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MATERNITY AND NEONATAL SERVICES UPDATE – DECEMBER 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**

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.

Recommendation

- Quality and Patient Safety Academy/Board of Directors is asked to note the contents of the Maternity and Neonatal Services Update, December 2022.
- Quality and Patient Safety Academy/Board of Directors is asked to note appendix 1, Obstetric attendance audits, 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 3 completed reports including learning and recommendations are included as appendices 3.1 to 3.3.

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- There are 7 ongoing maternity SI's/Level 1 investigations, 3 HSIB and 4 Trust level.
- Quality and Patient Safety Academy/Board of Directors is asked to note that there were 0 HSIB reportable Serious Incident's (SI) declared in December.
- Academy/Board is asked to note Appendix 4 the PMRT Quarterly report required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme. The service has achieved full compliance with this standard with the caveat that 1 case which did not meet the surveillance completed within 1 month due to extreme mitigating circumstances, is reported as such on the NHSR self-declaration submission.
- Appendix 5, local Maternity Dashboard, has demonstrated that 1:1 care in labour has fallen below the 90% target for 2 of the last 3 reported months. Academy/Board is asked to note the action in the narrative.

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?	☒	☐	☐

Risk Implications (see section 5 for details)	**Yes**	**No**	**N/A**

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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.

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. There are no updates on progress to share during December but Academy/Board is assured that this remains high priority and a solution continues to be actively sought.

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 13.9 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 39.61 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.

International recruitment is progressing well and our first International Midwife has successfully passed her OSCE and will be admitted to the NMC register. A second International Midwife is due to arrive in early January, with a further 3 anticipated.

Obstetric Staffing

Appendix 1 is the Obstetric attendance audits required to demonstrate compliance with Safety Action 4 of the Maternity Incentive Scheme, Year 4.
The audits have highlighted that documentation on Cerner of Consultant attendance at the required cases is poor and has deteriorated from previous audits. The audits, findings and recommendations will be discussed at the January consultant meeting and be re-audited in 3 months.

We currently have 23 consultants in post, 24 posts financially approved plus a locum until September 2023. There are 4 pure Consultant Obstetricians on the Out of hours on call Obstetric rota and currently 3 pure Consultant Gynaecologists on the Gynaecology on call rota as well as colleagues who cover both (14).

An advert for a 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 did not meet the requirements for an interview. As this post is funded we plan to try and convert it into a substantive O+G post in the near future.

We plan to advertise an Obstetric only substantive post (interest in Maternal Medicine) In January 2023 and an interview date has been set up for 28th February 2023.
The strain and burden on the consultant body is summarised in a risk assessment (score 15) that has been escalated to the trust board in November 2022.

Due to the volume of flexible sessions being delivered across the service, the Gynaecology out of hour's rota, covering for colleagues who have left with adjustments in remaining job plans 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.

A decision to stop Medinet Gynaecology clinics following months of discussion at a number of consultant meetings means that the WL for patients waiting to be seen through Gynaecology waiting list is likely to increase. However there is a willingness from the consultant body to

contribute and do extra clinics (at weekends if required) if the trusts recognises the 'time' spent doing these clinics and are remunerated at the same rate as an extra theatre session at a weekend.

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 2.5 sessions 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 (4 x daily).
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.

Gynaecology 'HOT WEEKS' commence in January 2023.

Even with the proposed locum, we still require 4 further consultants to contribute to 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.

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 2 x staff grades + 1 clinical fellow.
2 adverts have gone out to try and recruit 2 further registrars to fill the known 2 full time gaps.

SHOs:-
We currently have 11 SHO's working full time. There are currently 2 SHO gaps as fewer FY2 doctors were posted to BRI between December 2022 and April 2023. We should have a full quota of 13 from April 2023.
2 adverts have gone out for SHO grades as well to help with these predicted gaps.

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.

Appendix 2 includes the action plan tab relating to Maternity Incentive Scheme action plans, required to demonstrate compliance with Safety Action 5 of the scheme, has been updated to reflect progress with recruitment and retention actions, and the provision of 1 to 1 care in labour.

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 on 10 January. We are awaiting final confirmation from the National team that the service has been exited from the programme.

Stillbirth Position

There was 1 stillbirth in December of a woman who had not received any antenatal care in Bradford who presented as an emergency with a placental abruption. See appendix 3 available to Closed Board members.

The total number of stillbirths in 2022 is 32, 8 of whom were babies with a known anomaly, not expected to survive. This is an increase on the 25 deaths occurring in 2021; however there is also a significant increase in the number of babies not expected to survive from 2 in 2021 to 8 in 2022. This demonstrates that the service is proactively supporting the choices of women and their families in continuing a pregnancy where the outcome is known to be poor and should be celebrated as good practice.

The stillbirth rate for the calendar year January to December 2022, based on a birth rate of 5001, is 6.39/1000 births

However when the 8 Butterfly babies for 2022 are removed the adjusted rate is 4.8/1000

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
October	5	28	1	2 (HSIB SI)
November	3	31	1	
December	1	32	0	0

Hypoxic Ischaemic Encephalopathy (HIE)

There were 0 babies requiring cooling for HIE in December.

Serious Incidents (SIs) and serious harms

The December 2020 Ockenden Report, independent review of Maternity services at the Shrewsbury and Telford Hospital NHS Trust, contained 7 immediate and essential actions (IAE) to improve care and safety in maternity services for all Trusts.

IAE 1: Enhanced Safety, recommends that all maternity SI reports and a summary of the key issues, must be sent to the Trust Board and the Local Maternity System (LMS).

There were 0 HSIB reportable cases occurring in December.

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:

3 completed reports including learning and recommendations are included as appendices 3.1 to 3.3 for the attention of Quality and Patient Safety Academy and Closed Board.
There are 7 ongoing maternity SI's/Level 1 investigations, 3 HSIB and 4 Trust level.

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 December and no ongoing neonatal SI's under investigation.

Neonatal Deaths (NND)

There was 1NND in December.

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		
December	1	21		0

Perinatal Mortality Review Tool Quarterly Report:

Appendix 4 is the PMRT Quarterly report required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme. The service has achieved full compliance with this standard with the caveat that 1 case which did not meet the surveillance completed within 1 month due to extreme mitigating circumstances, is reported as such on the NHSR self-declaration submission.

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 were 0 cases meeting the HSIB referral criteria in December.

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 December.

Coroner Regulation 28 made directly to Trust

Again, the implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

The service can confirm that there have been no such requests to date this year.

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Maternity and Neonatal Bi-Monthly Safety Champion meetings

The Maternity and Neonatal Maternity Safety Champions did not meet in December and are next due to meet in January.

Monthly staff feedback from Safety Champions and walk-rounds

Due to industrial action pressure, the December floor to board maternity and neonatal safety champion meeting was cancelled. No safety issues have been escalated to any of the safety champions outside of any meetings.

Maternity Unit Diverts

In the 2019 inspection, the CQC commented on the number of times the maternity unit 'diverted' services. Unfortunately there is no national, regional or LMS level benchmarking available which would highlight the service as an outlier.

The NHSI maternity support team have also indicated that they believe that the service 'diverts' more frequently than other organisations. In response, the service agrees that a more robust process is required to review unit diverts, which will identify any themes requiring interrogation.

There were no partial or attempted diverts recorded on Datix or the closure log during December. This brings the total for 2022 to 14 partial and 6 attempted, which is a significant improvement on the number reported during 2021.

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
December	0	0	0	0
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 has not resumed intrapartum on calls due to a number of the team opting to work in other areas of the service. Acorn team will resume on calls in the New Year when the team is fully recruited.
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 is attached as appendix 5.
Areas to note:

- 1:1 care in labour has fallen slightly below the 90% target in 2 of the last 3 months reported. The Labour Ward co-ordinator team have picked up the data validation of the cases where 1:1 has not been achieved. This approach has resulted in an improved position in the past.
- Number of women booked by 9+6 days is consistently below 50%. The booking gestational age has changed nationally from 12+6 to 9+6 for antenatal screening purposes. The Act as One, Better Births work stream is leading a piece of work to improve awareness of the importance of early booking.

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 took place in December and future meetings are planned for the New Year to ensure that outstanding issues and challenges continue to be prioritised.

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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.

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 was originally intended to run for 2 years and is currently being evaluated with a view to becoming part of the Women's CSU permanent structure/business as usual.

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.

Progress since last report:

- **Programme Governance**.
  - Practitioner support in development with QI team.
  - Decisions finalised regarding where OMS sits in the new CSU structure.
- **Moving to Digital**
  - Community midwives all have smart phones.
  - Trialling long worker app on smart phones and what 3 words.
- **Investing In Our Workforce**
  - International recruit for Maternity Theatre in post.
  - Apprentice Midwife Post recruited and starts in March 2023.
  - Midwife education re alternative therapies explored-training available, funding from PDP budgets. Dates and midwives confirmed.

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- **The Women's Journey**
  - Personalised Care and Support plans benchmark completed and 5 improvements identified – training, education, availability in alternative languages and methods, linking with MVP and identifying digital solutions.

- **A Building Fit For The Future**.
  - Planning and board meetings for building work with project management company Hive continue.
  - Date set for shared staff room work January 2023.

- **Linking Learning and Quality Through Our Information**
  - Qi project re blood transfusion errors – reduced number by 100 in first few weeks.
  - MVP review of Accreditation tool.
  - Increased Greatix from Quality and Safety team for good practice.

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.

During December a representative from the MVP joined the focus group panel for the recruitment of substantive matrons. This ensures that service users are involved in all aspects of planning the delivery of the service, including recruitment of senior roles within the structure.

Service users have also participated in the review of guidelines and patient information leaflets, including the Surrogate Pregnancy guideline and information for women having a termination of pregnancy for medical reasons.

The appointment of a new chair is expected in early 2023 and the service looks forward to continuing to build and strengthen the existing good relationship with the MVP.

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.

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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, December 2022.
- Quality and Patient Safety Academy/Board of Directors is asked to note appendix 1, Obstetric attendance audits, 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 3 completed reports including learning and recommendations are included as appendices 3.1 to 3.3.
- There are 7 ongoing maternity SI's/Level 1 investigations, 3 HSIB and 4 Trust level.
- Quality and Patient Safety Academy/Board of Directors is asked to note that there were 0 HSIB reportable Serious Incident's (SI) declared in December.
- Academy/Board is asked to note Appendix 4 the PMRT Quarterly report required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme. The service has achieved full compliance with this standard with the caveat that 1 case which did not meet the surveillance completed within 1 month due to extreme mitigating circumstances, is reported as such on the NHSR self-declaration submission.

- Appendix 5, local Maternity Dashboard, has demonstrated that 1:1 care in labour has fallen below the 90% target for 2 of the last 3 reported months. Academy/Board is asked to note the action in the narrative.

7 Appendices

- Appendix 1 Obstetric attendance audits.
- Appendix 2 MIS action plan, recruitment, retention, continuity of carer.
- Appendix 3 Maternity and Neonatal Harms December 2022 Closed Board (31-3.3 Final HSIB/Level 1 reports).
- Appendix 4 Perinatal Mortality Review Tool Quarterly Report.
- Appendix 5 Maternity Dashboard.
- Appendix 6 Perinatal Quality Surveillance Model minimum data set for Trust Board's.