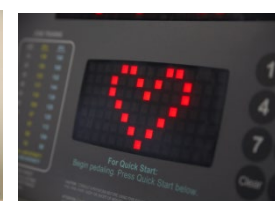


Spotlight on Maternity Quality and Patient Safety Academy

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Why are Maternity Services so high profile?

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- Maternity Services have been high on the BTHFT agenda for the last 5 years
- Monthly updates presented to Trust Board and/or Quality and Patient Safety Academy
- This is now an embedded process that is here to stay

Why?

- Internal factors:
 - 2016 Maternity Quality Summit
 - Requires Improvement Ratings in 2018 and 2019 CQC inspection
 - Maternity Support Programme
- National agenda:
 - High profile reports from Morecombe Bay to Ockenden
 - More to come: East Kent, Nottingham
 - MMBRACE-UK reports
 - National Maternity Transformation- Better Births
 - Saving Babies' Lives Care Bundles
 - Maternity Incentive Scheme years 1-4
 - Perinatal Mortality Review Tool (PMRT)
 - Maternity Services Data Set (MSDS)

Internal Factors

- Journey started in 2016 following a cluster of maternity safety incidents
 - High stillbirth/perinatal mortality rate
 - Poor escalation of clinical concerns
- Triggered a Maternity Quality Summit
- Deep Dive into the service
 - Recognition and acknowledgement of the issues and challenges
 - Different approach to how we addressed issues
- 2018 CQC 'Requires Improvement'
 - Shock and disappointment
 - Prompted 'Be the Best' action plan
 - Good intentions but unsuccessful- 'just another action plan'
- 2019 CQC 'Requires Improvement'
 - Inspection team acknowledged that some progress had been made but identified need for further action
 - Much needed 'wake up call' and the need to take a different approach to improvement
 - Triggered referral to the NHSI Maternity Support Programme

Progress to date

- Team acknowledgement of the need to change and do things differently
- Executive support, sponsorship and 'permission' to do things in a different way
- Launch of the Outstanding Maternity Services Programme in 2020
 - Back drop of a Global Pandemic
 - Full team engagement
 - Dedicated time and project team
 - Trust investment, support and belief
 - Service user involvement
- CQC Maternity Improvement Plan
 - Actions complete, embedded and 'business as usual'
 - Linked transformation work complete- Maternity theatre build
 - Internal Audit gave 'High Level of Assurance'
 - Escalation guideline is the only ongoing action- delayed due to regional changes
- Maternity Support Programme
 - Pandemic delayed initial visit
 - Improvement work well underway by the time the team visited
 - Likely exit from the programme in August
- Board oversight
 - Maternity and neonatal services are a standing agenda item on Board/QPSA agendas
 - Monthly update on harms including immediate learning and recommendations

- The National Maternity Agenda, safety initiatives and high profile reports, significantly influence the information presented monthly to Board/QPSA
- Ockenden Assurance Visit
 - Positive visit with high level of assurance that the initial 7 safety actions are compliant and embedded
 - Further progress required is linked to digital challenges (MSDS confidence and Portal to support Personalised Care Plans)
 - Service benchmarking the next 15 safety actions and awaiting East Kent and Nottingham reports
 - Ockenden requires compliance with implementation of the revised Perinatal Quality Oversight Model which includes metrics to be presented to Board (number of SI's/ training compliance/service user feedback/midwifery and obstetric staffing)
 - Board paper structured to include the minimum requirements
- Maternity Incentive Scheme Year 4
 - Service has declared full compliance with the 10 safety actions, years 1-3
 - Year 4 paused nationally. Re-launched in May 2022 with 5 January submission date
 - Number of safety actions require Board oversight/sign off including quarterly PMRT reports, Saving Babies' Lives audits, ATAIN quarterly data, Midwifery Continuity of Carer progress

Progress and Risks

- **Ockenden**
 - As described
- **Maternity Incentive Scheme**
 - Progress in 9/10 safety actions on target
 - Safety Action 2: Are you submitting MSDS to the required standard is a key concern following change from Medway to Cerner Maternity
 - Non-compliance in 1 domain results in automatic failure of the whole scheme
- **Stillbirths**
 - Stillbirths reported monthly
 - Positive downward trajectory in line with the 'Halve it Campaign'
 - Utilising indices of deprivation to inform further improvement work
- **Midwifery and Obstetric Staffing**
 - National recruitment challenges in both disciplines
 - Pro-active recruitment processes in place, good response
 - High levels of sickness and absence both midwifery and obstetric
 - Impacts on clinical care and the quality and safety agenda
 - Priority is safe staffing of the unit using daily mitigation of redeployment/flexible bed bases
 - Once safe staffing achieved will progress MCoC plans
- **Outstanding Maternity Services Programme**
 - Main driver for transformation
 - Successful model now replicated across the Trust



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Questions?