

Meeting Title	Board of Directors		
Date	13.07.23	Agenda item	Bo.7.23.10

MATERNITY AND NEONATAL (PERINATAL) SERVICES UPDATE – MAY 2023

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 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 assurance		
Previously discussed at/ informed by			
Previously approved at:	Academy/Group	Date	
	Quality and Patient Safety Academy	28.06.23	

Key Options, Issues and Risks

The December 2020, NHS publication ‘Implementing a revised perinatal quality surveillance model’ set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety.

The requirements to strengthen and optimise Board oversight for maternity and neonatal safety includes:

- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.
- That all maternity Serious Incidents (SIs) are shared with Trust Boards and the Local Maternity System (LMS), in addition to reporting as required to Healthcare Safety Investigation Branch (HSIB).
- To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at Board meetings.

This paper is prepared on a monthly basis and presented to Quality and Patient Safety Academy as a Committee of the Board, holding delegated authority to interrogate, challenge and approve/agree maternity and neonatal information and recommendations, including papers and reports prepared to demonstrate compliance with the NHS Resolution Maternity Incentive Scheme (MIS). A separate summary paper is presented to Trust Board providing assurance that Quality and Patient Safety Academy has executed its delegated authority.

The monthly maternity and neonatal services report presented to 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 Academy on behalf of Board has an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services.

Meeting Title	Board of Directors		
Date	13.07.23	Agenda item	Bo.7.23.10

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.

The monthly paper also serves as the main mechanism for Quality and Patient Safety Academy on behalf of Trust Board to have oversight of key elements of the NHS Resolution Maternity Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool reports, quarterly Avoiding Term Admissions Into Neonatal Units (ATAIN) reports, and monthly midwifery and obstetric staffing updates.

This paper is shared with the Maternity Leads at Bradford District and Craven, Health Care Partnership and feeds into the West Yorkshire and Harrogate (WY&H) Local Maternity and Neonatal System (LMNS) perinatal quality oversight groups.

Analysis

This paper provides Quality and Patient Safety Academy on behalf of Trust Board with information and data regarding perinatal quality and safety, enabling Academy members to rapidly identify any emerging concerns, trends or issues.

It is open and transparent and provides information and evidence of compliance with national maternity reports and schemes.

The overarching maternity improvement plan has been updated to include the Ockenden Assurance action plan and a sustainable Care Quality Commission (CQC) action plan.

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 is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, May 2023.
- Quality and Patient Safety Academy to note the publication of the Maternity CQC inspection report which is presented as a separate paper.

Meeting Title	Board of Directors		
Date	13.07.23	Agenda item	Bo.7.23.10

- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 5, including the description of incidents and any immediate actions/lessons learned.
- Academy is asked to note that a table top review of the 5 stillbirths has been undertaken and that no emerging themes were identified.
- Quality and Patient Safety Academy is asked to acknowledge appendix 2, Neonatal Mortality Report, noting the increase in neonatal deaths in April and May compared to other months and that the variation is believed to be comparable with similar units in the region.
- There are 8 ongoing maternity SIs/Level 1 investigations, 4 HSIB and 4 Trust level.
- Appendix 1a is a copy of a completed level 1 investigation including recommendations for Quality and Patient Safety Academy's information.
- Quality and Patient Safety Academy is asked to note that there were 0 HSIB reportable Serious Incidents (SI) declared in May.

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for our patients, delivered with kindness			g			
To deliver our financial plan and key performance targets			g			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors						
Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Meeting Title	Board of Directors		
Date	13.07.23	Agenda item	Bo.7.23.10

Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and / or Board Assurance Framework Amendments	<input type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Equality Diversity and Inclusion implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Performance Implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Regulation, Legislation and Compliance relevance
NHS England: (please tick those that are relevant) <input checked="" type="checkbox"/> Risk Assessment Framework <input checked="" type="checkbox"/> Quality Governance Framework <input type="checkbox"/> Code of Governance <input type="checkbox"/> Annual Reporting Manual
Care Quality Commission Domain: Choose an item.
Care Quality Commission Fundamental Standard: Choose an item.
NHS England Effective Use of Resources: Choose an item.
Other (please state):

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Other (please state)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Meeting Title	Board of Directors		
Date	13.07.23	Agenda item	Bo.7.23.10

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 December 2020, NHS publication 'Implementing a revised perinatal quality surveillance model' set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety.

The requirements to strengthen and optimise Board oversight for maternity and neonatal safety include:

- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.
- That all maternity Serious Incidents (SIs) are shared with the Trust Board and the LMS, in addition to reporting as required to HSIB.
- To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at Board meetings.

This paper is prepared on a monthly basis and presented to Quality and Patient Safety Academy as a Committee of the Board, holding delegated authority to interrogate, challenge and approve/agree maternity and neonatal information and recommendations, including papers and reports prepared to demonstrate compliance with the NHS Resolution Maternity Incentive Scheme (MIS). A separate summary paper is presented to Trust Board providing assurance that Quality and Patient Safety Academy has executed its delegated authority.

The monthly maternity and neonatal services report presented to 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 Academy on behalf of Board has an open and transparent oversight and scrutiny of perinatal (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.

The monthly paper also serves as the main mechanism for Quality and Patient Safety Academy on behalf of Trust Board to have oversight of key elements of the NHS Resolution Maternity Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool reports, quarterly Avoiding Term

Meeting Title	Board of Directors		
Date	13.07.23	Agenda item	Bo.7.23.10

Admissions Into Neonatal Units (ATAIN) reports, and monthly midwifery and obstetric staffing updates.

This paper is shared with the Maternity Leads at Bradford District and Craven, Health Care Partnership and feeds into the West Yorkshire and Harrogate (WY&H) Local Maternity and Neonatal System (LMNS) perinatal quality oversight groups.

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 followed by the 2nd Report on 30 March 2022. The reports 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. A further 15 IAE's were included in the 2nd report.

The service had its Regional Maternity Team assurance visit on 29 June 2022. The full report was received in August 2022 and reflects the initial feedback presentation shared with Board in the July 2022 update paper. An Ockenden Assurance Action Plan update is to be shared with West Yorkshire and Harrogate (WY&H) Local Maternity and Neonatal System (LMNS) in January.

The services outstanding compliance action is regarding the lack of ability to audit of the use of the Personalised Care Plan (PCP).

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 May. However, this was escalated to Trust Board in May 2023 following review of the recently published Three Year plan and the potential compliance risks associated with digital capability. A meeting is to be arranged with the Chief Digital and Information Officer to discuss the risk and any mitigation available.

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 October 2022 examining failings in maternity and neonatal services at The Queen The Queen Mother Hospital

Meeting Title	Board of Directors		
Date	13.07.23	Agenda item	Bo.7.23.10

(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 2022 Board. There have been no Regional or National updates or requests for information/local action since the report was published.

NHS England published the 'Three year delivery plan for maternity and neonatal services' at the end of March. The purpose of the three year plan is to improve the safety and quality of maternity and neonatal services, incorporating recommendations from key reports such as Ockenden and Kirkup.

A summary of the plan was presented to Executive Team Meeting (ETM) and Trust Board in May, including the risks associated with delivering the plan. This includes a digital solution for the PCP and women being able to access and input into their digital records.

Perinatal Cultural Leadership Programme

Following a regional nomination process, 4 members of the senior maternity and neonatal (perinatal) leadership teams have embarked on a 6 month programme intended to support a positive and nurturing safety cultural in perinatal services.

The aim is to support all perinatal teams in England to create and craft the conditions for a positive culture of openness, safety and continuous improvement. Reviews of maternity services have highlighted cultural and leadership issues as a common theme that contributes to underlying patient safety failures across organisations. Strong and positive leadership creates effective teamwork and therefore improved clinical care.

The programme will focus on the perinatal quadrumvirate, or 'quad', groups of senior leaders in perinatal services (typically including senior midwifery, obstetric, neonatal and operational representation). Co-designed by frontline teams and leadership experts, this programme will bring together senior leaders from across maternity and neonatal services to improve the quality, safety and experience of care for women.

The programme commenced in January with the Director of Midwifery, Deputy Clinical Director for Obstetrics and Gynaecology, Consultant Neonatologist and General Manager for Women's CSU, attending a 3 day course in London.

The 'quad' have continued to attend a series of individual action learning sets (ALS), focusing on their individual leadership styles and learning needs, in addition to a further session in London.

The SCORE culture survey was launched at the end of March and closed in May.

Meeting Title	Board of Directors		
Date	13.07.23	Agenda item	Bo.7.23.10

The quad team have a series of meetings planned with an external company who will support the analysis of the survey results and the associated actions required.

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.

The bi-annual midwifery staffing paper was presented to People Academy and Board in May, as an appendix to the overarching Nursing and Midwifery staffing paper.

The recommendations, including that the full Birth Rate Plus tool is recommissioned for autumn 2023, in line with the 3 yearly cycle national recommendation, were approved. This will ensure that there is an up to date, accurate calculation taking into account the decrease in birth rate but considering the acuity of the women and pregnant people using the service.

Based on the revised table top calculations the current vacancy against the safe staffing establishment is 20.17 WTE which includes the agreed uplift for maternity leave. There are currently 9.22 WTE midwives on maternity leave.

Achieving the safe staffing establishment continues to be our priority figure.

Current vacancy against the revised funded establishment, which includes the number of midwives required to provide Midwifery Continuity of Carer (MCoC) is 51.81 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 continues along with pastoral support for newly qualified midwives (NQM) and new starters to the organisation. Funding is available from Health Education England for a remaining 2 International Midwives. However, the service is requesting a pause in the process due to the significant challenges supporting the International Midwives already appointed during the 12 month transition period.

24 WTE NQM have been offered positions at BTHFT following successful completion of the midwifery programme in October 2023. This is an improved number on the initial position predicted, but does include a number of NQM who selected BTHFT as a 2nd choice, and therefore carries a risk that these individuals will not accept if their 1st choice becomes available.

Meeting Title	Board of Directors		
Date	13.07.23	Agenda item	Bo.7.23.10

Obstetric Staffing

We continue to ensure a 100% consultant presence on the labour ward for 98 hours per week. A detailed position will be provided in the June update paper.

Maternity Improvement Plan and CQC rating

The Maternity Services received an onsite inspection in January, focusing on 'Safe' and 'Well-Led' domains only.

The final report was received in May and reflects the positive improvements made and since the 2019 inspection. Whilst the overall rating remains 'Requires Improvement', the 'Well-Led' domain has improved from 'Inadequate' to 'Good', with 'Safe' remaining as 'Requires Improvement'.

A separate update on the CQC report was presented to May QPSA.

An action plan addressing the 2 'Must Do' actions and 5 'Should Do', has been returned to the CQC and presented to May QPSA. It is currently going through the internal governance process and progress will be monitored through 'Women's Core Governance Group' and QPSA.

Stillbirth Position

There were 5 stillbirths in May plus a feticide for abnormality at 30 weeks gestation. Details are included in appendix 1.

A table top review of the deaths was undertaken to identify any emerging themes or trends. The deaths included a Butterfly baby, an inutero transfer from another organisation where BTHFT had no influence on antenatal care, a late booker who presented with a demised twin at first scan. 2 women under the care of Acorn (vulnerable women's team) who had good care, documentation and plans in place, but risk factors and chaotic life styles were significant contributors to the deaths. The reviewing team are satisfied that there are no emerging themes.

Table 1 is the running total of stillbirths in 2023, including the number of cases requiring further detailed investigation, and the number of butterfly babies whose deaths were expected.

Stillbirths 2023			Expected deaths within total number	Further detailed investigation
Month	Number of babies	Running total	Butterfly babies	Number of cases
January	1	1	1	0

Meeting Title	Board of Directors		
Date	13.07.23	Agenda item	Bo.7.23.10

February	1	2	0	0
March	2	4	0	0
April	2	6	0	1 (HSIB)
May	5	11	1	0

Table 1:

Hypoxic Ischaemic Encephalopathy (HIE)

There were 0 babies requiring cooling for HIE in May.

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 May and no internal SIs.

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. It is anticipated that this standard will continue in the Year 5 publication.

Ongoing Maternity SIs:

Appendix 1 includes a position summary of ongoing maternity SI's. There is 1 completed report for the attention of Quality and Patient Safety Academy and Closed Board in April, appendix 1a.

There are 8 ongoing maternity SI's/Level 1 investigations, 4 HSIB and 4 Trust level.

There were 0 neonatal SIs declared in May and no ongoing neonatal SIs under investigation.

Neonatal Deaths (NND)

There were 6 NND in May. The deaths included a non-viable baby below 20 weeks gestation, 3 extremely premature, 1 baby with a metabolic disorder.

The neonatal team would like to highlight the increase in deaths in April and May, and provide Academy with the assurance that these have been reviewed and have reviewed how the number of deaths varies in comparison to other similar units from the Yorkshire

Meeting Title	Board of Directors		
Date	13.07.23	Agenda item	Bo.7.23.10

and Humber Neonatal ODN and note that BTHFT variation is similar (appendix 2). There have been a total of 9 deaths which meet PMRT (MBRRACE Perinatal Mortality Review Tool) criteria, 2 of which occurred following discharge from the neonatal unit (1 on the paediatric ward and 1 in hospice care).

Please see Table 2 below:

Table 2:

NND 202			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	1	1	1	0
February	5	6	4	0
March	2	8	0	0
April	3	11	1	0
May	6	17	4	0

HSIB Cases and Progress in achieving Maternity Incentive Scheme Safety Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Following the Ockenden Report, all cases referred to the Health Safety Investigation Branch (HSIB) will be declared as SIs. There were 0 cases meeting the HSIB referral criteria in May.

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 May.

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.

Meeting Title	Board of Directors		
Date	13.07.23	Agenda item	Bo.7.23.10

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

Perinatal Bi-Monthly Safety Champion meetings

There were no planned safety champion meetings in May and nothing escalated to the Safety Champions outside of the meeting. .

Monthly staff feedback from Safety Champions and walk-rounds

The Trust Level Safety Champion shared the recent CQC report and the actions with staff on the call. The infant feeding co-ordinator raised her concern regarding some of the information shared on the 'Baby TV' in antenatal clinic waiting area, which is provided by an external company. The service is having difficulty establishing who the company is and the contracting arrangements. KD is looking into this.

Maternity Unit Diverts

There was a notable increase in partial unit diverts during May with 4 recorded on the closure log including 3 consecutive days. These have been attributed to increased activity and an increase in the acuity of some of the women accessing the service, compounded by staffing levels. There is a table top review meeting planned for June to look at any further mitigation or actions required to prevent diverts from occurring. This will be reported back to QPSA in July.

Table 4:

MONTH	Full Divert	Partial divert	Attempted Divert	Number of women diverted
JANUARY	0	0	0	0
FEBRUARY	0	1	0	TBC
MARCH	0	1	0	4 (no births)
APRIL	0	2	0	2
MAY	0	4	0	10
Total	0	8	0	16

Meeting Title	Board of Directors		
Date	13.07.23	Agenda item	Bo.7.23.10

Midwifery Continuity of Carer (MCoC) Action plan

There has been no further progress on MCoC due to the ongoing focus on safe staffing. Acorn team resumed the provision of intrapartum care on 1 April and the team are reporting positive outcomes for both women and the midwifery staff providing care. This is still not achievable for Clover due to vacancy within the team. Clover continues to provide an enhanced level of antenatal and postnatal care to the vulnerable women on their caseloads, and may still receive care from a team member allocated to work in the intrapartum area.

Maternity Dashboard

Appendix 3 is a copy of the maternity dashboard including data up to April 2023.

- Continued focus on booking below 10 weeks which had been improving steadily, but has dropped slightly in April. Discussed at Maternity Services Forum including how primary care can support promoting early booking.
- 1:1 care in labour has dipped just below the 90% target to 89.5%. This metric is monitored closely by the labour ward co-ordinator team and may require further scrutiny if it remains below 90%.

Perinatal Quality Surveillance Model minimum data set for Trust Boards

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

Service User Feedback

There have been no Maternity and Neonatal Voices Partnership (MNVP) meetings during May and no concerns were raised via the 'grassroots feedback' route. The next meeting is planned for 23 June.

3 PROPOSAL

The service proposes that the Perinatal Update paper continues to be presented to Quality and Patient Safety Academy on a monthly basis with an assurance paper presented to Board bi-monthly.

This is to ensure that Trust Board receives timely information regarding perinatal quality and safety issues, in addition to quality improvement and transformation.

The service also proposes that the report will include the minimum data set described within the Perinatal Quality Surveillance Model.

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.

Meeting Title	Board of Directors		
Date	13.07.23	Agenda item	Bo.7.23.10

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 Midwifery Continuity of Carer pathways are on the maternity risk register, updated regularly and monitored through Women's Core Governance Group.

6 RECOMMENDATIONS

- Quality and Patient Safety Academy is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, May 2023.
- Quality and Patient Safety Academy to note the publication of the Maternity CQC inspection report which is presented as a separate paper.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 5, including the description of incidents and any immediate actions/lessons learned.
- Academy is asked to note that a table top review of the 5 stillbirths has been undertaken and that no emerging themes were identified.
- Quality and Patient Safety Academy is asked to acknowledge appendix 2, Neonatal Mortality Report, noting the increase in neonatal deaths in April and May compared to other months and that the variation is believed to be comparable with similar units in the region.
- There are 8 ongoing maternity SIs/Level 1 investigations, 4 HSIB and 4 Trust level.
- Appendix 1a is a copy of a completed level 1 investigation including recommendations for Quality and Patient Safety Academy's information.
- Quality and Patient Safety Academy is asked to note that there were 0 HSIB reportable Serious Incidents (SI) declared in May.

7 Appendices

- Appendix 1 - 1a - Maternity and Neonatal Harms and completed SI/HSIB reports May.
- Appendix 2 - Neonatal Mortality Report.
- Appendix 3 - Maternity Services Dashboard.
- Appendix 4 - Perinatal Quality Surveillance Model minimum data set for Trust Boards.