

Meeting Title	Board of Directors		
Date	14.07.22	Agenda item	Bo.7.22.18b

MATERNITY AND NEONATAL SERVICES UPDATE – JUNE 2022

Presented by	Karen Dawber, Chief Nurse		
Author	Sara Hollins, Director of Midwifery		
Lead Director	Karen Dawber, Chief Nurse		
Purpose of the paper	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.		
Key control	N/A		
Action required	To note		
Previously discussed at/ informed by	N/A		
Previously approved at:	Academy/Group	Date	
	N/A		

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 the Board of Directors 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 now complete (phase 1 theatre build). 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, June 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 was 1 HSIB reportable Serious Incident (SI) declared in June and 0 internal SIs.

Quality and Patient Safety Academy/Board of Directors is asked to note appendices 2 and 3, Saving Babies Lives quarterly care bundle survey results.

Quality and Patient Safety Academy/Board of Directors is asked to acknowledge that an updated Midwifery Continuity of Carer implementation plan (appendix 4) was submitted to the Local Maternity System and Regional team on 15 June.

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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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1	PURPOSE/ AIM
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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.

2	BACKGROUND/CONTEXT
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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.

The service had its Regional Maternity Team assurance visit on 29 June. The visit was extremely positive and feedback very complimentary regarding the attitude and behaviours of the staff and unit. The team were assured by the evidence provided, which they were able to triangulate and test with staff and service users on the day.

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The service shared the outstanding areas of compliance with the team, in relation to the audit of the use of the Personalised Care Plan (PCP) and our current lack of confidence with our ability to submit Maternity Services Data Set (MSDS) to the required standard.

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.

The service was fully compliant with MSDS submission prior to the transition from Medway to Cerner Maternity. The first 'test' of Cerner's ability to submit to the required standard is in July, and until we have completed this submission we can give no assurance of compliance.

The Regional Team were informed that both of these outstanding issues were key points of concern raised at the recent Maternity Digital Quality summit, and have been escalated appropriately.

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 10.63 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. Achieving the safe staffing establishment is our priority figure.

Current vacancy against the funded establishment, which includes the number of midwives required to provide Midwifery Continuity of Carer (MCoC) is 37.05 WTE.

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.

The service has offered 24 newly qualified midwives (NQM) posts to commence in the autumn and international midwifery recruitment is starting to make progress. If the service follows the expected attrition trajectory, safe staffing should be achieved by October/November.

Obstetric Staffing

There are currently 21 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.

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There are 2 consultants off at present- one with Covid and the other has a longer sickness absence that began on 10th June with no plan as yet on their return date.

Our Gynaecology Oncology lead resigned and left the trust on 10th June 2022 to work in another unit in the region closer to his home. There is now only one candidate to interview for this replacement on 6th July, as the other candidate has pulled out of the recruitment process despite being offered an interview. One of our existing consultants with a back ground experience and skills in Gynaecology Oncology is covering the MDTs and Gynaecology oncology clinics until we have appointed a new lead to ensure a safe service. This has left aspects of her job planned role that we have to cover with other colleagues as she is unable to complete all of her own job planned work as well as covering the Gynaecology Oncology service safely.

We interviewed and appointed one candidate for the Fetal medicine consultant post on 23/5/22. This candidate will start in post towards the end of September 2022. 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. The documents are ready and need to go out on NHS jobs.

The CBU has achieved approval for a further locum in O+G with an interest in Urogynaecology on to help reduce the waiting lists and back logs in General Gynaecology and Urogynaecology. This advert has now closed and been shortlisted on NHS jobs. There is only one applicant who is a senior registrar within the unit at present with this interest and subject to a successful interview, she is keen to obtain this post.

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

From May 2022 and moving forward, all Obstetric consultants have allocated job planned time to deliver daily Obstetric ward rounds on the antenatal wards. This is embedded and was highlighted to the Ockenden assurance team who visited the unit on 29th June 2022. This ensures consultant ward rounds across the 7 days of the week.

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.

With the strain of the extra Gynaecology on calls, the need for extra OP Hysteroscopy due to a marked surge in sheer numbers being referred in from GPs, losing our Gynaecology Oncology consultant and having to cover his work as well as sessions needing support that would be normally covered by a general consultant and 2 consultants away with sickness, we have never been under so much strain for covering work and it has become a daily struggle to ensure safe staffing within the unit.

Even with the proposed locum, we still could benefit from at least 2 further locum consultants to help with the sheer volume of work. Through July and August when there is also a great deal of annual

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leave planned as well to allow consultants a much need a break and a rest, puts even more strain on the consultants working within the unit during these 2 months.

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.

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 2xstaff grades + 1 clinical fellow (until September 2022 and their contract will need extending after that), 2xST7, 1xST6 (only these 5 senior registrars are able to cover ST3 entrust ability nights), 2xST5, 2xST4 and 2xST3.

There has been sickness in recent weeks with one registrar with Covid and another registrar on long term sickness creating junior gaps that need to be covered and filled.

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.

Plans are developing for a compliant rota with a 13 slot (from current 11 slot reg template) registrar template from August 2022 and this has been discussed with HR. There will actually be 15 registrars in total (2 extra from the deanery) but we need to double up in at least 3 slots for entrustability until the ST2/ 3s are entrustable to be left alone without SR or a consultant present.

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.

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The 2019 CQC action plan has one remaining action in progress with the majority of actions now 'business as usual' or ongoing. The completion of phase 1 of the Maternity Theatre build removes the ventilation risk and impact on infection rates. On-going surveillance of all women who have had a caesarean birth remains in place to ensure that any other recurrent themes linked to infection are rapidly identified and addressed.

The outstanding action is around the updated maternity escalation guideline, which has been circulated for comments but requires comments from the wider MDT. The service continues to follow the existing escalation policy which is considered to be safe and appropriate.

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. It was presented to Board as part of the May update paper bundle.

Stillbirth Position

There was 1 stillbirth in June. See appendix 1 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
June	1	12	0	1 (HSIB SI)

Hypoxic Ischaemic Encephalopathy (HIE)

There were 0 babies requiring cooling for HIE in June.

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.

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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 was 1 HSIB reportable case occurring in June as described in appendix 1 available to Quality and Patient Safety Academy and Closed Board members.

There are 7 ongoing maternity SI's, 5 HSIB 2 Trust level.

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 1.

This is available to Quality and Patient safety Academy and Closed Board members only. There were no closed HSIB or internal SI reports to share in June. 1 case was downgraded to a level 1 investigation following rejection by HSIB.

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 June and no ongoing neonatal SI's under investigation.

Neonatal Deaths (NND)

There was 1 NND in June.

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	0

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			Bradford baby)	
June	1	7	1 (known congenital anomaly on Butterfly Pathway)	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.

There were no direct requests for action made directly to the Trust in June.

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.

Saving Babies Lives Care Bundle Version 2 (SBLCBV2) quarterly care bundle survey

Completion of the SBLCBV2 quarterly care bundle surveys were not required as part of the Maternity Incentive Scheme (MIS) year 4, national pause. The scheme recommenced in May and survey 6 was completed in June. The completed submission and summary are attached as appendices 2 and 3. BTHFT progress remains positive, however confidence in and the ability to submit MSDS to the required standard remains an ongoing challenge. Of note for Element 3 there has been a reduction in the number of Trusts meeting the requirements including MSDS from 9 of 13 in survey 5 to 8 of 13 in Survey 6.

Maternity and Neonatal Bi-Monthly Safety Champion meetings

The Maternity and Neonatal Maternity Safety Champions did not meet in June as planned due to conflicting pressures. However, the safety champions have met at other points during June, including the Ockenden Assurance visit. . The next scheduled meeting is in July. 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 7 June attended by maternity and neonatal colleagues.

The Trust wide shortage of lone worker devices for community midwives was raised. This issue is being addressed at Trust level.

Neonatal colleagues discussed current improvement work around handovers and the improved neonatal staffing position.

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 0 attempted diverts in June recorded on Datix or the closure log.

Table 4:

MONTH	Full Divert	Partial Divert	Attempted Divert	Number of women diverted
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
JUNE	0	0	0	0
Total	0	7	1	9

Midwifery Continuity of Carer (MCoC) Action plan

Appendix 4 is a copy of the MCoC high level implementation timeline, submitted to the LMS and Regional Maternity team on 15 June.

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As previously mentioned, the initial recruitment priority is to achieve safe staffing and it is anticipated that it will be October before this is achieved. The service therefore, has not implemented any further MCoC teams, but has continued to support the well-established teams already embedded.

Maternity Dashboard

The Maternity Dashboard was presented to Board in the May update paper. Following the changeover to Cerner Maternity, there is no further 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.

- Capture of OMS framework final draft received.
- OMS shortlisted for HSJ awards.
- QI team and OMS working together for QI training strategy.

Moving to Digital

- Viewpoint software roll out (scan reporting system) launching in July.
- Language line icon on all maternity staff logins.
- 100% of parent education classes can be accessed on line.

Investing In Our Workforce

- Partnership work with Little Minds Matter- supporting secondary stress using reflective discussion. Offer to all staff groups. Will commence in July 22.
- Derry the wellbeing dog visited the hub and over 21 staff came to see him.

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The Women's Journey

- Diabetic Pathway –capacity/demand review work to inform clinic provision ongoing.
- Theatre sub-group commenced.
- Midwife scan competencies completed by numerous midwives.

A Building Fit For The Future.

- Presented to “Dragons Den” to gain funding for phase one of build.

Linking Learning and Quality Through Our Information.

- Progressing Accreditation reviews of tools with MVP.
- Nice guideline analysis tracker completed.

Service User Feedback

The first Main MVP meeting of the year following recommissioning of the service, took place in June. The meeting was attended by the Director of Midwifery who provided an update on the maternity service at BTHFT including MCoC position, completion of the theatre build, staffing position and use of the Birth Centre.

The MVP chair participated in the regional Ockenden Assurance visit as part of the review panel.

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 were addressed as part of a Maternity Digital Quality and Safety Summit held in early July.

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

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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
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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
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Quality and Patient Safety Academy/Board of Directors is asked to note the contents of the Maternity and Neonatal Services Update, June 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 was 1 HSIB reportable Serious Incident (SI) declared in June and 0 internal SIs.

Quality and Patient Safety Academy/Board of Directors is asked to note appendices 2 and 3, Saving Babies Lives quarterly care bundle survey results.

Quality and Patient Safety Academy/Board of Directors is asked to acknowledge that an updated Midwifery Continuity of Carer implementation plan (appendix 4) was submitted to the Local Maternity System and Regional team on 15 June.

7	Appendices
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- Appendix 1 – Maternity Neonatal Stillbirth/MatSIs/NNUSIs – Closed Board/QPSA June/July.
- Appendix 2 - Copy of Survey 6 - RAG for RAE
- Appendix 3 - SBLCB (v2) Survey 6 - Key Findings
- Appendix 4 - MCoC Implementation high level timeline