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MATERNITY AND NEONATAL SERVICES UPDATE – NOVEMBER 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 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.12.22.12	14.12.22

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 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, November 2022.
- Quality and Patient Safety Academy/Board of Directors is asked to note appendix 1, the Obstetric Staffing Risk Assessment. This was a request from October Quality and Patient Safety Academy.
- Quality and Patient Safety Academy/Board of Directors is asked to note Appendices 2, 3 and 4, the neonatal medical and nursing action plans and supporting review paper, required to demonstrate compliance with safety action 4 of the Maternity Incentive Scheme, Year 4.

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- 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 available to Closed Board only.
- Quality and Patient Safety Academy/Board of Directors (Closed Board) is informed that 5 completed reports including learning and recommendations are included as appendices 5.1 to 5.5
- There are 11 ongoing maternity SI's/Level 1 investigations, 6 HSIB and 5 Trust level.
- Quality and Patient Safety Academy/Board of Directors is asked to note that there was 1 HSIB reportable Serious Incident's (SI) declared in November.
- Quality and Patient Safety Academy/Board of Directors is informed that 90% of all staff groups completed PROMPT and Neonatal Life Support training by the 4 December, meeting compliance with Safety Action 8 of the Maternity Incentive Scheme, Year 4.

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?	☒	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☒	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☒	☐	☐

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Risk Implications (see section 5 for details)	Yes	No	N/A
Corporate Risk register and/or Board Assurance Framework Amendments	☐	☐	☐
Quality implications	☒	☐	☐
Resource implications	☐	☒	☐
Legal/regulatory implications	☐	☒	☐
Diversity and Inclusion implications	☒	☐	☐
Performance Implications	☐	☒	☐

Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant) ☒Risk Assessment Framework ☒Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: Choose an item.
Care Quality Commission Fundamental Standard: Choose an item.
NHS Improvement Effective Use of Resources: Choose an item.
Other (please state):

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
☐	☒	☐	☐

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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, Ockenden Assurance Plan and East Kent Report

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 1AE'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.

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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.

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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. A solution continues to be sought by the service and IT colleagues. However, there has been no progress to report in November.

East Kent Report:

The Kirkup Report, 'Reading the signals: Maternity and neonatal services in East Kent- the Report of the Independent Investigation' was published on 19 0ctober 2022 examining failings in maternity and neonatal services at The Queen The Queen Mother Hospital (QEQM) and the William Harvey Hospital (WHH), part of East Kent Hospitals University NHS Foundation Trust, between 2009 and 2020.

A precis of the report and actions for the maternity service and Trust Board was presented to November Board. There have been no Regional or National updates or requests for information/local action since the report was published.

Midwifery 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 11.48 WTE which includes the agreed uplift for maternity leave. Achieving the safe staffing establishment is our priority figure.

Current vacancy against the funded establishment, which includes the number of midwives required to provide Midwifery Continuity of Carer (MCoC) is 37.9 WTE.

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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.

Our first International midwife arrived from the Philippines in November and is currently at the York assessment centre prior to undertaking her OSCE examination in early December. A second International midwife will arrive in January and a further 3 are in the offer confirmation process.

Obstetric Staffing

There are currently 23 Consultant Obstetricians and Gynaecologists within the CBU. There are 4 pure Consultant Obstetricians on the Out of hours on call Obstetric rota and currently 3 pure Consultant Gynaecologists on the Gynaecology rota as well as colleagues who cover both.
Gynae Oncology: A new Gynaecology Oncology lead consultant started in post on 21st November 2022. One of our existing consultants with back ground experience and skills in Gynaecology Oncology has covered the MDTs, Gynaecology Oncology clinics as well as performing complex operating lists to ensure a safe service but this has put considerable strain on other Obstetric services that have had to be back filled to ensure safe cover for the Gynaecology Oncology service.

Hysteroscopy: We have recently replaced our Hysteroscopy lead consultant with one of our locum consultants who has an interest in Hysteroscopy. The Hysteroscopy lead role has been taken on by another consultant colleague who is already in post and who shares this interest.

Fetal Medicine: A new Fetal medicine consultant started in post in September 2022
Locum for back logs: A new locum in General Gynae and Urogynae, was appointed to assist with the significant back logs also started in post in September 2022.

An advert 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 closed on 23rd November 22 but the single applicant does not meet the requirements for interview.

We plan to advertise an Obstetric only substantive post (interest in Maternal Medicine) early in the New Year when we know that a suitable candidate will be eligible to apply. An interview date is being set up for February 2023.

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 puts continued stress and burden on the remaining consultant body. The monthly extra spend for the CSU on consultant extra sessions is in the order of £22,500 every month which was highlighted at the recent CSU to exec meeting.

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). Some of the OPH work is currently being outsourced to assist with the back logs. 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. We also only have 3.5PAs 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. 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 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 2/3 further 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. A new rota to help share the burden of the on calls more fairly across the consultant body is under way and will start early 2023.
The number of extra sessions delivered by my colleagues has at times been excessive and had a negative impact on health, morale and I am worried about many individuals within the CSU.

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

From January 2023 there will be 2.3 gaps in the middle grade rota.
A senior registrar is leaving us late December 2022 (he has got a sub spec training place in London) and his slot will then be empty until mid-April (Training Gap).
Another trainee is 24wk pregnant and is expected to start Maternity Leave in early December 22, leaving this slot completely empty till Sept 2023 (another Training Gap).
There are also 2 trainees who have both extended their OOPE time until at least March 2023.

There is also one registrar off sick with work related stress and is considering leaving O+G and the medical profession.

From August 22 we had (on paper) a complete tier of registrars (total of 15 on a 13 slot rota).
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 an SR or consultant present on each shift out of hours (to meet entrustability standards set by the RCOG), until they acquire all the necessary skills to be competent on the labour ward.
There are 2xstaff grades + 1 clinical fellow (until September 2022 with their contracts extending after that).

2 adverts have gone out to try and recruit 2 further registrars to fill the known 2 full time gaps.

SHOs:-
We currently have 13 SHO's working full time. 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.

However further SHO gaps are predicted from December 2022 as fewer FY2s doctors are coming to the unit.

Two adverts have gone out for SHO grades as well to help with these predicted gaps.

Appendix 1 is a copy of the Obstetric Staffing risk assessment, requested by October Quality and Patient Safety Academy.

Neonatal medical and nursing workforce.
Appendices 2, 3 and 4 are the neonatal medical and nursing action plans and supporting review paper, required to demonstrate compliance with safety action 4 of the Maternity Incentive Scheme, Year 4. The updated action plans were approved at November People Academy and the neonatal nursing plan submitted to the Yorkshire and Humber neonatal ODN and the Royal College of Nursing as per recommendations.

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.

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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 has been updated to include sustainability plans for the actions described. Trust Board approved the sustainability plan at November Board. The plan has since been approved at the West Yorkshire and Harrogate (WY&H) Local Maternity and Neonatal System (LMNS) Board meeting on 22 November and will now be reviewed at the North East and Yorkshire (NEY) Regional Perinatal Quality Oversight Meeting before final approval at the National meeting.

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.

Stillbirth Position

There were 3 stillbirths in November. See appendix 5 available to 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.
1 of the 3 stillbirths was an expected death.
1 baby was an unbooked pregnancy with no antenatal care and the gestation was indeterminate. This baby has been counted in the numbers but may be removed if coroners post mortem determines that the baby was likely under 24 weeks gestation.

The service has recently undertaken an independent review of all of the stillbirths occurring in 2022 to date. The reviewer found that the 72 hour reviews including timelines and immediate learning, were of an extremely high standard. Common themes and trends were similar to those identified by the internal team, including the failure to identify small babies. The reviewer did note that a significant number of 'missed' small babies, were of Pakistani ethnicity and has asked the service to consider if additional scans should be routinely recommended for this cohort of women, above what is already offered and recommended within the Saving Babies Lives Care Bundle.

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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
October	5	28	1	2 (HSIB SI)
November	3	31	1	

Hypoxic Ischaemic Encephalopathy (HIE)

There was1 baby requiring cooling for HIE in November.

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).

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There was 1 HSIB reportable case occurring in November as described in appendix 5 available to Closed Board members.

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:

5 completed reports including learning and recommendations are included as appendices 5.1 to 5.5 for the attention of Quality and Patient Safety Academy and Closed Board.
There are 11 ongoing maternity SI's/Level 1 investigations, 6 HSIB and 5Trust level.
Of the ongoing investigations, 2 families have not engaged with HSIB and the cases are being investigated internally. 3 ongoing cases are concluded to draft report stage.

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 November and no ongoing neonatal SI's under investigation.

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Neonatal Deaths (NND)

There were 2 NND in November.

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
October	2	18	2	0
November	2	20		

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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 November as previously described.

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 November.

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 November. Areas for discussion included the ATAIN reports and TCU audits and the recent external review of stillbirths in 2022 to date and neonatal deaths/stillbirths/HIE cases occurring in October and November.

The Chief Nurse requested a further meeting between maternity, business intelligence and digital colleagues to discuss progress on outstanding Cerner issues post go-live.

Monthly staff feedback from Safety Champions and walk-rounds

Members of the maternity and neonatal team met with Karen Dawber in November. There were no significant safety issues raised by staff present. The digital midwife gave a robust update on progress made with data quality issues.

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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 partial divert in November recorded on Datix or the closure log. This was triggered by an increase in activity and acuity versus the number of available staff. 1 woman was diverted to a neighbouring unit.

The overall number of diverts and attempted diverts to date is significantly reduced compared to those reported in 2021

Year	Partial Divert	Attempted Divert
2019	22	15
2020	31	5
2021	22	16
2022 to date	14	6

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
OCTOBER	0	1	0	2
NOVEMBER	0	1	0	1
Total	0	14	6	22

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.
It is unlikely that Clover will resume on calls as half of the team have requested to remain in the labour ward environment which is affecting the ongoing viability of the team. This is being discussed with Better Start Bradford who fund the team.

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.

A further meeting between maternity, business intelligence and digital colleagues is imminent to discuss outstanding issues and concerns.

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 next report will be presented in February.

PROMPT compliance has been achieved in all staff groups and Neonatal training compliance has also been achieved meeting the 4 December Maternity Incentive Scheme deadline.

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

Appendix 6 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.

Outstanding Maternity Service Programme

The Outstanding Maternity Service (OMS) Programme is a transformation programme, intended to improve the service from 'Requires Improvement' to 'Outstanding'.
The programme contains 5 work streams:

- The Woman's Journey and Clinical Excellence.
- Moving to Digital.
- Streamlining Systems.
- A Building Fit for the Future.
- Investing In Our Workforce.

Programme Governance.

- ✓ Working with Qi team to deliver & increase foundation basics training
- ✓ Practitioner and coaching support in development with Qi team
- ✓ 37 projects on Life Qi, 1 completed
- ✓ Qi café pilot well attended

Moving to Digital

- ✓ CRIS has reduced calls to check appointments by 60%.
- ✓ Community midwifery appointment letters aligning with trust and being rolled out with DoctorDoctor to become digital
- ✓ Use of QR codes on posters to capture patient experience, signpost to website and information

Investing In Our Workforce

- ✓ 11 Newly qualified midwives started in October, 6 more start next year.
- ✓ First international recruit started November 2022 – 4 more arrive next year.
- ✓ Partnered with peoples promise team in November for well-being walk-around to publicise financial support for staff

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The Women's Journey

- ✓ GTT process map has been updated. Electronic process being trialled with positive results.
- ✓ Personalised Care and Support plans benchmark completed and improvements identified – liking with MVP and identifying digital solutions.

A Building Fit For The Future.

- ✓ Asbestos Survey of M2 completed.
- ✓ Public toilet plans signed off and to be commenced in January 2023
- ✓ Designs for staff room shared – to commence Jan/Feb 2023

Linking Learning and Quality Through Our Information

- ✓ MDT VRE on labour ward undertaken for 1 year on review
- ✓ Lesson of the week page developed to cascade learning through the labour ward daily MDT.
- ✓ As part of the new guideline review template, current patient information has been reviewed and loaded onto website. QR code available for women to use.

Service User Feedback

The final MVP meeting of the year took place on 2 December, attended by senior representatives from the maternity service. The meeting reviewed the structure and work plan for 2023. The work plan was successfully submitted to the West Yorkshire and Harrogate Local Maternity and Neonatal System November board meeting for ratification. This meets compliance with safety action 7 of the Maternity Incentive Scheme, year 4.

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, November 2022.
- Quality and Patient Safety Academy/Board of Directors is asked to note appendix 1, the Obstetric Staffing Risk Assessment. This was a request from October Quality and Patient Safety Academy.
- Quality and Patient Safety Academy/Board of Directors is asked to note Appendices 2, 3 and 4, the neonatal medical and nursing action plans and supporting review paper, required to demonstrate compliance with safety action 4 of the Maternity Incentive Scheme, Year 4.
- 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 available to Closed Board only.
- Quality and Patient Safety Academy/Board of Directors (Closed Board) is informed that 5 completed reports including learning and recommendations are included as appendices 5.1 to 5.5
- There are 11 ongoing maternity SI's/Level 1 investigations, 6 HSIB and 5 Trust level.
- Quality and Patient Safety Academy/Board of Directors is asked to note that there was 1 HSIB reportable Serious Incident's (SI) declared in November.
- Quality and Patient Safety Academy/Board of Directors is informed that 90% of all staff groups completed PROMPT and Neonatal Life Support training by the 4 December, meeting compliance with Safety Action 8 of the Maternity Incentive Scheme, Year 4.

Meeting Title	Board of Directors		
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7 Appendices

- Appendix 1 Risk assessment consultant medical staffing
- Appendix 2 Copy of MIS Action log Medical and AHP Update Nov 22
- Appendix 3 ETM paper MIS Neonatal Staffing Nov 2022
- Appendix 4 Copy of MIS Action log Nursing Nov 22
- Appendix 5 Closed Board Harms November 2022
- Appendix 5.1 Closed Board SI 2022.12072 Final report
- Appendix 5.2 Closed Board 20221011_MI-008109_HSIB_Maternity_Report_FINAL_v1.0
- Appendix 5.3 Closed Board 20220926_MI-008602_HSIB_Maternity_Report_FINAL_v1.0
- Appendix 5.4 Closed Board SI 2022 11354 Final APH 36w
- Appendix 5.5 Closed Board 20221124_MI-008974_ HSIB_Maternity_Report_FINALv1.0 _
- Appendix 6 Perinatal Quality Surveillance Model minimum data sets