Bradford Teaching Hospitals
NHS Foundation Trust

# Board Maternity Update
# 9 July 2020

1. Update OMS
2. Maternity Dashboard (May 2020) – Key Indicators
3. Maternity COVID Update
4. Care Quality Commission – Getting Safer Faster

*Together, putting patients first*

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# OMS Programme Highlight Report: 03/06/2020 – 24/06/2020

Version 0.1

**Senior Responsible Owner (SRO):** Tim Gold **Programme Manager (PM):** Kate Lavery **Clinical Lead (CL):** Debbie Horner

## Overall Project Summary

OMS Programme Mobilisation has been initiated and the Women's CBU have been engaged in the Programme. Some initial concerns raised through Obs & Gynae consultant body, however engagement session held to understand and address concerns. A similar session has been held with midwifery leadership. The programme is now supported and a detailed communications and engagement plan is being produced to maintain engagement and momentum.. The key focus for the next few weeks is to create a unique and motivating Programme launch event for the CBU. The success of the Programme will depend upon the engagement of the clinicians from the outset. The Programme team is now fully established and in the process of being located in the Maternity building.

## Key activities this highlight period

1. Programme Mandate approved by EMT & Board
2. OMS Programme Team Mobilised and in process of relocating to Maternity building
3. Communicated OMS Programme Mandate to Womens CBU through Consultant Body and Midwives session - and overall positively received
4. Mobilised OMS PMO and Reporting

## Planned next highlight period

1. OMS Programme Board
2. OMS Launch Event – 22nd July
3. OMS Vlog to BTHFT community
4. Confirm key Workstreams inc Workstream Leads and Charters
5. Initial view of OMS Quick wins

| Programme/Workstream | Overall | Plan | Costs | Benefits | Issues | Risks | Resources | Stakeholders |
|---|---|---|---|---|---|---|---|---|
| OMS PROGRAMME | | | | | | | | |

## Key Project Milestones

| # | Milestone | Due by | Status |
|---|---|---|---|
| 1 | OMS Programme Mobilisation Completed | 01/07/2020 | |
| 2 | Vision Statement, key work areas, and design decisions approved | 01/08/2020 | |
| 3 | OMS Vision Completed – Proceed to Phase 2 of OMS Programme | 15/08/2020 | |

## Key Project Risks

| # | Risk Description | Owner | Score | Mitigated Score |
|---|---|---|---|---|
| 1 | Launch event venue still to be confirmed | KL | | |
| 2 | Co-locating programme team and creating an OMS Programme Hub could be delayed | HA | | |
| | | | | |

## Key Project Issues

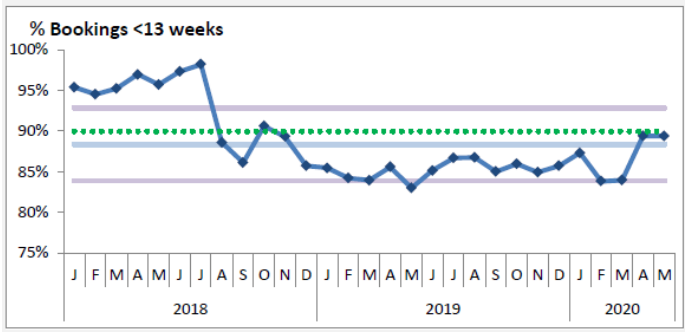
| # | Issue | Owner | Rating | Action | Due by |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

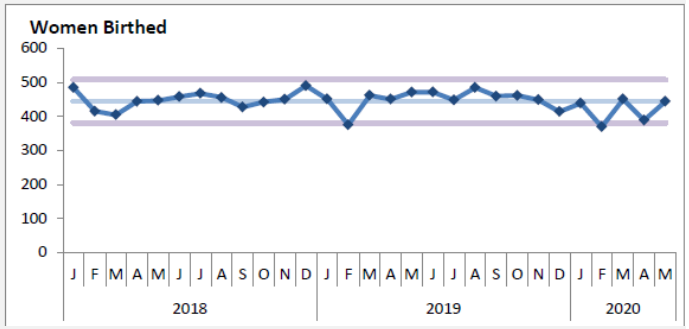
Key:
On track | Slightly off-track | Requires intervention | Significant improvement this period | Improvement this period | Performance unchanged this period | Deterioration this period | Significant deterioration this period

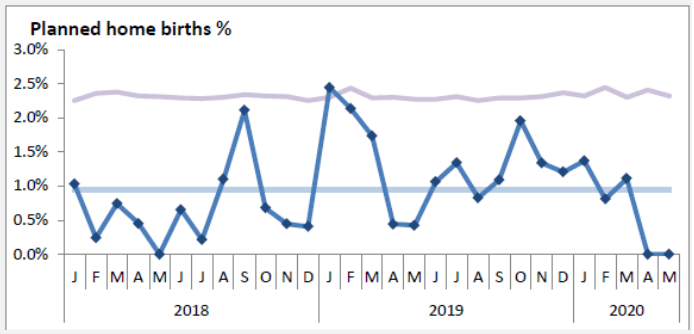
10.00 x 7.50 in

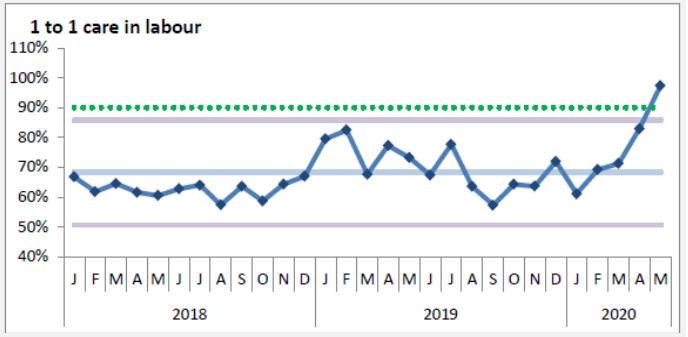
# Maternity Theatres Project

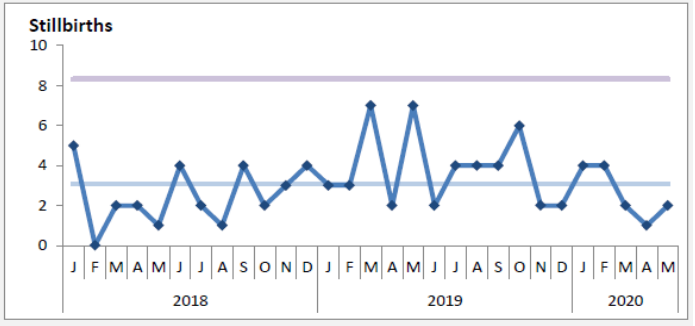
| Milestone | Description | Target Delivery Date | Progress |
|---|---|---|---|
| 1 | Floor Plan signed off | Jun-20 | Completed |
| 2 | Services Surveys & Due Diligence | Jun-20 | On Track |
| 3 | Final design for Tender | Jul-20 | On Track |
| 4 | Planning Application Submission | Jul-20 | On Track |
| 5 | Prepare BoQ & Compile Tender Documents | Jul-20 | On Track |
| 6 | Planning Decision Notice | Aug/ Sept 20 | On Track |
| 7 | Contract Award /Start on site | Sept-20 | On Track |
| 8 | Build Phase 1: New Theatres | Dec-20/Jan 21 | On Track |
| 9 | Build Phase 2: Create enhanced recovery area in existing building | Mar-21 | On Track |

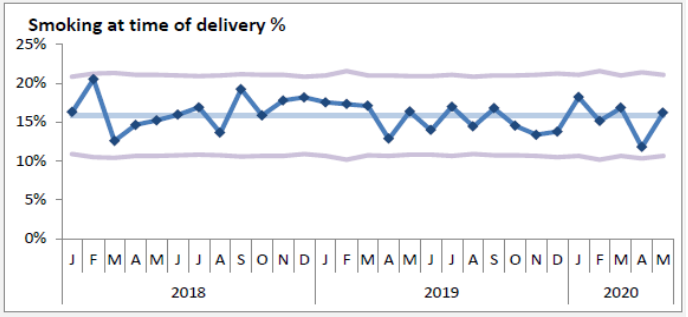

% Bookings <13 weeks
100%
95%
90%
85%
80%
75%
J F M A M J J A S O N D J F M A M J J A S O N D J F M A M
2018
2019
2020


Women Birthed
600
500
400
300
200
100
0
J F M A M J J A S O N D J F M A M J J A S O N D J F M A M
2018
2019
2020


Planned home births %
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
J F M A M J J A S O N D J F M A M J J A S O N D J F M A M
2018
2019
2020


1 to 1 care in labour
110%
100%
90%
80%
70%
60%
50%
40%
J F M A M J J A S O N D J F M A M J J A S O N D J F M A M
2018
2019
2020


Stillbirths
10
8
6
4
2
0
J F M A M J J A S O N D J F M A M J J A S O N D J F M A M
2018
2019
2020


Smoking at time of delivery %
25%
20%
15%
10%
5%
0%
J F M A M J J A S O N D J F M A M J J A S O N D J F M A M
2018
2019
2020

# Still Birth Rate

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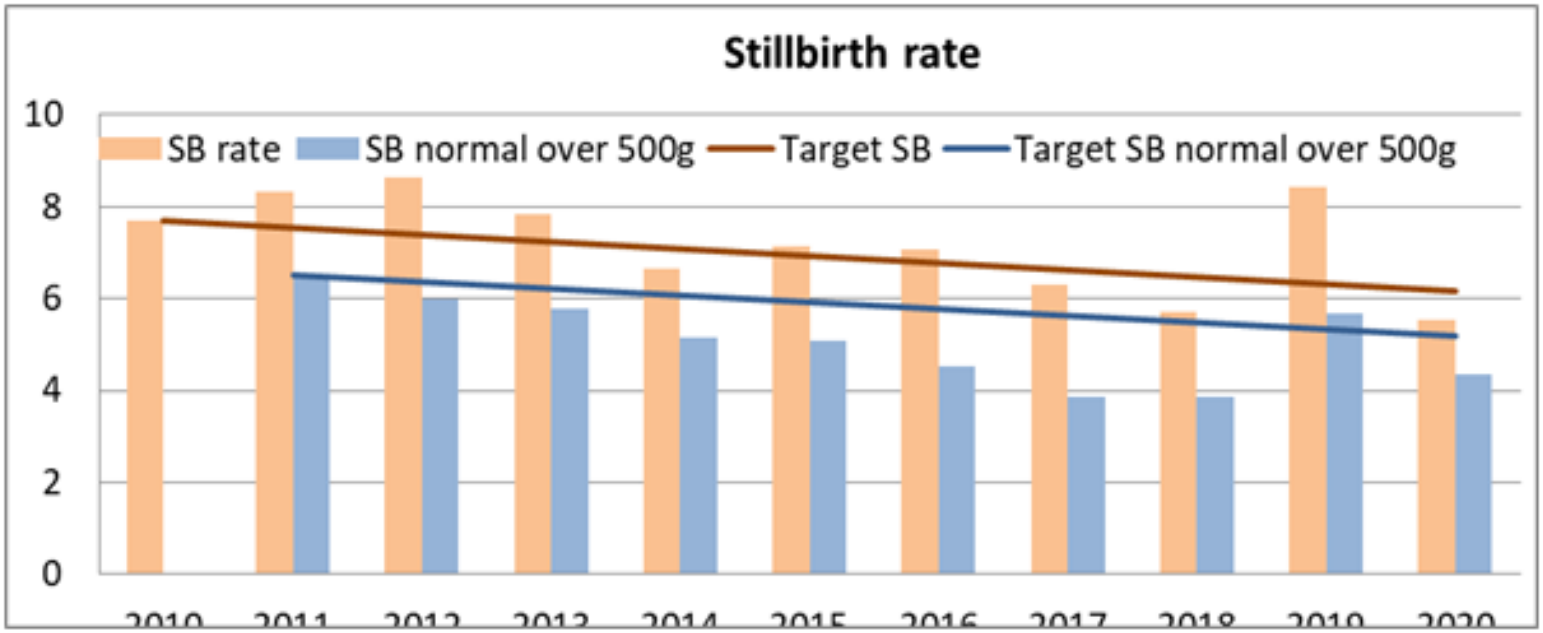

# COVID Update

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## WY&H Stillbirth data during pandemic

Total stillbirth data

**Please note this data is only approx. due to small numbers and short timescale**

| Trust | 2019 | March/April 2020 crudely aggregated to annual |
|---|---|---|
| Trust A | 7 | 0 |
| Trust B | 46 | 18 |
| Trust C | 10 | 12 |
| Trust D | 8 | 6 |
| Trust E | 36 | 36 |
| Trust F | 30 | 24 |

- Outcomes for women and babies have been generally positive.
- 24/7 midwifery led telephone triage introduced.
- All women swabbed.
  - Isolation processes in place.
- Running the ground floor as one team.
- ATTAIN data positive trends re babies admitted to neonatal unit.
- Visiting restricted.
  - MVP are surveying women presently for future plans.
- BAME focus (based on national guidance and LMS plans being developed).
- Breast feeding initiation rates reduced.

# Getting safer faster: key areas for improvement in Maternity services CQC – March 2020

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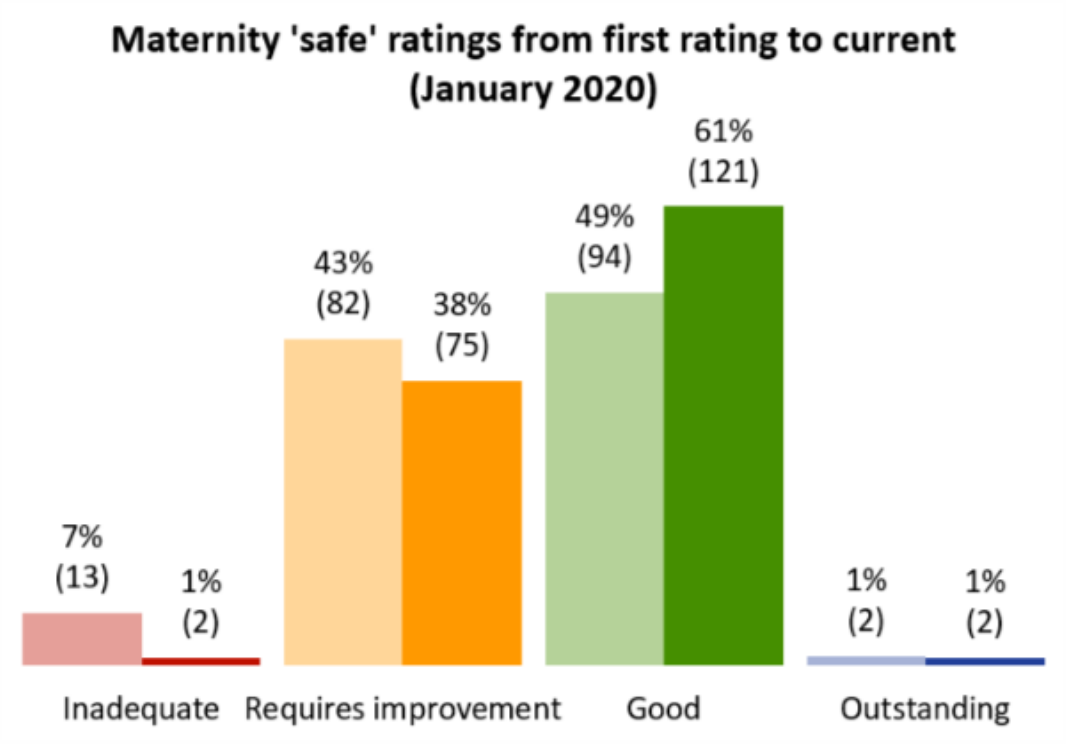


Source: CQC ratings data, all first ratings, and snapshot at 20 January 2020

# Why the focus?



- Maternity services stand out as one of the core services we inspect that is not making improvements in safety fast enough:
  - Staff not having the right skills or knowledge.
  - Poor working relationships between obstetricians, midwives and neonatologists.
  - Poor risk assessments.
  - Failures to ensure that there is an investigation and learning from when things go wrong.
- When looked at internationally, perinatal mortality rates in the UK remain higher than many other European peers and other similar high-income countries.
- Most women are getting good care, factors including ethnicity increased risk significantly, with black women five times more likely to die as a result of complications in their pregnancy than white women. Neonatal mortality is also considerably higher for babies of black or Asian ethnicity.

# Facts and Figures

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MBRACE-UK

- 9.2 maternal deaths per 100,000 pregnancies in the UK
- 3.7 stillbirths per 1000
- 1.7 neonatal deaths per 1,000 births in England

BTHFT

- 1 in 2018 (pre this was 2016)
- The rolling 12 month rate up to December 2019 was 8.4/1000
- The rolling 12 month rate up to May 2020 is 6.9/1000
- The cumulative 6 months total to May 2020 is 6.25/1000

# Key Areas for Improvement

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- **Governance, leadership and risk management.**
- **Individual staff competencies, team working and multi-professional training.**
- **Active engagement with women using Maternity services.**

Based on:

- Analysis of a sample of current CQC inspection reports for services that have been rated as outstanding or inadequate.
- The findings from the 2019 CQC maternity survey.
- Discussion with providers and members of the public at a CQC NHS co-production workshop held in February 2019.

# Governance, Leadership and Risk Management

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Services that were rated as outstanding:

- Clear governance processes in place with effective policies, assurance, risk management and leadership at every level.
- Encouraged openness and continuous learning, with effective incident reporting and investigations, and learning processes in place.
- Prioritised learning to ensure that staff had the correct skills, knowledge and experience to do their job.
- Supported to maintain and further develop their professional skills and experience.

Services that were rated as Inadequate/ RI:

- Lack clear governance and leadership structures.
- Leadership teams not effectively monitoring failures in:
  - Team working.
  - Core training.
  - Incident management.

Trusts who encourage a culture of learning and *openness alongside a willingness to listen to and prioritise the needs of the women using their services are more likely to deliver care that is not only safe, but person-centred and empowering.*

# Individual staff competencies, team working and multi-professional training

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Three elements to be addressed:

- Core competencies of individual members of staff.
- Effective team working between different staff groups.
- Scenario training that role plays planning for serious complications that require an effective multidisciplinary team response.

BTHFT:

- Some areas of non compliance identified.
- K2 CTG training mandated for all relevant staff and compliant.
- MDT training including in situ embedded.

*There is especially strong evidence to highlight the importance of regularly updated training in fetal heart monitoring – delivered in a multidisciplinary setting that covers team working and situational awareness as well as use of equipment.*

# Active engagement with women using Maternity services

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CQC 2019 Maternity Survey:

- Half of women surveyed reported that midwives appeared to be always aware of their medical history during their antenatal check-ups. This is an area that services should explore as it is crucial to assessing risk and planning appropriate management throughout pregnancy.
- Scores for questions about postnatal care remained particularly poor with information provision, emotional support and communication after birth all highlighted as areas where experiences could be improved.

BTHFT:

- We continue to benchmark well against the CQC survey questions.
- Close working with MVP.
- Good online presence.

*Services need to ensure that they proactively engage with their local population to define their priorities, and make sure that women are at the centre of their vision and service.*

# In summary from CQC …

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The work underway to improve the safety of Maternity services is welcome, but our inspections have found there is more that needs to be done to ensure that women and babies get consistently safe care.

- This briefing highlights three key areas for improvement:

  - The development of the Board level maternity safety champion role is crucial to ensure a proactive approach to the maternity services that the organisation provides.
  - The issues of staff competencies, team working and training will require support from professional organisations and regulators. We welcome the launch of NHS England and NHS Improvement's Maternity Safety Support Offer self-assessment tool, which will allow Maternity services to benchmark themselves against good and outstanding services.
  - Finally, we want to see evidence from all providers of maternity care that there is true engagement and involvement with individuals and groups who use maternity services through Maternity Voices Partnerships.