

Meeting Title	Board of Directors		
Date	10 March 2022	Agenda item	Bo.3.22.9

MATERNITY AND NEONATAL SERVICES UPDATE – FEBRUARY 2022

Presented by	Sara Hollins, Director of Midwifery		
Author	Sara Hollins, Director of Midwifery		
Lead Director	Karen Dawber, Chief Nurse		
Purpose of the paper	To provide the Quality Academy/Board with a monthly update on progress with the Maternity Improvement Plan, including CQC Action Plan, monthly stillbirth position and continuity of carer. Ensures that key elements of the Perinatal Clinical Quality Surveillance Model are visible and transparent at Trust Board level.		
Key control	Identify if the paper is a key control for the Board Assurance Framework		
Action required	For decision		
Previously discussed at/ informed by	Details of any consultation		
Previously approved at:	Academy/Group	Date	
Key Options, Issues and Risks			
<p>The Maternity Service was rated as ‘Required Improvement’ following the November 2019 Care Quality Commission (CQC) inspection. The service has acknowledged the findings and recommendations, and is committed to addressing the issues raised and becoming an ‘Outstanding’ service.</p> <p>Following Executive approval, the service have embarked on a significant quality improvement and transformation project, intended to improve the stillbirth rate and other outcomes highlighted by the CQC, and ultimately support the journey towards being an outstanding maternity service.</p> <p>Bradford is a regional and national outlier for stillbirths and concerns were raised by the CQC in November 2019 that the service had failed to identify a rising trend during 2019. The service has improved the monthly review process and will provide the Board of Directors/Quality Academy with a monthly stillbirth position, in order that they are fully informed and able to scrutinise and challenge as required. The service reported an annual reduction in stillbirths during 2020, with a further reduction in 2021. However, stillbirth reduction remains a key priority for the service as we continue to work towards the national ambition and ‘halve it’ trajectory.</p> <p>The monthly maternity and neonatal services report presented to Trust Board/Quality Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Board has an open and transparent oversight and scrutiny of maternity and neonatal services.</p> <p>The format of this report supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible and transparent at Trust Board level.</p>			

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Analysis

The service has acknowledged the recommendations of the CQC 2019 report, and has incorporated them into the existing maternity action plan. The 'must, should, could' do actions and recommendations are summarised on the first page of the overarching action plan, with additional tabs providing more detailed descriptions of the actions required to evidence compliance. The overarching improvement plan has been updated to include the Ockenden Assurance action plan. Significant progress and compliance has been achieved with outstanding actions linked to major maternity transformation plans which are not yet complete.

The service presented proposed transformation plans to Board of Directors in May 2020, focusing on key areas of improvement identified as necessary to reduce the stillbirth rate. The Outstanding Maternity Service Programme has been temporarily paused for 6 weeks from the beginning of January, to support safe staffing across the service at this challenging time.

Monitoring of the monthly stillbirth rate continues, with every case subject to a 72 hour review and discussion with the Executive, Non-Executive and Trust level Maternity Safety Champions. This process is well embedded, including the rapid identification and escalation of in-month 'spikes' in the stillbirth rate which are subject to thematic reviews and reporting of any findings and subsequent learning to Trust Board.

During the last 6 months of 2021, this monthly update paper included Neonatal harms and data, in addition to maternity. This is to ensure that neonatal harms, learning and improvements are visible at Board level.

Recommendation

Quality and Patient Safety Academy/Board is asked to note the contents of the Maternity and Neonatal Services Update, February 2022.

Quality and Patient Safety Academy/Board is asked to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned.

Quality and Patient Safety Academy/Board is asked to note that there were 0 HSIB reportable Serious Incident (SI) declared in January.

Quality and Patient Safety Academy/Board is asked to note appendices 2 and 3 which include learning and recommendations from 2 recently closed HSIB cases and appendix 4, final internal SI report including learning and recommendations. These appendices are included on the closed Board agenda due to the sensitivity of the information.

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Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

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

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

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

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

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1	PURPOSE/ AIM
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The purpose of this paper is to provide a monthly update on progress with the Maternity Improvement Plan, including the Care Quality Committee (CQC) Action Plan, the monthly stillbirth position and continuity of carer. It also provides an update on the Outstanding Maternity Service quality improvement/transformation programme, intended to improve key areas of the service and support the journey towards being outstanding.

The paper also provides a brief narrative of the maternity outcomes and metrics reported in the monthly maternity dashboard.

Bradford is a regional and national outlier for stillbirths and concerns were raised by the CQC in November 2019 that the service had failed to identify a rising trend during 2019. This failing contributed to the 'Requires Improvement' rating applied to Maternity Services on 9 April. The service reported an annual reduction in stillbirths during 2020. However, stillbirth reduction remains a key priority for the service as we continue to work towards the national ambition and 'halve it' trajectory.

The monthly maternity services report presented to Trust Board/Quality Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Board has an open and transparent oversight and scrutiny of maternity and neonatal services as described in the Perinatal Clinical Quality Surveillance Model.

2	BACKGROUND/CONTEXT
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Ongoing Impact of Covid-19 pandemic on Maternity Services:

The service has responded to the pandemic in line with local, regional and national recommendations/directives, and has adapted the provision of maternity services to ensure that women, babies and staff are protected whilst maintaining safe, responsive maternity care.

The service is fully compliant with NHS England (NHSE) request that woman are supported, to have a support person of their choice with them at every stage of the pregnancy and birth journey.

The service also meets the recommendations in the NHSE Frequently Asked Questions relating to Maternity services and Covid, and has a process in place to request that women and their birth support partners access the government lateral flow testing scheme, and are requested to perform a lateral flow test prior to attending any routine antenatal appointments including scans.

In line with the rest of the organisation, the maternity service has implemented evidence of a negative lateral flow test prior to visiting on wards M3/M4/Transitional Care and Neonatal Unit.

The service continues to submit the fortnightly Maternity Covid SitRep to confirm the visiting and testing arrangements in place.

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The Regional Chief Midwifery Officer's team have also requested that a daily maternity sitrep be returned to them Monday to Friday, to capture the current pressures faced by maternity services in the North East and North West, including unit escalations, staffing pressures, neonatal unit status and delays in care. This process commenced in late July 2021 and continues until further notice. .

The service has responded to the national information that 58% of the pregnant population are unvaccinated, by increasing public awareness of the importance and benefits.

The surveillance of women who are Covid positive in the community setting continues, ensuring that pregnant women from black, Asian and minority ethnic (BAME) and vulnerable communities are monitored and any deterioration in condition is rapidly identified and acted upon.

We do not, to protect our women and staff, move staff from maternity services to the acute main site.

Covid-19 related sickness and absence continued during February, but slightly improved. Staffing gaps have been managed daily by the Matron's and maternity bed managers, redeploying staff within the unit where required, utilising non-clinical/specialist midwives to support in clinical areas, closing beds to maintain safe staffing ratios in all areas.

Additional mitigation to manage current staffing pressures was reported to Board in the December update paper. This included the redeployment of seconded midwives back to clinical practice and pausing the intrapartum element of midwifery continuity of carer in 2 teams. This additional mitigation remained in place during February.

The Bed Manager role has also been extended to include weekends and bank holidays on a Temporary Nurse Register (TNR) basis, to provide support with flow and staff redeployment which usually falls to the labour ward co-ordinator.

Ockenden Report of Maternity Services at Shrewsbury and Telford NHS Trust

The Ockenden report of Maternity Services at Shrewsbury and Telford NHS Trust was published on 10 December 2020. The report looked at maternal and neonatal harms occurring between 2000-2019 at Shrewsbury and Telford Hospital and resulted in 27 recommendations for the named Trust with a further 7 early recommendations, referred to as immediate and essential actions (IAE's) to be implemented by all NHS Maternity services.

The service received positive feedback on the Ockenden assurance evidence submission on 5 November and was complemented on the quality of the submission.

An internal audit of the Ockenden assurance evidence submission, found a high level of assurance with the evidence provided and governance processes.

In anticipation of the 2nd Ockenden report expected to be published at the end of March, an update on progress with the Ockenden assurance evidence and the 7 IAE's will be presented at Open Board in March 2022, to meet national requirements.

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The Ockenden assurance action plan is included in the overarching Maternity Improvement Plan and was robustly reviewed during February. Progress has been made during the last 12 months with some outstanding areas of amber as the service continues to embed and further improve the processes implemented including:

- The outstanding audits linked to IAE 4, Management of Complex pregnancies are complete but have not yet been through the appropriate governance processes. The delay has been due to clinical priorities during the continued pandemic pressures.
- Improving the non-executive director (NED) safety champion links with the local Maternity Voices Partnership, to ensure that seldom reached voices are represented and heard.
- Multidisciplinary Team Working is well established and consistently meets the Maternity Incentive Scheme (MIS) standards. However, the training needs analysis is yet to be aligned to the NHS core framework. The delay is due to long-term sickness within the Professional Development team, which is now resolved.
- The outstanding audits linked to IAE 5, Risk Assessment during Pregnancy and IAE 7, Informed Consent, will be completed following maternity CERNER go-live. This is due to a requirement to audit Personalised Care and Support Plans (PCSP's), which are currently in paper format, held by the mother. The PCSP will be part of the electronic care record and the service will have the ability to access the plan as well as the mother.

Maternity Staffing

Safety Action 9 of the Maternity Incentive Scheme, Year 4, requires that there is evidence that discussions regarding safety intelligence, including minimum staffing in maternity services are taking place at Board level.

The vacancy rate for February is -12.55 whole time equivalent (WTE). This is against the revised establishment calculated by Birth Rate Plus, which recommended an increase of 12.52 WTE to maintain safe services based on the acuity of women accessing the existing pathways and models of care, and an overall increase of 32.2 WTE to achieve midwifery continuity of carer (MCoC).

	Original establishment	BR+ safe staffing	BR+ MCoC
December	+3.69 WTE	-8.83 WTE	-28.51 WTE
January	+0.21 WTE	-11.79 WTE	-33.19 WTE
February	-0.55 WTE	-12.55 WTE	-34.15 WTE

Whilst the current vacancy rate is acknowledged as a significant deficit and the service continues its pro-active recruitment and retention campaign, it must be noted that the larger figure is the Birth Rate Plus calculation to deliver MCoC as a default position for all women. Achieving this remains a priority but the national emphasis from maternity leaders is that safe staffing is the first priority before achieving full continuity.

The service is therefore focussing on achieving the 12.52 WTE increase and although there is a deficit of 12.55 WTE, the service mitigates maternity staffing on a daily basis, by redeploying staff across the service, utilising specialist midwives and senior leaders to work clinically where

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appropriate, closing beds to maintain safe staffing levels and utilising the escalation policy to 'divert' services if activity and acuity outweigh the number of staff available.

It is anticipated a further 6.21 WTE new appointments due to start in early 2022 will help to close this gap. However, there have been a number of resignations during December and January which has impacted on the vacancy rate.

Mitigation put in place during December to support Community midwifery services were very successful and alleviated significant staffing gaps. This mitigation continued during February and the actions described below have proved sufficient.

- Midwifery specialist support secondments have been paused and midwives returned to community teams.
- Specialist Midwife for teenage pregnancy has a small caseload and has capacity to pick up a small caseload in Crystal Team.
- The intrapartum continuity elements for Acorn vulnerable women's team and Amber MCoC team was paused during January and February to allow unstaffed clinics and caseloads to be supported. This will be closely monitored and pathways resumed at the earliest opportunity.

Obstetric Staffing

There are currently 21 Consultant Obstetricians and Gynaecologists within the CBU. One of our long term consultant locums left the trust on 4th February 2022 as she had secured a substantive consultant post in another trust.

We interviewed 2 Obs and Gynae locum consultant candidates on 26th January 2022 and offered one of these candidates a locum post at the trust. They have accepted the post and are going through HR checks and we will need to agree a start date with them.

There are 3 pure Consultant Obstetricians on the Out of hours on call Obstetric rota and 3 pure Consultant Gynaecologists.

The jobs advertised nationally in October 2021 following the Ockenden requirements and funding(2 substantive Obstetric jobs and 1 locum Obstetric post) had very few applications or suitable candidates for interview. We only appointed one candidate in this round.

We intend to advertise for a Fetal Medicine consultant post at the end of February 2022. There is at least one local trainee who is eligible to apply for consultant posts from February 2022 with a special interest in Fetal Medicine who we are keen to appoint to the unit.

Labour ward is always covered by a consultant and there are no exceptions to report. Labour ward consultant led ward rounds (4x daily) are currently being audited. Given there have been very few candidates to interview and appoint in recent months to assist in staffing daily consultant Obstetric ward rounds along with ambulatory area cover , we have taken measures to deliver this activity from within the existing consultant body with all consultants who do an ANC, contributing and sharing in the delivery of daily obstetric ward rounds. This proposal has been designed to work as

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a teams approach to different days but with all the existing demands on the consultants with heavy job plans, this is proving very difficult to deliver consistently.

The Acute out of hours Gynaecology on call rota (commenced 1/11/21) is in place ensuring a separate consultant is on call for Obstetrics and Gynaecology 24 hours/ day. Some consultants are delivering this on top of their job plans and some are taking down clinical activity in order to provide it. This is also an extra strain on the consultant body especially as much of the cover is out of hours in the evenings, overnight and across weekends.

The junior staffing grades have some large gaps.

We have 3 gaps on the registrar rota and 3 gaps on the SHO rota. In a recent round of registrar recruitment on 8th December 2021, 2 candidates were offered posts but they both declined the offers. We have been approached by an individual who is keen to work at Bradford who has many years of experience working at registrar level abroad. A clinical fellow post has gone out to advert and we are confident that this individual will apply. We will advertise again for further registrar.

Maternity Action Plan and CQC rating

Maternity Services received a 'Requires Improvement' rating in the 2019 inspection report published in April 2020. The service has acknowledged the recommendations including monitoring and escalation of stillbirth rates, monitoring and management of infection risks in maternity theatres, and have incorporated 'must, should and could' do's into the existing maternity action plan for immediate attention.

The 2019 CQC action plan is complete with the majority of actions now 'business as usual' or ongoing. For example, the action relating to closely monitoring infection risks in obstetric theatre will be categorised as 'ongoing' until the completion of the planned theatre rebuild. On-going surveillance of all women who have had a caesarean birth remains in place as part of the risk mitigation until the work is complete. As part of CQC inspection preparation and for our own assurance given that the majority were closed prior to the global pandemic, the service will be reviewing the closed actions to ensure that these are sustained and embedded in practice.

The action plan now incorporates the Ockenden assurance actions and outstanding actions from Serious Incidents (SI's) and a national benchmarking tab. It is reviewed as a minimum, 4-6 weekly by the Director of Midwifery, Clinical Director and Risk and Governance Lead Midwife. The most recently updated version is attached as appendix 1.

The Ockenden assurance actions and update on progress is described earlier in this paper and will be presented at open Board in March.

The CQC action plan is currently subject to an internal audit and the outcome will be shared in a future paper.

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Stillbirth Position

There were 3 stillbirths in February, 2 Butterfly babies/ expected poor outcome and 1 transfer into the area following care in Wales. A summary of these cases is included within the closed Board papers.

Table 1 is the running total of stillbirths in 2022, including the number of cases requiring further detailed investigation, and the number of butterfly babies whose deaths were expected.

Table 1:

Stillbirths 2022			Expected deaths within total number	Further detailed investigation
Month	Number of babies	Running total	Butterfly babies	Number of cases
January	1	1	0	1
February	3	4	2	0

Hypoxic Ischaemic Encephalopathy (HIE)

There were 0 babies requiring treatment for HIE in February.

Serious Incidents (SIs) and serious harms

The December 2020 Ockenden Report, independent review of Maternity services at the Shrewsbury and Telford Hospital NHS Trust, contained 7 immediate and essential actions (IAE) to improve care and safety in maternity services for all Trusts.

IAE 1: Enhanced Safety, recommends that all maternity SI reports and a summary of the key issues, must be sent to the Trust Board and the Local Maternity System (LMS).

There were 0 HSIB reportable cases occurring in February.

There are 7 ongoing maternity SI's, 5 HSIB and 2 Trust level.

Safety Action 9 of the Maternity Incentive Scheme, Year 4, requires that there is evidence that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues, are taking place at Board level.

A summary of ongoing Maternity SIs is included as part of the closed Board papers due to the sensitivity of the information.

Appendices 2 and 3 are recent HSIB final reports with learning and recommendations for Board information. These appendices are available as part of the closed Board papers.

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The Ockenden report is clear that neonatal harms should also be visible at Trust Board level. This report already covers monthly neonatal harms regarding care provided during pregnancy and birth, and has not previously featured neonatal harms regarding the care received after birth. A brief description of any neonatal SI's declared in month, including any immediate lessons learned is included as part of the closed Board papers. It must be noted that the responsibility to escalate, investigate and action any learning, sits with the Neonatal Service and not the Maternity Service. The exception will be any case which crosses both specialties.

It also includes the number of Neonatal Deaths (NND) in month and brief description. There were 0 neonatal SI's declared in February.

Neonatal Deaths (NND)

There was 1 NND in February. This baby was transferred from Calderdale with severe HIE and a poor prognosis.

Table 2:

NND 2021			Expected deaths within total number	Further detailed investigation
Month	Number of babies	Running total	Extreme preterm/congenital anomalies/life limiting conditions	Number of cases
January	2	2	Expected preterm twins (not Bradford babies)	0
February	1	3	0	0

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

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

HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with the Trust

The implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

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

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Coroner Regulation 28 made directly to Trust

Again, the implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

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

Maternity and Neonatal Bi-Monthly Safety Champion meetings

The Maternity and Neonatal Safety Champions met on 10 February. The group discussed unit diverts in detail and agreed that whilst awaiting the ratification of the revised escalation policy which is aligned with both the LMS and the Regional maternity policies, the decision to divert will involve a conversation with the Executive Director on call. This approach will ensure that the Executive team are aware of maternity service challenges and also ensure that diverts are visible and transparent at Board level. This change took effect on 14 February. The ATAIN action plan and quarter 3 report, presented to January Board, were also discussed. Jamie Steele, Associate Director of Paediatric Nursing, will attend future meetings to represent neonatal nursing.

No concerns were raised to any of the safety champions outside of planned meetings.

Monthly staff feedback from Safety Champions and walk-rounds

The February maternity and neonatal floor to board safety meeting was chaired by Karen Dawber.

There were no significant safety issues raised. However, the ongoing challenge with broken printers was raised. Karen Dawber will urgently escalate to Digital colleagues.

The risk assessment completed to support the return of Breastfeeding peer supporters to the inpatient ward areas was discussed and is supported by the Executive Safety Champion, with its aim of improving experience and reducing infant feeding readmissions to the paediatric ward.

Staff are informed of safety actions and progress through the monthly Maternity and Neonatal Safety Champions Newsletter, Appendix 5.

Maternity Unit Diverts

In the 2019 inspection, the CQC commented on the number of times the maternity unit 'diverted' services. Unfortunately there is no national, regional or LMS level benchmarking available which would highlight the service as an outlier.

The NHSI maternity support team have also indicated that they believe that the service 'diverts' more frequently than other organisations. In response, the service agrees that a more robust process is required to review unit diverts, which will identify any themes requiring interrogation.

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There was 1 partial divert in February with escalation triggered by unit activity and suboptimal staffing levels. 1 woman was asked to attend a neighbouring unit but declined and presented to MAC. After assessment she was advised to go home to await events but did not like this advice and proceeded to present to the neighbouring unit.

The unit continued to accept antenatal women for review and assessment. No other women were affected.

There was a 2nd attempted divert with escalation again triggered by unit activity and sub optimal staffing levels. Unfortunately no neighbouring units were in a position to support, therefore the unit continued to accept women.

The service has re-written the escalation policy which aligns with the WY&H LMS escalation policy and utilise OPEL. This is currently going through the relevant governance processes and will be rolled out in March/April.

As already discussed, unit diverts were discussed at the bi-monthly maternity and neonatal safety champion meeting, and the decision taken to include the Executive Director on-call of any decisions to divert maternity services from 14 February.

Table 3:

MONTH	Full Divert	Partial Divert	Attempted Divert	Number of women diverted
JANUARY	0	1	1	3
FEBRUARY	0	1	1	1
Total	0	2	2	4

Midwifery Continuity of Carer (MCoC) Action plan As previously discussed under midwifery staffing, community midwifery pressures require the service to temporarily pause a number of MCoC pathways, in order that safe care is maintained for all community caseloads. This decision will be closely monitored and pathways will be recommenced at the earliest opportunity.

Inevitably this has impacted on the number of women booked on an MCoC pathway during January:

TOTAL % booked for MCoC = 20% BAME % = 18%

The monthly MCoC highlight report for January included:

- Amber team paused, along with Acorn team on-calls, to support wider community teams due to significant staffing issues.
- Homebirth team have had recruitment drive.
- Work carried out to find venues for up and coming MCoC teams.
- Plan for full implementation of MCoC approved by Trust Board.
- The Home Birth team continue to function as intended, in order that choice of place of birth is not compromised.

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Maternity Theatres

Building work commenced in January 2021, immediately revealing a technical issue of sub-main distribution cables that need to be diverted prior to the project continuing. This essential work was completed in March. Internal building work commenced in August and during September, resulting in the loss of the original recovery area and another birthing room. Mitigation to protect flow includes the use of rooms on the Birth Centre for the lower acuity, high risk women.

Phase 1 of the build was due for completion on 24 December 2021. Unfortunately delays with procurement channels and an issue with access to a central gas mains outside of the trust site, for which permission is required to access for the new build, has caused delays to the completion of the build. Completion is now predicted to be in March/April and phase 2 completed by summer 2022.

Mitigation of the current maternity theatre has continued throughout the pandemic, including the use of the Public Health England, surgical site infection surveillance tool, for all women who have had a caesarean birth. Weekly Datix reporting of the frequency of theatre 2 usage is well embedded and consistent. Additional mitigation is not required as a result of the build delay.

Maternity Dashboard

The maternity dashboard has not been updated with January or February data and will be presented in the March update paper.

Training Compliance

The revised Perinatal Quality Surveillance Model minimum data set for Trust Board's, requires oversight of the training compliance of all staff groups in maternity related to the core competency framework and wider job essential training.

Training compliance is shared with Board on a quarterly basis, and will be included in the April paper.

A drop in compliance for all mandatory training with the exception of PROMPT, is expected in the next report. This is due to prioritisation of CERNER EPR training for all staff, in preparation for the March go-live. This approach was supported by Board in January following presentation of the December update paper.

Outstanding Maternity Service Programme

The Outstanding Maternity Service (OMS) Programme is a transformation programme, intended to improve the service from 'Requires Improvement' to 'Outstanding'.

The programme contains 5 work streams:

- The Woman's Journey and Clinical Excellence.

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- Moving to Digital.
- Streamlining Systems.
- A Building Fit for the Future.
- Investing In Our Workforce.

The OMS work streams were temporarily paused in January and February to release clinical capacity during the ongoing staffing challenges, although behind the scenes activity has continued by the programme team. The programme will 're-start' on 1 March and will formerly include Neonatal transformation.

Service User Feedback

There have been no MVP meetings held in February and the service have not received any 'Grassroots' feedback this month.

The CQC national maternity survey results were published in February, which surveyed women who gave birth in February 2021.

Bradford had an improved response rate of 34%, improved on the 23% response rate in 2019. This equated to 108 women completing the questionnaire.

Unfortunately the service was only benchmarked against other maternity service providers for the intrapartum questionnaire, due to problems uploading attribution data relating to antenatal and postnatal onto the portal. This was not escalated to the service at the time.

From the intrapartum responses, the service was benchmarked in a distinctly average position but reassuringly there were no questions in the significantly below average range.

The service are very disappointed with the limited report, but will work with the MVP to co-design an action plan and consider other ways of obtaining antenatal and postnatal feedback between now and the publication of the 2022 response next year.

Maternity Cerner

The Maternity Cerner Project Board meets monthly and have to date agreed a high level of confidence that the project is on track and within budget.

Due to the increased staffing pressures due to Covid, the service has significant concerns regarding the ability to facilitate the required level of staff training to enable 'go-live' alongside maintaining safe staffing levels in the clinical areas. This was raised at the January Board meeting.

Training commenced in January and has continued during February with a moderate number of staff managing to access training sessions and reasonable uptake of further planned sessions. This is being closely monitored at a weekly EPR training meeting which is additional to the weekly EPR operational readiness meetings.

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The project is still proceeding with an expected go-live date of 26 March at this time.

3 PROPOSAL

The service proposes that the Maternity Improvement Plan incorporating the Ockenden assurance action plan is presented to Quality and Patient Safety Academy/Board on a monthly basis as part of this report.

The service also proposes that progress on the Outstanding Maternity Service programme is included in this monthly update.

Any urgent concerns emerging outside of the monthly reporting arrangements will be escalated by the Trust Level Safety Champions to the Board Level Safety Champion.

4 BENCHMARKING IMPLICATIONS

The service will continue to benchmark and monitor performance and position at both regional and national level, using the existing benchmarking tools including the Yorkshire and Humber regional maternity dashboard, MBRRACE-UK publications etc.

Continuity of Carer is monitored through the West Yorkshire and Harrogate LMS.

5 RISK ASSESSMENT

Stillbirths and Continuity of Carer pathways are on the maternity risk register, updated regularly and monitored through Women's Core Governance Group. All risks have been reviewed to reflect any increased risk as a result of changes to the service to maintain safety of women, babies and staff during the pandemic.

6 RECOMMENDATIONS

Quality and Patient Safety Academy/Board is asked to note the contents of the Maternity and Neonatal Services Update, February 2022.

Quality and Patient Safety Academy/Board is asked to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned.

Quality and Patient Safety Academy/Board is asked to note that there were 0 HSIB reportable Serious Incident (SI) declared in January.

Quality and Patient Safety Academy/Board is asked to note appendices 2 and 3 which include learning and recommendations from 2 recently closed HSIB cases and appendix 4, final internal SI report including learning and recommendations. These appendices are included on the closed Board agenda due to the sensitivity of the information.

Meeting Title	Board of Directors		
Date	10 March 2022	Agenda item	Bo.3.22.9

7	Appendices
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1. Appendix 1 - Maternity Improvement Plan.
2. Appendix 2 - HSIB learning and recommendations SBAR WR112551. (see closed Board papers)
3. Appendix 3 - HSIB learning and recommendations SBAR WR111019. (see closed Board papers)
4. Appendix 4 - Internal SI final report 2021/17062. (see closed Board papers)
5. Appendix 5 - Maternity and Neonatal Safety Champions Newsletter, February 2022.
6. Appendix 6 – Maternity and Neonatal Services Update and Appendices 1 to 4 – January 2022.