Executive Summary

Report to the Board of Directors

Being Held on 27 September 2022

Subject	Maternity & Neonatal Safety Report
Supporting TEG Member	Chris Morley, Chief Nurse
Author	Laura Rumsey, Interim Midwifery Director, Obstetrics, Gynaecology and Neonatology (OGN) Andrea Galimberti, Interim Clinical Director, OGN Sue Gregory, Operational Director, OGN
Status[1]	A

PURPOSE OF THE REPORT

To present a monthly safety and quality overview of Jessop Wing Maternity and Neonatal Services to the Board of Directors reporting period of 1st July – 31st July 2022.

The report will provide an oversight position on:

- Maternity Incentive Scheme (MIS) Year 4
- Perinatal Quality Surveillance Model (PQSM)
- Health Care Safety Investigation Branch (HSIB) investigations
- Serious Incidents (SI)
- Midwifery Continuity of Carer (CoC)
- Training
- Maternity Dashboard
- Maternity Improvement Advisor (MIA) Thematic Review
- Maternity Safety Champions activities
- Workforce: Maternity and Neonatal Staffing
- Care Quality Commission (CQC) Review
- Compliance with the Immediate and Essential Actions (IEAs) outlined in Part One of the Ockenden Report

KEY POINTS

Key Risks

- Following the MIA Thematic Review work has continued progressing the recommendations through the Maternity Improvement (MIP) Quality and Safety workstream.
- Maternity specific information system is not in place at the Jessop Wing, identified as a maternity service quality and safety risk by CQC, HSIB, LMNS, and by the Ockenden Assurance visit (06/05/22) panel.
  - Outline Business case currently being written to detail the case for investment in an appropriate system.
  - In the interim, mitigation has been proposed by the Triumvirate and agreed by the Maternity Improvement Board.
  - From September, a full paper based end to end maternity record (hand held record) is in place including paper documentation from the Birmingham Specific Obstetric Triage System (BSOTS) this will facilitate a complete pregnancy history for clinicians to risk assess and plan care safely.
- Historical Perinatal Mortality Review Tool (PMRT) reports not shared with families from 2019, 70

in total. Communication with affected families has commenced informed by Maternity Voices Partnership (MVP), Psychologist and bereavement services. 39 out of 43 cases have been progressed and families contacted from phase one of the identified legacy backlog. Further work continues to recover a real-time position and effectively and sensitively communicate with families.

- SI investigation backlog, external maternity governance support and plan to recover position is in progress.
- CQC **must do** action plan agreed and being implemented by the triumvirate .

Improvements

- Continued development of the electronic SitRep (Situation Report) allowing enhanced oversight of staffing, women awaiting Induction of Labour (IOL), activity and acuity in Maternity and Neonatal Services. Twice daily position now reported. BR+ acuity score to be included in future update.
- External senior maternity governance support continues 0.4 wte.
- Successful appointment of Fetal Surveillance Matron.
- Successful appointment of NHSEI funded Recruitment & Retention midwife role.
- First draft of BR + full assessment report received Midwifery Director and Operations Director have planned meeting with finance colleagues in September to progress.
- The Jessop Wing has a sustained term admission rate to the Neonatal Unit (NNU) as a percentage of live births below the local target of 5% (national aim <6%). The year 2021-2022 overall was 3.6% which was lower than previous years and will have had a positive impact on women, babies and families. July reflected continued sustained reduction in term admissions to NNU at 2.9%.
- Fetal monitoring and PROMPT training has now exceeded 90% target for midwives.
- Successful BSOTS launch 5th September, positive feedback from staff. Early data reflects increased compliance with rapid reviews within a 15 min timeframe

IMPLICATIONS[2]

Aim of the STHFT Corporate Strategy		✓ Tick as appropriate
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Create a Sustainable Organisation	✓
6	Deliver Excellent Research, Education & Innovation	

RECOMMENDATIONS

The Board of Directors are asked to receive and discuss the content of the report particularly noting, the changes to documentation ahead of the deployment of an end-to-end maternity information system, and the introduction of BSOTS to improve safety for women attending for triage.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
TEG	14 September 2022	Y
Board of Directors	27 September 2022	

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the six aims of the STHFT Corporate Strategy ‘Making a Difference – The next Chapter 2022-27’

1. REPORT OVERVIEW

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) Board and the Board of Directors, monthly, of present or emerging safety concerns or activity to ensure safety with a two-way reflection of *Ward To Board* insight across the multi-disciplinary, multi- professional maternity services team. The information within the report will reflect actions in line with the Ockenden Independent Maternity Review (2020), and progress made in response to any identified concerns at provider level.

- Aligned with the Perinatal Quality Surveillance Model (PQSM) Jessop Wing, maternity and neonatal services are required to report information outlined in the data measures proforma monthly to the Board of Directors (appendix 1). The report covers the period July 2022.
- The report also provides evidence to NHS Resolution (NHSR) Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 4.

2. PERINATAL MORTALITY

NHS England set out a national ambition to halve the rates of stillbirth, neonatal deaths, maternal deaths, and brain injuries during birth by 2025, (from a 2010 baseline). In addition, the NHS is working towards an interim ambition of a 20% reduction by 2020.

The national average for stillbirth, (any baby loss from 24 weeks gestation), is 3.74 per 1000 births, and 1.67 per 1000 births for neonatal deaths (a liveborn baby who died before 28 completed days after birth, for Trusts with Level 3 Neonatal units, (MBRRACE), 2019).

A review of maternity governance processes and practices was undertaken in March 2022, by the Maternity Improvement Advisor (MIA) team. It was highlighted that PMRT reports from 2019 to 2022 had not been consistently shared with families. Work is in progress to sensitively communicate this position to all families affected by this omission. As previously reported the triumvirate has liaised with a wide range of stakeholders to agree an approach to remedy this position in the most sensitive way possible. Progress and feedback from families will be reported monthly to the Board of Directors through this paper.

A process for phoning women to inform them of the completion of the PMRT report and to offer them a choice of how they wish to view the report was completed and trialled in June 22. 12 women were contacted by phone and a further 4 women were unable to be contacted. This process has now been further improved and women receive a letter inviting them to make contact with us. Progress is being tracked and to date 36 women have been contacted. Work is now focussed on the 13 historic cases that do not have a PMRT ready to be published to expedite this process.

Phase 1 from 22nd December 2019 – 30th December 2021

68 cases of late fetal loss, stillbirth, termination of pregnancy (TOP) and neonatal death were reported to MBRRACE-UK,
58 cases met the MBRRACE-UK reporting criteria for review using the national Perinatal Mortality Review Tool (PMRT). All cases have had a PMRT review completed. 43 cases have a published report available to be shared with families

Progress:

Phase 1
39/43 women have been contacted to advise a PMRT report is available to share. The remaining 4 families are either unable to be contacted or have current ongoing pregnancies. Sharing of reports for these families is being progressed sensitively.

Work is now focused on 15 historic cases that do not have a PMRT report ready to be published.
All 15 have a report available in draft. A named midwife and obstetrician have been identified to expedite the finalising and approval of these reports.

Phase 2 from 1st January 2021 – 30th April 2022.
115 cases were reported to MBRRACE-UK
101 cases are eligible for PMRT review
None of the cases have published reports available to share with families.

Progress

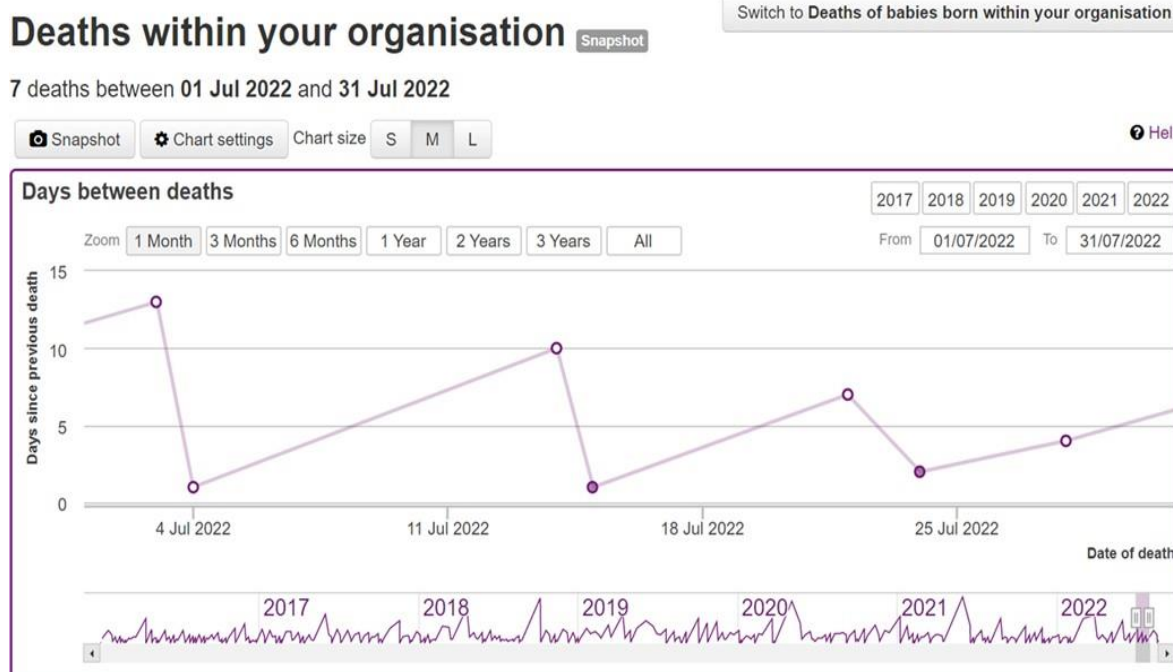
Phase 2
Two Maternity Quality and Safety Midwives are leading on the PMRT review process with support from a named Obstetrician. The PMRT review process has been reviewed and updated
A scheduled PMRT review meetings with external multi professional representation is being developed to support review of the 2021-2022 cases. Once meeting dates have been confirmed a trajectory to share the final reports with families will be developed.

2.1 PMRT figures

During July, the Jessop Wing reported 7 mothers and babies to MBRRACE UK, (Mothers and Babies Reducing Risk through confidential Enquiry Across the UK):

Figure 1 shows the MBRRACE report indicating deaths within STH during July, along with the trend since 2017.

Figure 1



2.2 Surveillance findings for the 7 cases reported to MBRRACE-UK from 01/07/2022 - 31/07/2022:

Stillborn babies reported to MBRRACE-UK

- All of the stillborn infants reported to MBRRACE-UL were singleton pregnancies
- 0 late fetal losses reported
- 0 intrapartum stillbirths
- 3 antenatal stillbirths

Gestational age of stillborn infants

- 24-27 weeks gestation = 1
- 32-36 weeks gestation = 1
- 37-41 weeks gestation = 1
-

Neonatal Deaths reported to MBRRACE-UK

- There were 4 neonatal deaths. All of the neonatal deaths were admitted to STH NNU.
- There were 0 term neonatal deaths in July 2022
- 1 infant was aged 22-23 weeks gestation
- 3 infants were 24-27 weeks gestation
- 3 of the infants were singletons and 1 infant was a twin
- All 4 infants had birthweights below 1500 grams. There weights were within the expected range for gestational age.

Ethnicity

- 5 white ethnicities
- 1 Asian or Asian British ethnicity
- 1 Other ethnicity

Maternal Age

- 20-24 years = 1
- 30-34 years = 3
- 35-39 years = 3

Smoking Status at booking

- 5 women did not smoke. All 5 women had a carbon monoxide reading below 3 ppm which confirmed their non-smoking status.
- 2 women did not have their smoking status recorded at booking

Initial Cause of Death

- For 2 stillborn babies the initial cause of death is thought to be associated with placental dysfunction. For 1 case the cause of death is unknown.
- All 4 neonatal deaths were associated with extreme prematurity.
- PMRT panel review, post-mortem and histology reports where completed will be required to confirm the final cause of death.

Patient Safety Reviews have been completed for all the cases and are awaiting Perinatal Mortality Panel review. In each case the care provided to the mother and her unborn baby is reviewed using the national Perinatal Mortality Review Tool (PMRT). This tool was designed to support high quality, standardised, multidisciplinary perinatal reviews observing the principle of 'review once, review well'. Each review considers all care provided leading up to and surrounding each stillbirth or neonatal death.

Two maternal deaths were reported to MBRRACE UK:

- One woman who had a pre-existing terminal illness and sadly died 11 months post birth. This is a late maternal death and meets the MBRRACE reporting criteria but does not require reporting to HSIB. A patient safety review has been undertaken; no care issues have been identified.
- Jessop Wing were notified of a maternal death. The case is reportable to MBRRACE as the woman was known to have had a pregnancy within 12 months of the death. A Patient Safety Review was undertaken where there were no omissions in care identified.

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2.3 Action plan following MIA led thematic review of stillbirths

A thematic review of all stillbirths occurring over a 14-month period 2021/22 was undertaken in May 2022 and was presented to this Board in July 2022. The associated action plan has been incorporated into the wider Maternity Improvement Plan and the Triumvirate will report on progress quarterly through this report.

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3. HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB) AND MATERNITY SERIOUS INCIDENTS (SI'S)

3.1 Background

HSIB undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018). In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

- **Maternal Deaths:** Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy
- **Intrapartum stillbirth:** where the baby was thought to be alive at the start of labour but was born with no signs of life.
- **Early neonatal death:** when the baby died within the first week of life (0-6 days) of any cause.
- Severe brain injury diagnosed in the first seven days of life, when the baby:
    - Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
    - Was therapeutically cooled (active cooling only) or
    - Had decreased central tone and was comatose and had seizures of any kind

Any case referred by the Trust for investigation by HSIB is also automatically logged as a Serious Incident, although the investigation is undertaken by HSIB and not the Trust.

3.2 STH HSIB cases July 2022

HSIB cases since 2019	July 2022
Total referrals	56
Referrals / cases rejected	17
Total investigations to date	39
Total investigations completed	35
Current active cases	4
Exception reporting (more than 6 months)	2

3.3 HSIB Investigation active case progress update

Two cases are delayed:

- One case is because of records awaited from a tertiary centre providing cross boundary care and delayed staff interviews due to unexpected absence.
- The second is due to an outstanding placental histology report.

Of the remaining two active cases:

- One has a final report with an addendum of a recalculated baby's age and amended timings of age when treatment was given.
- One report has been received in draft format and is awaiting factual accuracy checks.

There were 0 new cases reported to HSIB in July 2022.

Two maternal deaths reported to MBRRACE-UK did not meet the HSIB reporting criteria as both deaths were indirect maternal deaths of women outside of the 42 day of the end of pregnancy reporting timescale.

No final investigation reports were received.

The Maternity Service continues to receive regular investigation progress updates from HSIB. A HSIB Quarterly Update Review meeting is scheduled for 12th September 2022. Members of Jessop Wing Maternity Service, HSIB and NHS England & Improvement will meet to review progress with HSIB reported cases and progress of HSIB action plans. Compliance with safety action 10, HSIB reporting standards, will be included as part of the Trust Board final MIS Year 4 submission declaration to NHS Resolution on 5th January 2023.

HSIB Investigations Report July 2022

Ref	HSIB Reference	HSIB Criteria	Progress
W259661	MI-005710 / MI-006528	Cooled Baby / Maternal Death	2 staff interviews still to be arranged. Date for 1 staff member scheduled for 18th July 2022. Second member cancelled an appointment due to clinical commitments. This was rescheduled for 27th July HSIB Team were awaiting maternal medical notes this has now been resolved. Second clinical panel (SMART 2) scheduled for 23rd August 2022.
			The two cases are the same family. Both cases are outside of the 6-month reporting deadline of 29th June 2022
W266190	MI-008645	Intrapartum Stillbirth	Interviews in progress. Some still to be arranged. Awaiting placental histology report Second clinical advice meeting (SMART 2) arranged for 26th July 2022. Reporting Deadline 20th October 2022
W266515	MI-008638	Cooled Baby	Staff interviews ongoing with one interview outstanding. Second clinical advice meeting (SMART 2) arranged for 4th August 2022. Reporting Deadline 20th October 2022

3.4 Coroner's Inquests including Reg 28 made directly to Trust

There was one concluded inquest on 21 July 2022. This case related to a delayed diagnosis of maternal pancreatitis. Learning from this incident has been share with staff and the ensuing action plan is being monitored by the safety and quality governance team.

3.5 Maternity Serious Incidents

A Serious Incident tracker including progress updates, completion timescales and RAG rating is in operation and provides focus for the Governance Team's weekly check in/ update meetings. This is shared with the triumvirate.

During July 2022 there were 5 Serious Incidents (SI) declared in maternity services.

Serious Incidents continue to be reported to SYB LMNS Quality and Safety Group and up through Yorkshire and the Northeast (NE) Perinatal Quality Surveillance Group (PQSG) for regional oversight.

Serious Incident Investigations Report July 2022

Ref:	Summary	Progress
W273123	Antepartum intrauterine fetal demise at 40+1	• Duty of Candour has been completed with the family. • Incident investigation in progress
W274240	The mother was admitted at 36+1 weeks with signs of preeclampsia she was cared for on the Advanced Obstetric Care Unit (AOCU) and received antihypertensive medication. A caesarean section was planned, overnight the fetal heart rate trace deteriorated, and the mother was taken for a CAT 1 (within 30 mins of decision)) caesarean under general anaesthetic. The mother was extubated but did not wake, she was reintubated and admitted to critical care following a CT scan. Diagnosis of cerebral oedema.	• Duty of Candour has been completed with the family. • The Critical Care Team are supporting the investigation and writing the report.

W274798	The mother attended the labour ward at 37+0 weeks with a small antepartum haemorrhage. Staff were unable to locate the fetal heart and an intrauterine fetal death was confirmed.	• Duty of Candour has been completed with the family. • Incident investigators have been appointed and an initial scoping exercise of the circumstances surrounding the incident are underway.
W274483	The mother was admitted to the labour ward at 41+0 weeks in early labour. She made slow progress and developed a tachycardia (abnormally rapid heartrate) a decision was made to take for an emergency caesarean section due to lack of progress in labour. This was delayed by over 4 hours due to other emergencies. The mother had what appeared to be a fit at the point of the placenta being delivered. The mother was stabilised and transferred to critical care.	• Duty of Candour has been completed with the family. • The Critical Care Team are supporting the investigation and writing the report. Incident investigators have been appointed and an initial scoping exercise of the circumstances surrounding the incident are underway.
W239512	The mother was admitted at 37+0 weeks for an elective caesarean section for breech presentation, pre-term rupture of membranes. During the caesarean section, the baby was found to be in a cephalic position.	• Duty of Candour has been completed with the family. • Incident investigators have been appointed and an initial scoping exercise of the circumstances surrounding the incident are underway
W276771	The mother was transferred from the Trusts emergency department via ambulance. There was a delay in the mother arriving in the correct area of the maternity unit. The baby's heart rate was noted to be low; an emergency caesarean section was performed. The baby was born in a poor condition and following resuscitation was transferred to the neonatal unit and received therapeutic cooling.	• Duty of Candour has been completed with the family. Incident investigators have been appointed.

3.6 Serious Incidents in progress

Serious Incidents in progress							
	Over 12 months	**Over 6 months**	**HSIB requires action plan**	**HSIB in progress**	**Less than 6 months but beyond 12 weeks**	**In time**	**Approved subject to minor amends**
June 2022							
Number	1	7	13	4	10	8	2
July 2022							
Number	2	7	13	4	8	12	5

- 2 SI investigations in progress have incident dates over 12 months from the time of reporting. One report is completed in draft and is awaiting quality assurance review before submission for Departmental approval.

The second case is a historic incident occurring in March 2021. A HSIB investigation into care of the baby was completed however the care of the mother following the birth was excluded from the investigation. HSIB recommended STH should investigate the care of the mother following a major obstetric haemorrhage. The incident was reported as a SI on 08/11/22 and an investigation has commenced.

- 5 SI investigations have been completed and the final reports submitted to the Serious Incident Group for approval before submission to the NHS South Yorkshire Integrated Care Board, Sheffield Place team.
- 29 SI investigations are underway. Progress with the investigations is monitored at a weekly governance meeting to identify any potential delays to reporting timescales or areas of concern for escalation.
- 13 HSIB completed investigations and supporting action plans are to be shared with the Integrated Care Board. Work is underway to develop the supporting action plans.

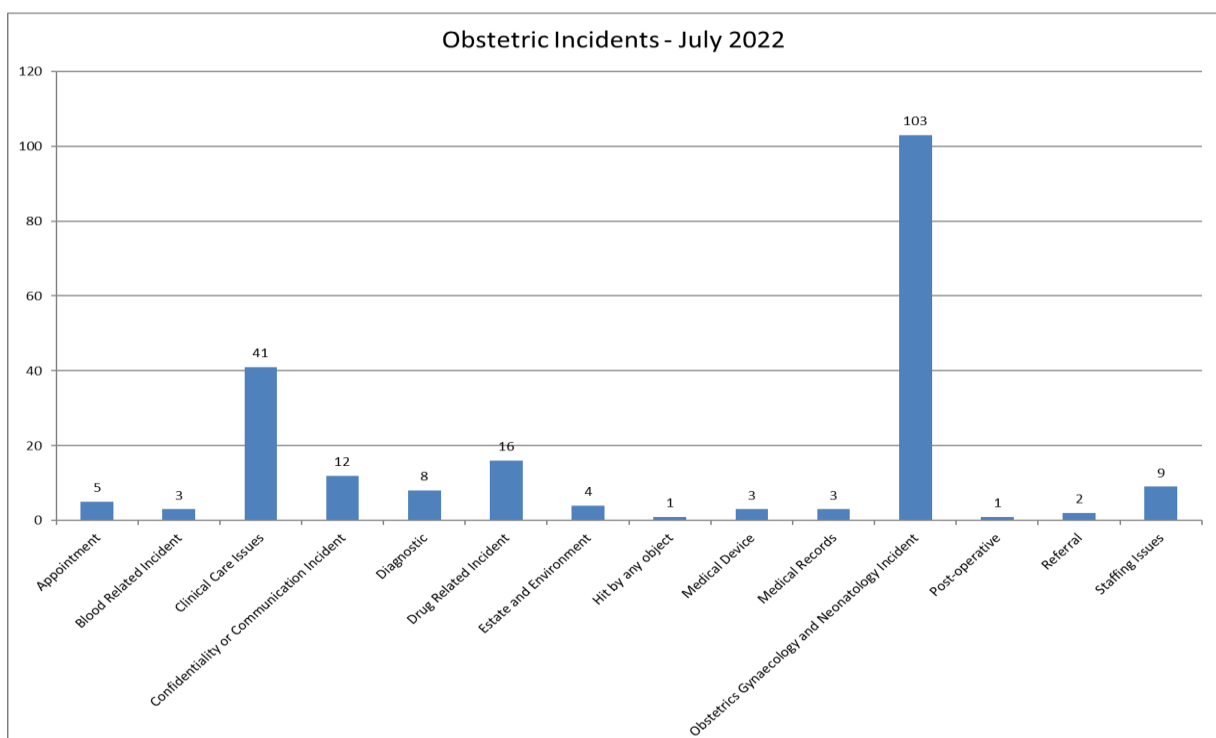
3.7 Outstanding SI Investigations

- 15 SI investigations have exceeded the original CCG reporting closure deadlines of which 2 incidents are over 12 months old.
- 5 are awaiting final approval at SIG and are expected to be completed by the end of July.
- 15 are progressing and are anticipated to be completed by the end of September.

3.8 Overview of Incidents reported in July 2022

In July 2022, 211 incidents were reported by OGN through the Datix incident reporting system. The graph below shows the breakdown for 211 cases. Unfortunately, the Datix system aggregates a range of incidents under the heading Obstetric, Gynaecology and Neonatology, this is being explored to enable more granular detail and commentary to be included in future reports.

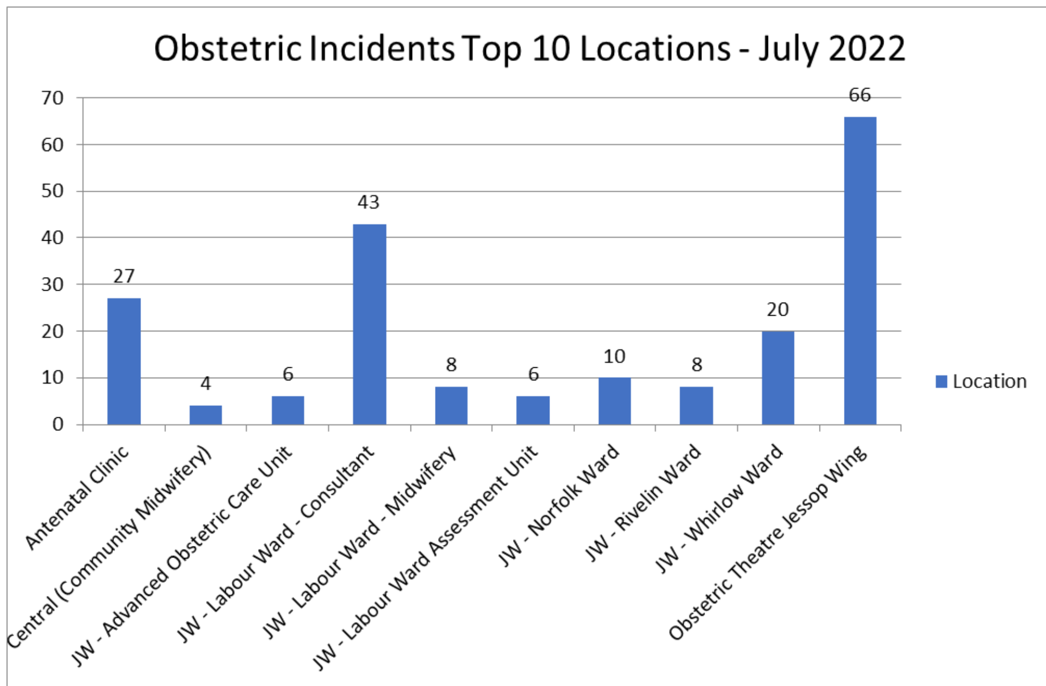
All incidents are rigorously reviewed by the Quality and Safety team on a daily basis, (Monday-Friday), identifying any potential moderate or above harm graded incidents for escalation to the Patient Safety Review meetings which are held three times per week.



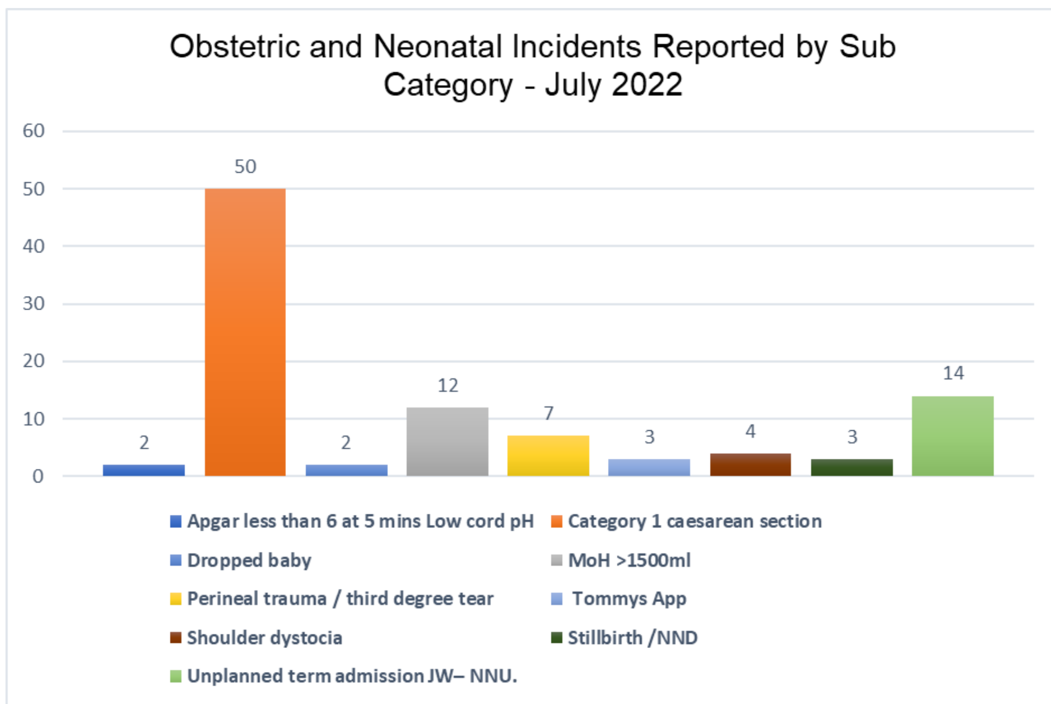
At the time of reporting 242 incidents are in review, of which:

- 20 incidents are overdue and have passed the 21-day review timescale
- 27 incidents are overdue and have passed the 28-day review timescale
- 157 incidents are overdue and have passed the 35-day review timescale

Top 10 Obstetric Incident Reporting Locations



Top 5 Reporting Sub-categories



3.9 Incident Grading of Harm / Impact –

Row Labels	1 – No Harm / Impact	2 – Low Harm / Impact	3 – Moderate Harm / Impact	4 – Severe Harm/ Impact	Total
July 2022	86	127	26	3	242

Moderate Harm Incidents by Sub-category July 2022

26 moderate harm/impact incidents were reported in July 2022. All of the incidents have been reviewed via Patient Safety Review, ATAIN or PMRT meetings.

11 infants were reviewed as part of ATAIN (Avoiding Term Admissions in Neonatal Units) review programme. Reasons for the unanticipated admissions included respiratory conditions (5), suspected infection (4) and low APGAR score (2).

14 incidents were reviewed at Patient Safety Review Meetings. 3 of the incidents have been reported as Serious Incidents. (see further details in the Serious Incident Investigation section).

1 incident involving an antenatal stillbirth will be reviewed as part of the PMRT review process.

4. CONTINUITY OF CARE (COC)

Each Local Maternity & Neonatal System (LMNS) is required to be working towards having 35% of women booked for maternity care on to a CoC pathway. The NHS Long-Term Plan also added that 75% of Black and Asian women (BAME) should receive continuity of carer by 2024, and this has been made more urgent in light of the increased risk facing Black and Asian women of poor outcomes, both maternity and from COVID-19.

The publication *Delivering Midwifery Continuity of Carer at Full Scale: Guidance on Planning, Implementation and Monitoring* 2021/22 published in October 2021 states that key building blocks should be in place prior to further roll out of CoC as the default model of maternity care. These include safe staffing, staff engagement and education; this supports the current decision at Jessop Wing to suspend the rollout of CoC until the workforce reflects recommended NICE (2015) and Birthrate Plus (BR+) levels of midwifery staffing within the service. The key building blocks ensures readiness to implement and sustain continuity of care.

NHSE Regional Midwifery Teams have requested a projected CoC commitment from all maternity providers in England. JW have submitted a plan with an agreed trajectory to SYB LMNS for the service CoC implementation.

In view of the current workforce challenges in JW the service aims to launch the first CoC teams in Quarter 4 23/24. Jessop Wing will continue to report the position monthly to the Board of Directors and LMNS Board. A full Birthrate Plus (BR+) assessment was received in its first draft at the end of July and will underpin all maternity workforce decisions and future planning over the coming two years. The Midwifery Director and Operations Director have a scheduled meeting with finance colleagues to establish a forward plan informed by BR+ recommendations and the rebased funded maternity establishment to include the funding from the successful Ockenden workforce bid (2021).

Once maternity services workforce plan is agreed a biannual maternity workforce paper will be written and presented to the Board of Directors by the Midwifery Director as recommended by NHS Resolution in the CNST Maternity Incentive Scheme (MIS). The first paper is planned for October Board of Directors.

5. TRAINING DATA – APRIL TO JULY 2022

Mandatory Training / JSET Maternity Services July 2022 - Medical				
	April	May	June	July
Data Security and Information Governance - Level 1 (1 Yearly)				
Target	90%	90%	90%	90%
Total Headcount	40	40	39	45
% Compliance achiev ed	90%	85%	90%	87%
Equality & Diversity: General Awareness - Level 1 (3 Yearly)				
Target	90%	90%	90%	90%
Total Headcount	40	40	39	45
% Compliance achiev ed	90%	93%	92%	91%
Fire Safety Theory - Level 1b (1 Yearly)				
Target	90%	90%	90%	90%
Total Headcount	40	40	39	45
% Compliance achiev ed	93%	85%	92%	89%
Health Safety & Welfare Level 1 (3 Yearly)				
Target	90%	90%	90%	90%
Total Headcount	40	40	39	45
% Compliance achiev ed	93%	95%	95%	93%
Infection Prevention and Control - Level 2 (1 Yearly)				
Target	90%	90%	90%	90%
Total Headcount	40	40	39	45
% Compliance achiev ed	88%	83%	87%	84%
Moving and Handling - Level 2a (4 Yearly)				
Target	90%	90%	90%	90%
Total Headcount	40	40	39	45
% Compliance achiev ed	85%	78%	85%	91%
Resuscitation: Adult Basic Life Support - Level 2a (1 Yearly)				
Target	90%	90%	90%	90%
Total Headcount	40	40	39	
% Compliance achiev ed	90%	93%	95%	87%
	April	May		
Safeguarding Children & Young People - Level 2 (3 Yearly)				
Target	90%	90%	90%	90%
Total Headcount	37	37	36	38
% Compliance achiev ed	92%	92%	92%	92%
Safeguarding Children & Young People - Level 3 (3 Yearly)				
Target	90%	90%	90%	90%
Total Headcount	1	2	2	1
% Compliance achiev ed	100%	100%	100%	100%
Safeguarding Vulnerable Adults - Level 2 (3 Yearly)				
Target	90%	90%	90%	90%
Total Headcount	40	40	39	45
% Compliance achiev ed	93%	95%	95%	93%
Mental Capacity Act - Level 2a (3 Yearly)				
Target	90%	90%	90%	90%
Total Headcount	40	40	39	45
% Compliance achiev ed	90%	90%	90%	82%
Deprivation of Liberty - Level 2b (3 Yearly)				
Target	90%	90%	90%	90%
Total Headcount	40	40	39	45
% Compliance achiev ed	93%	93%	92%	84%

JSET Maternity Services July 2022 - Medical consultants and Trainees				
Obstetric Emergency Drills (PROMPT)				
Target	90%	90%	90%	90%
Total Headcount	40	40	39	45
% Compliance achiev ed	73%	83%	85%	71%
Fetal Monitoring				
Target	90%	90%	90%	90%
Total Headcount	40	40	39	45
% Compliance achiev ed	88%	90%	97%	93%

Mandatory Training / JSET Maternity Services Compliance Trajectory July 2022 - Midwifery				
90% Compliance Target for all courses	Apr	May	Jun	Jul
Conflict Resolution (Trajectory)	85.60%	88.04%	90.00%	90.00%
% Compliance achiev ed	82.72%	85.34%	81.98%	80.00%
Total Headcount	353	341	344	350
Compliant Headcount	292	291	282	280
Data Security and IG L1 (Trajectory)	69.29%	65.22%	73.37%	81.79%
% Compliance achiev ed	75.92%	75.66%	83.72%	87.14%
Total Headcount	353	341	344	350
Compliant Headcount	268	258	288	305
Equality & Diversity L1 (Trajectory)	90.00%	90.00%	90.00%	90.00%
% Compliance achiev ed	98.87%	99.12%	99.13%	99.14%
Total Headcount	353	341	344	350
Compliant Headcount	349	338	341	347
Fire Safety Theory L1b (Trajectory)	67.76%	67.49%	75.96%	84.15%
% Compliance achiev ed	73.22%	75.07%	82.56%	85.71%
Total Headcount	351	341	344	350
Compliant Headcount	257	256	284	300
Health Safety & Welfare (Trajectory)	90.00%	90.00%	90.00%	90.00%
% Compliance achiev ed	99.15%	99.71%	99.71%	98.57%
Total Headcount	353	341	344	350
Compliant Headcount	350	340	343	345
Infection Prevention (Trajectory)	66.85%	65.22%	74.18%	82.88%
% Compliance achiev ed	73.58%	74.19%	82.85%	85.43%
Total Headcount	352	341	344	350
Compliant Headcount	259	253	285	299
Moving & Handling L1 (Trajectory)	90.00%	90.00%	90.00%	90.00%
% Compliance achiev ed	98.58%	98.83%	98.55%	98.00%
Total Headcount	353	341	344	350
Compliant Headcount	348	337	339	343
Moving & Handling L2b (Trajectory)	57.73%	63.26%	72.38%	81.22%
% Compliance achiev ed	40.63%	41.64%	46.51%	91.43%
Total Headcount	352	341	344	350
Compliant Headcount	143	142	160	320

JSET Maternity Services July 2022 - Midwifery				
90% Compliance Target for all courses	Apr	May	Jun	Jul
Obstetric Emergency Drills (Trajectory)	80.50%	85.20%	89.89%	90.00%
% Compliance achiev ed	69.29%	78.76%	85.23%	90.53%
Total Headcount	267	259	264	264
Compliant Headcount	185	204	225	239
Fetal Monioring (Trajectory)	64.71%	67.46%	77.11%	87.13%
% Compliance achiev ed	70.00%	80.80%	93.80%	94.14%
Total Headcount	260	251	258	256
Compliant Headcount	182	201	242	241

Mandatory Training / JSET Maternity Services Compliance Trajectory July 2022 - Midwifery				
	Apr	May	Jun	Jul
Resuscitation: ABLS L2a (Trajectory)	63.18%	63.54%	72.38%	80.66%
% Compliance achiev ed	67.72%	69.73%	77.71%	78.16%
Total Headcount	347	337	341	348
Compliant Headcount	235	235	265	272
Resuscitation: NLS L2 (Trajectory)	67.38%	73.12%	82.80%	88.89%
% Compliance achiev ed	58.02%	65.18%	78.35%	82.14%
Total Headcount	262	247	254	251
Compliant Headcount	152	161	199	208
Safeguarding Children L1 (Trajectory)	90.00%	90.00%	90.00%	90.00%
% Compliance achiev ed	88.61%	92.11%	88.46%	100.00%
Total Headcount	79	76	78	20
Compliant Headcount	70	70	69	20
Safeguarding Children L2 (Trajectory)	90.00%	90.00%	90.00%	90.00%
% Compliance achiev ed	100.00%	100.00%	100.00%	60.00%
Total Headcount	3	2	2	65
Compliant Headcount	3	2	2	39
Safeguarding Children L3 (Trajectory)	90.00%	89.79%	90.00%	90.00%
% Compliance achiev ed	80.07%	74.90%	72.18%	72.08%
Total Headcount	271	263	266	265
Compliant Headcount	217	197	192	191
Safeguarding Adults L2 (Trajectory)	90.00%	90.00%	90.00%	90.00%
% Compliance achiev ed	95.85%	95.74%	95.10%	91.95%
Total Headcount	289	282	286	348
Compliant Headcount	277	270	272	320
Mental Capacity Act - Level 2a (3 Year	54.33%	58.80%	63.83%	68.58%
% Compliance achiev ed	57.76%	63.50%	69.50%	73.28%
Total Headcount	348	337	341	348
Compliant Headcount	201	214	237	255
Deprivation of Liberty - Level 2b (3 Yea	54.20%	58.12%	61.48%	65.41%
% Compliance achiev ed	57.93%	63.80%	70.67%	74.43%
Total Headcount	347	337	341	348
Compliant Headcount	201	215	241	259

The OGN planned trajectories are focused on initially achieving training compliance in three focused areas. Obstetric Emergency Drills (PROMPT), Fetal Monitoring (K2 training package) and Neonatal Life Support (NLS). These three areas were identified as the greatest focus for improvement to ensure the quality and safety of maternity services. Matrons for each area undertake a focused 1-1 with staff whose training is overdue to support and facilitate access and time to undertake training during the months May to August 2022. Compliance rates are managed, monitored, and reported weekly to the triumvirate.

Significant progress has been made with the fetal monitoring K2 training compliance and PROMPT skills and drills. A 90% compliance is required for each staff group. This threshold has now been met for all midwives however it is noted Obstetric medical compliance for PROMPT is 71% for July. The Clinical Director is aware and is aiming to increase PROMPT training compliance in the team once the annual leave period is over.

Fetal monitoring training compliance for midwives is now 94.1% and obstetricians 93%.

A new senior midwifery role was appointed to in July to with the aim of continuing to drive clinical excellence at pace in all elements of fetal surveillance. The successful candidate will commence in post in November 2022.

Fresh Eyes rolling weekly Case Review Audit (commenced May 2022) **–**

- Rolling weekly review of 10 CTG cases to benchmark against NICE guidance
- July data shows 82% compliance in Fresh Eyes review (increase from 15% from 2021 audit)
- All cases reviewed were categorised and escalated appropriately

Training compliance trajectories >90% for PROMPT and NLS by August 22, (additional training days have been introduced) are progressing. The PROMPT position for July 2022, Midwifery,90.5% (May 78.8%) Obstetricians 71% (May 82.5%). June NLS Midwifery compliance 88.9% (May 65.2%). Progress is steadily improving.

The updated trajectory for midwives and obstetric colleagues has been developed around the principle of preventing harm for women and babies. To do this, priority has been given in the allocation of training to midwives working in the intrapartum environment first, followed by antenatal wards and then other staff.

The next three priority training compliance trajectories have been identified by the triumvirate which are: Safeguarding L3, MCA and DoLs. Compliance progress will be reported through this paper.

6. JESSOP WING - MATERNITY DASHBOARD (APRIL - JULY 2022)

The Jessop Wing Maternity Dashboard and will continue to evolve over time to reflect data agreed regionally and nationally to assess the Trust progress against various quality indicators. Data is validated monthly at OGN Directorate Governance meeting.

Following receipt of communication from NHS England on the 15th February 2022, the caesarean section rate data will not be used as a maternity services quality metric.

The Robson Criteria are now recommended for use to monitor caesarean section activity without attached targets. The Robson Criteria classifies all women into one of 10 categories that are mutually exclusive and, as a set, totally comprehensive.

The categories are based on 5 basic obstetric characteristics that are routinely collected in all maternity provider organisations (parity, number of foetuses, previous caesarean section, onset of labour, gestational age, and fetal presentation).

The World Health Organisation (WHO) expects the Robson Criteria to support maternity care providers to:

I. Identify and analyse the groups of women which contribute most and least to overall caesarean section rates
II. Compare practice in these groups of women with other units who have more desirable results and consider changes in practice
III. Assess the effectiveness of strategies or interventions targeted at optimizing the use of caesarean section
IV. Assess the quality of care and of clinical management practices by analysing outcomes by groups of women
V. Assess the quality of the data collected and raise staff awareness about the importance of this data, its interpretation and use

Jessop Wing - Maternity Dashboard (to July 2022)

Antenatal	Green	Amber	Red	Apr 22	May 22	Jun 22	Jul 22
Community First Visits				492	554	497	516
Community First Visits Within 10 Weeks %	$n \geq 90$	$75 \leq n < 90$	$n < 75$	77.64	75.63	69.62	74.81
Smokers at Community First Visit %	$n \leq 6$			7.72	11.01	8.65	8.53
Clinic First Visits				464	513	466	453
Clinic First Visits Under 13 Weeks %				72.2	63.16	65.24	64.02
Clinic First Visits Smoker %	$n \leq 6$			9.91	10.14	11.37	10.38
Clinic First Visits CO Measured %				4.74	6.63	34.12	41.94
Clinic First Visits CO ≥ 4ppm				4.55	0	15.72	13.68
Community 36 Week Visits CO Measured %				15.21	36.83	51.58	55.86
Community 36 Week Visits CO ≥ 4ppm				2.13	13.79	10.71	12.71
CO reduced below 4ppm by 36 weeks %				15.79	0	13.33	0
Deliveries	**Green**	**Amber**	**Red**	**Apr 22**	**May 22**	**Jun 22**	**Jul 22**
Total Deliveries (mothers)				454	475	434	515
Registerable Births				456	483	441	528
Elective C Section Deliveries %				17.4	17.05	18.66	13.59
Emergency C Section Deliveries %				26.43	23.16	24.65	23.69
Assisted Deliveries %				9.69	9.26	8.53	11.26
Inductions %				21.81	25.68	27.88	24.47
Waterbirths				12	17	11	18
Homebirths				4	10	9	6
Born Before Arrival (BBA)				3	3	4	8
APGAR 0-6 %				4.46	3.87	3.33	3.59
Low birthweight (≤ 2500g) %				10.53	7.87	9.98	10.98
Under 3rd Centile delivered at 38wks+ %				55.17	70.59	65.22	72.41
Singleton Livebirths < 30wks with $MgSO_4$ %				75	83.33	83.33	100
Preterm births %				6.98	4.53	8.17	6.01
Singleton births 16w - 23+6 %				0.67	0.43	0.71	0.2
Singleton births 24w - 36+6 %				7.11	4.29	8.75	6.37
PPH ≥ 1500ml %	$n < 3$	$3 \leq n \leq 5$	$n > 5$	6.86	4.22	4.41	3.69
3rd and 4th degree tears (all) %				2.49	4.4	3.21	2.29
3rd and 4th degree tears (Normal) %	$n < 3$	$3 \leq n \leq 4$	$n > 4$	1.51	3.48	2.2	1.2
3rd and 4th degree tears (Assisted) %	$n < 5$	$5 \leq n \leq 9$	$n > 9$	7.14	9.3	8.33	7.14
Smokers At Delivery %	$n \leq 6$			9.51	9.07	10.67	7.38
First Feed Breastmilk %	$n \geq 75$	$70 \leq n < 75$	$n < 70$	67.92	71.16	66.13	67.05
Robson Group 1 having LSCS %				28.72	27.27	31.25	24.42
Robson Group 2 having LSCS %				64.29	60.76	56.45	54.02
Robson Group 5 having LSCS %				76.71	74.32	82.67	76.39
VBAC (Local) %				21.98	25	22.47	20.99
VBAC (NHSD) %				14.55	17.07	23.81	21.57
Neonatal	**Green**	**Amber**	**Red**	**Apr 22**	**May 22**	**Jun 22**	**Jul 22**
Neonatal Unit Admissions				47	45	50	41
Neonatal Unit Admissions %				10.4	9.34	11.44	7.81
Neonatal Unit Admissions at Term				22	23	27	14
Neonatal Unit Admissions at Term %				4.87	4.77	6.18	2.67
Mortality	**Green**	**Amber**	**Red**	**Apr 22**	**May 22**	**Jun 22**	**Jul 22**
Stillbirths				4	1	4	3

Stillbirths ‰ (per thousand)	$n \leq$ 2.55			8.77	2.07	9.07	5.68
Stillbirths at Term				2	1	1	0
Stillbirths at Term ‰ (per thousand)				4.39	2.07	2.27	0
Feticide (Stillbirth)				1	0	2	0
Stillbirths excluding feticide ‰ (per thousand)				6.58	2.07	4.54	5.68
Neonatal Deaths				2	4	3	
Neonatal Deaths ‰ (per thousand)	$n \leq$ 1.45			4.42	8.3	6.86	
Neonatal Deaths ≥ 24 weeks				1	3	2	
Neonatal Deaths ≥ 24 weeks ‰ (per thousand)				2.21	6.22	4.58	
Neonatal Deaths at Term				0	1	0	
Neonatal Deaths at Term ‰ (per thousand)				0	2.07	0	
LW Assessment	**Green**	**Amber**	**Red**	**Apr 22**	**May 22**	**Jun 22**	**Jul 22**
Calls to Triage Service				3011	2906	2861	3252
LWAU Admissions				1110	1051	1038	1180
LWAU Rapid Reviews %	$n \geq 95$	$80 \leq n <$ 95	$n <$ 80	89.82	95.81	93.06	94.49
LWAU Rapid Review Time (mins)	$n \leq 30$	$30 < n \leq$ 45	$n >$ 45	38	32	30	33

- LWAU rapid review timings continue to remain stable.
- PPH rate continues to reduce month on month

7. NHS RESOLUTION (NHSR)

7.1 Maternity Incentive Scheme (MIS)

Year 4 of the MIS was launched in August 2021. All maternity care providers in England were notified in December 2021 that in recognition of the current pressure on the NHS and maternity services, the majority of reporting requirements demonstrating achievement against the MIS 10 Safety Actions were paused with immediate effect for a minimum of 3 months.

Trusts were asked to continue to apply the principles of the 10 safety actions, given that the aim of the MIS is to support the delivery of safer maternity care. Examples of continuing to apply the principles include undertaking midwifery workforce reviews, ensuring that as far as possible the oversight provided by the maternity, neonatal and board level safety champions continue, as well as using available online training resources.

NHSR relaunched the MIS on 6th May 2022 when updated guidance was published. The scheme's submission deadline has been extended from June 2022 to 5th January 2023 to provide Trusts with extra time to achieve the standards. Interim timeframes within each of the safety actions have also been reviewed and extended. The scheme's conditions have also been reviewed and strengthened. The new conditions include the following additional requirements: The declaration form to be submitted to Trust Board with an accompanying joint presentation detailing maternity safety action by the Midwifery Director and Clinical Director for Maternity Services. The CEO of the Trust will ensure that the Accountable Officer (AO) for their Clinical Commissioning Group/Integrated Care System (CCG/ICB) is appraised on the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution.

STH were informed that following a review of the evidence submissions for MIS Years 1 and 2, the trust did not achieve the required standard of evidence compliance. STH/Jessop Wing Maternity services were encouraged to bid for additional compensatory NHSR funding awards to support maternity improvement for Year 2. MIS Year 2 award bid was successful at £184,000.

7.2 Current CNST position

	Safety Action	Aug 22	Confidence for compliance by Jan 5th 2023	Notes
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?			Reporting dates missed on Y4 tracker.
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			Evidence available
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?			Evidence available
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?			BR+ assessment undertaken workforce plan in progress
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?			BR+ assessment undertaken workforce plan in progress
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?			Element 1 - Not meeting the required standard. Element 2 - Unable to report metric (not collected in MIS). Audit of Q1 to be completed by end of Sept 22. Element 3 - Audit of Q1 to be completed by end of Sept 22. Element 4 - Compliant. Element 5 - Not meeting the required standard.
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?			Evidence available
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?			PROMPT - Not meeting the required standard. CTG - Compliant. NLS - Not meeting the required standard.
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?			The Maternity and Neonatal Safety Report is a component of this evidence.

10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?			Evidence available

7.3 Thematic Review

As described previously, in November 2021 NHSR undertook a thematic analysis of the cases that Sheffield Teaching Hospitals NHS Foundation Trust (STHNFT) reported to the Early Notification (EN) scheme. The thematic analysis was undertaken in response to the recent Care Quality Commission (CQC) inspection. The purpose of the review was to provide details of the themes on cases reported into the EN scheme, which should be used to inform future quality and safety improvement work within the Trust.

The triumvirate have met to address the points raised and a response was returned within the given time frame of 29th July.

NHS Resolution responded on 26th August confirming they were reassured with the Jessop Wing maternity improvement work and no further actions were planned.

8. BOARD LEVEL SAFETY CHAMPIONS MEETINGS

The role of this group is to share and as necessary escalate locally identified issues to the board via the executive board member who is the named Maternity & Neonatal Safety Champion.

Specific responsibilities are:

- To review and summarise published national reports, providing assurance that all actions required locally are being monitored and completed in the required timescales
- To review inspection reports and any feedback from women and their families
- To receive the quarterly Yorkshire and Humber Maternity Dashboard and review the benchmarked position
- To report by exception any concerns on local patient safety
- To receive and discuss any themes identified from internal sources around mortality and quality improvement
- To report on progress against the Maternity Incentive Scheme (CNST)
- To report on progress with achieving aims of the Maternity & Neonatal Transformation and LMS

The inaugural meeting was held on July 14th where the Maternity Safety Plan, Ockenden report, Perinatal Clinical Quality Surveillance, LMNS updates Maternity and Neonatal Health service collaborative, staff feedback, patient experience plan and ATAIN were discussed.

Feedback from staff generated during the Board level Safety Champion walk round included:

- Escalation concerning delays in Estates work on Whirlow ward
- Positive comments about the contribution of the IR RNs and skill mix.

9. WORKFORCE

9.1 Maternity Workforce

NHS Maternity services have seen significant change and development over the last decade, driven by an ambition and vision to deliver the best care to women, babies and families. Central to this has been the overarching policy publication of the National Maternity Review (2016) *Better births: improving outcomes of maternity services in England – a five year forward view for maternity care.*

Subsequently, recommendations from the Ockenden Independent Maternity review (December 2020) have further strengthened the requirement for providers and Local Maternity & Neonatal Systems (LMNS's) to provide safe high-quality care; with workforce included as one of the seven immediate and essential action's (IEA's) for staff training and working together. The NHS Planning guidance March 2020/21 have reset these priorities with a focus on LMNS's continuing to drive the Better Births (2016) ambitions including an emphasis on the health and wellbeing of the workforce to ensure a sustainable pipeline of recruitment and subsequent retention of staff.

There continue to be vacancies in the midwifery workforce, however, RM and RN fill rates are predominantly greater than 90%.

Jessop Wing Fill Rates								
	April		May		June		July	
	Day	Night	Day	Night	Day	Night	Day	Night
Labour Suite	86.5%	85.5%	93%	95.2%	95.7%	91.9%	93.5%	88.2%
Rivelin	97.7%	96.7%	89.4%	98.6%	87.6%	100.3 %	90.4%	93.8%
Norfolk	107.8 %	100%	117.5 %	92.2%	110.5 %	95%	103.1 %	103.6 %
Whirlo w	100.7 %	100.1 %	111.4 %	101.9 %	119.6 %	105.1 %	111.5 %	102.7 %
NICU	86.6%	84.3%	82.5%	86.4%	80.3%	82.3%	89.0%	85.2%

Table 4 Midwifery staffing fill rates for April-July 2022

* Advanced Obstetric Care Unit(AOCU), Norfolk and Whirlow wards are using Registered Nurses (RN) alongside midwives to provide care for post-natal women and their babies.

Where there are identified challenges to safe staffing the following steps are taken:

- Request midwifery staff undertaking specialist roles to work clinically
- Elective workload prioritised to maximise available staffing
- Managers at Band 7 level and above work clinically
- Reallocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained
- The on-call midwives from the community to support labour ward during times of escalation.
- Request additional support from the on-call midwifery leadership team.
- Enhanced NHSP rate continues
- Use of Agency Midwives
- Supporting midwives by using Registered Nurses (RN) as part of the skill mix to enhance safety in postnatal and Advanced Obstetric Care Unit (AOCU) environments.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies. It is preferable to have higher fill rates during the night-time when there is less support available from specialist midwives and managers. Actions taken to support safe staffing are captured in the live Birth-rate Plus (BR+) web-based acuity tool. The BR+ acuity tool is now live on the Labour suite (Consultant led and Midwifery Led), the antenatal ward (Rivelin), and the Postnatal wards (Whirlow and Norfolk). Realtime acuity and activity information is available to maternity services leadership teams on or off site. Teams are being supported to continually improve the quality of data input and they continue to grow in confidence in using this tool. The matrons for inpatient areas and Labour Suite are working with the Midwifery Director to utilise the Birthrate Plus acuity app data to undertake a monthly red flag report which will facilitate triangulation of incidents, complaints, with maternity workforce Red flags.

A maternity Red flag section will be shared in future papers for assurance and oversight. Birthrate Plus representatives are undertaking further training for band 7 midwives and matrons in August. This will enable a review of all information to date and enable further understanding of acuity and activity in the service.

Further initiatives to enhance the maternity workforce include:

- Five RNs in NNU are due to start Qualified in Specialty (QIS) training in September and a further five are due to start Foundation training (pre-QIS) in October.
- A Fetal surveillance matron has been successfully appointed and is expected to commence in the Trust in November 2022.
- A rolling recruitment advert for experienced AFC band 5/6 midwives continues.
- LMNS centralised recruitment for newly qualified midwives (NQM's) complete. 28 NQM's offered positions at JW. This position reflects an increase in the number of NQM's requesting to work at JW. 19 NQM's have confirmed they have accepted roles at JW and are due to start from September 2022 onwards.
- NHSEI funded (2 years), Recruitment and Retention, Pastoral Support Midwife AFC band 7 role has now been appointed externally.
- HEE funded RM shortened course for STH RNs progress continues in collaboration with Sheffield Hallam University (SHU) roll out planned for January 2023.
- Feedback to SHU from interim Midwifery Director on behalf of SYB LMNS HoMs/DoM's in support of a midwifery apprentice course opportunity to enhance the inclusivity of midwifery training opportunities in the system.
- Recruitment of 15 WTE AFC band 2 Clinical Support Workers (CSW) who will undertake the AFC band 3 Maternity Support Worker (MSW) apprentice course at Sheffield College. Now in post, course commences September 2022.
- Recruitment of 12 WTE International Recruited (IR) Registered Midwives (RM)s. The first IR midwife has passed her OSCE and is having a period of supportive practice. One further IR midwife is scheduled to arrive in November 2022 and four further IR midwives in January 2023.
- Reintroduction and communication of family friendly/flexible work patterns. Midwifery leaver rates have reduced, full workforce data not available at time of report.
- Work continues to review, develop and improve current skill mix practices in the Jessop Wing. Key principles to observe when incorporating maternity support workers and RNs in the maternity workforce skill mix is to utilise skills to complement maternity care and are not a substitute for RMs. BR+ recommendations reflect that 20 - 25% of midwifery time spent delivering postnatal care in hospital and community can be safely, and without reducing quality, be delivered by a MSW or Registered Nurse (RN) (hospital setting only).

9.2 Obstetric Workforce

Current Gaps:

Number of posts	Reason for gap	Resident Night Rota
2	Maternity Leave	Yes
2	Phased return – no clinical work or resident nights	Yes
1	Long Term Sick	Yes
1	Funded vacancy – recently advertised	Yes
1	Sabbatical – Health related- phased return; no clinical work	No

Recruitment:

2 jobs recently advertised on NHS jobs:

Post	Closing date	Outcome
Consultant Obstetrician	12th June 2022	No applicants
Consultant Obstetrician with a specialist interest in Fetal Medicine	12th June 2022	Shortlisted candidate withdrew

Posts not appointed to; no posts currently being advertised. Currently working with an agency to secure the most appropriate locum colleagues.

Mitigation:

- 3 Locum Consultants in place (2 contribute to resident night rota)

Registrar Level

Current Gaps:

WTE	Level	Reason for gap	Labour Ward On Call
3.8	ST3+	Training programme gap	Yes
2	ST1/2	Training programme gap	Yes

It is anticipated that the registrar level vacancies will be filled by the end of September 2022.

Recruitment:

Post	Interview date	Outcome
Staff Grade Specialty Doctor	4th July 2022	2 WTE candidates appointed – recruitment process ongoing and a start date of October is expected pending right to work sponsorship.

Mitigation:

- ST3+ - existing team being utilised to cover Labour Ward / On Call gaps at the detriment to gynaecology clinic/activity
- ST1/2 – Locums in post to offset the gap

9.3 Neonatal Workforce

The neonatal unit (NNU) team continue to work toward compliance with the British Association of Perinatal Medicine (BAPM) standards. The Neonatal Operational Delivery Network (ODN) has completed a workforce review which shows deficits in staffing. Rolling recruitment is in place, 11 IR RNs have commenced in post in May, 10 have now passed their OSCE's. Work continues towards achieving 70% of RN staff to be qualified in speciality (QIS).

10. INSIGHTS FROM SERVICE USER ENGAGEMENT AND MATERNITY VOICES PARTNERSHIP (MVP) CO-PRODUCTION

Jessop Wing maternity and neonatal services continue to have a collaborative relationship with the MVP in jointly working on the experience of women and families including:

- Overseeing the mechanism for collecting service user feedback: Friends and Family Test; MVP Flyers / posters in clinical areas and information/links to contacting the MVP in handheld records
- Bimonthly minutes of MVP meetings with Terms of Reference
- Successful co-produced recruitment of a second MVP co-chair
- Chief Nurse and Interim Director of Midwifery support for increased financial renumeration for MVP Chairpersons raised with CCG (now ICB) colleagues. Additional funding now confirmed.

- Co-production work:
    - Designing bed boards for clinical areas
    - Developing a new website/ coproducing films following the pregnancy journey with an ethos of being multicultural, equity and inclusivity
- Supporting the PMRT process of communication with families where a PMRT report had not been shared.
- MVP members attendance at maternity governance meetings.
- Co-design of patient information leaflets May 2022 onward.
- Planned MVP attendance at all interviews of senior midwifery positions.

The MVP attended Jessop Wing to conduct a 15 steps challenge looking at infant feeding. Full feedback will be provided at September's MVP meeting however one initial action of decluttering notice boards is already being carried out. The event highlighted the need for a more diverse selection of art to be displayed around Jessop Wing and reinforced the need to progress the Estates improvement plan to improve the environment. A meeting has been scheduled for September with the Estates Director to finalise an action plan for the forthcoming year.

11. CARE QUALITY COMMISSION (CQC)

11.1 Maternity Action Plan/ Birmingham Symptom Specific Obstetrics Triage System (BSOTS)

The triumvirate can confirm that Birmingham Symptom Specific Obstetrics Triage System (BSOTS) was successfully launched on 5th September 2022. As described previously, BSOTS standardises the care received and timely risk assessment of women attending the Labour Ward Assessment Unit now renamed the Maternity Assessment Center (MAC). The MAC Lead Midwives have undertaken clinical pathway training with midwives and obstetric staff prior to the launch.

Interim estates work began in July 2022 to provide a monitoring bay for 4 women, a dedicated triage / rapid review clinical room and new office with set up aligned with BSOTs flow. The Jessop Maternity Information System (JMIS) logs the time of a mothers arrival and clinical triage outcome. The BSOTS pathway and patient record is paper based to ensure a complete contemporaneous clinical picture for clinical risk assessment.

Progress with BSOTS will continue to be reflected and monitored with the other CQC must do actions in the Maternity Quality & Safety Improvement Programme. The programme was shared at the June Board of Directors by the Chief Nurse.

11.2 CQC escalations

For the month of July 2022 there was one issue raised with the Trust by the CQC following a concern by a mother awaiting an induction of labour on Rivelin ward. This concern arose during the period of extreme hot weather which compounded the experience of an extended inpatient stay for this mother. All care was reviewed, the mother had been risk assessed appropriately and received care in accordance with Trust guidance. The mother went on to birth a healthy baby and discussed her concerns with the Intrapartum Matron following the birth. CQC were satisfied with the Trust response.

12. OCKENDEN REPORT 2020 7 IMMEDIATE AND ESSENTIAL ACTIONS (IEA'S)

The 7 IEAs are:

- IEA 1 Enhancing safety by partnership working between trusts to investigate and share learning from serious incidents
- IEA 2 Listening to women and families by having advocates on boards

- IEA 3 More partnership working through a focus on multidisciplinary staff training and twice daily consultant led ward rounds
- IEA 4 Specialist expertise in managing complex pregnancies
- IEA 5 Regular antenatal risk assessments
- IEA 6 Improved fetal monitoring training and embedding of *Fresh Eyes* review and audit.
- IEA 7 Women need to have accurate information to make informed choices to enable informed consent

A current state self-assessment exercise was undertaken by the Triumvirate and the Maternity Improvement Advisor in addition to a review of the evidence provided to date. This has resulted in a robust plan to progress and evidence the Trust's position at pace. All evidence to support our submission is being stored in one central location with live links inserted into the overall Maternity Improvement Programme tracker, which incorporates the Ockenden IEA's.

Work has now begun on the remaining 15 Ockenden IEA's

Progress has been made on:

- The production and further development of this Maternity and Neonatal Safety Report, presented monthly by the Clinical Director, Midwifery Director, and the Operations Director to the Board of Directors meeting.
- The Maternity Dashboard
- On-going development of MVP relationship and Jessop Wing website
- Refreshed Maternity Safety Champions programme and schedule of meetings, with Terms of reference, agenda, and infographic for all clinical areas.
- Launch of BSOTS scheduled for 5th September.
- Audit of "Fresh Eyes" fetal surveillance compliance and escalation commenced in May, reflecting standards from SBLvs2 and CNST MIS Year 4.
- New Fetal Surveillance 8a matron role appointed
- Intense support and effort to improve the Governance processes around Serious Incident reporting and investigating
- Refresh of the Training Needs Analysis (TNA)
- The Trust has been fully involved with the Networked Maternal Medicine service and will now focus on local SOPs to support this service once it is operational.

Full compliance all Ockenden IEA's will continue to be compromised by the on-going lack of an integrated and effective Maternity Information System (MIS) to both guide practice, record evidence of actions undertaken and report on compliance through robust audits.

Outline Business case currently being written to detail the case for investment in an appropriate MIS.
In the interim, mitigation has been proposed by the Triumvirate and agreed by the Maternity Improvement Board. From September, a full paper based end to end maternity record (hand held record) is in place, including paper documentation from BSOTS, this will facilitate a complete pregnancy history for clinicians to risk assess and plan care safely.

The backlog and on-going capacity and process issues around Serious Incidents (SI's) – notably the Perinatal Mortality Review Tool (PMRT) and Health Services Investigation Board (HSIB) cases – remain a significant factor in our non-compliance, despite plans being in place to remedy this.

13. AVOIDABLE TERM ADMISSIONS INTO THE NEONATAL UNIT (ATAIN)

13.1 The National Ambition

In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The

safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030.

This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on:

a. Reducing harm through learning from serious incidents and litigation claims
b. Improving culture, teamwork, and improvement capability within maternity units.

13.2 Why is ATAIN important?

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

13.3 Jessop Wing Transitional Care

A weekly review of all term admissions is undertaken by the ATAIN team which includes representation from obstetric, maternity, and neonatal services and are classified as an avoidable, or unavoidable admission using the LMNS classification criteria. The collated data is submitted monthly onto the electronic SYB LMNS ATAIN Quality Improvement dashboard. Actions are developed and agreed to address any themes highlighted by the review process and reflects the requirements outlined in the year four Maternity Incentive Scheme. The action plan triangulates with actions and themes via other governance routes; Quality & Safety Meeting, HSIB, SI reports, CQC recommendations for term admissions.

The Jessop Wing has a sustained term admission rate to NNU as a percentage of live births below the local target of 5% (national aim <6%). The year 2021-2022 overall was 3.6% which was lower than previous years and will have had a positive impact on women, babies, and families.

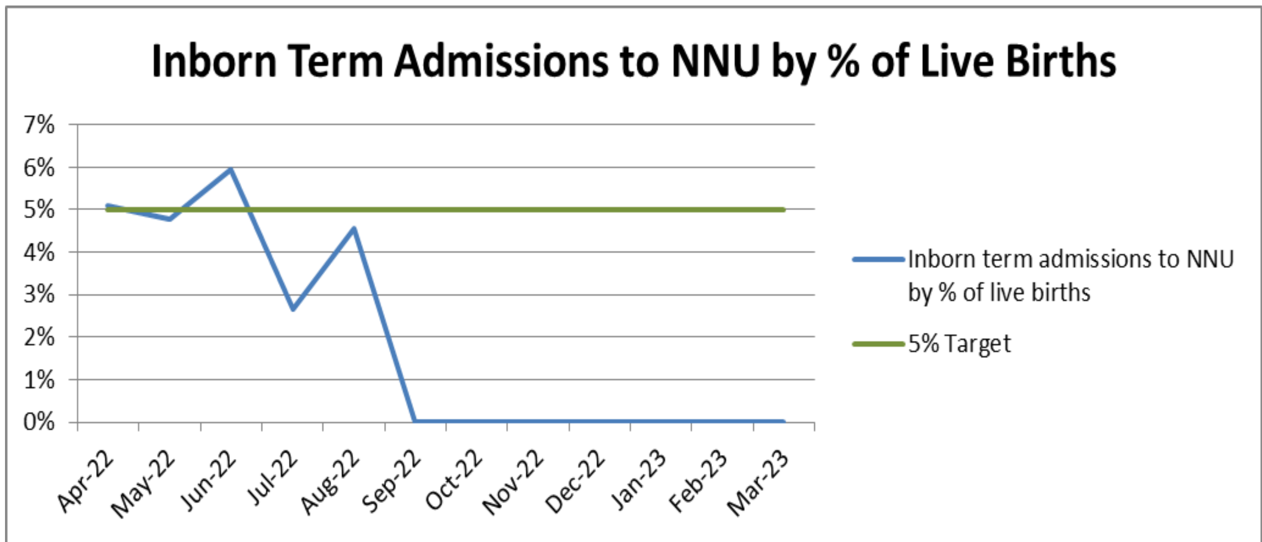
In quarter 4, for the month of March we saw an increase to 5.8% which remains just below the national aim but above the local target of 5%. In April, the term admission rate was 4.82%, returning below the local target, this was maintained in May 2022 with a term admission rate of 4.77%. In June 2022 an increase to 5.9% was observed, which is above the local target, but below the national target. Of the 26 term admissions to the NNU in the month of June five babies were considered potentially avoidable on review by the team, with one baby term admission declared an SI via the Patient Safety Review process.

In July term admissions to the NNU were 2.9% which continues to be below both the local (5%) and national (6%) target. Of the 14 term admissions to NNU in July, one baby was excluded from the review process due to congenital anomalies, two babies were considered potentially avoidable on review by the ATAIN team

Overall, Q1 2022/23 25% of term babies admitted to the NNU were considered potentially avoidable and an Action plan for 2022-2023 has been updated by the ATAIN team to address the 4 themes:

- Hypothermia
- Delayed transition post birth/period of observed grunting
- Babies with a raised lactate
- Facilitating discharge back to mu

Year 2022 – 2023



14. CONCLUSION

This report has outlined locally and nationally agreed measures to monitor maternity and neonatal safety to inform the Board of Directors of present or emerging safety concerns and the work currently being undertaken to mitigate and address those risks.

In summary the report has identified the following issues to be addressed:

a. An Outline Business Case is being prepared for a Maternity specific information system as this is not currently in place at the JW, and this has been identified as a barrier to progressing improvements at pace. In the interim, mitigation has been proposed by the Triumvirate and agreed by the Maternity Improvement Board. A full paper based end to end maternity record (hand held record) is in place, this will facilitate a complete pregnancy history for clinicians to risk assess and plan care safely.
b. Significant progress has been made in the top three maternity training compliance priorities.
c. A plan is in place to ensure that historical PMRT reports not shared with families is addressed on a case-by-case basis. Steady progress with families continues from 2019/20 cases.
d. External maternity governance support has been secured to help recover the backlog of SI investigations and upskill the maternity governance team.
e. A key element of the CQC must do action plan is to ensure the completion of risk assessments for women on arrival via the implementation of BSOTS. This is now in place and has been positively received

APPENDIX 1

Trust: Sheffield Teaching Hospitals NHS Foundation Trust April 2022

CQC Maternity Ratings 2019	**Overall**	**Safe**	**Effective**	**Caring**	**Well-Led**	**Responsive**
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:
Jessop Wing	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate

Maternity Safety Support Programme	Select Y / N	**Yes**

	April	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
1.Findings of review of all perinatal deaths using the real time data monitoring tool	0	0	0	0					
2. Findings of review of all cases eligible for referral to HSIB	No cases reviewed	1	0	0					
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	See section 3.6	See section 3.6	See section 3.6	See section 3.6					
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	See section 5	See section 5	See section 5	See section 5					
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	See section 9	See section 9	See section 9	See section 9					
3.Service User Voice Feedback	See section 10	See section 10	See section 10	See section 10					
4.Staff feedback from frontline champion and walk-abouts				YES					
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	HSIB-1 CQC-1 NHSR-1	HSIB-0 CQC-0 NHSR-0	HSIB-0 CQC-3 NHSR-0	HSIB-0 CQC-1 NHSR-0					
6.Coroner Reg 28 made directly to Trust	2	0	0	0					
7.Progress in achievement of CNST 10	To be assessed	In progress	In progress	In progress					

8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	Reported annually
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	Reported annually

Annual Work Plan

April 2022 - March 2023

Prepared by: Kris McKeown, Ella Sprung and Sharon Tunnacliffe

Date: 13/04/2022

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Executive Summary

Sheffield MVP has had an active year, we have conducted a '15 Steps' process for the Antenatal Clinic area, the findings of which have been gratefully received by staff, and taken part in the recruitment of the Cultural Safety lead midwife, as well as being an open route for feedback to be collected and to reach the heart of the service. Sheffield Teaching Hospitals has had the challenge of an 'inadequate' CQC rating, as well as the actions required due to the findings of the Ockenden report; work which is still ongoing, and will involve the MVP being placed ever more at the centre of the development of the maternity service.

Overview

The Sheffield MVP is a team of maternity professionals and lay people who work together to review and improve local maternity services, by putting birthing people and their families at the centre. Members include, midwives, representatives of the Sheffield CCG, perinatal mental health and 0-19 service, Healthwatch Sheffield, La Leche League Sheffield, Sheffield Light, NCT, and Sheffield Autism Partnership Network, as well as service user representatives.

The Sheffield MVP holds the philosophy that people are the experts in their own needs and their own lives, and that having people's voices at the centre of their care is key. One of our aims is to continue to work towards reaching more diverse groups of people, building on the work that has already been done. To do this we plan to reach out through visiting community groups across the city, especially in areas from which we don't often receive feedback.

The Team

Kris McKeown: Co-chair, Sheffield MVP
Ella Sprung: Co-chair, Sheffield MVP
Sharon Tunnacliffe: Obstetrics, Gynaecology and Neonatal Experience Lead Midwife

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Action Plan

Goal 1: Core MVP tasks						
Key Action Steps	**Timeline**	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**	**Comments**	**Co-chairs time allocation (days)**
Outreach sessions around Sheffield	Ongoing	Learning from a wider range of service users and bringing that expertise back to the Trust	Meeting notes	Ella Sprung and Kris McKeown	Aim for 6 sessions in the first year	**12**
Receiving, compiling, and passing on feedback from online form	Ongoing	Issues fed back to the relevant staff member at Jessop Wing	Document held on MVP Drive – meeting notes when fed back	Ella Sprung and Kris McKeown	Report at quarterly MVP meeting	**4**
15 Steps: four areas	Ongoing	Increased awareness of patient experience leading to improvements in four areas, celebrate positives	Records made during process	Ella Sprung and Kris McKeown	Offered to four areas over this year (eg wards, triage). 1 day each co-chair per area. Other service users will be invited to participate.	**8**
Responding to enquires from staff and service users	Ongoing	Being a point of contact for the MVP	Email	Ella Sprung and Kris McKeown	1 hour in total per week	**7**
Regular meetings with external groups	Ongoing	Maintain and create new relationships with groups whose	Meeting minutes	Ella Sprung and Kris McKeown	Approximately 2 meetings per month, 1 hour each	**3.5**

		work is relevant to Sheffield MVP				
Maintaining a social media presence	Ongoing	Regular activity on MVP Facebook group and responsiveness to contacts via social media		Ella Sprung and Kris McKeown	One post per week plus shares of relevant information (30 mins per week)	**3.5**
Regular MVP meetings: prepare and chair	Quarterly	Preparation of agenda, chairing of meetings, editing minutes. Networking with other potential members (groups and individuals).	Meeting minutes	Ella Sprung and Kris McKeown	One co-chair: 2-hour meeting + preparation (both co-chairs)	**4**
Recruiting and supporting volunteers	Ongoing			Ella Sprung and Kris McKeown	Total of one day per month	**12**
Attend STH Cultural Safety Forum meetings	Monthly	Learn from and contribute to the work of this group	Meeting minutes	Ella Sprung and Kris McKeown	One co-chair (1.5-hour meeting)	**2.5**
Attend LMNS meetings	Bimonthly	Co-ordinate regionally	Meeting minutes	Ella Sprung and Kris McKeown	One co-chair (1.5-hour meeting)	**1.5**
LMNS Service User Lead (Hayley McGovern) catch up meeting	Monthly	Co-ordinate regionally	Meeting minutes	Ella Sprung and Kris McKeown	One co-chair (30 min meeting)	**1**
Meet with senior staff members from STH	Quarterly	Communicate on current issues, give feedback where relevant	Meeting minutes	Ella Sprung and Kris McKeown	Both co-chairs (1 hour meeting)	**1**
Attend city-wide perinatal mental health meetings	Quarterly	Learn from and contribute to work of this group	Meeting minutes	Ella Sprung and Kris McKeown	One co-chair (90 min meeting)	**1**

Meet with Head of Midwifery	Monthly	Communicate on current issues, give feedback where relevant	Meeting minutes	Ella Sprung and Kris McKeown	One co-chair present (30-minute meeting)	**1**
Attend internal Trust meetings: Governance and Safety	Monthly	Taking service user voice to meetings.	Meeting minutes	Ella Sprung and/or Kris McKeown	1 day/month	**12**
Co-chair update meetings	Weekly	Able to efficiently co-ordinate activities	Meeting minutes	Ella Sprung and Kris McKeown	30 mins weekly catch up (both co-chairs)	**7**
Regional MVP chair meetings	Monthly	Support and information enabling joint working across the Yorkshire region	Meeting minutes	Ella Sprung and Kris McKeown	One co-chair, 1 hour meeting	**1.5**
New co-chair training	One off training for new co-chair (tbc, mid 2022)	Training for new role		Ella Sprung		**1**
Induction process for new co-chair	One off (April-May 2022)	Induction to role, creation of resources to enable joint working (e.g. Action Tracker, Workplan, resource mapping)	Action Tracker, Workplan, resource mapping document	Ella Sprung and Kris McKeown	3 days for new co-chair, 2 for existing co-chair	**5**
Other training and events (external)	Ongoing	Increase knowledge, widen knowledge and reach of Sheffield MVP		Ella Sprung and Kris McKeown	4 days over the year total	**4**
Responding to ad hoc requests from Trust (eg baby loss letter)	Ongoing	Respond to small requests from the Trust for input on specific issues		Ella Sprung and Kris McKeown	4 days in total over the year	**4**
Creation of Annual Report 2022/3	March - April 2023	Communicating on work done and plans for following year	Annual Report	Ella Sprung and Kris McKeown	1 day for each co-chair	**2**

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Work planning for 2023/4	Late 2022 - early 2023	Forward planning for next year	Workplan 2023/4	Ella Sprung and Kris McKeown	1 day for each co-chair	**2**
Goal 2: Improvements to the antenatal clinic areas of Jessop Wing						
Key Action Steps	**Timeline**	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**	**Comments**	**Total co-chair time input 4 days**
New seating	Ordered Feb 2022, expected July 2022.	More comfortable seating in clinic	Walk the patch in clinic	Sharon Tunnacliffe and Laura Perkins	Review impact once in place Dec 2022	
Shop at the front	Conversation with estates April 22. Work prior to covid on installing a shop at the main entrance. Due March 2024.	Entrance more welcoming, place for people to get refreshments, help with flow through the building	Walk the patch/15 steps	Sharon Tunnacliffe / Operational managers STH		
Signage	In development – old signage being replaced. Due July 2022.	Easier for people to find their way through the building.	15 steps	Sharon Tunnacliffe, Kris McKeown, Ella Sprung	Signage can be adapted easily in the future if needed.	
Creation of new artwork for main level one corridor, FMU rooms, Clinic waiting area, parentcraft room.	Initial sketches in production, timeframe tbc with artist with work to begin by April 2023.	Improvement of environment throughout level one areas.	15 steps	Kris McKeown and Ella Sprung		
Investigate symbols for signs	Due May 2022	Find out what other units use and find effective.	National MVP group, ask service users for opinions.	Kris McKeown		
Appointment letters	Looked at once signage is updated. Due August 2022	People have a clearer idea about who their appointments are	Walk the patch / feedback from service users	Kris McKeown and Ella Sprung /		

		with and what they are for and tie with signage.		Sharon Tunnacliffe/ Admin Team		
Evaluation/gathering feedback on changes	Autumn 2022	Learn what is working and what might need further changes in future	Walk the patch, social media feedback, included in outreach work where possible	Kris McKeown and Ella Sprung		
Goal 3: Creation of video library						
Key Action Steps	**Timeline**	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**	**Comments**	**Total co-chair time input 20 days**
Identify and prioritise which videos are required – guided by CQC National Maternity Survey 2021 and local feedback and outcomes.	Due September 2022	A list of videos to be produced, in priority order.		May Stevens Cultural Safety Midwife / Sharon Tunnacliffe / MVP leads		
Scope multilingual staff for filming	To align with video productions July 2022- Mar 2023	Relevant staff members can contribute their skills to the project; films are made available in different languages	Positive video reviews/ feedback	Sharon Tunnacliffe		
Gathering service user input into each film	July 2022 – Mar 2023	Co-produced project, films are useful and relevant to all people accessing the maternity service	Positive video reviews/ feedback	MVP Leads / Patient experience feedback		
Participation in filming	July 2022 – Mar 2023	MVP features in relevant films	Positive video reviews/ feedback			

Gathering feedback once some films have been created	July 2022 – Mar 2023	Later films are informed by feedback given to earlier films	Positive video reviews/ feedback			
General project administration	July 2022 – Mar 2023	Attending meetings, communication by email	Positive video reviews/ feedback			
Goal 4: Participation in Induction of Labour information project						
Key Action Steps	**Timeline**	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**	**Comments**	**Total co-chair time input 20 days**
Facilitating service user input into project	July 2022 – Mar 2023	Project is coproduced in a meaningful way from start to finish, leading to information being produced that is useful and relevant, and improves care during induction of labour				
Project management/general project administration	July 2022 – Mar 2023	Attending meetings, communication by email				
Goal 5: Jessop Wing website update						
Key Action Steps	**Timeline**	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**	**Comments**	**Total co-chair time input 8 days**

Providing review work previously completed to staff working on updating Jessop Wing website (review of website)	April 2022 – Mar 2023	Website update project benefits from review work previously completed by MVP co-chairs		Kris McKeown		
Liaising with staff to create content and structure of website, bringing in service user voices	April 2022 – Mar 2023	Updated website, which is easier to use, more friendly and welcoming, and more informative. Work is coproduced with service users.		Ella Sprung and Kris McKeown		
Gathering feedback on changes	August – Mar 2023	Website changes are confirmed to be working for people, or if not then further changes are made	Feedback from service users and service user groups, feedback via social media	Ella Sprung and Kris McKeown		
General project administration	April 2022 – Mar 2023	Attending regular meetings, communication by email				

Tasks outside of this workplan:

- Ockenden visits

This is a working document; please email info@nationalmaternityvoices.org.uk if you have any suggestions to improve it for the benefit of other MVPs.

Title	Author	Date