Bradford Teaching Hospitals
NHS Foundation Trust

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

MATERNITY AND NEONATAL SERVICES UPDATE – APRIL 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**

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

Quality and Patient Safety Academy/Board of Directors 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 of Directors is asked to note that there was 1 HSIB reportable Serious Incident (SI) declared in April and no internal SIs.

Quality and Patient Safety Academy/Board of Directors is asked to note the Quarterly Perinatal Mortality Review Toolkit report, appendix 1, which is a requirement of compliance with Safety Action 1 of the Maternity Incentive Scheme, year 4.

Quality and Patient Safety Academy/Board of Directors is asked to acknowledge that following the publication of the 2nd Ockenden report, BTHFT Maternity service will not be progressing any additional midwifery continuity of carer pathways, until safe staffing levels are achieved, but that existing pathways will continue to function.

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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.
Other (please state):
Relevance to other Board of Director's academies: (please select all that apply)

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People	Quality	Finance & Performance	Other (please state)
☐	☒	☐	☐

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 and Patient Safety 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.

In April support person access to the antenatal and postnatal wards was extended from a 1 hour, pre-arranged visit, to an extended period of 10am until 7pm. Arrangements have also been agreed to allow the woman's own children to visit the unit if she has been an inpatient for 3 days.

Following the end of the government's free lateral flow testing scheme, the service are asking women and their support person to perform a lateral flow test prior to attending appointments at the hospital, but are not enforcing this and accepting of the fact that a large portion of the Bradford population will not purchase commercial testing kits.

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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 April. 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 Appendix 1, 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 has commenced benchmarking of the new IAE's in early April, in preparation for any national evidence requests.

The service has also reviewed the National letter to all Trusts from Amanda Pritchard, sent on 1 April, and will comment on the Midwifery Continuity of Carer (MCoC) position later in this report.

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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.

The bi-annual maternity staffing paper was presented to Quality and Safety Academy and People Academy in April, and will be presented to Board in May as an appendix to the Nursing and Midwifery Staffing paper. The paper outlined the staffing priorities for 2022/23, which in brief is to achieve the Birth Rate plus recommendation for safe staffing between now and October 2022, before progressing plans to achieve 50% and ultimately 100% MCoC models.

Current vacancy against the safe staffing establishment is around 7.7 WTE. This is mitigated on a daily basis with redeployment of staff, use of non-clinical midwives where required, and flexing beds in inpatient areas. This process is managed by the daily Midwifery Bed Manager under the supervision of the Matron team.

Despite a relatively small vacancy rate, the service continues to experience daily staffing challenges as a result of sickness and absence and increased rates of maternity leave.
The Director of Midwifery has approached Human Resource colleagues for support in analysing recent sickness and absence trends, which continue to be affected by Covid, and to look at innovative ideas as to how we can encourage staff to come to work.

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 and has been replaced by a new O+G locum who started in post on 21st April 2022.

There are 3 pure Consultant Obstetricians on the Out of hours on call Obstetric rota and 3 pure Consultant Gynaecologists on the Gynaecology rota as well as colleagues who cover both.

Our Gynaecology Oncology Lead consultant will leave the Trust on 20th June to take a post closer to home. Documents to go out for recruitment are in the HR process and we hope to be able to recruit to his post either externally or potentially internally. It is essential that we ensure senior consultant presence in managing this service to maintain patient safety in this area of Gynaecology.

The jobs advertised nationally in October 2021 following the Ockenden staffing 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 who is in post in the unit.

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We have advertised and shortlisted 2 candidates for a Fetal Medicine consultant post. If both candidates are suitable for appointment and perform well at interview, we are keen and have approval to appoint both candidates.

Labour ward is always covered by a consultant and there are no exceptions to report. Labour ward consultant led ward rounds (4 xs 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. We are hoping to have more consistent and 7 day a week consultant ward round cover in place by May 2022

The Acute out of hours Gynaecology on call rota 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 (claiming extra pay) 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 continue to have some large gaps. Due to recent gaps sickness, we have been required to reduce patient numbers in Antenatal and Gynaecology clinics in order to ensure safety and safe numbers in the clinics.

Registrars:-

Currently we have 12 Registrars (4 of them are only 60%) occupying 10 slots on a 1:11 rota leaving one slot completely empty as a gap. There will be another predicted gap from 20th May 2022 as one of the registrars is pregnant and won't be able to fulfil her out of hours on calls from that time.

We have 2 ST3 registrars that need senior cover and support with an SR or consultant present on each shift out of hours (to meet entrustability standards set by the RCOG) until they acquire all the necessary skills to be competent on the labour ward.

There are 2xstaff grades, 2xST7 , 1xST6(only these 5 senior registrars are able to cover ST3 entrust ability nights) , 2xST5, 2xST4 and 2xST3. There were 15 slots in all but 2 were 60% but now we have 12 slots all full time.

SHOs:-

There are 13 full time SHO'S. New Fy2's have recently joined us and are new to O+G as a specialty. The rota gaps in early April allowed the new FY2 to work 2 days in the department shadowing to become familiar with the unit before taking up on call shifts.

Recent success with Trust HR in being able to offer escalated locum rates in line with other specialities within the Trust has ensured that we have managed to cover many of the immediate gaps in the junior staffing tiers to ensure the shifts are safe. HR have agreed to escalated rates until the end of August 2022 for the registrars and until the end of June 2022 for the SHOS to be reviewed again at these points.

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We are very mindful that all the extra shifts that our current junior doctors are filling, as well as the senior registrars covering extra night shifts for entrustability is having a tiring and detrimental effect on the juniors and in some cases affecting their training opportunities as well when they are asked to cover acute or elective work in preference to some of their learning sessions/ special interest sessions.

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 which is now imminent.

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.

The service is currently re-visiting the 2018 CQC recommendations in addition to the 2019/20 to ensure that these are embedded in practice. The updated action/improvement plan will be presented in the May paper.

Stillbirth Position

There were 2 stillbirths in April. 1 baby 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 2nd baby was 35+ weeks presenting with reduced fetal movements and intrauterine death confirmed.

Table 1 is the summary of cases occurring in April.

Information available in Closed Board appendix

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.

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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
April	2	8	1	1- Level 1

Hypoxic Ischaemic Encephalopathy (HIE)

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

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 April as already described.

There are 5 ongoing maternity SI's, 3 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.

Table 3: Ongoing Maternity SIs:
Information available in Closed Board appendix

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.

There were 0 neonatal SI's declared in March.

Ongoing Neonatal SIs

Table 4:
Information available in Closed Board appendix

Neonatal Deaths (NND)

There was 1 NND in April.

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 April 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.

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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.

Quarterly Perinatal Mortality Review Toolkit (PMRT) report:

The Maternity Incentive Scheme, Year 4, Safety Action 1 requires evidence that Trust Boards have received a quarterly Perinatal Mortality Review Tool (PMRT) report. The last report was received as an appendix to the December maternity update paper, presented in January 2022.

Using the national PMRT to review perinatal deaths to the required standard has been a condition of the incentive scheme for the last 3 years. Appendix 2 provides a summary of the current position and demonstrates that the service is either already achieving the required standard for some elements, or is within the required timeframe for completion.

Maternity and Neonatal Bi-Monthly Safety Champion meetings

The Maternity and Neonatal Maternity Safety Champions met in April. The main focus of the meeting was midwifery and neonatal staffing updates and feedback from the recent Maternity Cerner EPR go-live, including concerns regarding the quality of reported data from April onwards, which is currently unknown.

Monthly staff feedback from Safety Champions and walk-rounds

Karen Dawber walked the unit in April and commented on the predominantly positive feedback following Cerner go-live. There were no safety concerns escalated during April.

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.

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There were 4 partial diverts in April with escalation triggered by unit activity and suboptimal staffing levels. A number of women were accepted at neighbouring units but a larger number of women continued to attend all areas of the service.
The individual episodes have not yet been reviewed, including the number of women diverted from the service. This will be included in the subsequent update paper.

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
APRIL	0	4	0	TBC
Total	0	7	1	9

Midwifery Continuity of Carer (MCoC) Action plan

Due to the timing of this paper the March highlight report is not yet available and will be included in the May update.

The second Ockenden report published on 30 March has generated a national conversation regarding the continued roll out of MCoC as a default position for all women, in the current midwifery staffing crisis.
The letter received from Amanda Pritchard on 1 April, asks Trusts to immediately assess their staffing position and make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.

2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.

3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

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Having reviewed the current midwifery staffing position, the service falls into description 2. As mentioned in the staffing update and recent bi-annual midwifery staffing report, the current priority is to continue to recruit and retain staff to meet the establishment required to maintain safe staffing levels based on existing pathways of care, which includes a number of MCoC teams.
Consideration has been given to ceasing MCoC in its entirety, but the benefit to the overall unit and community staffing position would be negligible. In addition, existing teams focus on women who are from BAME or vulnerable backgrounds, and it is felt that the needs of this group must continue to be prioritised.

Once safe staffing levels have been achieved, further recruitment will continue with an incremental approach until the ultimate ambition of MCoC as a default position is achieved.

The existing MCoC plan submitted to the LMS, will be updated to reflect the decisions made and the revised plan.

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 of phase 1 is now imminent with handover expected in the next few weeks. Phase 2 will then commence with an expected completion 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.

Appendix 3 is the quarterly training compliance report.

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PROMPT multidisciplinary maternity training remains on target to meet the annual target of 90% of each staff group trained

A drop in compliance for all mandatary training with the exception of PROMPT, was anticipated 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.

As predicted, training compliance is below expected and the Professional Development midwife is working hard to review the trajectory and support the service to get back on track. Priority areas include children's safeguarding which we are hoping to increase to 85% by the end of May. This will be a challenge but it is hoped that the use of a pre-recorded training session and additional sessions, will help to achieve this target.

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 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

The OMS team supported the EPR go-live during March and April, and as a result there is limited progress to share this month.

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Service User Feedback

There have been no MVP meetings held in April and the service have not received any 'Grassroots' feedback this month. The next meeting is planned for June following recommissioning of CNET to host the MVP.

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.

Immediate life support has now ceased, and the service is now transitioning to life with the system and agreeing ongoing processes to escalate and highlight concerns.

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 of Directors 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

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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 of Directors is asked to note the contents of the Maternity and Neonatal Services Update, April 2022.

Quality and Patient Safety Academy/Board of Directors 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 of Directors is asked to note that there was 1 HSIB reportable Serious Incident (SI) declared in April and no internal SI's.

Quality and Patient Safety Academy/Board of Directors is asked to note the Quarterly Perinatal Mortality Review Toolkit report, appendix 1, which is a requirement of compliance with Safety Action 1 of the Maternity Incentive Scheme, year 4.

Quality and Patient Safety Academy/Board of Directors is asked to acknowledge that following the publication of the 2nd Ockenden report, BTHFT Maternity service will not be progressing any additional midwifery continuity of carer pathways, until safe staffing levels are achieved, but that existing pathways will continue to function.

7 Appendices

1. Appendix 1 Ockenden 2nd Report April 2022
2. Appendix 2 PMRT Quarterly report April 2022
3. Appendix 3 Quarterly Training Compliance report April 2022