East Cheshire
NHS Trust

Return of inpatient intrapartum maternity services: Post Implementation Review

January 2024

Contents

Executive Summary

Inpatient intrapartum maternity services at Macclesfield DGH were suspended in March 2020 in preparation for an anticipated surge in critical care demand linked to the COVID-19 pandemic.

Initially it was hoped that the suspension would only be for a 6-month period, however this was extended on a number of occasions, and, ultimately, services remained suspended for just over three years.

Throughout the suspension, women were given the option to choose which site they wanted to attend, with most delivering at neighbouring 'host' hospitals in Stockport, Wythenshawe and Crewe. A small number of women chose other options including Royal Stoke Hospital or home birth. Most antenatal and post-natal care continued to be provided by East Cheshire NHS Trust (ECT) at MDGH and in the community across eastern Cheshire.

ECT remained committed to returning services when safe to do so. Throughout most of 2022 and into 2023 the trust worked tirelessly, including significant work with partners across the NHS as well as Cheshire East Council, to be able to achieve this and in June 2023 the trust celebrated the re-opening of intrapartum services under the headline "Macc is Back!"

This report captures the significant programme of work undertaken that led up to the return of services and sets out the key lessons learned to inform future service changes.

Board members, staff, partners, key stakeholders, and patient representatives who were involved in the project were all invited to take part in this Post Implementation Review, which has taken place three months after the return of the service.

In summary, feedback regarding the implementation process has been broadly positive, and there are lessons to be learned from the maternity experience that could be useful for future projects.

These can be summarised as:

- The importance of ongoing engagement:
    - With staff, including face to face, to listen to and understand their perspectives,
    - With clinical leadership, ensuring they play a role in feeding in to and out of a project,
    - With patients, ensuring patient voice is central to the service change, and wherever possible patients, or patients' groups are involved in co-producing service change.
- To take time to map out all the wider stakeholders affected by the changes, their drivers and motivations, and ensuring that they are fully engaged in the development and implementation of plans.
- Each project needs to establish appropriate governance arrangements that are proportionate to the scale and complexity of the task. Involving external partners in this governance should be considered for all projects.
- It is important for any major project to understand any external decision-making factors. To take time to understand any critical dependencies required to secure the service change and that all relevant decision makers are appropriately and effectively engaged.
- Project may need to appoint a Senior Responsible Officer and Clinical Lead to help lead any given project, these leaders need appropriate levels of authority and decision making to help drive the project.
- Snagging issues and unintended consequences should be expected and where possible anticipated.

The return of intrapartum maternity services to Macclesfield DGH after a significant suspension is great news for current and future expectant women and their families and should be celebrated. Everyone involved in this project are to be thanked and congratulated for their hard work and determination.

1 Introduction and purpose

1.1 Intrapartum maternity services at Macclesfield District general Hospital (MDGH) were suspended in March 2020 in preparation for a surge in critical care demand linked to the COVID-19 pandemic.

1.2 East Cheshire NHS Trust (ECT) remained committed to returning services when safe to do so and worked tirelessly, including significant work with partners across the NHS as well as Cheshire East Council, to be able to achieve this.

1.3 This Post Implementation Review focusses on the programme of work that led to the successful return of services in June 2023. In doing so, the report provides details of the background to the suspension, a high-level overview of the arrangements for intrapartum services pre-suspension as well as arrangements during the suspension, and our plans for a safe and sustainable service moving forwards.

1.4 The report details the programme of work undertaken to return services and captures the views of people involved in the work, reflecting on the approach taken by ECT and our partners and whether improvements could have been made. The report also reflects on the first three months of running the service including any successes, any emerging issues and any unintended consequences caused by the return of services.

1.5 The report concludes with several lessons that future projects should consider when planning significant service changes.

2 Background

2.1 **Service Provision at East Cheshire Trust up to 2019/20**

Prior to the COVID-19 pandemic, ECT's maternity and gynaecology services were delivered from the Macclesfield site. Facilities include**:**

- Ante natal unit,
- Inpatient maternity unit with:
    - Delivery suite comprising of three standard and two water-birth ensuite rooms,
    - Triage assessment bay with 6 beds,
    - 22 antenatal/postnatal beds,
- Dedicated obstetrics theatre.

In addition, community midwifery antenatal and postnatal clinics were held in locations across eastern Cheshire with a homebirth service also available.

ECT had six substantive consultants (with an established budget for 6.8) who shared obstetrics and gynaecology commitments, and all contributed to the on-call rota. Complex foetal-maternal medicine was jointly managed through relationships with neighbouring specialist units at St Mary's in Manchester and Liverpool Women's Hospital.

The maternity service supported the births of around 1,500 babies a year (4 per day), supported by a Level 1 neonatal unit. In 2019, ECT's maternity service was rated 'Good' by the CQC in all five areas.

2.2 **Decision making leading up to closure of the maternity unit at Macclesfield MDGH**

In March 2020, at the start of the COVID-19 pandemic, NHS England instructed trusts to prepare for and respond to large numbers of inpatients requiring respiratory support, particularly mechanical ventilation. Almost immediately, ECT had concerns about the ability to respond.

- In 2020 the critical care unit at MDGH was extremely small by modern standards with capacity for just 6 Level III patients (normally hosts a mixture of Level II and Level III patients).

- Medical staffing to the unit was provided by a small anaesthetics department which consisted of just 8 consultants and 12 juniors (mixture of SAS, and trainees). 6 of the 8 consultants provided dedicated daytime weekday cover to the ICU; all other times were covered by the on-call consultant anaesthetist. Anaesthetic cover to the critical care unit was provided by a 24/7 resident SAS anaesthetist who also simultaneously provided anaesthetic cover to the labour ward.

It rapidly became apparent that the major limiting factor to the trust's ability to increase critical care capacity was the anaesthetic workforce and that it would not be possible to increase critical care capacity if 24/7 anaesthetic cover to the labour ward and emergency caesarean section cover was also required.

ECT liaised with partners across the NHS – including neighbouring maternity units and the NHSE Regional Team. All fully understood and appreciated the rationale for ceasing births and gave the proposal their unanimous support. The ECT Board took the decision to close the unit from 25th March 2020.

In 2021, and in response to concerns raised by the anaesthetic team regarding the return of Maternity services, ECT invited the Royal College of Anaesthetists (RCoA) to conduct a review of the anaesthesia service in relation to provision of maternity care and to provide independent and expert advice with regard to reinstating maternity services at the hospital. The RCoA report has helped to provide a framework for managing and implementing change linked to the full return of consultant delivered maternity care.

The RCoA review recommended that two tiers of middle-grade anaesthetists would be required on the on-call rota to ensure sustainability – one to support maternity and the other the critical care unit – and that significant consultant expansion was required. The review was accepted by the ECT Board and supported by the Cheshire and Merseyside ICB. The service has subsequently recruited an additional four consultant anaesthetists and eight specialty doctors, which has enabled a dedicated obstetric anaesthetic rota and robust consultant coverage of the labour ward.

2.3 Service provision during suspension (April 2020 - June 2023)

Inpatient intrapartum maternity services were suspended at Macclesfield DGH for slightly more than three-years, with most registered women delivering at neighbouring 'host' hospitals in Stockport, Wythenshawe and Crewe.

Whilst the service has been suspended, all inpatient intrapartum activity has been provided by host Trusts - Stockport NHS Foundation Trust (SFT) at Stepping Hill Hospital, Manchester University NHS Foundation Trust (MFT) at Wythenshawe Hospital and Mid Cheshire NHS Foundation Trust (MCFT) at Leighton Hospital. Women were given the option to choose which host site they want to attend by the time they were 20 weeks pregnant.

Delivery Provider	20/21	21/22	22/23
Mid Cheshire FT	330	261	290
Stockport FT	474	337	370
MFT (Wythenshawe)	407	563	443
Royal Stoke	107	41	13
Home births	14	41	17
Others	41	37	23
Total ECT registered births	**1373**	**1320**	**1156**

Most antenatal and postnatal care, including scans, tests and support for home births, continued to be provided throughout the suspension by ECT on site at MDGH and in the community across eastern Cheshire. Some women may have had their care transferred if considered high risk or complex.

2.4 Governance and Decision Making

The initial suspension of inpatient services was for a period of up to six months arising from the limited anaesthetic capacity in the Trust to deal with the COVID pandemic. The suspension was extended on three occasions following assessment against Board approved recovery criteria.

At its March 2022 Board meeting, the Board agreed that intra-partum services should be returned to the Macclesfield site when safe to do so with an initial goal of doing so by April 2023. Key to ensuring safety was the response to a Royal College of Anaesthetists invited review of obstetric anaesthesia provision and the final report of the Ockenden maternity review into another NHS Trust.

3 Preparation for the Return of Service

3.1 In September 2022, a detailed paper was considered by the ECT Board which set out options for how the service could be re-instated safely. These had been developed through significant work over the spring / summer, involving staff, partners, stakeholders, and patients including 3 workshops attended by 68 people many of who attended more than one workshop. The workshops brought people together to identify and consider the important issues in returning the service, and how it could be safely re-instated.

In order to return the agreed model (i.e., a full consultant led obstetric unit with an Alongside Midwife Led Unit and Special Care Baby Unit (SCBU)]), and in light of the output from the workshops, the Board confirmed that a supportive partnership model should be established with a neighbouring trust.

Two reports were critical to the Board's considerations:

- The Findings, Conclusions and Essential Actions from the Independent Review of Maternity services at the Shrewsbury and Telford Hospital NHS Trust ('The Ockenden Report, March 2022).
- The Royal College of Anaesthetists invited review of the anaesthesia service in relation to provision of maternity care at East Cheshire NHS Trust (February 2022) (attached).

3.2 To oversee this, the Board established a regular cycle of meetings of two groups:

- Maternity Oversight Group provided senior trust and partners organisation oversight of the plans to repatriate maternity services, it was chaired by ECT CEO, attended by representatives of Cheshire and Merseyside ICB; Cheshire East ICB Place Team; Cheshire East Council; and Greater Manchester and East Cheshire Local Maternity and Neonatal Network

- Maternity Implementation Group co-ordinated the delivery of the programme of work required to return maternity services, it was chaired by the ECT Medical Director, attended by ECT representatives plus the Maternity Voices Partnership.

Key risks to the safe re-instatement of the service were agreed as:

a) The need to develop robust arrangements to deliver high quality, safe and sustainable intrapartum services with a supporting partner,
b) The need to secure support from NHS England the Cheshire & Merseyside ICB for the proposals,
c) ECT's ability to recruit, retain and train sufficient staff to sustainably deliver the service,
d) The need to reduce the requirement for escalation beds, allowing Ward 6 to return to its previous function as the maternity ward.

3.3 Criteria to confirm the decision to return the service were reviewed and amended and agreed by ECT Trust Board in November 2022:

Local Level

1. *National modelling indicates that further C19 surge is unlikely and local capacity to meet clinical need would be manageable within enhanced workforce and environment.*
2. *Robust arrangements are in place to deliver high quality, safe intrapartum services with a supporting partner; this includes support for the ongoing training and development of staff.*
3. *Workforce recruitment, attendance and resilience is at a level sufficient to maintain safe staffing levels in obstetrics, midwifery, neonatal, anaesthetic and theatre services:*
    1. *Obstetrics – full establishment required.*
    2. *Midwifery – 90% establishment seen as safe.*
    3. *Neo-natal – 87% establishment seen as safe.*
    4. *Anaesthetics – please see note below.*
    5. *Theatres – service can accommodate 1.27 ODP vacancy.*
4. *Capacity for patients (including any COVID 19 positive patients, any linked to seasonal pressures and any with no criteria to reside) can be accommodated to core wards without the requirement to utilise additional estate and facilities in maternity.*
5. *The Trust has robust plans in place to guarantee access to emergency theatres when necessary.*

System Level

6. *Local Maternity Systems in Cheshire & Mersey and Greater Manchester are safely resilient to the impact of the ECT recovery plan.*
7. *Support is received from commissioners and regulators for proposals to return intrapartum services.*

3.4 Assessment of readiness against these criteria were considered by the ECT Board each month. In March 2023, the ECT Trust Board assessed that they were confident that all criteria would be met by June 2023 and that it would therefore be safe to reinstate the service. The Trust continued to monitor readiness against the criteria which is illustrated on the dashboard below.

DASHBOARD

UPDATED 21/06/2023 - FOR BOARD APPROVAL

Maternity Return Criteria Review	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23
Local Criteria								
1. National modelling on C19 surge								
2. Robust arrangements with a supporting partner								
3. Safe staffing levels								
Obstetrics								
Midwifery								
Anaesthetic Consultants								
Anaesthetic SAS Doctors								
Theatres								
Neonates								
4. Bed Capacity								
5. Emergency Theatres								
System Criteria								
6. Host resilience								
7. Regulator and commissioner support								

Blue	Green	Amber	Red
Criteria Met	Solution identified – on track	Solution not yet confirmed	Solution not identified

4 Pathway to 'Go Live'

4.1 A detailed project plan to 'go live' was developed and proactively managed, which captured over 400 tasks required to be completed before the service could return. This plan was overseen by both the Maternity Implementation Group (chaired by the ECT Medical Director) and Maternity Oversight Group (chaired by ECT Chief Executive). Five key strands of this plan included:

i. Staffing training and re-orientation

Plans for all necessary staff to be re-trained to be competent and confident to deliver a safe service from early summer. Ongoing training may be required, for which arrangements are in place.

ii. Estates & facilities

Work took place to convert Ward 6 back into the Maternity ward, including aesthetic improvements to improve patient experience, upgrading IT equipment and installation of a new baby tagging system.

iii. Equipment

New equipment was purchased, including major items such as Labour Ward Beds and Phototherapy Units and other equipment serviced.

iv. Communications & patient engagement

A robust Communications Plan was created, including open days for pregnant women and families as well as work with Maternity Voices Partnership (MVP). MVP and service users were invited to take part in a 15 Step Assessment to review the new unit from a patient perspective.

v. Transfer of care

Robust plans were in place to care for women booked with ECT to deliver from early summer. Women were advised of the date of reinstatement and be expected to attend ECT from that date this should minimise the requirement of the host sites providing care without ECT staff. Beyond the re-start date, host sites were only required to care for women who were in active labour or recently given birth. A small amount of the babies requiring neonatal care may require care by the neonatal unit at the host site, and an individual assessment was to be undertaken for any baby that does to see if they could be transferred to ECT.

Engagement session.

Maternity recruitment event.

4.2 ECT Executives and Operational teams worked closely with a range of external partners on issues of assurance:

- ECT Executives met regularly with senior colleagues from Cheshire & Merseyside ICB, Cheshire East Place, NHS England North West and Greater Manchester & East Cheshire Local Maternity and Neonatal System (LMNS) to appraise them of progress and deal with any issues and concerns.
- The Maternity Service was in close contact with the Regional Chief Midwife and Regional Chief Obstetrician to provide ongoing assurance and responded to several clinical and operational queries.
- The service worked closely with the ECT Planning team to ensure plans for 2023/24 are in line with Operational Planning Guidance.

- A new GMEC LMNS safety progress and performance meeting was created to monitor all trusts against the national standard 3 year delivery plan for Maternity and Neonatal services (2022) at which the trust will present and update on a quarterly basis to the board.

5 The return of The Service

5.1 On Monday 26th June 2023 staff celebrated the re-opening of intrapartum services under the headline "Macc is Back!"

Later that day, the first baby to be born at Macclesfield DGH was a little boy called Oakley, born via caesarean section at 38 weeks weighing 7.3lb. Mother, Stacey and Dad, Lewis were delighted to deliver their second baby at Macclesfield as their first son was born one week after the unit closed in April 2020 at Stepping Hill following an emergency caesarean section.

The first babies born on the unit were each given personalised baby grows and hampers.

5.2 In the first three months since the service reopened there were 270 births at Macclesfield maternity (up to end of September 2023). This is in line with predictions for the service (approx. 2 to 3 babies each day).

Activity has grown each month, again, in line with predictions. In September 2023 there were 86 births:

	June (from 26/06/23)	July	August	September
Bookings	103	124	136	115
Births	15	89	80	86
Vaginal births	9 (60%)	53 (59.5%)	48 (60%)	47 (54.7%)
Elective Caesarean sections	3 (20%)	12 (13.5%)	14 (17.5%)	18 (20.9%)
Emergency Caesarean sections	3 (20%)	24 (27%)	18 (22.5%)	21 (24.4%)

Of the 270 births there has been:

- 1 stillbirth
- 157 had vaginal births (58%)
- 37 had Elective Caesarean sections (13.7%) (regional comparison 17.7%)

- 66 had Emergency Caesarean sections (24.4%) (regional comparison 25.8%)
- 4 had post-partum haemorrhage >1500mls (0 > 2500mls)
- 3 had 3rd degree tears
- 15 admissions to the Special Care Baby Unit
- 10 babies received transitional care on the maternity ward

With no diverts, deflects or closure of the unit.

6 Post Implementation Review

6.1 ECT is committed to learning from the experience of the suspension and return of intrapartum maternity services and has conducted a post implementation review. In doing so we hope to capture good practice from this successful project as well as learn any lessons that may be useful in the future.

The review has taken place three months after the return of services. Board members, staff, partners, key stakeholders, and patient representatives who were involved in the project were all invited to take part in this process, and feedback has been received through a combination of surveys, one-to-one discussions, and small workshops.

6.2 Views have been sought on a range of component parts of the project to return services including workshops held in 2022 to identify future models for delivering services, the return criteria used by the trust to assess our readiness to return the service, governance arrangements, risk management, communications and engagement as well as identifying any unforeseen issues that were not predicted as part of the planning process.

6.3 Given the nature of the feedback received and the number of internal and external stakeholders involved in this review, the report is primarily qualitative, seeking to identify and explain any good practice or lessons for the future.

7 Findings

7.1 **2022 Workshops:**
A series of workshops were held between April and June 2022 to engage stakeholders from clinical, commissioning and lived experience groups. The purpose of the workshops was set out by NHS England/Improvement (NHSEI) and Cheshire & Merseyside ICB to fully explore the potential to return consultant led obstetric services to Macclesfield and to understand the preferred options to do this safely.

Over the three workshops participants helped to create criteria for success, develop a long list of 14 potential service model options, refine this to a short list of nine and ultimately agree a set of three preferred options for further consideration by ECT.

The workshops took place in community venues across eastern Cheshire and were attended by representatives from ECT (including midwifery, obstetric, theatre, anaesthetic and paediatric clinicians and managers) plus external representatives from host sites, Greater Manchester & East Cheshire Local Maternity & Neonatal System, NHS England, Royal College of Midwives, Cheshire Clinical Commissioning Group and Macclesfield Maternity Voice Partnership.

Following the workshops, the ECT Board received a detailed report at its private meeting in September 2022 and fully endorsed the model of care which was scored highest by the workshop (which was a full consultant led obstetric unit with an Alongside Midwife Led Unit and Special Care Baby Unit (SCBU)).

Some materials from the workshops are included in the appendices. Full details of the workshops and the tools used throughout are available upon request from the Strategy Team at ECT.

Feedback:

All participants in the workshops were invited to take part in a survey, in addition a meeting with heads of Midwifery also discussed the workshops.

Feedback has been very positive.

- All survey respondents thought the workshops format was either "very appropriate" or "somewhat appropriate" in helping to design future services.
- Most people thought that the format and invite list for the workshops was right, and that adequate time and focus was given to the discussions.
- Some made comments about possible improvements – for example,
    - allowing people to participate online,
    - having more clinicians in attendance (this included more ECT clinicians, plus clinicians from NHSE, the ICB and NWAS), and
    - allowing more 'shopfloor' representation.
- One person said that they didn't find the process for shortlisting and selecting a preferred model to be helpful, saying that all models should have still been considered.

7.2 Return Criteria

The initial suspension of inpatient services was for a period of up to six months. The suspension had been extended on three occasions following assessment against recovery criteria that had initially been agreed by the Board at ECT shortly after the original suspension.

In September 2022 the ECT Board received a detailed report into the 2022 workshops and agreed that the original 2020 recovery criteria should be reviewed. In November 2022, Board agreed a revised set of recovery criteria (featured above in section 3.3) this revised criteria included a blend of the original criteria, some updated criteria plus some new criteria.

Assessment against these criteria was regularly reported to Board having been thoroughly considered by Maternity Implementation Group (MIG) and Maternity Oversight Group (MOG). Progress towards meeting the criteria could easily be seen via the BRAG dashboard (featured above in section 3.4).

Feedback:
Board members, members of MIG and MOG as well as ECT clinicians and service managers were asked for their views on the return criteria.

- There has been broad support for the return criteria with no suggestions made for additional criteria that may have been useful.
    - A potential refinement was suggested, questioning whether the continued focus on C19 preparedness was right and whether it could have been broadened to cover any pandemic response.
- Widespread support from all for the BRAG assessments and dashboard;
    - these are seen to have helped to keep the project focussed,
    - seen as useful to review detail as the project progressed, including discussion on levels, and ability to be self-critical against what level was being achieved,
    - good visual tool and method of recording a snapshot on progress and progress over time,
    - It was noted the BRAG was not regularly reviewed at the MPG and that this could have been beneficial in terms of oversight, progress, and motivation for MPG members.

7.3 **Governance arrangements:**

To support the programme of work to return services, the Trust established a number of time limited working groups, these were:

- Maternity Oversight Group (MOG): chaired by ECT Chief executive, attended by representatives of Cheshire East ICB Place Team; Cheshire East Council; and Greater Manchester and East Cheshire Local Maternity and Neonatal Network as well as key ECT clinical leads.
- Maternity Implementation Group (MIG): chaired by the ECT Medical Director, attended by ECT clinical and managerial representatives plus the Maternity Voices Partnership.
- Maternity Project Group (MPG): chaired by the Director of Operations and attended by key internal project leads including the Head of Midwifery, anaesthetic lead, theatre lead, HR, IT and Estates.

Monthly meetings were scheduled for these groups with MPG feeding into MIG, MIG feeding into MOG and MOG providing updates to Board on a regular basis.

Feedback:
Members of the ECT Board, MIG, MOG and MPG were asked for their views on the governance arrangements.

- Having three separate but connected meetings was seen as helpful;
  - It provided a clear escalation process,
  - Helped to capture and consolidate progress,
  - Allowed a wide range of people to be involved,
  - Allowed focussed time to discuss blockages to the project,
  - Provided a good rhythm to the project.
- Involvement of external stakeholders (in MIG and MOG) was seen as useful;
  - It allowed for robust check and challenge,
  - It allowed external representatives to understand the complexity of the issue and the relationships between competing factors,
  - External representatives were also able to have more informed discussions within their own organisation,
  - It enabled longer term discussions to take place as well as a focus on the immediate task in hand – this has put Place arrangements in a stronger position as a result.
- The membership and Terms of Reference for the groups are seen to have been fit for purpose;
  - One potential oversight was not including the Deputy Director of Operations (who chaired MPG) as a member of MOG.
- Overall, Board members felt that they were provided with enough information in regular board updates to provide them with sufficient assurance in the whole process and allow them to make informed decisions.
  - One anonymous board member, a relatively new member on the Board, said that they didn't feel they knew enough of the background to the project. This is potentially a lesson for the future in terms of the induction of new board members.

7.4 **Risk Management**
The project, working through MPG, MIG and MOG, created a risk log to identify and manage risks. This was kept under constant review through the project. The risk log used a standard trust template to capture risks, gaps and mitigations. The log identified 12 risks, however four were identified as ''principal'' risks and were reviewed in greater detail.

Feedback:
Members of MIG, MOG and MPG were asked for their views on the approach to risk management.

- Survey responses showed support for the way that risks were identified and managed, and that sufficient emphasis was given to each one and that they supported decision making.
- MIG and MOG members found the process helpful.

- Having a long list of all risks as well as a shortlist of principle risks allowed sufficient focus on those principal risks (such as anaesthetic recruitment),
- Members were confident that sufficient mitigations were in place to appropriately manage risks,
- Members thought that it may have been more helpful to have risk discussions at the end of MIG and MOG agendas to allow more informed discussion.

7.5 **Project Plan and plan to 'go live'**

The trust's Strategy team established a detailed project plan that led up to the final 'go live' date. This was proactively managed through one-to-one discussions and discussions primarily at MPG, with any concerns escalated to MIG or MOG as appropriate. Each task on the plan had an owner, a target date to complete and progress notes. Broad areas covered by the plan also had leads who took responsibility for any actions that were overdue or facing barriers.

Feedback:

Survey responses show support for the project plan and the approach taken by the project, with no suggestions made for improvements.

Members of MPG and MIG felt the structure of the project plan was clear on responsibilities and useful in helping to drive work forward, hold people to account and reduce delays.

- MPG felt that the fact that so few actions had to be escalated to MIG showed how well the plan worked,
- The detail in the project plan was helpful in reassuring external partners how well-thought-out the plans to reinstate services were, and gave reassurance on progress being made towards the target date to re-open services,
- Executive members said that they had confidence in the process. They trusted action owners and MPG to manage actions and trusted that issues would be escalated where appropriate.

7.6 **Decision-making**

In addition to internal decision-making structures (individual managers, MPG, MIG, MOG and Board) the project also had to operate within a changing external decision-making landscape brought about by the implementation of the Health and Care Act of 2022. This included the abolition of statutory bodies such as Clinical Commissioning Groups and the establishment new Integrated Care Systems and Integrated Care Boards. These changes coincided with the period when plans for the reinstation of maternity service were being implemented and it meant that part way through the programme there were significant changes in terms of organisational responsibilities and of the individuals involved in the programme.

Feedback:
Members of MIG and MOG as well as external stakeholders were asked for their views on the decision-making process associated with the project.

- Clearly the timing of the project and the changes brought about by the Health and Care Act caused some confusion.
- New organisations, teams and individuals were brought into the programme part way through, which added some delay into the programme as new relationships and arrangements needed to be formed, and new roles and responsibilities needed to be understood.
- This was further complicated by the fact that the project needed to look towards ICB arrangements in Cheshire and Merseyside as well as towards Local Maternity and Neonatal arrangements in Greater Manchester.

- Engagement with system partners was seen to be good – with positive feedback received from external attendees of the Checkpoint meetings with NHS England, ICB, CEP and LMNS.
- Given the heightened national focus on Maternity safety issues (such as the Ockenden and Kirkup reviews with their separate requirements) a high level of system interest was to be expected. Other future services might not face such levels of interest.

7.7 **Communications and Engagement**

Throughout the suspension, and then in preparation for the return, the trust aimed to keep staff, stakeholders and patients informed on progress; this has been achieved through a combination of briefings, press releases, meetings and in the case of patients, through work with Maternity Voice Partnership.

Feedback:

Whilst the focus of the review is the period running up to the return of services, some comments have been received relating to the overall suspension, these include:

- Recognising it was difficult to keep people fully updated and dealing with the uncertainty of the long suspension,
- Focus was given to keeping midwifery teams fully informed, including regular briefings with the trust Chief Executive and Director of Nursing, and this is seen to have worked well, however some other teams did not feel so well informed,
- Often these briefings were verbal, with nothing shared for those unable to attend,
- Communication and engagement improved throughout the suspension, particularly in the last 12-18 months as the service prepared for return.

In terms of the period of the project focussed on the return of the service, the review considered communications and engagement for staff, stakeholders and patients.

7.7.1 **Staff engagement:**

- Regular meetings of the project group helped support a consistent message across departments that could be fed back to staff. These meetings also improved relationships between group members that improved working outside of the meetings.
- It was easier to liaise with staff on site. More difficult to liaise with staff off site particularly where work was moving at pace.
- The workshops in 2022 were very valuable to midwives to allow them to be part of the process, understand the work, and build trust with the Executive team and wider project team. It is believed that this helped to minimise some of the conflict that may have developed.
- There was no one-size-fits-all approach to keeping staff informed – especially midwifery staff. A combination of briefings, newsletters, team meetings and WhatsApp were all seen to have helped to keep staff informed.
- Not all interested staff groups felt as involved as the midwifery teams. It was not always possible for clinical staff to be released from clinical activity to take part. The role of clinical leads in cascading information could have been better understood and explained.
- A mix of informal and formal communications are seen to have been successful – examples include attending staff meetings as well as circulating emails.
- It may have been helpful to include 'key messages' as a standard agenda item for MIG and MOG – agreeing what information could and should be shared.

7.7.2 **Stakeholder engagement:**

Heads of Midwifery from host sites and members of the NHS England checkpoint meetings have confirmed they were happy with the way they were engaged and communicated with.

- A regular Heads of Midwifery meeting was established at the start of the suspension. The good relationships built up over the whole period are seen to have helped with understanding and joint working in the lead up to the return of the service.
- NHS England established a regular 'Checkpoint' meeting for external partners to receive regular updates. Members of this group have confirmed they were happy with their engagement and thought that the group was a useful opportunity to raise issues, discuss risks and develop plans.

7.7.3 **Patient Engagement:**

The project aimed to provide a 10-week window to share information with pregnant women and the wider public on the return of the service, however, the complexity of the decision making and associated delays in announcements meant that this was not possible.
Feedback from MPG, MIG and host sites shows that maternity teams worked hard to make sure that pregnant women were kept informed as best as they could be of the planned changes and how they may affect plans for delivery. At all times patient safety was prioritised and expectant women with imminent due dates were provided with information on host sites (including key phone numbers) as well as the Macclesfield service.

This period of delay:

- is thought to have reduced trust in what the maternity teams were saying to expectant mothers. The lack of ability to give clear communication to women due to give birth close to their due date was not supportive and fell short of what the project aspired to.
  could have caused mixed messages that could have posed a risk.
- led to a lack of communication through official trust social media or the web site which is seen to have given a negative impression to patients.

Maintaining a good working relationship with Maternity Voices Partnership (MVP) is seen to have been crucial – MVP is a trusted partner for many pregnant women and their families as well as for statutory agencies. MVP were actively involved throughout the project to return the service (indeed, throughout the suspension) including the 2022 workshops, being members of MIG and supporting patient communications and engagement.

7.8 **'Snagging issues'**

Everyone involved in the project was asked to identify any snagging issues in the hope that the trust, and any future projects, may be able to learn from them.

Feedback:
Snagging issues identified can be grouped into 3 broad areas:

- **Staffing:**
  - Short notification of a change of guidelines linked to the second scrub in theatre meant that there was little time to re-arrange rotas and shift patterns. This was a potential 'showstopper' which required bank and permanent staff to work flexibly to cover.
  - There have been difficulties in signing off job plans part way through the year as would normally be done prior to April. This has been compounded with in-year recruitment.

- **Digital & Telephony:**
  - An NHSE site visit two weeks before re-opening advised the need for centralised cardiotocographs. This required additional data points, licences and support from IT. Such short notice changes are challenging in terms of cost and lead times – this needs to be considered for any future re-fit or relocation across the trust.
  - There was an interface issue with the IT systems which meant that many babies were being allocated two hospital numbers rather than one, this led to delays to tests for blood and radiology. Additional admin support was required to work around this issue until it was resolved.

- **Estates:**
    - Prior to re-opening, plans were made for the renovation of the maternity ward. These plans were later changed without the full involvement of the maternity team which led to delays. These plans should have had oversight by the maternity team to ensure that the plans were appropriate.
    - Some minor estates work was incomplete at time of opening,
    - Due to the delays in the estates work, the cleaning team had issues gaining access to the unit to undertake a deep clean. This meant that the Maternity staff came into the unit to clean the unit the weekend before the re-opening.

- **Equipment and stock:**
    - Not all of the equipment or stock was available initially. Although it is worth noting that all essential items were in place,
    - Five new resuscitaires were purchased and in place at the time of the reinstatement, it was soon realised they connected to the medical air and oxygen supply differently and that cylinders were emptying quicker than expected. With support from the EBME the manufacturers quickly created adaptors for the equipment.

7.9 **Unintended consequences**

Similar to snagging issues, any large project such as the return of a major service is likely to have unintended consequences – these are often difficult to recognise or predict. It is hoped that by identifying any unintended consequences connected to this project it may support future projects.

Feedback:
Feedback has helped to identify a number of positive as well as negative unintended consequences.

Positive:
- ✓ **Investment** continues to flow to East Cheshire Trust and people want to work here
- ✓ **Better opportunities** for paediatric medical staff, focus on up skilling
- ✓ **Heightened confidence** in MDGH for the future
- ✓ **Anaesthetics** were able to increase their establishment.
- ✓ Better **continuity of care** for pregnant women
- ✓ Seeing patients on the children's ward who have already been seen on neonates - **better follow through of care**.

Neutral
- the number of **staff changes** leading to change in leadership, management and ownership.

Negative:
- × Acute **medical beds that were gained during the suspension were lost which in turn has impacted on Paediatric beds and flow through the organisation**
- × **Operating Department Practitioner (ODP) structure**. Model of Care is managed in line with policy, however fallout from minority of team increased demand on the service
- × Loss of theatre capacity and in particular **elective gynaecology operative lists** to accommodate the elective caesarean section lists and its impact on gynaecology waiting lists and skill maintenance in clinicians. This will have a detrimental financial impact and exacerbate long waits for elective operations.
- × Without significant increase in births, **Unit likely to remain sub-scale** and questions over future sustainability will remain.
- × Will contribute significantly to trust's financial deficit as **loss making service.**

8 Lessons & Recommendations

8.1 The return of intrapartum maternity services to Macclesfield DGH after a significant suspension is great news for current and future expectant women and their families, and should be celebrated. Everyone involved in this project are to be thanked and congratulated for their hard work and determination.

Feedback from this review has been broadly positive and there are lessons to be learned from the maternity experience that could be useful for future projects.

The lessons from this review can be grouped under the following headings:

8.2 **The importance of ongoing engagement**
For maternity this included wider participation workshops, a number of working groups, plus regular formal and informal briefings. Not all projects would need to follow the exact same approach, however, the lessons from maternity would stress the importance of:

- Clinical engagement and the role of clinical leadership. Not just the teams and services that are immediately impacted by a project but interconnected services as well (in this case, not only maternity, but paediatrics, anaesthetics, and theatres). Clinical leads can play a vital role in ensuring wider teams are aware of and involved in change programmes.
- Clear and regular communication processes with staff members affected by the changes and to listen to understand their perspectives.
- Ensuring all staff members affected by the changes are actively involved in taking forward the service change.
- Regular and timely messages to patients and the community. Each project will need to consider how best to keep patients and the community informed. Clinical teams could be one of the strongest assets to any similar project. They are trusted by patients, their direct communication with patients is probably more important than any official press release or post on social media. Any future project needs to harness these assets.
- Coproduction – patient voice is central to the service change having the support and active engagement in design and implementation plans of the local MVP ensured that the opening of the maternity unit took into consideration the needs of the local population and ensured strong relationships were developed with the clinical teams.

Stakeholder Mapping:

From 2020 onwards, it was crucial for the maternity project to understand the needs of various internal and external stakeholders including patients, clinicians, regulators and local politicians.

Future projects should take time to map out all the wider stakeholders affected by the changes, their drivers, and motivations, and ensure that they are appropriately engaged in the development and implementation of plans.

8.3 **Establishing appropriate governance arrangements.**
For maternity this involved three internal groups, plus regular updates for Board and external partners, escalation processes and decision making processes were clearly set out in terms of reference.

It is not the case that this approach should be replicated for future programmes, rather that each project needs to develop its own approach and be appropriately managed and controlled. Potential future projects need to consider their own needs; the approach taken needs to be proportionate to the scale and complexity of the task.

External involvement in governance has been shown to work in this project and should always be considered, including involvement of patients or patient representatives via an appropriate VCSE organisation.

8.4 **Project management approach.**

All major projects need some form of project management and this needs to be proportionate to the project. Key elements of the approach to maternity are likely to be needed for all projects such as a project plan, risk management, action logs with escalations where appropriate to ensure projects remain on target and any barriers are overcome.

For maternity a clear set of return criteria helped the project to focus on an end goal. Such criteria may not be suitable for all projects; however, a clearly articulated set of objectives, goals and milestones is necessary for any major project.

8.5 **Decision making**

Having appropriate governance arrangements in place, being clear on your purpose and having robust project management arrangements will all aid good internal decision making. However, external factors can also affect project decision making.

It is important for any major project to understand any external decision-making factors, to understand the critical dependencies to secure the service change and any new arrangements and involve them in the development and implementation of plans as part of a coherent overarching programme.

It is essential that there is clarity regarding decision making across statutory bodies which have an interest in the service change, and that all relevant decision makers are appropriately and effectively engaged.

This could be straightforward for example where a local or even national commissioner needs to approve a proposal or business case, but this could also be more complicated, for example where several regulators or statutory bodies have partial responsibilities in any area.

8.6 **Leadership**

The maternity project had significant Executive input, from the Chief Executive and several key Executives including Chief Nurse, Medical Director and Chief Operating Officer, in recognition of the strategic importance of the project and the complexity of returning such a major service.

Project management resources were identified to support the work, ensuring clarity of actions required and a proactive approach to achieving them.

Not all projects will require such Exec level input (although some may be required), but projects do need leadership, and it is common to see large projects at the Trust have designated Senior Responsible Offers (SRO) and Clinical Lead roles. These roles often play formal governance roles in decision making and reporting arrangements, they also play less formal roles in negotiations, setting direction and overcoming any obstacles, as such, the SRO and Clinical Lead will need to be decision makers with appropriate levels of authority within the Trust.

Similarly, not all projects will require dedicated project management support, however, all projects should adopt appropriate project management approaches commensurate with the size and complexity of the project.

8.7 **Snagging issues and unintended consequences should be expected and where possible anticipated.**

The maternity project has experienced snagging that can be grouped into categories such as estates, digital and staffing issues, unintended consequences included a mix of positive and negative issues – future projects could consider these themes and try to anticipate potential issues before they arise.

Appendices

1. Agenda – Workshop 1
2. Agenda – Workshop 2
3. Agenda – Workshop 3
4. Criteria for Success – Updated post-Workshop 2
5. Scoring Outcomes
6. Return criteria
7. Terms of Reference – Maternity Implementation Group
8. Terms of Reference – Maternity Oversight Group
9. Dashboard of Maternity Return Criteria
10. Project Plan – Example for Host Provider actions
11. Maternity Project Group – Project Progress Report
12. Maternity Implementation Group – Project Progress Report
13. Risk Register
14. Public Board Paper – March 2023

Workshop 1 – Agenda

Time	Item	Presenter
13:00-13:10	**1. Welcome & Introductions**	Kate Daly-Brown
13:10-13:20	**2. Background** • Where are we now in East Cheshire? • What is the current situation?	KDB/FW
13:20-13:30	**3. The national context**	NB/JA
13:30-13:40	**4. The patient perspective**	JN
13:40-14:20	**5. The task for today** • Group work • What criteria is important to ensure a safe and successful maternity service for women and families? • Write each criterion on a piece of A4 paper	KSh/FW/NB
14:20-14:40	**6. Coffee break and theming of the feedback**	
14:40-15:00	**7. Review and understanding the criteria/themes** • What would that give us? • What are the challenges in meeting this?	FW/NB
15:00-15:15	**8. Weighting of criteria – Group discussion and share thoughts**	Facilitators
15:15-15:30	**9. Weighting of criteria individually**	KSh
15:30-15:45	**10. Reflections on the scoring**	NB/JA
15:45-15:55	**11. Next steps – outline for the next workshop**	FW
15:55-16:00	**12. Close**	
Workshop 2: Friday 23rd May 22		

Workshop 2 – Agenda

Purpose: Review and confirm criteria for success and develop service model options (long list).

Time	Item	Presenter
13:00-13:10	**1. Welcome & Introductions** ○ Purpose of today	Kate Daly-Brown John Hunter
13:10-13:30	**2. Why are we here?** ○ Suspension of services ○ Recent considerations ○ Importance of work	Kate Daly-Brown John Hunter Eileen Stringer
13:30-14:15	**3. Follow up from Workshop 1: Developing Criteria for Success** ○ Summary of criteria developed last meeting 10 mins ○ Table discussion on criteria: What does good look like? 20 mins ○ Wider group feedback 10 mins ○ Summarise changes and key points from discussion 5 mins	 Katherine Sheerin Groupwork All Katherine Sheerin
14.15-14.30 Break		
14:30-15:55	**4. Developing the long list of options to deliver the service:** ○ Introduction 5 mins ○ Table discussions – Creating the long list 15 mins ○ Wider group feedback of options 10 mins ○ Review of the options – SWOT analysis of each options 55mins	Nicky Biggar & Jyotsna Acharya Groupwork Katherine Sheerin Groupwork
15:55-16.00	**5. Reflections and Close**	Kate Daly-Brown
Workshop 3: Friday 24th June 22		

KD-B

Workshop 3 – Agenda

Purpose: Review options against the criteria to create a list of preferred options

Time	Item	Presenter
09:00	**1. Welcome & Introductions** ○ The process so far ○ Purpose of today ○ Context setting	Kate Daly-Brown
09:20	**2. Confirming the process** ○ Criteria	Kathrine Sheerin
09:30	**3. What have we learned?** ○ Feedback from the various clinical groups ○ Long list to short list ○ Pre-scoring	Alex Vincent Dave Nunns Nicky Biggar
09:45	**4. Clinical Standards** ○ Ockenden standards ○ Anaesthetics & Theatres ○ Neonates	Nicky Biggar John Hunter
10:00	**5. Scoring of the remaining options using the criteria** ○ Definitions	Dave Nunns Groupwork
	Break	
11:30	**6. Feedback and discussion of scoring**	Groupwork
12:30	**7. Clarification of outcomes, preferred options and next steps**	Kate Daly-Brown
13:00	**8. Close**	

KD-B

Criteria for Success – updated version

Agreed criteria:	Dots	%
1. Meets quality standards including safe staffing	231	30
2. Staff health and wellbeing	83	11
3. Good patient experience	81	10
4. MDT working and training	66	9
5. Accessibility	66	9
6. Promotes Choice	60	8
7. Enables effective partnership working	55	7
8. Sustainable and implementable	54	7
9. Equipment and estates	39	5
10. Cost	37	5

There was a vote to ask feedback on whether the criteria should be grouped into themes or kept as 10.

Vote to Group Criteria:

Grouped: 7 Keep as ten: 22

There was an agreement in the room that the criteria should be kept as a list of 10 and this is what will be used to score the models.

KS

Scoring outcomes

Option	Group	Meets quality standards including safe staffing	Staff health and wellbeing	Good patient experience	MDT working and training	Accessibility	Promotes Choice	Enables effective partnership working	Sustainable and implementable	Equipment and estates	Cost	Individual Option Weighted Totals	OVERALL OPTION TOTAL
	Weighting	30%	11%	10%	9%	9%	8%	7%	7%	5%	5%		
	Group	Score	Score	Score	Score	Score	Score	Score	Score	Score	Score		
Full Obstetric Unit with Alongsice Midfifery Led Unit (AMLU) & SCBU provided by ECT	Group 1	3	4	4	3	4	4	2	2	4	3	3.32	
	Group 2	3	3.5	4	2.5	4	4	2	1.5	4	3	3.185	
	Group 3	3	4	4	3	4	4	3	2	4	3	3.39	**3.265**
	Group 5	3	4	4	2	4	4	2	2	3	3	3.18	
	Group 6	2.5	4	4	3	4	4	3	2.5	4	2.5	3.25	
Full Obstetric Unit with AMLU & SCBU delivered as a managed clinical service	Group 1	3	2	2.5	4	4	4	2	2	2	4	2.99	
	Group 2	3	3	4	3.5	4	4	3	3	4	3.5	3.42	
	Group 3	3	3	4	4	4	4	4	2	4	3	3.44	**3.303**
	Group 5	4	3	4	3	4	4	4	3	4	3	3.72	
	Group 6	2.5	1	3	4	4	4	3	3	4	2.5	2.945	
Full Obstetric Unit with AMLU & SCBU delivered as a shared service	Group 1	3	3	2.5	3.5	4	4	3	2	3	3	3.125	
	Group 2	3	3.5	4	3.5	4	4	3	2.5	4	3	3.415	
	Group 3	3	3	4	4	4	4	4	2	4	3	3.44	**3.473**
	Group 5	4	3	4	3	4	4	4	3	4	3	3.72	
	Group 6	4	2.5	3	4	4	4	4	3.5	4	2.5	3.665	
Freestanding MLU with 24/7 staffing delivered by ECT	Group 1	2	3	2	2	2	2	2	2	4	2	2.23	
	Group 2	3	2.5	2.5	3	2	2	2.5	1.5	4	1	2.565	**2.368**
	Group 3	2	3	2	2	2	3	2	2	4	2	2.31	
Freestanding MLU with 24/7 staffing delivered as a managed	Group 1	2	2	2	2.5	2	2	2.5	1.5	2	2.5	2.09	
	Group 2	3	2	2.5	3	2	2	3	2	4	1.5	2.605	**2.388**
	Group 3	2	3	2	3	2	3	3	2	4	2	2.47	
Freestanding MLUwith 24/7 staffing delivered as a shared service	Group 1	2	2	2	2.5	2	2	2.5	1.5	3	2	2.115	
	Group 2	3	2	2.5	3	2	2	3	2	4	1	2.58	**2.388**
	Group 3	2	3	2	3	2	3	3	2	4	2	2.47	
Freestanding MLU with on-call staffing delivered by ECT	Group 3	2	1	2	1	2	3	2	2	3	2	1.95	
	Group 5	1	1	1	1	1	1	1	1	2	1	1.06	**1.473**
	Group 6	2	1	1.5	1	1	1	1	1	2	1	1.41	
Freestanding MLU with on-call staffing delivered as a managed	Group 3	2	1	2	2	2	3	3	2	3	2	2.11	
	Group 5	1	1	1	1	1	1	2	1	2	1	1.13	**1.45**
	Group 6	1	1	1.5	1	1	1	1	1	2	1	1.11	
Freestanding MLU with on-call staffing delivered as a shared	Group 3	2	1	2	2	2	3	3	2	3	2	2.11	
	Group 5	1	1	1	1	1	1	2	1	2	1	1.13	**1.45**
	Group 6	1	1	1.5	1	1	1	1	1	2	1	1.11	

Maternity Return Criteria

Local Level

1. *National modelling indicates that further C19 surge is unlikely and local capacity to meet clinical need would be manageable within enhanced workforce and environment.*
2. *Robust arrangements are in place to deliver high quality, safe intrapartum services with a supporting partner; this includes support for the ongoing training and development of staff.*
3. *Workforce recruitment, attendance and resilience is at a level sufficient to maintain safe staffing levels in obstetrics, midwifery, neonatal, anaesthetic and theatre services:*
    1. *Obstetrics – full establishment required.*
    2. *Midwifery – 90% establishment seen as safe*
    3. *Neo-natal – 87% establishment seen as safe*
    4. *Anaesthetics – please see note below*
    5. *Theatres – service can accommodate 1.27 ODP vacancy*
4. *Capacity for patients (including any COVID 19 positive patients, any linked to seasonal pressures and any with no criteria to reside) can be accommodated to core wards without the requirement to utilise additional estate and facilities in maternity.*
5. *The Trust has robust plans in place to guarantee access to emergency theatres when necessary.*

System Level

6. *Local Maternity Systems in Cheshire & Mersey and Greater Manchester are safely resilient to the impact of the ECT recovery plan.*
7. *Support is received from commissioners and regulators for proposals to return intrapartum services.*

East Cheshire NHS Trust

Title: Maternity Implementation Group	**EAST CHESHIRE NHS TRUST**	
Authors Name: Associate Director of Strategy		
Scope: East Cheshire NHS Trust	**Classification:** Trust Organisation Structure and Minutes	
Replaces: Not Applicable		
To be read in conjunction with the following documents:		
Unique Identifier:	**Review Date:** March 2023 **This document is no longer authorised for use after this date**	
Issue Status: Confirmed	**Issue No:** 1	**Issue Date:** August 2022
Authorised by: Maternity Oversight Group	**Authorisation Date:** TBC	
Document for Public Display: No		
After this document is withdrawn from use it must be kept in an archive for 6 *years.*		
Archive:	**Date added to Archive:**	
Officer responsible for archive:		

1. Purpose

The Maternity Implementation Group has been established as a sub-group of the Maternity Oversight Group and coordinates the delivery of the programme of work required to return intra-partum (in-patient birthing) maternity services to Macclesfield District General Hospital by April 2023.

2. Duties

The group will:

- Produce a project plan, action plan, and timeline for the return of intrapartum care to Macclesfield Hospital based on the clinical model agreed by ECT's Trust Board
- Review and identify the inter-dependencies and implications for other service areas at the trust e.g., theatres, paediatrics, anaesthetics
- Determine the requirements for the midwifery and medical workforce availability and capability and monitor progress against plan, including staff orientation to site, statutory & mandatory training and role specific simulation training.

- To ensure that the physical estates/ premises are fit for purpose to support the return of services and that appropriate equipment/ medical devices are available.

- To identify operational challenges and associated clinical and non-clinical risks associated with the return of the service

- Ensure appropriate consideration is made for the continuity of care and service for the current host sites ensuring an appropriate plan is in place for a phased return of service to reduce to risk to host site services

- To ensure communication and engagement supports effective on-boarding of new staff, deployment back of staff from host sites and ensures interdependent services are fully briefed and prepared.

3. Chairmanship

The Chair of the group will be the Medical Director and vice chair the Director of Nursing Quality.

4. Membership

The membership will include:

- Medical Director (Chair)
- Director of Nursing and Quality (Vice Chair)
- Chief Operating Officer
- Director of Transformation & Partnerships
- Deputy Director of Operations for Planned Care, Women & Children, Allied Health, and Clinical Support Services
- Head of Midwifery
- Clinical Lead for Obstetrics & Gynaecology
- Clinical Lead for Anaesthetics
- Clinical Lead for Paediatrics
- Associate Director of Estates
- Chair, Macclesfield Maternity Voices
- Associate Director of Strategy
- Acting Head of Financial Management, Income and Costing
- Strategic Workforce Lead
- Media and Communications Manager

5. Quorum

The quorum shall be at least three members, one of which shall be the chair or vice-chair.

6. Frequency and Attendance

75% attendance standard will be required, and this will be monitored by the meeting chair with appropriate action taken to address persistent attendance issues.

Members of the Committee should make every effort to attend meetings in person via Microsoft teams. If members are on annual or sick leave, deputies who have the appropriate level of authority, should attend. The Chair should be notified of members wishing to join by telephone, and the attendance of deputies, at least 24 hours in advance of the meeting.

Other specialists and clinical leads may be co-opted to discuss specific items on the agenda.

7. Minutes

Abridged minutes of the meeting, with key decisions and actions, will be produced and presented for agreement at the ensuing meeting.

8. Authority

Decisions will be made by members in line with East Cheshire NHS Trust's Scheme of Reservation and Delegation and that of delegated authority of partner organisation's representatives.

Members will be asked to declare any interests in agenda items at the start of each meeting. Any trust member conflicts, that are not already recorded on the trusts register, will be noted along with any partner organisation representatives' conflicts. The chair of the group, with advice from the Director of Corporate Affairs and Governance, will determine measures to be taken to mitigate any potential impact of declared conflicts.

9. Conduct of Meetings

Agendas will normally be prepared and circulated 5 working days in advance.
Any member or attendee may request an item for the agenda through the Chair.

10. Reporting

The group will provide monthly assurance reports to the Maternity Oversight Group on the progress of the repatriation work programme, escalate key risks or concerns with proposed mitigating actions.

11. Review of the Group

The establishment of this group is time-limited and will extend until the service is repatriated safely and assurance that all milestones have been reached. The disestablishment of the group will be determined by the Maternity Oversight Group.

12. Terms of Reference

The terms of reference will be reviewed initially after three months.

East Cheshire NHS Trust

Title: Terms of Reference for Maternity Oversight Meeting	**East Cheshire NHS Trust**
Authors Name: Lorraine Jackman, Director of Corporate Affairs and Governance	
Scope: Trust Wide	**Classification:** Trust Organisation Structure and Minutes
Replaces: Not applicable	
To be read in conjunction with the following documents: Corporate Governance Manual	

Unique Identifier:	**Review Date:** April 2023 **This document is no longer authorised for use after this date**	
Issue Status: Confirmed	**Issue No:**	**Issue Date:** June 2022
Authorised by: Chief Executive	**Authorisation Date:** 11/08/2022	
Document for Public Display: No		
After this document is withdrawn from use it must be kept in an archive for 6 years.		
Archive:	**Date added to Archive:**	
Officer responsible for archive: Executive PA to the Director of Nursing and Quality		

1. Purpose

The Maternity Oversight Group is a sub-group of the Clinical Leadership Board and provides senior trust and partner organisation oversight of the repatriation plan for intra-partum (in-patient birthing) maternity services. As such, it is time-limited until members agree that the service has been safely repatriated and business as usual resumes.

2. Duties

To receive assurance reports in relation to the implementation of the programme of work to return services by April 2023, including the following;

- Midwifery and medical workforce – availability and capability
- Operational issues, impact and mitigations
- Estates infrastructure
- Equipment and medical devices

- Communication – clinical and corporate
- Service compliance with regulations and clinical standards

To receive assurances on the management of risks relating to service repatriation, including how gaps in control will be mitigated and managed.

To establish a Maternity Implementation Sub-group to lead on the operationalisation of the programme of work.

3. Membership

Chief Executive -ECT
Medical Director (Deputy Chief Executive) - ECT
Director of Nursing and Quality – ECT
Director of Corporate Affairs and Governance – ECT
Chief Operating Officer – ECT
Director Transformation and Partnership - ECT
Head of Midwifery – ECT
Clinical Lead for Obstetrics and Gynaecology - ECT
Cheshire East Place Director – Cheshire and Merseyside ICB
Cheshire East Council Representative

Open invitation to the Non- Executive Director - Maternity Safety Champion to attend

4 Quorum

Chief Executive or Medical Director in their absence – chair
Two Executive Directors
Head of Midwifery or their deputy

5. Attendance

75% attendance standard will be required, and this will be monitored by the meeting chair with appropriate action taken to address persistent attendance issues.

Members of the Committee should make every effort to attend meetings in person via Microsoft teams. If members are on annual or sick leave, deputies who have the appropriate level of authority, should attend. The Chair should be notified of members wishing to join by telephone, and the attendance of deputies, at least 24 hours in advance of the meeting.

Other specialists and clinical leads may be co-opted to discuss specific items on the agenda.

6. Meeting Chairing

The Chief Executive will act as the meeting chair and in their absence the Medical Director (Deputy Chief Executive)

7. Minutes

Abridged minutes of the meeting, with key decisions and actions, will be produced and presented for agreement at the ensuing meeting.

8. Frequency of Meetings

The group shall meet monthly with extra-ordinary meetings convened at the discretion of the chair.

9. Authority

Decisions will be made by members in line with East Cheshire NHS Trust's Scheme of Reservation and Delegation and that of delegated authority of partner organisation's representatives.

Members will be asked to declare any interests in agenda items at the start of each meeting. Any trust member conflicts, that are not already recorded on the trusts register, will be noted along with any partner organisation representatives' conflicts. The chair of the group, with advice from the Director of Corporate Affairs and Governance, will determine measures to be taken to mitigate any potential impact of declared conflicts.

11. Conduct of Meetings

Agendas will normally be prepared and circulated 5 working days in advance.
Any member or attendee may request an item for the agenda through the Chair.

12. Reporting

Board assurance on the progress against the repatriation milestone plan and associated risks to delivery will be via the Chief Executive's report to Board.

Clinical Leadership Board will receive risk oversight via monthly project highlight report with quarterly high level risk reporting via the Board Assurance Framework and Corporate Risk Register Report.

Assurance on safety, quality and standards will be via the Safety Quality and Standards Committee of the Board (e.g. spotlights, assurance reports) and via the quarterly Board Assurance Framework and Corporate Risk Register Report.

13. Review of the Group

The establishment of this group is time-limited and will extend until the service is repatriated safely and assurance that all milestones have been reached. A self-assessment of the effectiveness of the group will be undertaken prior to dissolution and reported to Clinical Leadership Board.

15. Terms of Reference

The Terms of Reference will be subject to gateway reviewed after three months and at April 2023. Changes to the terms of reference must be authorised by the Chief Executive.

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DASHBOARD

UPDATED 21/06/2023 - FOR BOARD APPROVAL 06/07/2023

Maternity Return Criteria Review	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23
Local Criteria								
1. National modelling on C19 surge								
2. Robust arrangements with a supporting partner								
3. Safe staffing levels								
Obstetrics								
Midwifery								
Anaesthetic Consultants								
Anaesthetic SAS Doctors								
Theatres								
Neonates								
4. Bed Capacity								
5. Emergency Theatres								
System Criteria								
6. Host resilience								
7. Regulator and commissioner support								

Blue	Green	Amber	Red	
Criteria Met	Solution identified – on track	Solution not yet confirmed	Solution not identified	

ID	Workstream	Workstream lead	Key activities/outputs	Notes	Owner	Start Date	End Date	Status
RMCHFT1	Host providers - MCHFT	N Biggar	**Provide 6 weeks formal notice for return of service**		N Biggar	Decision Date	6 weeks before opening	In progress
RMCHFT10	Host providers - MCHFT	N Biggar	Closure of governance items - Incidents	Depends on severity	N Biggar / E Boland	In progress	2 weeks after opening	In progress
RMCHFT11	Host providers - MCHFT	N Biggar	Plan for preceptorship going forwards		N Biggar	In progress	Ongoing	In progress
RMCHFT12	Host providers - MCHFT	N Biggar	Return of handheld records to ECT	Ongoing	N Biggar	30/11/22	1 month after opening	Planned/Not started
RMCHFT13	Host providers - MCHFT	N Biggar	Confirmation of activity done by staff in [Month before opening] for payroll / enhancements - Maternity	BAU - Staff confirm shifts via E-Roster every month	N Biggar	Decision Date	1 week after opening	In progress
RMCHFT14	Host providers - MCHFT	N Biggar	Confirmation of activity done by staff in [Month before opening] for payroll / enhancements - Neonates	BAU - Staff confirm shifts via E-Roster every month	N Biggar	Decision Date	1 week after opening	In progress
RMCHFT15	Host providers - MCHFT	N Biggar	Remove staff from MCHT roster and access to Roster - Maternity	Have discussions prior	J Butters	Decision Date	1 week after opening	Planned/Not started
RMCHFT16	Host providers - MCHFT	N Biggar	Remove staff from MCHT roster and access to Roster - Neonates	Have discussions prior	J Butters	Decision Date	1 week after opening	Planned/Not started
RMCHFT17	Host providers - MCHFT	N Biggar	**Return equipment that belongs to ECT**	CTG Equipment - Could be closer to return but needs a plan	J Butters	01/03/23	1 month before opening	Planned/Not started
RMCHFT18	Host providers - MCHFT	N Biggar	**Review patients which are booked for elective sections**	Taken to HoM (April)	J Butters	19/12/22	03/04/2023	In progress
RMCHFT19	Host providers - MCHFT	N Biggar	**Review patients which are booked for inductions**	Taken to HoM (April)	J Butters	19/12/22	03/04/2023	In progress
RMCHFT2	Host providers - MCHFT	N Biggar	Agree approach to return of babies - Neonates	Approach has been agreed with the ODN, and Partners will be advised of their recommendation at the Partners meeting 26th October	N Biggar	30/11/22	1 month before opening	Planned/Not started
RMCHFT3	Host providers - MCHFT	N Biggar	**Finalise return of babies - Neonates**		N Biggar	01/03/23	1 week before opening	Planned/Not started
RMCHFT4	Host providers - MCHFT	N Biggar	Inform all patients service is returning - Maternity	Awaiting NHSE Confirmation	N Biggar / JA	Decision Date	17/04/23	Planned/Not started
RMCHFT5	Host providers - MCHFT	N Biggar	Inform all parents service is returning - Neonates		N Biggar / JA	30/11/22	1 month before opening	Planned/Not started
RMCHFT7	Host providers - MCHFT	N Biggar	Get assurance from IG regarding closure of information sharing agreements		C Hepplestone	30/11/22	1 month before opening	Planned/Not started
RMCHFT8	Host providers - MCHFT	N Biggar	Closure of governance items - risks	Depends on severity	N Biggar / E Boland	30/11/22	2 weeks after opening	Planned/Not started
RMCHFT9	Host providers - MCHFT	N Biggar	Provide assurance to LMS and project group of activity versus staffing		N Biggar	In progress	31/12/22	Completed

Maternity recovery - Project Progress Report

East Cheshire NHS Trust

Author	Nicky Biggar	Period	26/04/2023 to 22/05/2023

Progress in the past week – *key achievements*

Progress as of 12pm, Tuesday 24th #May

- Estates works are underway to revert the ward back to Maternity. The target completion date is the end of the month, with Estates providing assurance weekly.
- Implementation project plan is underway, planned for the next 5 weeks. Workstream leads are engaged weekly at MPG to ensure actions are completed.
- Heads of Midwifery meetings are underway to ensure smooth transition of staff, women and babies. These meetings have stepped up in frequency to continue providing assurance to host sites.
- Work has progressed on gaining feedback from staff who have rotated to Stepping Hill, with the feedback being recording on the master training document.
- All midwives at host sites have had their rosters confirmed to finish on 25/06/23, ready for the new roster to begin at ECT on 26/06/23.

- The current status of the project plan is as follows:

In progress	Overdue	Complete	Planned/ Not started	Retired	Total
97	0	182	51	37	375

Focus for following month – *key milestones*

- Training at SHH to continue as noted in the training plan.
- Progress with equipment ordered.
- Progress with ward renovations.
- To continue to advertise for any vacancies for all staff groups, with particular focus on locum anaesthetic shift gaps and theatre staffing recruitment.
- Pulling together an assurance document relating to staff training / competency.
- Meeting with Digital/Telephony staff to complete actions.
- Neonatal review of safe staffing for an agreed allocation of cots.
- Continue to meet action plan deadlines.

Challenges – *what themes are emerging? Suggested course of action?*

- Offered temporary appointment to anaesthetic locums to cover gaps in shifts until anaesthetic consultants start. Awaiting full confirmation.

Lessons Learned

Escalation – *any issues requiring escalation?*

- ‘Go public’ date (KDB)
- Bed capacity for medical patients (SG)

New Risks Identified – *to be scored and recorded on risk log*

Maternity recovery - Project Progress Report

East Cheshire NHS Trust

<table>
<tr><td>Author</td><td>Charlotte Danford</td><td>Period</td><td>20/09/2022 to 04/10/2022</td></tr>
<tr><td colspan="2">Progress this week – key achievements</td><td colspan="2">Focus for following fortnight – key milestones</td></tr>
<tr><td colspan="2">• Progress as of 12pm, Tuesday 4th October:
• Initial meeting taken place with all but 1 workstream lead.
• Updates were given and dates assigned.
• Further meetings were put in the diary – majority of these started in January where appropriate.
• Status update of actions in project plan:
<table>
<tr><th>In progress</th><th>Overdue</th><th>Complete</th><th>Planned/not started</th><th>Retired</th><th>Total</th></tr>
<tr><td>57</td><td>1</td><td>8</td><td>286</td><td>12</td><td>364</td></tr>
</table></td><td colspan="2">• Meet with remaining Workstream lead to supply dates and current action status.
• Meet with Nicky and Emma regarding their actions and start dates.
• Prepare to give an update at the next Maternity Implementation Group (13/10/22)
• Final check that estates timeline does not affect the dates in other sections
• Continuing to meet action plan deadlines, including:
○ Continue focus on recruitment across Maternity, Anaesthetics and Theatres
○ Developing Comms plan
○ Beginning stock and equipment actions
○ Theatre consultation paper – 21st October
○ Cascade competency plan with medical staff</td></tr>
<tr><td colspan="2">Challenges – what themes are emerging? Suggested course of action?</td><td colspan="2">Lessons Learned</td></tr>
<tr><td colspan="2">• Input from Paeds is awaited, in order to populate the action plan for these areas
• Confirmation of the Anaesthetic clinical lead for Maternity</td><td colspan="2"></td></tr>
<tr><td colspan="2">Escalation – any issues requiring escalation?</td><td colspan="2">New Risks Identified – to be scored and recorded on risk log</td></tr>
<tr><td colspan="2">• Some actions raised further questions:
○ Training updates and closure of incident information from host sites not being received back by ECT;
○ Maternity theatre refurb and requirement for separate elective theatre.</td><td colspan="2"></td></tr>
</table>

Project Risk Register (Updated 21/06/2023) **Project: Maternity Oversight Group** **Lead: Ged Murphy**

Ref	Status	Date added	Datix Ref	Risk category	Principle risk description	Initial Likelihood	Initial Impact	Initial Rating	Key controls established	Current Likelihood	Current Impact	Current Rating	Gaps in controls	Actions to reduce the risk if current controls are insufficient	Final Likelihood	Final Impact	Final Rating	Assurances	Gaps in assurance	Actions to mitigate gaps in assurance	Adequacy of controls	Risk owner
1	Closed	15/09/2022		Wider System	**PRINCIPLE RISK**: If an agreeable partner organisation cannot be sourced as part of a shared service model, this may have an adverse impact patient safety and experience as a result of the inability to implement the preferred option of a shared service.	3 Possible	5 Catastrophic	15	• Monthly MOG & MIG established. • CEO written to all host Trusts. 2 have responded positively. • Board agreed shared model - September 2022. • Board agreed preferred partner organisation. • A draft MOU was written and supported by both Heads of Midwifery. This was then changed to a letter of confirmed support from SFT, which was received in May 2023.	1 Rare	5 Catastrophic	5	~~• MOU is not yet in place with preferred partner.~~ ~~• Currently no partner representation at the MOG and MIG meetings.~~	~~• MOU under development with preferred partner.~~ ~~• Partner representation at MOG & MIG to be defined and implemented.~~	1 Rare	5 Catastrophic	5	Assurance and update reporting provided to the Trust Board via the Clinical Leadership Board.	None identified	Not applicable	Further action required	K Sheerin / D Nunns
2	Closed	15/09/2022		Wider System	**PRINCIPLE RISK:** If the trust does not receive adequate financial support from the Integrated Care Board this may have an adverse impact on patient experience as a result of further delays to the return of the intrapartum service.	3 Possible	5 Catastrophic	15	• CEP Place Director is a member of MOG. • Monthly maternity checkpoint meetings in place with NHSE (NW) and C&M ICB. • ECT CEO Chair of MOG. • Indicative budgets were included in the November 2022 ICB paper • Update paper presented to ICB Board 23/02/23. • ICB has confirmed support for return of full service.	1 Rare	5 Catastrophic	5			1 Rare	5 Catastrophic	5	Assurance and update reporting provided to the Trust Board via the Clinical Leadership Board. DoF sighted on issues via EMT reporting/discussion.	None identified	Not applicable	Further action required	K Sheerin
3	In progress	15/09/2022		Workforce	**PRINCIPLE RISK:** If ECT (and any potential partners) are unable to recruit sufficient staff to run the new service this may have an adverse impact on patient safety due to the lack of suitably trained staff.	4 Likely	5 Catastrophic	20	• Newly recruited Anaesthetic middle grade, midwifery staff, obstetrics & gynaecology consultant staff to commence in post from November 2022 onwards. • Weekly anaesthetic updates provided to CEO. • Monthly update reporting on recruitment to MOG and MIG meetings. • Dedicated governance team with maternity to review risks and incidents. • Monthly governance meetings to monitor incidents. • Board approved recruitment and investment strategy • Maternity recruitment day completed with successful hires • Anaesthetic consultant adverts adapted to feature joint roles with SFT, daytime-only working, RRP and ability to build own job plan. • Strategy development for recruitment of anaesthetists • 8 Anaesthetic SAS doctors are in post. • 9 international midwives successfully recruited. • Safe levels achived for all staff groups predicted to now be fully met. • Midwifery has achieved 90% staffing in June 2023 (Safe staffing level), with 100% projected by September 2023. This is based on an estimate of 1500 births. • Midwifery bank staff have also been recruited to cover potential spikes in births at ECT following reinstatement of services. • 4 substanted Anaesthetic consultants have been recruited and are due to start before September 2023. Locums have been recruited to cover shift gaps between reinstatement and September.	2 unlikely	5 Catastrophic	10	~~• Vacancies remain in midwifery (90% safe level achieved, recruitment underway to achieve a full establishment) and Anaesthetics. 2 more Anaesthetic SAS doctors are not yet in post, due to start before May'23.~~	~~• Ongoing recruitment campaign for midwifery.~~ ~~• Ongoing Exec-led activity to attract and recruit anaesthetic consultants.~~ ~~• Interview dates are scheduled for both Anaesthetic Consultants and SAS doctors, with candidates available for each.~~	2 Unlikely	5 Catastrophic	10	Assurance and update reporting provided to the Trust Board via the Clinical Leadership Board. Incident monitoring via Datix. All incidents reporting directly to DNQ	None identified	Not applicable	Further action required	J Acharya A Gorman N Biggar S Dean
4	Closed	31/08/2022	3817	Wider System	**PRINCIPLE RISK:** If the number of patients with no criteria to reside continues at current levels or increases there is a risk that Ward 6 escalation capacity of 32 beds will not be able to be released to allow maternity services to return to Macclesfield Hospital site.	5 Almost Certain	4 Major	20	•Winter Planning preparation established •ICB winter planning meetings established •ECT winter planning meetings established •Winter planning schemes submission •Investment into winter schemes within ECT financial plan •Urgent and Emergency Care Action Plan in place •ECIST (NHSE Emergency care intensive support team) Support for Frailty and Wards - Test of Change events throughout October and November •Maternity Operational Group established •Spot purchase capacity •Weekly system wide KIT meeting re winter planning and community capacity •National funding of £500m confirmed for winter pressures •Cheshire East Place allocation of national funding confirmed - £2.5m •£1.1m in December 2022, £1.4m in January 2023 •On 9.12.22, there were 107 patients with No Criteria To Reside. A weekly update on these numbers will be received • Community Bed Capacity Modelling requirement commenced by ICB. • A robust action plan relating to the national discharge fund has been developed and implemented. •Discharges are monitored via the daily Reablement/Care Delays MDT •Weekly Operational Leads meetings increased to three-times weekly (09.12.22). Progress will be reported to the weekly Monday KIT meeting, and updates to the Monthly Operational Pesilience Group meeting and to the Operational Delivery Group Meeting. •Ward 6 successfully de-escalated on 13/02/23. •Estates works began on 14/03/23 to reinstate the maternity ward. •Capacity and community places are coming online funded by the National Discharge Fund	2 unlikely	5 Catastrophic	10	•Community bed deficit 60 •Local Authority Domiciliary Care Capacity core gaps in service		3 Possible	4 Major	12	Winter Planning Submission monitored at Winter planning meeting UEC action plan monitored Urgent and Emergency care group OTG and UEC monitoring actions, highlight reports and and test of change presentations Governance and Oversight Ward 6 Initiative established 09.12.22.	None identified.	None identified.	Managed	J Young
5	In progress	15/09/2022		Patient	If patients do not have sufficient confidence in the returned service they may continue to choose to book and give birth with host Trusts.	3 Possible	3 Moderate	9	• Patient engagement to date has shown high levels of support for the return of services to MDGH. Women continue to book with ECT in similar numbers to pre-suspension. • All women scheduled to birth around the reinstatement date have been contacted by letter to assure them of the key information regarding reinstatement.	2 unlikely	Minor 3	6	• Any futher delays could further remove confidence in the returned service. • Updates with the public are limited in the suspension phase due to project uncertainty.	• We are committed to working with Maternity Voices Partnership to understand the views of pregnant women and their families and will work with them to promote any new services. • Communications and Engagement plan will feature key initiatives to boost patient engagement, such as opportunities to visit the site and facilities.	1 Rare	3 Minor	3		None identified	Not applicable		N Biggar
6	Closed	15/09/2022		Finance	If the costs of any proposed model are higher than the pre-suspension service, this may have an adverse effect on the ability to return the service (either Trust or System).	3 Possible	4 major	12	MOG will be appraised of all known financial implications of any proposed service. • Monthly MOG & MIG established. • Board agreed shared model - September 2022. • Board agreed preferred partner organisation. • ICB board responsed favourably to paper September '22 detailing need for extra costs. • Modelling of the potential options includes a financial assessment, presented to ICB in November '22. • ICB has confirmed support for return of full service.	2 unlikely	4 major	8			2 unlikely	4 Major	8	Assurance and update reporting provided to the Trust Board via the Clinical Leadership Board.	None identified	Not applicable	Further action required	S Johnson

7	In progress	15/09/2022		Clinical	If the Trust is unable to safely run both elective and emergency maternity theatres, which is a requirement set by the Regional Chief Midwife and Regional Clinical Lead of Obsterics, there is both a risk to patient safety and to the likelihood of regulators supporting the return of the service.	3 Possible	4 major	12	• Guidence obtained from Regional Chief Midwife in October 2022 • Elective and emergency theatre proposal submitted on 8 September 2022, with work done by theatre staff. • SBAR of theatre lists suitable to be dropped and replaced with elective section lists confirmed and supported at Project Group. • The impact on existing elective activity has been discussed and agreed with services affected. • Theatre paper discussing dropped lists approved at MIG on 16/02/23 and MOG on 23/02/23.	2 unlikely	4 major	8		• Ongoing management of theatre lists to mitigate worst case scenario outlined in SBAR.	1 Rare	4 major	4	Assurance and update reporting provided to the Trust Board via the Clinical Leadership Board. Representative from GM LMS present at MOG	None identified	Not applicable	Further action required	F Walton
8	In progress			Project	If the Maternity Recovery criteria are not fully met by March 2023, there is a risk that the trust will not meet the target date for reinstatement of maternity inpatient services by the end of June 2023.	3 Possible	4 major	12	• A detailed Project Plan monitored by the Maternity Implementation Group. Where necessary issues will be escalated to the SRO and/or Maternity Oversight Group • Exceptions to meeting criteria are escalated to the Trust Board monthly. • Monthly assurance reporting from host sites on the impact of repatriated service provision is given. • Recovery criteria were reviewed and finalised in November '22. • Recovery criteria are reviewed internally and externally (via MIG and MOG) on a monthly basis. • Board approved recovery criteria on 16/03/23 as all criteria are met or on target. • The reinstatement date of 26/06/23 was confirmed by Executives in March '23. The project actions are scheduled to be completed and the service reinstated by that date.	2 unlikely	4 major	8		• ECT Board remain committed to return maternity services when safe to do so, and review readiness against the recovery criteria at monthly board meetings.	2 unlikely	4 major	8	Assurance and update reporting provided to the Trust Board via the Clinical Leadership Board. Reporting of project actions are cascaded upwards from Maternity Project Group, Maternity Implementation Group and Maternity Oversight Group.	None identified	Not applicable	Further action required	N Biggar
9	Closed			Wider System	If the current NHS Specialist Commissioners review of neonatal provision in the North West determines that the region has an over supply of neonatal (including Special Care Baby Unit) cots, there is a risk that it will not be possible to maintain a SCBU on the MDGH site.	3 Possible	4 Major	12	• ECT have already made contact with NHS Spec Com and will keep appraised of the review. • GM LMS is part of MOG and continued liaison will take place.	3 Possible	4 Major	12	• There is a need to fully understand the planned timescales and process of the NHS Spec Com review. • The review may take many years to conclude, and may only impact services at some stage in the future.	• Continued liaison with GM LMS will be required leading up to and beyond reopening the service	2 unlikely	4 Major	8	Assurance and update reporting provided to the Trust Board via the Clinical Leadership Board.	None identified	Not applicable	Further action required	N Biggar / F Walton (to be escalated to K Daly Brown with a score of 15)

East Cheshire NHS Trust

Update on the return of inpatient intrapartum services

The purpose of this paper is to update the Board regarding the state of readiness to safely return full intra-partum care to Macclesfield District General Hospital (DGH).

1 INTRODUCTION

Intrapartum maternity services remain suspended at Macclesfield DGH.

1.1 Inpatient intrapartum maternity services have been suspended at Macclesfield DGH since March 2020, with most registered women delivering at neighbouring 'host' hospitals in Leighton, Stockport and Wythenshawe.

1.2 The initial suspension of inpatient services was for a period of up to six months arising from the limited anaesthetic capacity in the Trust to respond to the Covid-19 pandemic. The suspension has been extended on three occasions following assessment against Board approved recovery criteria (which have changed over the period). The most recent extension (March 2022) set out the Board's commitment to return the services by April 2023 when safe to do so.

2 BACKGROUND

Significant work has been undertaken since the suspension to ensure services can be safely returned.

2.1 In September 2022, a detailed paper was considered by the Trust Board in private, which set out a number of appraised options for how the service could be re-instated safely. These had been developed through significant work over the spring / summer, involving staff, partners, stakeholders and patients.

2.2 Two reports were critical to the Trust Board's considerations: -

- The Findings, Conclusions and Essential Actions from the Independent Review of Maternity services at the Shrewsbury and Telford Hospital NHS Trust ('The Ockenden Report', March 2022).
- The Royal College of Anaesthetists invited review of the anaesthesia service in relation to provision of maternity care at East Cheshire NHS Trust (February 2022).

2.3 The board concluded that, in order to meet the requirements of these reports and in line with the options appraisal, a supportive partnership model should be established. This would allow for rotation of staff to ensure that skills are appropriately retained to meet the needs of service delivery.

2.4 The paper also set out the four key areas of risk to securing full service restoration at that time as follows: -

- The need to develop robust arrangements to deliver high quality, safe intrapartum services with a supporting partner.
- The need to secure support for the proposals, including financial, from NHS England and NHS Cheshire and Merseyside – Integrated Care Board.
- The trust's ability to recruit, retain and train sufficient staff to sustainably deliver the service.
- The need to reduce the requirement for escalation beds, allowing Ward 6 to return to being used for maternity patients.

2.5 Robust governance arrangements are in place (both internally and with partners) to oversee the safe return of services.

2.6 NHSE and NHS Cheshire and Merseyside are fully appraised of progress through monthly oversight meetings and reports to the NHS Cheshire and Merseyside Board.

3 RETURN CRITERIA

Revised return criteria were agreed by the Trust Board in November 2022.

3.1 The revised return criteria agreed by East Cheshire NHS Trust Board in November 2022 are as follows: -

Local Level

1. National modelling indicates that further a Covid-19 surge is unlikely and local capacity to meet clinical need would be manageable within enhanced workforce and environment.

2. Robust arrangements are in place to deliver high quality, safe intrapartum services with a supporting partner; this includes support for the ongoing training and development of staff.

3. Workforce recruitment, attendance and resilience is at a level sufficient to maintain safe staffing levels in obstetrics, midwifery, neonatal, anaesthetic and theatre services.

4. Capacity for patients (including any Covid-19 positive patients, any linked to seasonal pressures and any with no criteria to reside) can be accommodated to core wards without the requirement to utilise additional estate and facilities in maternity.

5. The trust robust plans in place to guarantee access to emergency theatres when necessary.

System Level

6. Local Maternity Systems in Cheshire & Merseyside and Greater Manchester are sighted and safely resilient to the impact of the recovery plan.

7. Support (including funding) is received from commissioners and regulators for proposals to return intrapartum services.

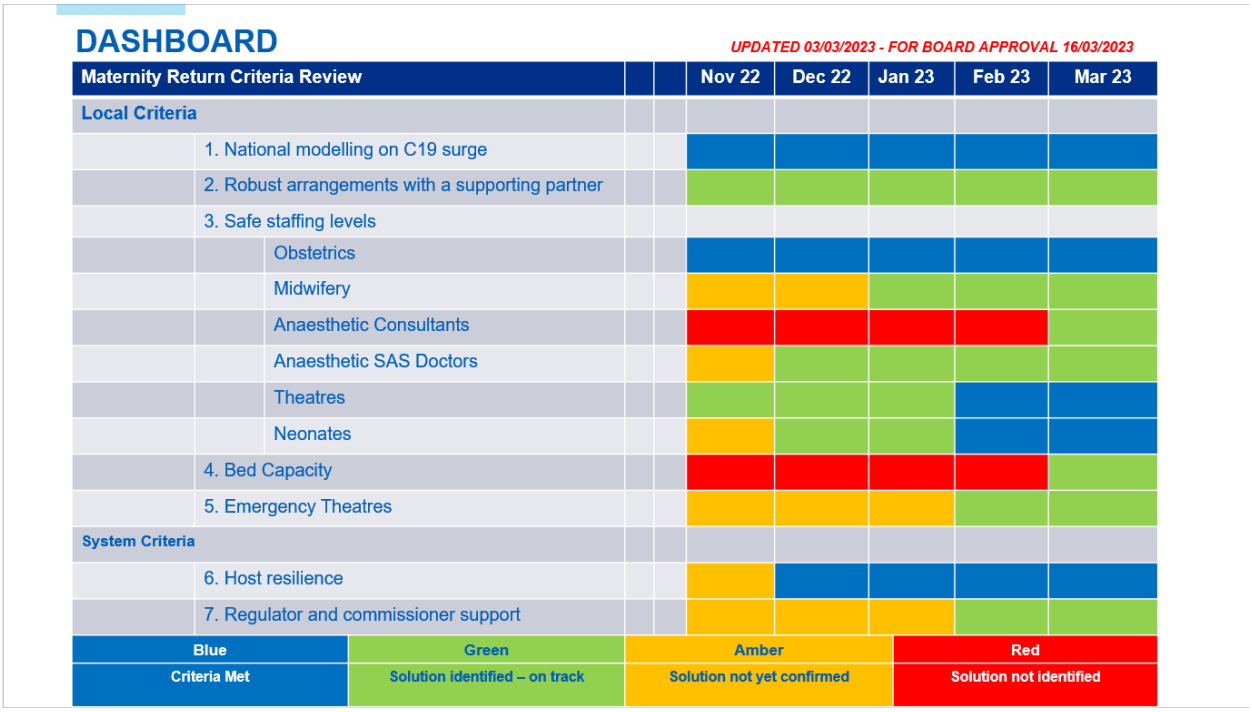
4 READINESS TO RETURN

Significant progress has been made to secure the safe return of the service

4.1 Progress against the return criteria has been monitored each month by Maternity Oversight Group and Board, most recently at Public Board in February 2023

4.2 Significant progress has been made against all the return criteria such that they have all been met or have secure plans to be delivered imminently.

4.2 A summary of progress against the criteria is as follows:-



5 OUTSTANDING RISKS

5.1 The risks highlighted to the Board in September 2022 have been reassessed as follows:-

Of the four key risks highlighted to the Board in September 2022, all have been reduced to 10 or below.

Risk	Score Sep 2022 (L x I*)	Score Jan 2023 (L x I*)	Score Mar 2023 (L x I*)	Notes
Confirmation of a partner	(2 x 5) 10	(1 x 5) 5	(1 x 5) 5	SFT confirmed as supportive partner.
Support from ICB	(2 x 5) 10	(2 x 5) 10	(1 x 5) 5	ICB has indicated financial support for return of full service.
Recruitment of staff	(4 x 5) 20	(3 x5) 15	(2 x 5) 10	Safe staffing numbers for all staff groups predicted to now be fully met.
Return of bed capacity	(5 x 4) 20	(5 x 4) 20	(2 x 5) 10	Ward 6 closed to admissions and estates work underway. Capacity in community now in place / coming on line funded through national Adult Social Care Discharge Fund.

*Likelihood v Impact

6 PATHWAY TO 'GO LIVE'

A detailed implementation plan to ensure safe 'go live' is in place; this has guided all the work to date.

6.1 Given that the criteria for safe return of the service have now been met or have a solution in place which is on track for delivery, and that the risks are under control, it is proposed that the service 'goes live' in early summer 2023.

6.2 There is a detailed implementation plan to support this, the key strands of which are as follows:-

Delivery of all the actions within the Implementation Plan will continue to be overseen by the Maternity Implementation Group (chaired by the Medical Director) and Maternity Oversight Group (chaired by the CEO).

6.3 **Staffing training and re-orientation**

Plans are in place for all necessary staff to be re-trained to be competent and confident to deliver a safe service from early summer. Ongoing training may be required, for which arrangements are in place.

6.4 **Estates & facilities**

Work is currently taking place to convert Ward 6 back into the Maternity ward, this includes aesthetic improvements to improve patient experience, upgrading IT equipment and installation of a new baby tagging system. Once completed, plans are in place to undertake soft facilities management actions including catering, laundry, cleaning etc..

6.5 **Equipment**

Equipment has already been already ordered. Some major items such as Labour Ward Beds and Phototherapy Units have already arrived. Minor IT tasks are planned along with PAT testing.

6.6 **Communications & patient engagement**

A robust Communications Plan is in place once a positive decision to confirm the date for reinstatement has been made. This includes planned open days for pregnant women and families as well as work with Maternity Voices Partnership (MVP). MVP and service users will be invited to take part in a 15 Step Assessment to review the new unit from a patient perspective.

6.7 **Transfer of care**

Robust plans are in place to care for women booked with ECT to deliver from early summer. Women will be advised of the date of

reinstatement and be expected to attend ECT from that date this should minimise the requirement of the host sites providing care without ECT staff. Beyond the re-start date, host sites should only be required to care for women who are in active labour or recently given birth. A small amount of the babies requiring neonatal care may require care by the neonatal unit at the host site, and an individual assessment will be undertaken for any baby that does to see if they can be transferred to ECT.

The Maternity Implementation Group and Maternity Oversight Group will continue until the service goes live, and then will be superseded by an enhanced internal assurance group.

6.8 **ASSURANCE FOLLOWING RETURN OF THE SERVICE**

6.8.1 **Internal**

The trust has well established internal assurance processes through committees of the Board up to the trust board. For maternity, this includes a Directorate Maternity Governance Group, which will report to the Safety, Quality and Standards Committee of the Board.

External

ECT Executives and Operational teams are working closely with a range of external partners on issues of assurance:

6.8.2

- ECT Executives meet regularly with senior colleagues from Cheshire & Merseyside ICB, NHS England North West and Greater Manchester & East Cheshire Local Maternity and Neonatal System (LMNS) to appraise them of progress and deal with any issues and concerns.
- The Maternity Service is in close contact with the Regional Chief Midwife and Regional Chief Obstetrician to provide ongoing assurance and have responded to a number of clinical and operational queries and will continue to do so.
- The service is working closely with the ECT Planning team to ensure plans for 2023/24 are in line with Operational Planning Guidance.
- A new GMEC LMNS safety progress and performance meeting has been created to monitor all trusts against the national standards (Ockenden and Kirkup) at which the trust will present and update on a quarterly basis.
- Further future external assurance arrangements will be agreed with commissioners and regulators (ICB, NHSE and CQC) in due course.

7 RECOMMENDATIONS

7.1 The Trust Board is asked:-

- To note the contents of this report and the significant progress made in order to safely return full intrapartum care to Macclesfield DGH.

- To note the plan for the safe return of the service with a revised reinstatement timescale of early summer 2023.

Name	Katherine Sheerin
Job Title	Director of Transformation & Partnerships