

Maternity Assurance Committee Key Issues Report		
Report Date: 16 July 2020		Report of: Maternity Assurance Committee
Date of last meeting: 13 July 2020		Membership Numbers: 12 Quoracy met = 100% attendance including the Chair or Deputy Chair
1	Agenda	<p>The Committee considered an agenda which included the following:</p> <ul style="list-style-type: none"> • Draft CNST Maternity Governance Requirements • Independent Maternity Review (IMR) • Maternity Improvement Plan (MIP) • Maternity Services Programme Update: Draft Transformation Plan • Maternity Dashboard Exception Report • Patient Experience Update • Risk Register Exception Report
2a	Alert	<p>The Committee wish to alert members of the Board that:</p> <ul style="list-style-type: none"> • The 'open' book' review as part of the Independent Maternity (Ockenden) Review (IMR) has been extended to include a further 386 records which were manual records not included in the original review of the trusts databases bringing the total to approximately 1,500. The team are finalizing the final number. It has been agreed with the review panel that the review will be closed to new cases in the near future and any cases raised after the 'close' date will be referred back to the Trust. It was noted that not all cases under review are cases of harm or avoidable harm - some cases are due to natural causes. • The Trust is working with NHS Business Services to 'digitise' the patient records associated with the IMR and to send them to the enquiry team. Given the scale of the task and ensuring compliance with GDPR there were some delays, however it is now moving at pace • Following the recent announcement of a police investigation resulting from the IMR, discussions have taken place and are ongoing with the police to ensure the processes for sharing records and the Trust contacting families can continue. Further details will be shared when these discussions are concluded, planned for next MAC meeting
2b	Assurance	<p>The Committee wish to assure members of the Board that:</p> <ul style="list-style-type: none"> • A document in response to the Deloitte CNST Maternity Incentive Scheme report over the governance and assurance roles and responsibilities of the various groups and committees involved in the CNST Year 3 submission was reviewed and approved by the committee and is being rolled out to the responsible committees and board. • Maternity Improvement Plan (MIP). A summary was provided to the meeting with a detailed supporting spreadsheet. The MIP pulls together the recommendations from numerous (12) external guidance documents and reports, to ensure improvement activity is comprehensive and coordinated. The CQC core assessment

		<p>framework for maternity services (2018) has been used as the basis for the MIP. Of a total of 463 actions, 44 were 'off track/ red' and 17 were paused due to Covid. The committee noted the report. It was recognised that report and supporting detailed plan were a work in progress and further work would be needed to take assurance from this .It is expected that further assurance will be available in the August MAC meeting</p> <ul style="list-style-type: none"> • A maternity dashboard was presented to the meeting including an exception report which highlighted the following: <ul style="list-style-type: none"> • Ongoing reduction in red flags in May • Bookings have reduced • DS achieved 93% positive acuity • Decreased % of consultant unit births with reopening Wrekin MLU • Increased IOL rate (a report expected at Sept meeting) • Decreasing birth rate • Decreased CO recording (in line with pandemic recommendations) • Increased smoking at birth rate • There were zero term admissions to NNU Remedial actions were noted and are to be included in the MIP. The dashboard will continue to be developed. • Patient Experience - main areas for noting: <ul style="list-style-type: none"> ○ 100% of women would recommend our service (Mar 2020 FFT) ○ CQC survey - Improvement on the 2018 results ○ SaTH performing "Better" than other trusts in 4 separate areas ○ One area of decline (patient contact number for midwife team) ○ Mat. Unit received 2 complaints in May '20 & 6 PALS complaints ○ 4 complaints were closed and all had of these had action plans • The Maternity risk register was reviewed. There were 24 risks (4 yellow, 20 amber). It was noted Risk assessments are reviewed at the monthly Risk Register meeting and added to the risk register as appropriate following a multi-disciplinary assessment. Within this meeting, a rolling programme of review of risks over 12 months old is also undertaken. Risks are also noted at the Maternity Governance meeting and concerns escalated to Care Group. The committee took assurance from the robustness of the process •
2c	Advise	<p>The Committee wish to advise members of the Board that:</p> <ul style="list-style-type: none"> • A draft report from the NHS Investigations team on the Trusts response to the RCOG report from July '17 (reviewed by the Board July 18) had been received by the Chair on the day of the meeting for factual checking by the Trust. It includes a number of improvement actions which will be shared on receipt of the final report • Following recent media reports the Maternity leadership assured the committee that a number of actions were ongoing to support staff including senior staff talking to their teams and engaging with external resources, including RCOG, in order to lift and maintain morale. • IMR - It has been agreed that the Review will work through the cases chronologically as far as is practical and by type of case grouping. The rationale for this is that the Trust is also providing the policies and procedures by year that were in place at that time and in addition the reporting and investigation processes that were operating. This will then enable the Reviewers to assess whether learning has taken place

		<p>from incidents year on year and also whether the policies and procedures in place at the time were followed by staff.</p> <ul style="list-style-type: none"> The committee received a high level Draft Maternity Transformation Plan to bring the maternity services to where we need to be in the future. This is largely based on themes identified from the leaked DO report and aligns to Morecombe Bay report. The Key Programme principles include 60 work streams with an Executive sponsor and Workstream lead for the Project teams. The External Expert Advisory Panel have asked SaTH to use a Workstream approach similar to Morecombe Bay. £1m of funding has been agreed to support this process and the Clinical Director confirmed a high degree of engagement from the clinicians. 		
2d	Review of Risks			
<p>a) The Committee reviewed the Board Assurance Framework for Assurance on the following risks:</p> <ul style="list-style-type: none"> BAF 1204 - IF our maternity services do not evidence learning and improvement THEN the public will not be confident that the service is safe. <i>Level of assurance provided: Moderate</i> <p>b) In considering these risks, the Committee can confirm:</p> <p style="text-align: right;"><i>Check box to confirm</i></p>				
<p>1 The BAF risks are up-to-date <input checked="" type="checkbox"/></p>				
<p>2 The direction of travel stated is current and correct <input checked="" type="checkbox"/></p>				
<p>3 The current risk rating is correct <input checked="" type="checkbox"/></p>				
<p>4 There is no additional/updated content (controls/assurances) or new risk(s) that needs to be added? <input type="checkbox"/></p>				
If there are changes to content or new risks identified the Committee recommends to the Board				
Click for BAF risk option				
Recommendation:				
3	Actions to be considered by the Board	<ul style="list-style-type: none"> Report to be noted Agree the recommendation to roll out CNST Governance Assurance Guidance to all relevant committees and Trust Board Risk note re Non-compliance with Fire regulations for storage of excess items in the delivery suite. Agree support required to remediate immediately 		
4	Report compiled by	Tony Bristlin, Non-Executive	Minutes available from	Louise Allmark EA to Chief Nurse