

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

MATERNITY AND NEONATAL SERVICES UPDATE – JANUARY 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.		
Key control	Identify if the paper is a key control for the Board Assurance Framework		
Action required	To note		
Previously discussed at/ informed by	Details of any consultation		
Previously approved at:	Academy/Group	Date	
	Quality and Patient Safety Academy QA.2.22.21	23.02.22	

Key Options, Issues and Risks

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.

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.

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.

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.

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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 Academy/Board is asked to note the contents of the Maternity and Neonatal Services Update, January 2022.

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

Quality Academy/Board is asked to note the annual reduction in stillbirths occurring in 2021.

Quality Academy/Board is asked to note that there was 1 HSIB reportable Serious Incident (SI) declared in January.

Quality Academy/Board is asked to note the findings described in appendices 2 and 3, Quarter 3 ATAIN review and ATAIN action plan.

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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.

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.

During December, Bradford District Care Trust colleagues were able to resume supporting the service with weekly pop-up vaccination clinics in the maternity unit. This was gratefully accepted. However, the uptake of the pop-up clinics is low and does not justify the amount of staff required to run each session. Pregnant and postnatal women will instead be sign posted to the main vaccination centre as an alternative.

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.

There were no babies with symptoms of Covid during this time. 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 January, this impacted on the need to escalate and divert services. 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.

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. Whilst there are a significant number of 'amber' responses, this is due in part to regional and local maternity system actions

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beyond our control. In addition, a number of new processes have been put in place and until these are audited and embedded in practice it is not possible to rate them as green.

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

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.

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 January is 31.99 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	-31.99 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 11.79 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 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.

January staffing remained challenging with sickness and absence due to Covid related issues remaining a key factor.

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Mitigation put in place during December to support Community midwifery services were very successful and alleviated significant staffing gaps. This mitigation continued during January 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 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 and 1 locum across the service. On 13th December 2021 we successfully appointed a further Obstetric consultant (who also has Gynaecology laparoscopic skills) to the department. The individual is one of our current locums taking the total number of consultants now to 21. A post was offered to a locum consultant Obstetrician and Gynaecologist to replace our other general locum who will be leaving the department in February 2021. However this individual gave back word and the post has been re advertised this locum O+G consultant post with interviews pending.

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. The intension is to advertise the pure Obstetric jobs again in the near future. 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. 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 MAC/ ANDU , the service 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 is still being devised but we hope to be able to deliver daily Obstetric ward rounds as well as cover in the morning for MAC / ANDU from 7th February 2022.

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.

The junior staffing grades have some large gaps. There are 3 gaps on the registrar rota and 3 gaps on the SHO rota for the foreseeable future. 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

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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 posts and have another interview panel for SHO grades on 26th January 2022.

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 'must, should, could' do actions and recommendations are summarised with additional tabs providing more detailed descriptions of the actions required to evidence compliance. A number of recommendations will require significant time to complete, as they are intrinsically linked to major maternity transformation plans. 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.

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 Ockenden assurance actions will be reviewed in detail prior to presentation at Open Board in March 2022.

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

Stillbirth Position

There was 1 stillbirth in January. A summary of the case is provided as part of the closed Board papers due to the sensitivity of the information.

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

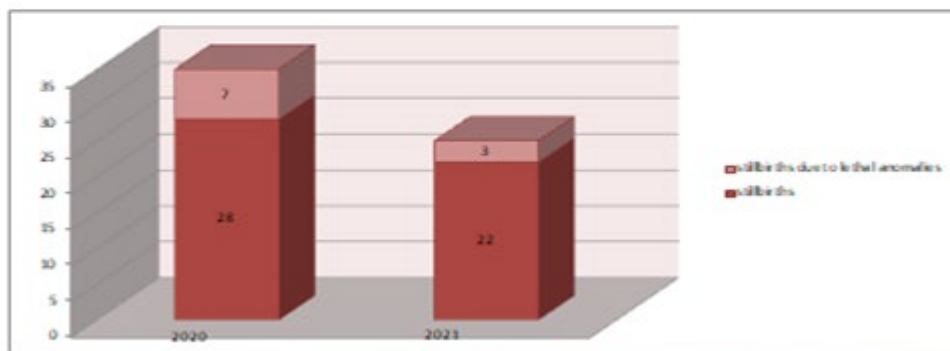
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Ongoing actions to address the stillbirth rate

2021 saw a reduction of 10 stillbirths compared to 2020 resulting in an adjusted rate of 4.2 per 1000 births from 5.6 in 2020. This is extremely positive despite a year filled with the challenges of an ongoing pandemic. It is thought that the rollout of updated guidance for identifying and managing small babies, partnership working with the MVP to disseminate important messages regarding reduced fetal movements, and revisiting and embedding the principles of symphysis fundal height measurement, have contributed to this success.

Stillbirth comparison

	Births	Crude total stillbirths	adjusted rate excluding lethal abnormalities
2020	5145	6.7/1000	5.6/1000
2021	5179	4.8/1000	4.2/1000



Together, putting patients first

However, the service does not intend to become complacent, and will continue to improve the stillbirth rate by ensuring that local and national guidance is followed and embedded in practice.

2022 will see further improvement work around smoking cessation, which we hope will reduce the number further.

The Service has achieved full compliance with implementing all 4 elements of the Saving Babies' Lives Care Bundle, Version 2, confirmed by the Yorkshire and Humber Clinical Network following submission of the latest survey. The improved identification and management of small for gestational age babies continues through the Outstanding Maternity Service (OMS) programme transformational work stream.

Hypoxic Ischaemic Encephalopathy (HIE)

There were 0 babies requiring treatment for HIE in January.

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Serious Incidents (SIs) and serious harms

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

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

There was 1 HSIB reportable case occurring in January. This is the 38+5 week stillbirth reported earlier. It meets the HSIB criteria as the mother reported irregular contractions when the intrauterine death was diagnosed. The case has been referred to and accepted by HSIB.

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.

The same stillbirth/HSIB/SI case is the only moderate harm reported in January.

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

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 was 0 neonatal SI's declared in December.

Neonatal Deaths (NND)

There were 2 NND's in January.

Table 2:

NND 2022			Expected deaths within total number	Further detailed investigation
Month	Number of babies	Running total	Extreme preterm/congenital anomalies/life limiting conditions	Number of cases

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January	2	2	Expected preterm twins (not Bradford babies)	0
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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. The 38+5 week intrapartum stillbirth is the only incident meeting the HSIB criteria in January.

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.

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

There was no planned Maternity and Neonatal Bi-Monthly Safety Champion meeting in January. The next meeting is 10 February. No concerns were raised to any of the safety champions outside of planned meetings.

Monthly staff feedback from Safety Champions and walk-rounds

The January maternity and neonatal floor to board safety meeting was chaired by Sara Hollins on behalf of Karen Dawber.

There were no safety issues raised and an opportunity was taken to inform and commend staff on their contribution to the stillbirth reduction during 2021.

Staff are informed of safety actions and progress through the monthly Maternity and Neonatal Safety Champions Newsletter, Appendix 1.

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Avoiding Term Admissions into Neonatal units (ATAIN) Quarter 3 update

Appendices 2 and 3 are the ATAIN Quarter 3 update and updated ATAIN action plan. The report and action plan were discussed at the bi-monthly Maternity and Neonatal Safety Champion Meeting, presented by the Neonatal Safety Champion. The quarterly admission rate remains below the accepted threshold of 5% at 3.57%, with only 1 of the 45 admissions determined as avoidable.

The updated action plan has a couple of red actions, including midwifery ATAIN e-learning which has not yet been progressed due to reduced training opportunities during the pandemic.

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.

Continued staffing challenges and a high volume of activity and acuity during January resulted in 1 partial unit divert and 1 attempted divert (2 women were asked to attend other units but declined). During both incidents, the unit continued to accept antenatal women for review and assessment and diverted women in labour only as the pressure was on intrapartum beds. A total of 3 women were diverted to other units in January.

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.

Table 3:

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

Midwifery Continuity of Carer (MCoC) Action plan

The updated continuity of carer action plan describing the building blocks and plans to achieve full continuity by 2023 was discussed with the Executive Maternity safety Champion in December and approved by Board in January 2022. The plan was submitted to West Yorkshire and Harrogate

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(WY&H) Local Maternity System (LMS) as required and was benchmarked against guidance-neighbouring units who have had a regional/national team visit.

Feedback from the LMS was positive:

- Well articulated report with clear planning
- Good documentation of training plan and tools
- Good description of team support approach/use of Professional Midwifery Advocates
- Well articulated staffing plan-progress conditions
- Good documentation of Cerner Implementation project impact influencing timeframes

Could strengthen:

- Communication approach (communication strategy outline in progress)
- Describe more about the use of MSW's and role of Band 7s in supporting/Implementation

The plan clearly describes our ambition to achieve full implementation by March 2023. However, whilst the service is committed to achieving continuity, this will not be at the expense of unit safety and will be prioritised when safe staffing levels are achieved and maintained. This approach is supported by the National Chief Midwifery Officer.

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.

The Home Birth team will continue to function as intended, in order that choice of place of birth is not compromised.

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.

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Maternity Dashboard

Review of the dashboard which contains data up to December 2021 (Appendix 4), does not reveal any areas of particular concern.

Of particular note:

- 1:1 care in labour has been consistently above 90% for over 18 months
- The rolling stillbirth rate as already described, shows a positive downward trajectory
- CO monitoring at booking, paused for a period of time during the pandemic, is steadily improving month on month.

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

The OMS work streams were temporarily paused in January 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 formally include Neonatal transformation.

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Service User Feedback

'Grassroots' feedback was shared with the service in January via the Maternity Voices Partnership during January. This was a combination of positive and negative feedback.

2 pieces of negative feedback related to a lack of privacy and dignity in the Maternity Assessment Centre (MAC) waiting area and environment. The MVP were assured that the physical environment has been subject to an architect review, to ascertain what changes can be made to the area to improve privacy, dignity and maximise the available space.

The second incident prompted a review of a particular incident in MAC, where a woman was concerned that another woman had given birth in MAC and was not transferred to an intrapartum area. The MAC team were able to identify the case and were able to assure that the birth was precipitate and occurred whilst transfer was being facilitated. The situation was unavoidable but lessons learned included the need for improved communication and support for others accessing the service.

Positive feedback included:

- I had really good care from the midwife in the home birth team. She explained in detail all the care I would get, made appointments close to home which was convenient, and I felt really safe in the clinic space. The midwife was kind and very supportive and answered all the questions my partner had too, so that he felt involved. Thank You
- I cannot fault the care that I received from at the antenatal clinic, staff have been fantastic and the care has been brilliant.

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 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.

3 PROPOSAL

The service proposes that the Maternity Action Plan, stillbirth rate, and continuity of carer continue to be presented on a monthly basis, until sustained improvement is noted in these key areas and the 2019/20 Maternity CQC action plan is complete.

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

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

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 Academy/Board is asked to note the contents of the Maternity and Neonatal Services Update, January 2022.

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

Quality Academy/Board is asked to note the annual reduction in stillbirths occurring in 2021.

Quality Academy/Board is asked to note that there was 1 HSIB reportable Serious Incident (SI) declared in January.

Quality Academy/Board is asked to note the findings described in appendices 2 and 3, Quarter 3 ATAIN review and ATAIN action plan.

7 Appendices

1. Maternity and Neonatal Safety Champions Newsletter, January 2022
2. ATAIN Quarter 3 report
3. ATAIN action plan
4. Maternity Services Dashboard