

Meeting Title	Board of Directors		
Date	22 September 2022	Agenda item	Bo.9.22.15b

## MATERNITY AND NEONATAL SERVICES UPDATE – AUGUST 2022

Presented by	Sara Hollins, Director of Midwifery		
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	Details of any consultation		
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			

<b>Meeting Title</b>	<b>Board of Directors</b>		
<b>Date</b>	<b>22 September 2022</b>	<b>Agenda item</b>	<b>Bo.9.22.15b</b>

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, August 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 and that the number occurring in August triggered the internal escalation process.

Quality and Patient Safety Academy/Board of Directors is asked to note that there was 1 HSIB reportable Serious Incident (SI) declared in August and 0 internal SIs.

Quality and Patient Safety Academy/Board of Directors to note the contents of the Perinatal Mortality Review Tool Quarterly report.

Meeting Title	Board of Directors		
Date	22 September 2022	Agenda item	Bo.9.22.15b

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			
<b>NHS Improvement: (please tick those that are relevant)</b>			
<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		
<b>Care Quality Commission Domain:</b> Choose an item.			
<b>Care Quality Commission Fundamental Standard:</b> Choose an item.			
<b>NHS Improvement Effective Use of Resources:</b> Choose an item.			
<b>Other (please state):</b>			
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"/>

Meeting Title	Board of Directors		
Date	22 September 2022	Agenda item	Bo.9.22.15b

## 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. The full report was received in August and reflects the initial feedback presentation shared with Board in the July update paper.

Meeting Title	Board of Directors		
Date	22 September 2022	Agenda item	Bo.9.22.15b

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. The service and IT colleagues are working closely to resolve the situation and are exploring the available options, none of which appear to meet the full PCP requirement. As yet there is no suggested date as to when this will be available.

### **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. The service is extremely appreciative of the Executive decision to implement a 'TNR Surge rate' to encourage uptake of shifts during this challenging time. There has been a small improvement noted over the last few weeks, and it is anticipated that this will improve in early September following the end of the school holidays. Uptake of agency shifts is currently 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.

International midwifery recruitment has been slow, but we have started to receive CVs from international candidates and will be interviewing 1 midwife imminently.

<b>Meeting Title</b>	<b>Board of Directors</b>		
<b>Date</b>	<b>22 September 2022</b>	<b>Agenda item</b>	<b>Bo.9.22.15b</b>

### **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.

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.

A detailed update was described in the July update paper presented alongside this paper and a further detailed update will be included in the September update paper.

### **Maternity Improvement 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.

Following a successful visit from members of the Maternity Safety Support Programme (MSSP) in August, the improvement plan is currently being updated to include sustainability plans for the actions described. This will require Executive/Board sign off prior to being submitted to the Regional Chief Midwifery Officer and the MSSP team and will hopefully result in the service being exited from the support programme.

The visiting team gave extremely positive feedback regarding the improvements made and sustained in the last 2 years, highlighting areas of exemplary practice.

Meeting Title	Board of Directors		
Date	22 September 2022	Agenda item	Bo.9.22.15b

### Stillbirth Position

There were 6 stillbirths in August. 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.

The number of stillbirths occurring in August has triggered the internal escalation process. All of the cases have been presented to the Chief Nurse and Deputy Medical Director and have been reviewed both individually and as a cluster to identify any emerging themes/trends. Appendix 2 is a copy of the lessons learnt circulated to all staff, and includes thematic learning, available to Quality and Patient Safety Academy and Closed Board members.

1 of the August stillbirths met the HSIB criteria for investigation, as the mother was experiencing uterine tightenings at the time of diagnosis. Another case will be investigated as a level 1 as the 72 hour review revealed missed opportunities which may have resulted in a different outcome.

1 of the deaths occurred in the last few days of the month and has not yet had a full review to determine the level of investigation required.

The CQC have been informed of the increase in month.

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)
July	3	15	1	0
August	6	21	0	1 (HSIB SI) 1 (level 1)

### Hypoxic Ischaemic Encephalopathy (HIE)

There were 0 babies requiring cooling for HIE in August.

Meeting Title	Board of Directors		
Date	22 September 2022	Agenda item	Bo.9.22.15b

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

There are 10 ongoing maternity SIs, 7 HSIB 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 0 closed HSIB or internal SI reports to share in August.

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 SIs 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 August and no ongoing neonatal SI's under investigation.

### **Neonatal Deaths (NND)**

There were 3 NND in August.

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	Number of cases

Meeting Title	Board of Directors		
Date	22 September 2022	Agenda item	Bo.9.22.15b

			anomalies/life limiting conditions	
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
August	3	12	1 (Termination of pregnancy born with signs of life)	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 was 1 case meeting the HSIB referral criteria in August.

**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 August.

**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.

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

The Maternity and Neonatal Maternity Safety Champions did not meet in August and are next due to meet in September.

Meeting Title	Board of Directors		
Date	22 September 2022	Agenda item	Bo.9.22.15b

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

Karen Dawber chaired a virtual meeting on 30 August attended by Band 6 midwives and below. There was a request that Band 7s and above did not attend in order that staff may voice concerns more freely. This request was respected for August and will reopen to staff of all grades and disciplines in September.

The meeting was well represented with concerns falling into 3 key areas of staffing, MAC and Community. Appendix 3 is the response letter from Karen, including actions taken and already in progress. This has been shared with staff individually and on the closed Facebook page.

### **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 was 1 partial diverts and 2 attempted divert in August recorded on Datix or the closure log. All incidents were triggered by an increase in activity and acuity versus the number of available staff.

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
July	0	3	1	6
August	0	1	2	2
<b>Total</b>	0	11	6	17

Meeting Title	Board of Directors		
Date	22 September 2022	Agenda item	Bo.9.22.15b

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

There has been no further progress on MCoC due to the ongoing focus on safe staffing. Clover and Acorn team have paused the provision of intrapartum care to facilitate staffing support elsewhere in the service. However, the vulnerable women booked with those teams continue to receive an enhanced level of antenatal and postnatal care, and may still receive care from a team member allocated to work in the intrapartum area.

### **Maternity Dashboard**

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

The BI team continue to work closely with the Digital Midwife and Quality and Safety team to improve the quality of data available and the required reports.

### **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 and will be next included in the October update paper

### **Perinatal Mortality Review Tool Quarterly Report**

The Maternity Incentive Scheme, Year 4, Safety Action 1 requires evidence that Trust Boards have received a quarterly Perinatal Mortality Review Tool (PMRT) report. Using the national PMRT to review perinatal deaths to the required standard has been a condition of the incentive scheme for the last 3 years.

Appendix 4 provides a summary of the current position and demonstrates that the service is either already achieving the required standard for some elements, or is within the required timeframe for completion.

### **Perinatal Quality Surveillance Model minimum data set for Trust Boards**

Appendix 5 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.

Meeting Title	Board of Directors		
Date	22 September 2022	Agenda item	Bo.9.22.15b

- Moving to Digital.
- Streamlining Systems.
- A Building Fit for the Future.
- Investing In Our Workforce.

### Programme Governance.

- ✓ OMS presented for the HSJ awards – 15<sup>th</sup> September is Awards Night in Manchester, when we will find out if successful
- ✓ Joint working across trust and system: Better Births, OD, Qi Team

### Moving to Digital

- ✓ Viewpoint software (scan reporting system) launched
- ✓ Secured funding with LMNS for patient information video creation in 4 top used languages – includes consent/normal birth/LSCS
- ✓ Maternity Capacity tile set-up

### Investing In Our Workforce

- ✓ Partnership work with Little Minds Matter- supporting secondary stress using reflective discussion. First two groups well attended in July 22.
- ✓ Staff survey-live local survey-83 comments, all areas, themed
- ✓ Investment in admin staff to support 24 hour service successful
- ✓ Secured additional obstetric trainees to start September

### The Women's Journey

- ✓ Induction of labour sub group capturing data to inform improvements
- ✓ NICE benchmark for IOL completed
- ✓ Obstetric Theatre visioning Driver created
- ✓ Personalised Care & Support Plan provision benchmarked
- ✓ Displaying waiting times in ANC, updated hourly

### A Building Fit For The Future

- ✓ Successful bid to "Dragon's Den" to secure funding for phase 1 of building works in the ambulatory care area & improve public toilet facilities
- ✓ Staff consultation to ascertain what they would like in their unit staff room

Meeting Title	Board of Directors		
Date	22 September 2022	Agenda item	Bo.9.22.15b

## Linking Learning and Quality Through Our Information

- ✓ Unit wide safety huddle embedded-being evaluated
- ✓ Two Data quality midwives recruited, starting in September and November
- ✓ Theatre Accreditation tool complete and review planned

## Service User Feedback

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

### 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, August 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 and that the number occurring in August triggered the internal escalation process.

<b>Meeting Title</b>	<b>Board of Directors</b>		
<b>Date</b>	<b>22 September 2022</b>	<b>Agenda item</b>	<b>Bo.9.22.15b</b>

Quality and Patient Safety Academy/Board of Directors is asked to note that there was 1 HSIB reportable Serious Incident (SI) declared in August and 0 internal SIs.

Quality and Patient Safety Academy/Board of Directors to note the contents of the Perinatal Mortality Review Tool Quarterly report

<b>7</b>	<b>Appendices</b>
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- Appendix 1 Closed Board Harms August 2022
- Appendix 2 Lessons Learnt Aug Stillbirths 01.09.22
- Appendix 3 Response letter following safety champion meeting
- Appendix 4 PMRT Quarterly update
- Appendix 5 Perinatal Quality Surveillance Model minimum data sets