Bradford Teaching Hospitals
NHS Foundation Trust

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Date	12.05.22	Agenda item	Bo.5.22.13

MATERNITY AND NEONATAL SERVICES UPDATE – MARCH 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 and Safety 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 decisionFor decision	
Previously discussed at/ informed by	Details of any consultation	
Previously approved at:	**Academy/Group**	**Date**
	Quality and Patient Safety Academy	27.04.22

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.

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.

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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 but nearing finalisation. Recent internal audit of the CQC action plan was assessed as 'Significant Assurance'.

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 resumed in March following a 6 week pause to support safe staffing levels during an episode of high sickness and absence.

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

Quality and Safety Academy/Board is asked to note Appendix 1, Bi-Annual Midwifery Staffing paper. This is a requirement of the Maternity Incentive Scheme, Year 4. It will be presented to People Academy in April prior to joining the overarching Nursing and Midwifery Staffing paper at May Board.

Quality and Safety 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 that there was 1 HSIB reportable Serious Incident (SI) declared in March and 1 internal SI.

Quality and Safety Academy/Board is asked to note appendices 2 and 3 which include learning and recommendations from 2 recently closed HSIB cases.

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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?	☒	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☒	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☒	☐	☐

Risk Implications (see section 5 for details)	Yes	No	N/A
Corporate Risk register and/or Board Assurance Framework Amendments	☐	☐	☐
Quality implications	☒	☐	☐
Resource implications	☐	☒	☐
Legal/regulatory implications	☐	☒	☐
Diversity and Inclusion implications	☒	☐	☐
Performance Implications	☐	☒	☐

Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant) ☒Risk Assessment Framework ☒Quality Governance Framework ☐Code of Governance ☐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.

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Other (please state):

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
☐	☒	☐	☐

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1 PURPOSE/ AIM

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, 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 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

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.

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

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 March. 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.

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.

March Open Board was provided with an update on progress with the Ockenden assurance evidence and the 7 IAE's, and an update on the obstetric and midwifery workforce position. This met Ruth May's national request.

This was ahead of the publication of the 2nd Ockenden Report at the end of March which included a further 15 1AE's for Trusts to consider and provide assurance of. The service is in the process of reviewing the report and recommendations in detail and will be commencing benchmarking of the new IAE's in early April, in preparation for any national evidence requests.

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The service has received notification of the Regional Maternity Team assurance visit, which is scheduled for 29 June 2022.

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.

Appendix 1 is the bi-annual maternity staffing paper, which is a requirement of the Maternity Incentive Scheme, and replaces the standard monthly update provided in this report. The paper will be presented to People Academy in April, prior to joining the overarching Nursing and Midwifery Staffing paper at May Board where any recommendations will be considered.

Obstetric Staffing

There are currently 21 Consultant Obstetricians and Gynaecologists within the CBU.
There are 3 pure Consultant Obstetricians on the Out of hours on call Obstetric rota and 3 pure Consultant Gynaecologists.

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 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.

Maternity Action Plan and CQC rating

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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.

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 CQC action plan was the subject of an internal audit in March and was given a rating of 'Significant Assurance' which is reflective of the robust systems and processes in place within the Foundation Trust. The 'ongoing' status of the escalation guideline review prevented the final rating of 'high' assurance. This piece of work is now in the final stages and has been delayed due to the need to align the local guideline with LMS and Regional maternity escalation guidelines.

Stillbirth Position

There were 3 stillbirths in March. 2 babies had a known antenatal diagnosis of a life limiting or fatal condition. These babies are collectively described as 'Butterfly Babies', where the family choose to continue the pregnancy, knowing that the baby may not survive birth or the early neonatal period.

The 3rd baby was to a type 1 diabetic mother who presented for routine Covid screening swab planned to appropriately timed induction of labour, reported reduced fetal movements and fetal heart absent

Table 1 is the summary of cases occurring in March.

Gestation	Summary	Outcome
34/40	G7 P2+4. 2 previous stillbirths in Pakistan. Multiple fetal anomalies identified on 20 week scan. Referred to Leeds Fetal Medicine, likely Edwards Syndrome. Couple counselled on poor prognosis and decided to continue the pregnancy. Presented to MAC at 34 weeks with reduced fetal	Clinical review completed. Examples of excellent care from the Clover Continuity Team. No further investigation required.

	movements. No fetal heart.	
41+6	G1 PO Type 2 diabetic on insulin. Anencephaly identified at anomaly scan. Counselled and continued pregnancy on the Butterfly pathway.	Awaiting clinical review
37+1/40	G1 P0, Type 1 diabetic. Presented to MAC with history of reduced fetal movements. Appropriate antenatal care on diabetic pathway. Planned induction of labour at 37+2. Presented for routine Covid screening swab prior to induction and reported no fetal movements since previous evening. No fetal heart.	72 hour review completed. Appropriate antenatal and diabetes management including timing of induction of labour. Information regarding reduced fetal movements had been given at various points. No care issues identified.

Table 2 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 2:

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	2	3	2	0
March	3	6	2	0

Hypoxic Ischaemic Encephalopathy (HIE)

There was 1 baby requiring cooling for HIE in March. This case meets the criteria for HSIB referral and has been accepted by the team with parental consent.

Initial review of the case has revealed a delay in escalating a deteriorating CTG in labour. This case occurred during the very early stages of Maternity Cerner ‘Go-Live’, and it is thought that this may have contributed to a loss of situational awareness. The baby is recovering well.

Serious Incidents (SIs) and serious harms

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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 March as already described.

There was a further case referred to QUOC in March but not meeting HSIB criteria, of a woman who sustained a 4th degree tear at the time of birth which was regrettably not identified until she represented at 9 days postnatal.

There are 4 ongoing maternity SI's, 2 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.

Appendices 2 and 3 are recent HSIB final reports with learning and recommendations for Board information.

Table 3: Ongoing Maternity SIs:

Date of Incident	Brief Description	Immediate Findings	Finalised Key Issues
September 2021	G1 P0, Covid positive pregnant woman requiring inpatient respiratory care deteriorated and required emergency CS; baby was IUD at 34+1 week's gestation. A 24 years old in her first pregnancy, diagnosed with gestational diabetes mellitus (GDM). BMI 27.6 and she is a non-smoker. She reported reduced fetal movements at 27, 28, 32 and 33 weeks	There were 3 missed opportunities to perform an USS and Doppler. Issues relating to the escalation of pregnant women in the main hospital to the obstetric team and following the guidance on the trust intranet (pregnant and postnatal women being seen through ED and escalation to the Obstetric team as well as the intranet Covid 19 guidance for managing pregnant	Internal SI Final draft out for comments

	gestation. At 32+ weeks gestation she was diagnosed with COVID and subsequently was admitted to the Trust on 4 occasions over an 8 day period.	women with Covid) and communication between clinical teams, Multidisciplinary (obstetric, medical and anaesthetic) reviews and decision making around delivery of complex high risk Covid pregnant patients, and use of Maternal Early Warning Scores (MEWs) rather than National Early Warning Scores (NEWS) for all pregnant women admitted to the trust all need to be addressed in regard to this case.	
October 2021	G2 P1. Vulnerable woman booked with the Acorn continuity team. History of reduced fetal movements at 38 weeks, appropriate review and management. Further report of reduced fetal movements at 38+6 and again at 39+5. On both occasions she was advised to attend MAC for review but DNA on either occasion. At 39+5, YAS were requested to attend due to labour. On arrival the baby had	Some evidence of great continuity and compassionate care from the Acorn team throughout pregnancy. Immediate learning includes that there is no current process in place for following up women who are advised to attend the unit and do not present.	HSIB investigation in progress- Final report received including learning and recommendations, appendix 3

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	been born and was blue, floppy, and unresponsive. Resuscitation was attempted but unsuccessful. Initial post mortem findings suggest the baby was stillborn.		
December 2021	G2 P1 with a BMI of 26.5 and a history of obstetric cholestasis with treatment commenced at 36 weeks gestation. A plan was made for delivery at 37 weeks however on the day of induction she presented with abdominal pain and reduced fetal movements. An emergency caesarean section was performed but baby was born with no signs of life, resuscitation was attempted but discontinued after 19 minutes.	No significant care issues identified but parents feel that the management of cholestasis was not timely	Referred to and accepted by HSIB. Draft report received.
January 2022	G1 P0 Attended mac reporting reduced fetal movements for 3 days. No fetal heart found, confirmed on portable scan along with reduced liquor. Baby noted to be macerated at birth and weight below 3rd centile. Estimated to be 20th centile at 32 week scan.	Lack of use of interpreter, failure to ask domestic abuse question	Referred to and accepted by HSIB in progress

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	Mother had Covid prior to birth.		
March 2022 New	4th degree tear sustained at delivery but not identified until 9 days postnatal. Woman required abdominal surgery and construction of a temporary colostomy.	Immediate review of perineal repair practice including routine rectal examination.	Internal SI
March 2022 New	Suboptimal CTG in 2nd stage of labour. Prepared for instrumental delivery but birthed spontaneously. Baby born in poor condition and required active cooling. HIE diagnosed. Baby making a good recovery	Coincided with Cerner Maternity go-live and the use of fetalink. Appears that situational awareness may have been lost due to adjusting to a new process.	Case referred to and accepted by HSIB.

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. This report features a brief description of any neonatal SI's declared in month, including any immediate lessons learned. 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 March.

Ongoing Neonatal SIs

Table 4:

Date of Incident	Brief Description	Immediate Findings	Finalised Key Issues
07/04/2021	Diagnosis of Osteomyelitis in limb where cannula inserted which is likely to impact on bone development in such a way that function of the right arm/wrist may be affected.	Documentation around cannula insertion, monitoring of the site, and decisions to keep / remove the cannula	SI declared & investigation commenced Report received in

	Baby born at 26 +3 gestation. 9+ weeks old at the time of the incident. Cannula inserted in right hand to take bloods with potential for blood transfusion. Blood transfusion was not commenced but cannula not removed. Decision to transfuse 2 days later. Cannula still in situ but leaking therefore further cannula sited in left hand. 2 days later, right hand noted to be red, hot, tender and tense. Blood cultures grew staph aureus.	were inadequate. There were also issues around prescribing which probably did not affect outcome.	draft out for comments
17/04/2021	34/40 infant born to Mum with GDM. Floppy at birth. Identified as having bilateral ventriculomegaly. Management being guided by Leeds neurosurgeons and baby had lumbar punctures to reduce hydrocephalus on 9th of April and 15th of April. Baby became meningitic and septicaemic 48 hours after a second Lumbar Puncture. Baby born with serious intracranial pathology of unknown cause. He has become severely unwell due to meningitis and septicaemia, which has led to additional brain injury. Care is being re-orientated with compassionate	Possible delay in identifying a deteriorating patient. Possible delay in commencing intravenous antibiotics.	SI declared. Investigation commenced. Extension agreed

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	extubation.		
November 2021	Klebsiella outbreak including the deaths of 2 very premature babies.		Ongoing

Neonatal Deaths (NND)

There were 0 NND's in March.

Table 5:

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	0	2	0	0
March	0	2	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 was 1 case meeting the HSIB referral criteria in March as previously described.

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

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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 Maternity Safety Champions did not meet in March.
No concerns were raised to any of the safety champions outside of the planned meetings.

Monthly staff feedback from Safety Champions and walk-rounds

The March maternity and neonatal floor to board safety meeting was chaired by
Karen Dawber.
There was minimal attendance due to Cerner Maternity Go-Live preparations and no concerns were raised.

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

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.

There was 1 partial divert in March with escalation triggered by unit activity and suboptimal staffing levels. 5 women were accepted at neighbouring units but a larger number of women continued to attend all areas of the service.

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 but has been delayed due to workload pressures as a result of Cerner roll out.

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Table 4:

MONTH	Full Divert	Partial Divert	Attempted Divert	Number of women diverted
JANUARY	0	1	1	3
FEBRUARY	0	1	0	1
MARCH	0	1	0	5
Total	0	3	1	9

Midwifery Continuity of Carer (MCoC) Action plan

The MCoC lead midwife, Director of Midwifery and Chief Nurse meet on a monthly basis to update and discuss progress on MCoC.
Progress has been limited due to ongoing pressures within the midwifery workforce, and in line with the national recommendations, the service is focussing on achieving safe staffing levels prior to embarking on any further MCoC pathways. However, it is agreed that the existing teams will be preserved wherever possible as they deliver care to some of the City's most vulnerable women.
Disbanding existing teams would not release a significant enough amount of additional midwifery hours to other areas of the service, and would impact on the provision of choice of place of birth should the home birth team be affected.

TOTAL % booked for MCoC = 17% BAME % = 18%

The monthly MCoC highlight report for February included:

- Communication and engagement events to recommence following implementation of new IT system
- Property scoping in collaboration with Act as One programme.
- Equipment ordered via LMS funding
- Plan for full implementation of MCoC approved by Trust Board

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.

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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. This remains on target.

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

There remains a delay in preparation and presentation of the Maternity Dashboard run charts which is being addressed with business intelligence.

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 mandatary 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.

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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 re-started on 1 March and will formerly include Neonatal transformation.

The 3 key priorities following re-start are:
•Maternity EPR Implementation support
•Safety projects-BSOT & safety Huddle
•Wellbeing

Service User Feedback

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

Maternity Cerner

Maternity Cerner 'Go-Live' took place on 26 March, without major complications.
The service is now in the process of working through this significant change and adapting to a new way of working. Go-Live has impacted all areas of the service, but the change has been particularly challenging for the Community Midwives who have switched from predominantly paper based record keeping to paper free. This has caused some concern and anxiety in the first few weeks, and additional support and resource has been provided to help.

The senior team are extremely proud of the way in which the whole maternity team have approached and engaged in the change from Medway to Cerner.

The service would like an opportunity to thank Paul Southern for his leadership and support in the run up to Go-Live, and to Kay Pagan for her fantastic leadership and support of the maternity team in the first few weeks.

3 PROPOSAL

The service proposes that the Maternity Improvement Plan incorporating the Ockenden assurance action plan is presented to Quality 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.

Meeting Title	Board of Directors		
Date	12.05.22	Agenda item	Bo.5.22.13

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

Quality and Safety Academy/Board is asked to note Appendix 1, Bi-Annual Midwifery Staffing paper. This is a requirement of the Maternity Incentive Scheme, Year 4. It will be presented to People Academy in April prior to joining the overarching Nursing and Midwifery Staffing paper at May Board.

Quality and Safety 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 that there was 1 HSIB reportable Serious Incident (SI) declared in March and 1 internal SI.

Quality and Safety Academy/Board is asked to note appendices 2 and 3 which include learning and recommendations from 2 recently closed HSIB cases.

7 Appendices

1. Appendix 1 Bi-annual midwifery staffing paper, March 2022
2. Appendix 2 HSIB learning and recommendations SBAR WR114871 (closed Board)
3. Appendix 3 HSIB learning and recommendations SBAR WR115349 (closed Board)