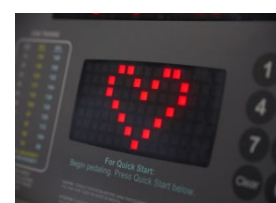
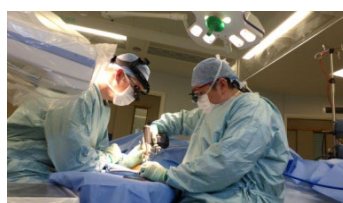


Maternity and Neonatal Services Update- May/June 2022

Sara Hollins, Director of Midwifery

Board of Directors July 2022



May Headlines

- HSIB escalation of concerns letter received and responded to:
 - Concerns regarding use of interpreting services including family members
 - Missed opportunities for growth ultrasound scans following slowing growth on Symphysis Fundal Height
 - Failure to complete small for gestational age audits
 - Discrepancies in audit data provided
- Quarter 4 Avoiding Term Admissions into Neonatal Units (ATAIN) review:
 - Overall rate of term babies admitted to NNU remains consistently lower than national average
 - GIRFT review complimented services on ATAIN rate
- Maternity Digital Quality and Safety Summit:
 - Number of issues post Maternity Cerner go-live particularly around data reporting
 - Quality and Safety Summit planned for July to address and find solutions

June Headlines

- **Regional Maternity Team Ockenden Assurance Visit:**
 - Very Positive and complimentary of the staff and maternity service
 - High Assurance that the initial 7 Immediate and Essential Actions have been acknowledged, actioned and embedded
 - Digital challenges delaying full compliance with embedding Personalised Care Plans and confidence in Maternity Services Data Set (MSDS)
 - A number of soft/low level recommendations to consider
- **Saving Babies Lives Care Bundle Version 2 survey results:**
 - Survey's resumed following agreed national pause
 - Overall positive but low assurance again around MSDS elements
- **Midwifery Continuity of Carer (MCoC)**
 - High level implementation plan reviewed following 2nd Ockenden report and re-submitted to the LMS and Regional team on 15 June
 - Safe staffing number is first priority and should be achieved by October/November. MCoC plans will then resume

Focus on SI's

- Provide Board with a refresher on how SI's are managed in Maternity
- All maternity cases of moderate or severe harm are datixed, referred to SEG and QUOC as appropriate
- Level of investigation agreed
 - Cases declared SI are referred to the LMS SI panel for peer review and system learning (Panel chaired by BTHFT consultant)
 - Internal SI's follow Trust process and agreed time frames
- Cases meeting HSIB Criteria:
 - All maternity cases meeting the HSIB criteria are referred to the regional HSIB team, following parental/next of kin consent
 - HSIB review the case and either accept or decline to investigate
 - Declined cases are referred back to QUOC to agree level of investigation
 - HSIB cases take on average 4-6 months to complete

Focus on SI's

- Both Internal and HSIB SI's follow the same immediate processes:
 - Duty of candour
 - Parental/family involvement including concerns raised
 - Maternity Quality and Safety team co-ordinate immediate family support and support for staff involved with the incident
 - Timeline of care/events
 - 72 hour clinical review of the case identifying immediate lessons learned, recommendations and good practice
 - Lessons Learned shared with relevant clinicians, areas and the wider team
 - Action on immediate lessons learned commences immediately
- Completion of reports both internal and HSIB:
 - Any recommendations/actions not identified during the 72 hour review are agreed and actioned
 - Final reports shared with family and clinicians/teams involved
 - Offer to meet with the family to discuss report and actions taken
 - Final reports and progress on actions monitored through Women's Core Governance Group

Focus on SI's

- Board and Executive Oversight:
- Internal and HSIB SI's are discussed at Bi-monthly maternity and neonatal safety champion meeting.
- All SI's/HSIB/NND's/Stillbirth's/HIE cases occurring 'in month' are included in the monthly Maternity/Neonatal update paper presented to Quality and Patient Safety Academy and Closed Board (numbers only presented to Open Board).
- Monthly progress on open SI investigations are included in the same report.
- Copies of the final internal SI or HSIB report, including learning and recommendations, are provided for the attention of QPSA and Closed Board monthly as received.

Thank you