

Meeting Title	Board of Directors		
Date	10 November 2022	Agenda item	Bo.22.19a

MATERNITY AND NEONATAL SERVICES UPDATE – SEPTEMBER 2022

Presented by	Professor Karen Dawber, Chief Nurse		
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 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	Identify if the paper is a key control for the Board Assurance Framework		
Action required	For decision		
Previously discussed at/ informed by	Details of any consultation		
Previously approved at:	Academy/Group	Date	
	Quality and Patient Safety Academy QA.10.22.12a	26.10.22	

Key Options, Issues and Risks

The Maternity Service was rated as 'Required 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 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

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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.

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 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, September 2022.

Quality and Patient Safety Academy/Board of Directors is asked to note the narrative describing the current obstetric staffing challenges and the impact this is having on the delivery of the service.

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

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learned.

Quality and Patient Safety Academy/Board of Directors is asked to note that there were 2 HSIB reportable Serious Incident's (SI) declared in September. 1 case was rejected by HSIB and will be investigated internally.

Quality and Patient Safety Academy/Board of Directors to note the ATAIN, Quarter 4 report, required to demonstrate compliance with safety action 3 of the Maternity Incentive Scheme.

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Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					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

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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"/>

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.

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

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.

There is nothing to update relating to Ockenden in September. The Kirkup report into failings at East Kent is expected to be published in mid-October and it is anticipated that the recommendations will be amalgamated with those of Ockenden.

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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 18.1 WTE which includes the agreed uplift for maternity leave. There are 10 WTE midwives on maternity leave which is slightly reduced on previous months but continues to contribute towards 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 44.52 WTE.

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 October/November. Unfortunately only 12 of the NQM are in a position to commence employment. A number of students have either not met the academic or clinical course requirements or will be deferred until the outstanding elements are completed. 2 students are pregnant and employment delayed until maternity leave has ended.

On a positive note, international midwifery recruitment is now picking up pace with 2 midwives receiving job offers and a further 10 interviewed in the last week. All candidates are from the Philippines.

Obstetric Staffing

There are currently 23 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. The current output from the CSU and work being delivered far exceeds the consultant job plans.

A new Consultant Gynaecology Oncology lead has been interviewed and appointed and it is hoped that they 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 but this is putting considerable strain on other Obstetric services that are also having to be back filled to ensure safe cover for the Gynaecology Oncology service.

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Another consultant who is our Hysteroscopy lead has also handed in their resignation letter to take up a post closer to home. We have interviewed and appointed one of our current locum consultant doctors to this post who has a keen interest in Hysteroscopy. The hysteroscopy lead role will be taken on by another consultant colleague who is already in post.

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 05/10/2022. We plan to advertise an Obstetric only substantive post early in the New Year when we know that a suitable candidate will be eligible to apply.

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 need to be seen for this investigation with extra sessions being performed by our 5 Hysteroscopy consultants (700 women on the Waiting list). It has become a daily struggle to ensure safe obstetric staffing within the unit. We also only have 3.5 PAs of consultant job planned time for MACU sessions per week (ambulatory Obstetric areas) and with the job plans being so full, we are unable to cover any more of these sessions at the present time.

We interviewed and appointed one candidate for the Fetal medicine consultant post on 23/5/22. This individual has started in post in September 2022.

The CSU 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 individual also started in post in 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.

Since 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 every morning for the high risk Obstetric patients.

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

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body especially as much of the cover is out of hours in the evenings, overnight and across weekends.

Even with the proposed locum, we would benefit from at least 2/3 further locum consultants to help with the sheer volume of work and contribute to the extra sessions some of which always have to be covered as they are acute cover sessions. Through July and August when there was also a great deal of annual leave planned as well to allow consultants a much need a break and a rest, put even more strain on the consultants working within the unit during these 2 months.

The number of extra sessions delivered by consultant colleagues has at times been excessive and had a negative impact on health, morale resulting in concern about many individuals within the CSU.

Registrars:-

Currently we have 4 registrars working only 80%, thereby creating a 0.8 WTE gap to fill on the rota.

A senior registrar is leaving us late December and this slot will then be empty until mid-April. (Training Gap)

Another trainee is expected to start Maternity Leave early December, leaving this slot completely empty till Sept 2023 (Another Training Gap)

From August there was (on paper) a complete tier of registrars (total of 15 on a 13 slot rota). However, in October there are gaps (3 nights, 1 long day) due to some juniors being LTFT. The level of workload stress and dissatisfaction is being reflected in the GMC survey.

We also have 2 ST3 registrars that need senior cover and support with a senior registrar 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 with their contracts extending after that)

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.

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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 no open actions and is now 'business as usual, /ongoing monitoring. This is following the ratification of the Maternity Escalation guideline at September Women's Core Governance Group.

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.

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 plan will be presented as an appendix to the October Maternity and Neonatal Update paper.

Members of the senior management team are meeting weekly with members of the Trust Quality and Safety team to review the action plan in preparation for an imminent CQC visit.

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Stillbirth Position

There were 2 stillbirths in September. 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)
July	3	15	1	0
August	6	21	0	1 (HSIB SI) 1 (level 1)
September	2	23	0	0

Hypoxic Ischaemic Encephalopathy (HIE)

There were 2 babies requiring cooling for HIE in September. Details are included in Appendix 1, available to closed Board members.

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 were 2 HSIB reportable cases occurring in September as described in appendix 1 available to Quality and Patient Safety Academy and Closed Board members. 1 case was accepted by the HSIB team, the other rejected as the baby had a normal MRI scan. The rejected case will be investigated internally.

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:

There are 9 ongoing maternity SI's, 6 HSIB and 3 Trust level. 1 HSIB case was closed in September; copy of the report, learning and recommendations is available to Quality and Patient safety Academy and Closed Board members only

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

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

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Neonatal Deaths (NND)

There were 4 NND in September

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
August	3	12	1 (Termination of pregnancy born with signs of life)	0
September	4	16	2 (1 termination of pregnancy born with signs of life, 1 20 week miscarriage born with signs of life)	0

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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 was 1 case meeting the HSIB referral criteria in September. A 2nd case was referred but declined due to the baby having a normal MRI scan.

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 September.

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 met in September and discussed the August rise in stillbirths including any themes/trends emerging. The group also discussed the extra-ordinary Ward to Board safety champion meeting with band 6 and below, held in August, and progress on the issues and actions raised.

Monthly staff feedback from Safety Champions and walk-rounds

In response to concerns raised by Band 6 and under in August, Karen Dawber and Sara Hollins met with members of the MAC team and members of Acorn, midwifery continuity of carer team in September, to discuss progress on specific actions. Appendix 2 is the 'You Said/We Did' feedback poster shared with the teams, highlighting the progress made to date.

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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 divert in September recorded on Datix or the closure log. This was triggered by an increase in activity and acuity versus the number of available staff. 2 women were diverted to neighbouring units but the unit then continued to accept women as no other units were able to take.

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
SEPTEMBER	0	1	0	2
Total	0	12	6	19

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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. This position is currently being reviewed to ascertain the feasibility of resuming intrapartum care in December.

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

Avoiding Term Admissions into Neonatal Units (ATAIN) Quarterly report

Appendix 3 is a copy of Quarter 1 ATAIN report, required to demonstrate compliance with Safety Action 3 of the Maternity Incentive Scheme.

Bradford ATAIN data remains below the national target of 5%, but has increased to 4.27% from previous quarters where it usually sits between 3-3.5%.

The increase is thought to be due to improved recording of babies admitted transiently, for example a social admission prior to discharge to foster care and a baby requiring antibiotics. It is not thought to be of a concern clinically and will be monitored in future reports.

Perinatal Quality Surveillance Model minimum data set for Trust Board's

Appendix 4 is the populated copy of the Perinatal Quality Surveillance Model minimum data set for Trust Board's. Much of the information required for presentation for Board is contained within the narrative of this report.

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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.

Appendix 5 is a copy of the OMS September highlight report which details what has been achieved since the start of the OMS Programme. It is focused on 2 workstreams. The October update paper will include the completed actions of the remaining workstreams.

Service User Feedback

There were no MVP meetings or events during September following the step down of both the MVP Chair and Project Lead. Concerns regarding the temporary lack of a functioning MVP have been escalated to the Commissioners and also the Regional Chief Midwifery Officer and West Yorkshire and Harrogate LMS.

The service has been advised that this is a temporary situation and a 'Main MVP' meeting is planned for October. .

As a result of the temporary hiatus, no 'grassroots' feedback has been received during September.

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.

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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, September 2022.

Quality and Patient Safety Academy/Board of Directors is asked to note the narrative describing the current obstetric staffing challenges and the impact this is having on the delivery of the service.

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.

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Quality and Patient Safety Academy/Board of Directors to note the ATAIN, Quarter 4 report, required to demonstrate compliance with safety action 3 of the Maternity Incentive Scheme.

7 Appendices

- Appendix 1 Closed Board Harms September 2022
- Appendix 2 'You Said/We Did' poster
- Appendix 3 ATAIN Q1 report 2022/23
- Appendix 4 Perinatal Quality Surveillance Model
- Appendix 5 September OMS Highlight Report