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Date	22.09.22	Agenda item	Bo.9.22.15A

MATERNITY AND NEONATAL SERVICES UPDATE – JULY 2022

Presented by	Sara Hollins, Director of Midwifery		
Author	Sara Hollins, Director of Midwifery		
Lead Director	Professor 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 Care Quality Commission (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	
Key Options, Issues and Risks			
<p>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.</p> <p>Following Executive approval, the service 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.</p> <p>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.</p> <p>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.</p> <p>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.</p>			
Analysis			
The service has acknowledged the recommendations of the CQC 2019 report, and has incorporated			

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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 Services Programme is now the key driver for transformation within the service and is well embedded within the culture of the unit.

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, July 2022.

Quality and Patient Safety Academy/Board of Directors is asked to note that the Ockenden recommendation regarding newly qualified midwives only working in hospital settings in the first year post qualification, has been reviewed and agreed it is up to individual Trusts to decide if services can safely support NQM in community settings.

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 0 HSIB reportable Serious Incident (SI) declared in July and 0 internal SIs.

Quality and Patient Safety Academy/Board is asked to acknowledge that there will be an incomplete data submission to the Yorkshire and Humber regional dashboard due to ongoing reporting and data quality issues post go-live. Plans are in place to address and improve this.

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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 & Patient Safety	Finance & Performance	Other (please state)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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1 PURPOSE/ AIM

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

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 (IAEs) to be implemented by all NHS Maternity services.

This was followed by the second Ockenden Report on 30 March 2022 which included a further 15 1AEs. The national request is that Trusts continue to focus on embedding the original 7 IAEs 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. Appendix 1 is the high level feedback slides shared by the Regional Team (see item Bo.9.22.15C). The full report is expected in late August.

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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. There has been no further progress on either of these issues during July, but they remain a subject of discussion at post-Cerner implementation meetings.

The service was fully compliant with MSDS submission prior to the transition from Medway to Cerner Maternity. Following submission of July data to MSDS, the service now has an indication of the data quality and essential areas for improvement. The first of 2 Data Quality Midwives is due to commence post in August, to support this work. However, the service is reviewing what capacity is available to support the cleansing and improvement of data quality between now and final submission in September.

On 22 July, all Directors and Heads of Midwifery received official communication from the Chief Midwifery Officer, confirming that the Ockenden recommendation that Newly Qualified Midwives must remain in hospital settings for the first year post qualification, has been reviewed by the RCM and with Donna Ockenden. It was concluded that where services have assessed safety, suitability, and are assured of the availability of adequate support for newly qualified midwives, they can be deployed in accordance with local leadership decisions.

Due to the robust preceptorship package, extended supernumerary status and additional support measures including the Pastoral Support Midwife and Legacy Midwife roles, the service will be rotating NQM into community settings at the point of qualification and within the first year.

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 16.33 WTE which includes the agreed uplift for maternity leave. There are 13.5 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 42.75 WTE.

Peak holiday season coupled with ongoing increased rates of short term sickness and absence is contributing to daily staffing challenges across all areas of the service. The demand for TNR shifts has increased but the uptake is not continuing at the same pace. Uptake of agency shifts is currently

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negligible. Anecdotally this is cited as due to agency staff picking up shifts closer to home due to increasing fuel costs.

Staffing gaps continue to be closely managed by the Bed Manager and staffing Matron of the day, utilising the amber risk assessment and escalation processes as required.

The service has offered 24 newly qualified midwives (NQM) posts to commence in the autumn and international midwifery recruitment is starting to make progress. Further NQM recruitment is taking place in August, and the service continues to pro-actively recruit band 6 midwives throughout the year with moderate success each time. 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 currently 2 pure Consultant Gynaecologists on the Gynaecology rota as well as colleagues who cover both.

There is one consultant on a phased return after a longer period of sickness absence that began on 10th June 2022.

Our Gynaecology Oncology lead consultant resigned and left the trust on 10th June 2022 to work in another unit in the region closer to his home. A new Consultant Gynaecology lead has been interviewed and appointed and it is hoped that he will start in post in early November 2022. One of our existing consultants with back ground experience and skills in Gynaecology Oncology is covering the MDTs and Gynaecology oncology clinics until the new lead is in post 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.

Another consultant who is our Hysteroscopy lead has also handed in her resignation letter. She also travels a significant distance to Bradford from Manchester and has secured a new job closer to her home. We have advertised for her replacement with a substantive Obstetrics and Gynaecology post with a special interest in Hysteroscopy. We will interview for this post on 20/9/2022.

We also have a further advert out for one further locum post in O+G (remaining 3rd consultant Obstetric post which is funded but not yet recruited to despite recruitment rounds)- advert out on NHS jobs which will close on 10/8/2022.

Due to the volume of flexible sessions being delivered across the service, the Gynaecology out of hour's rota, covering for colleagues who have left with adjustments in remaining job plans and sickness puts continued stress and burden on the remaining consultant body. The out -patient Hysteroscopy service is also under significant strain in terms of a surge in GP referrals and women that are needing to be seen for this investigation with extra sessions being performed by our 5 Hysteroscopy consultants (700 women on the Waiting list). 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.

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We interviewed and appointed one candidate for the Fetal medicine consultant post on 23/5/22. This individual will start in post at the start of September 2022.

The CBU has achieved approval for a further locum in O+G with an interest in Urogynaecology to help reduce the waiting lists and back logs in General Gynaecology and Urogynaecology. We have successfully recruited and appointed to this post and the successful individual is well known to the unit and will also start in post at the start of September 2022.

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.

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 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 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 entrust ability nights), 2 x ST5, 2 x ST4 and 2 x ST3.

From August we have a complete tier of registrars (total of 15 on a 13 slot rota).

All 3 of the ST3 registrars will be buddied up for entrustability with senior registrars ensuring safety and senior support for the St3 grades.

SHOs:-

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

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2 of our SHOs 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.

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 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. Comments are requested by 11 August and it is anticipated that the guideline will be ratified at September Women's Core Governance meeting at the latest. 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 (SIs) 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 updated action plan will be included in the August maternity update paper bundle.

Stillbirth Position

There were 3 stillbirths in July. 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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June	1	12	0	1 (HSIB SI)
July	3	15	1	0

Hypoxic Ischaemic Encephalopathy (HIE)

There were 0 babies requiring cooling for HIE in July.

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 0 HSIB reportable cases occurring in July as described in Appendix 2 available to Quality and Patient Safety Academy and Closed Board members.

There are 8 ongoing maternity SIs, 6 HSIB 3 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 2.

This is available to Quality and Patient safety Academy and Closed Board members only. There were 0 closed HSIB or internal SI reports to share in July.

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 SIs declared in June and no ongoing neonatal SI's under investigation.

Neonatal Deaths (NND)

There were 2 NND in July.

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Please see Table 2 below:

Table 2:

NND 2022			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
June	1	7	1 (known congenital anomaly on Butterfly Pathway)	0
July	2	9	2	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 SIs. There were 0 cases meeting the HSIB referral criteria in July.

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 July.

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.

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Maternity and Neonatal Bi-Monthly Safety Champion meetings

The Maternity and Neonatal Maternity Safety Champions met in July. The group followed the standard agenda and discussed a number of challenging cases occurring in June and July, including a maternal death and a woman who remains very ill on intensive care. The group agreed that the 3 maternal deaths occurring in 2022 to date, which all appear to be unconnected with no obvious themes or trends, and a number of significant events with good outcomes, including massive maternal haemorrhage, will be reviewed as a table top comparison to assure both the service and the Board that there are no emerging themes and trends. This will be presented to Quality and Patient Safety Academy in September and any findings to Board by exception.

Monthly staff feedback from Safety Champions and walk-rounds

Karen Dawber chaired a virtual meeting on 6 July attended by maternity and neonatal colleagues. Staff raised an increase in the number of incidences of violence and aggression towards staff, following the relaxation of visiting arrangements. The inpatient ward managers are meeting to agree a revised visiting plan and will work with the MVP to share communication regarding visiting and the expected behaviours of visitors attending the unit. Appendix 3 is a copy of 'You Said/We Did' feedback of safety concerns raised at the monthly meetings. This has been shared with all staff.

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 3 partial diverts and 1 attempted divert in July recorded on Datix or the closure log. All incidents were triggered by an increase in activity and acuity versus the number of available staff. This was despite all attempts at redeploying staff, including utilisation of the on call community midwives to support the acute service at the expense of community service provision. This has a significant impact both on the provision of routine antenatal and postnatal community care and surveillance, and also on community midwifery staff wellbeing. This approach is not sustainable and the service is reviewing strategies to improve the acute service staffing whilst maintaining community services. This includes not recommencing intrapartum on-calls in Acorn Team for the foreseeable future, and looking at Clover Team on call arrangements.

Table 4:

MONTH	Full Divert	Partial Divert	Attempted Divert	Number of women diverted
JANUARY	0	1	1	3

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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
July	0	3	1	6
Total	0	10	4	15

Midwifery Continuity of Carer (MCoC) Action plan

There has been no further progress on MCoC due to the ongoing focus on safe staffing.

Maternity Dashboard

The Maternity Dashboard has not been updated since Cerner Maternity Go-Live due to ongoing challenges with reporting and data quality.

This has also impacted on the provision of data to the Yorkshire and Humber Maternity Clinical Network. Minimal data was provided for the quarter 4 Regional Maternity Dashboard, due to an incomplete data set. The Digital Midwife has worked extremely hard to provide the required data for the quarter 1 submission, but has encountered challenges due to incomplete data entries.

To mitigate this going forwards a weekly newsletter will be circulated with hints and tips for reducing data quality/data completeness, including a rationale behind why this is important. The newsletter is shared on the Maternity Facebook page for further reach. The Digital Midwife has planned to shadow staff in all areas of inpatient maternity to get to the root cause of why certain fields are being omitted, along with meeting with the matrons to discuss which fields require mandating. A daily DQ report will also be created so that the service can start correcting errors at the time of the admission to the unit, rather than these problems being picked up in retrospect when the pregnancy is closed and options for amendments are limited.

The commencement of the Data Quality Midwives is also anticipated to have a positive impact on the quality of the data inputted by the midwifery team.

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 training compliance report is presented to Board on a 3 monthly basis.

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Appendices 4 and 5 are copies of PROMPT and mandatory training compliance up to the end of June 2022.

PROMPT emergency training requires 90% of all staff grades to attend an annual training session. Midwives are currently the only staff group who are achieving this. Ongoing operational pressures and staffing challenges are affecting attendance by anaesthetic and ODP staff groups. A recovery trajectory will be devised to ensure that the January Maternity Incentive Scheme submission is achieved.

The training compliance report is shared with ward and department managers who are promoting and encouraging the completion of the 'red' on-line compliance training such as fire, infection prevention and information governance and monitoring this at ward level.

Perinatal Quality Surveillance Model minimum data set for Trust Boards

Appendix 6 is the populated copy of the Perinatal Quality Surveillance Model minimum data set for Trust Boards. Much of the information required for presentation for Board is contained within the narrative of this report.

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.

Service User Feedback

There were no MVP meetings or events during July.
No 'grassroots' feedback has been received during July.

The Trust successfully submitted the attribution data required for the annual CQC Maternity Survey, which was completed by women and other birthing people using giving birth in February. The results will be published later in the year.

Maternity Cerner

The EPR Cerner Maternity project has now been completed. The project has delivered significant safety and efficiency changes to Women's Services and the overall conclusion would be that this has been a very successful project. There have been some key lessons learnt from the project, which have

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been recorded to be considered for future projects and there remains several areas for development for the system with the Trust EPR Service Delivery and Business Intelligence Teams. In June we had a Maternity Digital Quality and Safety Summit to bring all of these development areas together to enable teams to prioritise these requests.

Key areas for ongoing resolution are data quality and data correctness, the service are struggling to embed a business as usual process to this due to a lack of available resources, but are continuing to work with the Business Intelligence Team to better understand the extent of the issues and the best ways to address these.

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, July 2022.

Quality and Patient Safety Academy/Board of Directors is asked to note that the Ockenden recommendation regarding newly qualified midwives only working in hospital settings in the first year post qualification, has been reviewed and agreed it is up to individual Trusts to decide if services can safely support NQM in community settings.

Meeting Title	Board of Directors		
Date	22.09.22	Agenda item	Bo.9.22.15A

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 0 HSIB reportable Serious Incident (SI) declared in July and 0 internal SIs.

Quality and Patient Safety Academy/Board is asked to acknowledge that there will be an incomplete data submission to the Yorkshire and Humber regional dashboard due to ongoing reporting and data quality issues post go-live. Plans are in place to address and improve this.

7	Appendices
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- Appendix 1 Bradford Ockenden Feedback slides (see item Bo.9.22.15C)
- Appendix 2 CLOSED BOARD ONLY - Maternity and Neonatal Services Update
- Appendix 3 'You Said/We Did feedback
- Appendix 4 Mandatory Training Report 28.06.22
- Appendix 5 Copy of NHS Learning Compliance May 21 to June 22
- Appendix 6 Perinatal Quality Surveillance Minimum Data Set for Trust Boards 2022
- Appendix 7 Spotlight on Maternity