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Date	13.07.23	Agenda item	Bo.7.23.10

MATERNITY AND NEONATAL (PERINATAL) SERVICES UPDATE – APRIL 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	24.05.23	

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.

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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, April 2023.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned.
- There are 8 ongoing maternity SIs/Level 1 investigations, 2 HSIB and 6 Trust level.

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- Appendix 1a is a copy of a completed HSIB investigation including recommendations for Quality and Patient Safety Academy's information.
- Quality and Patient Safety Academy is asked to note that there were 2 HSIB reportable Serious Incidents (SI) declared in April.
- Quality and Patient Safety Academy is asked to note appendix 2 the ATAIN/TCU quarterly report, required to demonstrate compliance with safety action 3 of the Maternity Incentive Scheme.
- Quality and Patient Safety Academy is asked to note appendix 4, Maternity Training Compliance quarterly report and associated narrative.

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"/>

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"/>

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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"/>

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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 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

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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 April.

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 (QEQM) and the William Harvey Hospital (WHH), part of East Kent Hospitals University NHS Foundation Trust, between 2009 and 2020.

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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 will be 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.

On an extremely positive note, the service was delighted to welcome Donna Ockenden to the maternity Unit in late April, to showcase the positive changes and transformation undertaken in the last few years. Donna was highly complementary about the 'buzz' in the unit, staff engagement and the changes made to improve outcomes and reduce inequalities.

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.

Any updates on the programme will be reported via this paper.

The SCORE culture survey was launched at the end of March and is still open at the time of this update.

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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 20.25 WTE which includes the agreed uplift for 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 51.89 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 and new starters to the organisation.

Obstetric Staffing

We continue to ensure a 100% consultant presence on the labour ward for 98 hours per week.

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).

We have advertised for an Obstetric only substantive post (interest in Maternal Medicine) which is live on NHS jobs until 8th February 2023 with an interview date set up for 28th February 2023. We were not able to offer the post as the one suitable applicant (out of two) withdrew prior to final shortlisting. We advertised the post in April and there were no suitable candidates.

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An advert for substantive post in O+G resulted in 2 suitable candidates shortlisted and we are interviewing for this post on the 23rd of May.

The strain and burden on the consultant body is summarised in a risk assessment that has been escalated to the Trust Board in November 2022 and at the CSU to exec meeting in January 2023. The position is worsening with the significant build on the department general gynaecology back log.

Due to the volume of flexible sessions being delivered across the service, the Gynaecology out of hours' 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 CSU to exec meeting.

A decision to stop weekend 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 lists 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 Trust recognises the 'time' spent doing these clinics and are remunerated at the same rate as an extra theatre session at a weekend.

Despite of the strain on consultant body, consultant colleagues have agreed to work above and beyond and provide extra clinical activity to increase the number of general gynaecology clinics. This will be a temporary measure to help clearing the backlog on general gynaecology. This however will come with the risk of further gaps in MAC/ANDU (ambulatory Obstetrics services) cover in addition to the real risk of consultants' burnout. The GM and CD have been looking as well at agency consultant locums in the short term to help support the waiting lists for Gynaecology clinics. We have identified one suitable candidate but that individual has withdrawn the application since.

Labour ward is always covered by a consultant and there are no exceptions to report. Labour ward consultant led ward rounds (4 xs daily) and daily antenatal consultant ward rounds are embedded in the rotas (and job plans). The continuing problem of insufficient antenatal scan slots to meet the unit demands is an added burden on hot week consultant who is now asked repeatedly to re triage scan lists and find alternatives to ensure safe care.

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. Gynaecology 'HOT WEEKS' have commenced in January 2023 ensuring continuity and cover for Acute Gynaecology patients each week.

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Even with the potential next week's interview/employment, 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 sessions. Following a job planning meeting on the 14th of March, a new rota to help share the burden of the on calls more fairly across the consultant body is nearly finished and will be in effect as of the 24th of April. A further piece of work looking at CSU output and PAs against our existing job plans to work out what the deficit in PAs is and how that will relate to number of consultant appointments is the next step.

Registrars:-

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

From January 2023 there are 2.3 gaps in the middle grade rota the gap due to a registrar being off on long term sickness with work related stress and is now confirmed. The registrar has handed her resignation last week.

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 entrust ability 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 extra registrars were interviewed and offered Clinical Fellow roles to fill the described gaps on 27th January 2023. Both have now declined the job offer. The third candidate who was deemed employable was recruited from overseas and is due to start this week.

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 SHOs from April 2023.

Escalated junior locum rates have been confirmed and secured with HR until the End of June 2023 while we are in a position of having so many gaps for the existing trainees to cover.

Maternity Improvement Plan and CQC rating

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

High level feedback was provided, including:

- Friendly, welcoming staff.
- Positive feedback from staff regarding multi-disciplinary team working.

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- Positive feedback from staff regarding incident reporting culture.
- Positive feedback regarding the upgraded theatre suite.

Immediate safety actions:

- Risk assessment required for beds in corridors.
- Lack of oversight of the Maternity Assessment Centre (MAC) waiting area.
- Some issues with medication management.
- Lack of checklists for cleaning schedules in clinical areas.

A number of immediate actions were taken in response to the feedback including:

- Designated seating area ring fenced for women attending MAC.
- Introduction of hourly checks of women in the seating area and re-triage if necessary.
- Review of the destruction of epidural bags process.
- Medication storage solution for the antenatal day unit.

The CQC have been informed of immediate actions, wider learning shared within the Trust.

The service received a draft report in April and returned a significant number of factual accuracy comments. As yet, there is no expected date for the final report.

Stillbirth Position

There were 2 stillbirths in April. Details are included in appendix 1.

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.

Table 1:

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
February	1	2	0	0
March	2	4	0	0
April	2	6	0	1 (HSIB)

Hypoxic Ischaemic Encephalopathy (HIE)

There was 1 baby requiring cooling for HIE in April. See appendix 1 for details.

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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 2 HSIB reportable cases occurring in April relating to the baby requiring cooling for HIE, and a term stillbirth whose mother presented in labour at the time of diagnosis.

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, 2 HSIB and 6 Trust level, 1 with BDCT.

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

Neonatal Deaths (NND)

There were 3 NND in April including a baby with a known congenital anomaly, an inutero transfer from another unit and a 24 week gestation.

Please see Table 2 below:

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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

Avoiding Term Admissions Into Neonatal Unit/Transitional Care Unit (ATAIN/TCU)

Appendix 2 is the quarter 4 ATAIN/TCU report, required to demonstrate compliance with safety action 3 of the Maternity Incentive Scheme.

The quarter 4 review demonstrates a positive rate of term admissions, consistently below the 5% target rate. A preliminary meeting with relevant matrons and ward managers to try and increase engagement with the ATAIN process and newborn care has been held.

Review of this quarter has revealed no major changes and no relevant current actions.

There are 5 babies that still need reviewing from Q4 so the number of “avoidable” admissions may increase once a full review has been completed. The outstanding reviews are due to the lead consultant’s capacity and clinical demands, although there have been more reviews completed within a timely manner this quarter.

I’ve had a preliminary meeting with relevant matrons and ward managers to try and get some more engagement with the ATAIN process and newborn care.

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

Following the Ockenden Report, all cases referred to the Health Safety Investigation Branch (HSIB) will be declared as SIs. There was 1 case meeting the HSIB referral criteria in March.

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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 April.

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.

Perinatal Bi-Monthly Safety Champion meetings

The Safety Champions met in April as planned. The group discussed the Perinatal Mortality Report Tool quarterly report and learning and were updated on the trial of an updated language line interpreting solution, as use of interpreter's continues to be a recurring theme. There were no concerns raised requiring escalations to Board level.

Monthly staff feedback from Safety Champions and walk-rounds

There were no maternity or neonatal safety concerns raised at the April meeting. The impending RCN industrial action was discussed and possible need for maternity to support the neonatal unit if required.

Maternity Unit Diverts

There were 2 partial diverts recorded on the closure log in April due to high acuity and staffing challenges. 2 women were diverted to neighbouring organisations, 1 on each occasion.

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)

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APRIL	0	2	0	2
Total	0	4	0	6

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. 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.

MCoC data collection and production of the informatics have recommenced and the service continues to raise the profile of MCoC despite not being able to increase the offer.

Maternity Dashboard

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

- Born Before Arrival (BBA) at hospital - unplanned birth outside of the hospital setting, where there is no medical professional in attendance is noted to be frequently running at 6-8 per month, but has improved in February and further improvement noted in March.
- 3rd and 4th degree tears with instrumental deliveries were noted to have increased for 2 consecutive months but there were no recorded cases in February. This is high again in March but the monthly variance makes it difficult to assess. All cases are datixed and reviewed by an obstetrician.

Training Compliance quarterly report

Appendix 4 is a copy of the maternity training compliance quarterly report.

PROMPT compliance shows a reduction in the number of other obstetric doctors which has dropped to 72.41%. This is due to new GP trainees on the rota who are all booked on upcoming days. Overall obstetric compliance is 81.25%

Anaesthetists are 60% compliant as although 4 anaesthetists attended in May, 3 others became non-compliant in May. This has been escalated to the PROMPT anaesthetic lead who has been asked to review the data and escalate further if releasing staff continues to be a challenge.

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Mandatory training is overall positive and showing improvement. Further improvement actions include:

- Fit Testing leads have been contacted and asked to target maternity.
- Continued focus on delivering Blood Competencies training ad hoc.
- All managers/staff/consultants to focus on modules that have dropped since Maternity Day 2 stopped (Fire etc).
- Managers and consultant leads have been contacted with details of all staff who are showing as red for overall compliance and asked to address on an individual basis.
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Perinatal Quality Surveillance Model minimum data set for Trust Boards

Appendix 5 is the populated copy of the Perinatal Quality Surveillance Model minimum data set for Trust Boards. Much of the information required for presentation for Board is contained within the narrative of this report.

Service User Feedback

There have been no Maternity and Neonatal Voices Partnership (MNVP) meetings during April and no concerns were raised via the 'grassroots feedback' route.

The MNVP have recruited 2 new co-chairs who attended the recent Donna Ockenden/Naz Shah visit to the unit, along with a small number of recent service users. The service looks forward to working closely with them in the future.

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.

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.

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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, April 2023.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned.
- There are 8 ongoing maternity SIs/Level 1 investigations, 2 HSIB and 6 Trust level.
- Appendix 1a is a copy of a completed HSIB investigation including recommendations for Quality and Patient Safety Academy's information.
- Quality and Patient Safety Academy is asked to note that there were 2 HSIB reportable Serious Incidents (SI) declared in April.
- Quality and Patient Safety Academy is asked to note appendix 2 the ATAIN/TCU quarterly report, required to demonstrate compliance with safety action 3 of the Maternity Incentive Scheme.
- Quality and Patient Safety Academy is asked to note appendix 4, Maternity Training Compliance quarterly report and associated narrative.

7 Appendices

- Appendix 1 - 1a Maternity and Neonatal Harms and completed SI/HSIB reports February.
- Appendix 2 - ATAIN/TCU Quarter 4 report.
- Appendix 3 - Maternity Services Dashboard.
- Appendix 4 – Maternity Training Compliance Quarterly Report.
- Appendix 5 - Perinatal Quality Surveillance Model minimum data set for Trust Boards.