies/life limiting conditions	Number of cases
January	2	2	Expected preterm twins (not Bradford babies)	0
February	0	2	0	0
March	0	2	0	0
April	1	3	0	0
May	3	6	1 (23 weeks non Bradford baby)	0

## **HSIB Cases and Progress in achieving Maternity Incentive Scheme Safety Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?**

Following the Ockenden Report, all cases referred to the Health Safety Investigation Branch (HSIB) will be declared as SI's. There were 4 cases meeting the HSIB referral criteria in May.

## **HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with the Trust**

The implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

The Trust received an 'escalations of concerns' letter from HSIB (appendix 3) on 11 May.  
Concerns identified:

- Use of interpreting services including the use of family members
- Missed opportunities for growth ultrasound scans to being undertaken following a slowing growth trajectory on symphysis-fundal height measurements
- Failure to complete audits regarding the identification/monitoring of missed small for gestational age and fetal growth restriction babies
- Discrepancies between the audit data provided

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The service responded to the letter within the 5 working days' time frame, including actions taken to address the concerns raised to date, and future improvement plans. Appendices 4 and 5 contain the Trust response and associated action plan.

The service acknowledged that further improvements to the use of interpreting services can still be made, including improved documentation of when interpreting services are offered and declined by the woman in preference of a family member.

The service were able to clarify that the national requirement to complete audits regarding the identification/monitoring of missed small for gestational age and growth restricted babies, was paused for Trusts challenged with staffing in quarter 3, followed by a complete pause of the Maternity Incentive Scheme between December and 6 May.

The service confirmed that the methodology used for a 'snap shot' audit was flawed, resulting in a falsely elevated percentage of missed babies which did not tally with the lower number of babies recorded on a rolling basis.

HSIB were satisfied with the response and actions provided (appendix 6) and no further action is required. Progress with the action plan will be monitored through HSIB's quarterly attendance at Trust maternity governance meetings.

### **Coroner Regulation 28 made directly to Trust**

Again, the implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

The service can confirm that there have been no such requests to date this year.

### **Avoiding Term Admissions into Neonatal Units (ATAIN) Quarterly Review:**

Appendix 7 is a copy of the Quarter 4 ATAIN review findings, required to demonstrate compliance with Safety Action 3 of the Maternity Incentive Scheme. The findings and associated action plan will be discussed at the June Maternity and Neonatal Bi-Monthly Safety Champion meeting.

The review continues to demonstrate that the overall rate of term babies admitted to neonatal unit remains consistently lower than the national average. The neonatal and maternity teams were complimented on the consistently low ATAIN rate during a recent GIRFT review, suggesting that this was an area which did not require too much focus.

### **Maternity and Neonatal Bi-Monthly Safety Champion meetings**

The Maternity and Neonatal Maternity Safety Champions did not meet in May. The next scheduled meeting is in June. The Non-Executive Safety Champion is increasing attendance at maternity governance meetings, and attended the Women's Speciality Meeting in May. This is providing a welcome additional layer of scrutiny and positive challenge to the clinical governance agenda. No safety concerns were escalated to the team outside of the planned meeting.

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### **Monthly staff feedback from Safety Champions and walk-rounds**

Karen Dawber, Chief Nurse chaired a virtual meeting on 4 May and discussed the implementation of actions following 2 recent HSIB reports. Ongoing challenges following the roll out of Cerner Maternity EPR were also raised. There is a process in place to escalate and address issues via Remedy.

### **Maternity Unit Diverts**

In the 2019 inspection, the CQC commented on the number of times the maternity unit 'diverted' services. Unfortunately there is no national, regional or LMS level benchmarking available which would highlight the service as an outlier.

The NHSI maternity support team have also indicated that they believe that the service 'diverts' more frequently than other organisations. In response, the service agrees that a more robust process is required to review unit diverts, which will identify any themes requiring interrogation.

There were 2 attempted diverts in May with escalation triggered by unit activity and suboptimal staffing levels. In both situations no women were diverted away from the service due to a lack of capacity in neighbouring units.

Table 4:

<b>MONTH</b>	<b>Full Divert</b>	<b>Partial Divert</b>	<b>Attempted Divert</b>	<b>Number of women diverted</b>
JANUARY	0	1	1	3
FEBRUARY	0	1	0	1
MARCH	0	1	0	5
APRIL	0	4	0	TBC
MAY	0	0	2	0
<b>Total</b>	0	7	1	9

### **Midwifery Continuity of Carer (MCoC) Action plan**

Appendix 8 is the MCoC highlight report based on February data. Following the transition from Medway to Cerner Maternity there is no updated data available.

The service continues to support the existing MCoC teams and has not progressed any additional teams as part of the continued prioritisation of safe staffing.

A further updated MCoC action plan will be provided to the LMS for submission to the regional team on 15 June.

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TOTAL % booked for MCoC in February = 17%      BAME % = 18%

### **Maternity Theatres**

The service is delighted to share that phase 1 of the maternity theatre build is now complete and that new theatres 1 and 2 and associated recovery rooms are now fully operational.

The 'old theatres' are due to be handed over to the contractors to commence phase 2 of the project by the end of May.

The completion of phase 1 of the theatre build removes the ventilation risk and completes the associated CQC action regarding this risk. However, the service will continue to use of the Public Health England, surgical site infection surveillance tool, for all women who have had a caesarean birth and monitor the infection rate. Any concerns will now be reported by exception and will not be included in the monthly update paper from June.

### **Maternity Dashboard**

Appendix 9 is the current maternity dashboard containing data to the end of 2022. Following the change over to Cerner Maternity, there is no dashboard data available at present.

### **Training Compliance**

The revised Perinatal Quality Surveillance Model minimum data set for Trust Board's, requires oversight of the training compliance of all staff groups in maternity related to the core competency framework and wider job essential training. The most recent update was provided in the April paper and the next training compliance report will be presented in July.

### **Outstanding Maternity Service Programme**

The Outstanding Maternity Service (OMS) Programme is a transformation programme, intended to improve the service from 'Requires Improvement' to 'Outstanding'.

The programme contains 5 work streams:

- The Woman's Journey and Clinical Excellence.
- Moving to Digital.
- Streamlining Systems.
- A Building Fit for the Future.
- Investing In Our Workforce.

#### **Programme Governance**

- Learning pages created-' Learning from Each Other' format, capturing the non-Qi projects for trust wide sharing.

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- Capture of OMS framework for shared learning- first draft received.

#### Moving to Digital

- Olympus roll out completed (patient letter dictation software)
- Ongoing EPR Process work and improvements
- Viewpoint software roll out (scan reporting system)-planning in progress

#### Investing In Our Workforce

- Hug in a mug / pay it forward launched.
- Derry the wellbeing dog

#### The Women's Journey

- LSCS subgroup commenced
- Induction of Labour Subgroup commenced
- Sara Kenyon visited the unit to review BSOTS re cerner
- Scan review competency achieved by several midwives in clinic & MACU .

#### A Building Fit For The Future.

- Estates proposed option 4 to breakdown into phased works and costings-urgency is ground floor work to start, particularly Maternity Assessment, ANDU, ANC & waiting area

#### Linking Learning and Quality Through Our Information

- Maternal and Newborn Safety pages shared throughout the month of May
- Reviewed learning from MDT safety huddle Jan-Mar themes to inform improvements. Learning page produced

#### **Service User Feedback**

There have been no MVP meetings held in May and the service have not received any 'Grassroots' feedback this month. The next meeting is planned for June following recommissioning of CNET to host the MVP.

#### **Maternity Cerner**

The service continues to adapt to and embed Maternity Cerner into daily practice and is now working with the system as 'business as usual'.

Processes are in place to address daily operational and technical challenges.

A number of issues posing a potential patient safety concern persist, in addition to concerns regarding data reporting. These will be addressed as part of a Maternity Digital Quality and Safety Summit to be held in July.

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### **3 PROPOSAL**

The service proposes that the Maternity Improvement Plan incorporating the Ockenden assurance action plan is presented to Quality and Patient Safety Academy/Board of Directors on a monthly basis as part of this report.

The service also proposes that progress on the Outstanding Maternity Service programme is included in this monthly update.

Any urgent concerns emerging outside of the monthly reporting arrangements will be escalated by the Trust Level Safety Champions to the Board Level Safety Champion.

### **4 BENCHMARKING IMPLICATIONS**

The service will continue to benchmark and monitor performance and position at both regional and national level, using the existing benchmarking tools including the Yorkshire and Humber regional maternity dashboard, MBRRACE-UK publications etc.

Continuity of Carer is monitored through the West Yorkshire and Harrogate LMS.

### **5 RISK ASSESSMENT**

Stillbirths and Continuity of Carer pathways are on the maternity risk register, updated regularly and monitored through Women's Core Governance Group. All risks have been reviewed to reflect any increased risk as a result of changes to the service to maintain safety of women, babies and staff during the pandemic.

### **6 RECOMMENDATIONS**

Quality and Patient Safety Academy/Board of Directors is asked to note the contents of the Maternity and Neonatal Services Update, May 2022.

Quality and Patient Safety Academy/Board of Directors is asked to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned.

Quality and Patient Safety Academy/Board of Directors is asked to note that there were 4 HSIB reportable Serious Incident (SI) declared in May and 0 internal SIs.

Quality and Patient Safety Academy/Board of Directors is asked to acknowledge appendices 3 to 6: the HSIB escalation of concerns letter and the Trust response and associated action plan

Quality and Patient Safety Academy/Board of Directors is asked to note appendix 7 the ATAIN Quarter 4 review as a requirement of the Maternity Incentive Scheme, Year 4, Safety Action x compliance.

Quality and Patient Safety Academy/Board of Directors is asked to note that there will be a Maternity Digital Quality and Safety Summit in July.

<b>Meeting Title</b>	<b>Board of Directors</b>		
<b>Date</b>	<b>14.07.22</b>	<b>Agenda item</b>	<b>Bo.7.22.18a</b>

<b>7</b>	<b>Appendices</b>
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- Appendix 1 Maternity Improvement Plan v23
- Appendix 2 Stillbirths Maternity SIs NNU SIs Closed Board & QPSA June July
  - Appendix 2a HSIB Maternity\_Report\_Final\_v1.0 Closed Board QPSA June July
  - Appendix 2b SI report Closed Board QPSA June July
  - Appendix 2c HSIB Maternity\_report Closed Board QPSA June July
- Appendix 3 HSIB Escalation Letter\_Bradford
- Appendix 4 HSIB response May 2022
- Appendix 5 HSIB escalation of emerging concerns action plan
- Appendix 6 HSIB response to Escalation Letter\_Bradford
- Appendix 7 Quarter 4 ATAIN board report May 22
- Appendix 8 CoC Highlight report April 2022
- Appendix 9 Maternity Dashboard