

## **Appendix 1: Maternity Services Quarterly Report for the Quality Committee - Reporting Period: Quarter 3. 2019/2020**

### **1.0 Introduction**

This is the quarterly maternity services report for Quality Committee outlining activity, progress and improvements made during Quarter 3, October to December 2019.

### **2.0 Improvements made in patient safety and quality of care**

#### **2.1 Midwifery and Obstetric staffing**

Midwifery staffing has remained a challenge during Quarter 3, and was subject to much scrutiny during the November 2019 CQC inspection including the service's inability to consistently achieve acceptable rates of one to one care in labour.

21 newly qualified midwives joined the team in October and following a robust supernumerary period, contributed towards an improved staffing position at the end of Quarter 3. However, despite an improved position, the service have acknowledged the concerns of the CQC and as part of the comprehensive bi-annual midwifery staffing paper (appendix 2) presented to Senior Leadership Team (SLT) in January, a number of recommendations were made including:

- Increasing the establishment by 5.22 WTE to provide an additional midwife per shift on the Birth Centre.
- Recruitment of an additional 6.33 WTE to mitigate the consistently high rate of maternity leave.

The recommendations were supported and approved by SLT and recruitment is underway, with 3.83 WTE already appointed.

The bi-annual midwifery staffing paper includes one to one care in labour rates, midwife to birth ratios, red flag data, sickness and absence rates and unit escalations relating to the last 6 months which includes Quarter 3, and accompanies this paper for the information of Quality Committee.

New appointments in Quarter 3:

- Rea Halstead was successfully appointed as the substantive Specialist Midwife Infant Feeding Co-ordinator following her interim position.
- Vicky Jones commenced her role as Specialist Midwife for Risk and Governance.
- Dawn Bolton commenced her role as Specialist Midwife Antenatal Newborn Screening Co-ordinator.
- Reflecting the evolution of the Parent Education role, Becky Palethorpe's title was changed to Specialist Midwife Perinatal Mental Health and Complex Needs.

#### **Obstetric staffing**

The department is pleased that we have maintained our 17 Consultants in post. We are also in a much better position than 17/18 in regard to maternity leave with only one consultant currently on maternity leave which has been reliably covered with a locum consultant

colleague. A 3 month period of sick leave (September - December 2019) for one consultant has successfully been covered by a trainee (who had already achieved her CCT- Certificate of completion of training in O+G) within the department with the same area of specialist interest which has enabled elective work to continue while allowing her to develop her confidence at working at consultant level with support from other consultants within the department in day time hours.

We have successfully recruited two Consultants in the last financial year who bring necessary skills into the unit to enable responses to GIRFT and strengthening our maternal medicine expertise, specifically maternal cardio disease and diabetes care. This positions us well for managing developing trends in maternal morbidity. We have appointed one of these consultants to look specifically at the perinatal mortality review tool to review all of our cases of stillbirth. This will provide a detailed review of each case to allow learning from cases and the monthly stillbirth rate will be tracked and escalated to the trust board if concerns in the rates arise.

We have appointed a Post CCT fellow who started in post in November 2019. She will devote 50% of her time for service provision and 50% for service development in order to develop the Early Pregnancy Assessment Unit and the Gynaecology Assessment and Triage unit for Gynaecology acute cases. These areas for development form part of the Women's CBU plans and vision for the next 3-5 years.

The previous significant gaps in the middle grade rota (18/19) have improved from August 2019 as we have a greater number of rotated trainees to BTHFT. There are gaps due to maternity leave amongst the trainees which has been partially addressed through the contract extension of a speciality doctor until the end of July 2020. The remaining gaps on the registrar rota may be filled with MTI doctors once they gain adequate clinical skills.

We have recruited 2 MTI doctors who have begun working on the first on-call rota. They will move to working on the second on-call rota at a time dependent on gaining adequate knowledge and experience. These posts will provide resilience to the middle grade rota over the next 24 months.

Concerns about safety within Obstetrics and Gynaecology have been discussed within the CBU and escalated to the Planned Care group and Trust board at the end of 2019. Concerns arising from the way in which the consultants are working and the sustainability of the rota in terms of workload, complexity of patients, greater supervision of junior medical staff, time spent in the unit when on call and the effects on consultant staff in terms of burn out and a fall in morale. There are plans in progress to address these safety concerns with immediate changes in the short term with future plans to develop a hybrid consultant on call rota to provide separate Obstetric and Gynaecology cover for acute services to strength consultant ward round presence and junior doctor support, and expand same day emergency care provision. This may require a degree of expansion in the consultant numbers to be able to deliver safer care with a model of working that is sustainable.

## **2.2 Policies and Guidelines**

At the end of Quarter 3, 98.1% of maternity and gynaecology policies and guidelines are approved and in date. The remaining 1.9% are currently under review by the author or going through the ratification process. The guideline review process is managed by the Clinical Governance Support Officer with the support of the Clinical Director and Head of Midwifery.

## **2.3 Clinical Outcomes**

Maternity Dashboard attached as Appendix 2.

Breastfeeding initiation rates noted to be lower than normal in November and December.

This is thought to be a possible recording/ data entry error as there have been no changes in practice which are thought to have influenced this. This will be monitored.

## **3.0 Incidents and Challenges**

### **3.1 Serious Incidents:**

During Quarter 3 there was 1 Serious Incident declared relating to the 'Never Event' of a retained tampon following perineal repair. The incident occurred in a delivery room, and contributory factors include the opening of a second delivery pack in anticipation of an instrumental birth which did not occur. Fortunately there was no harm to the woman. A number of immediate actions were taken, including removal of the delivery pack from the instrumental birth trolley. Immediate actions were shared in the weekly 'Lessons Learned' bulletin, during safety huddles and handovers. A round table incident review including members of the team involved in the incident has been held, and further actions agreed as a result.

#### **3.1.1 Health Safety Investigation Branch (HSIB)**

In total there are 5 current HSIB cases. 3 cases were reported to HSIB during Quarter 3: 2 babies with HIE requiring cooling and 1 hypoglycaemic baby readmitted at 3 days and found to have an abnormal brain scan. Of the remaining 2 cases, 1 is in draft report and the other is still in the investigation phase from quarter 3.

The Trust has now received 4 completed reports, none of which identified any issues that had not been identified by the service during the initial 72 hour investigation phase. It has been agreed that HSIB reports, including a summary of lessons learned, will be presented to Patient Safety Sub Committee (PSSC) on a bi-annual basis. The first presentation will be in March 2020.

#### **3.1.2 Perinatal Mortality Review Tool (PMRT) and Stillbirth rates, themes and trends**

The PMRT was introduced to support the standardisation of perinatal mortality reviews across the United Kingdom and compliance with its completion is a requirement of the Maternity Incentive Scheme (MIS) year three, published December 2019.

To meet the required standard for safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard, quarterly reports including the details of all deaths reviewed and consequent action plans have to be submitted to Trust Board.

Please see appendix 3 for Quarter 3 PMRT report.

The recording of discussions with parents is currently below the target required to demonstrate compliance with Safety action 1 of the Maternity Incentive Scheme, Year 3. This in part is due to the capacity of the Neonatal Consultants, who currently do not have any allocated PA's in which to complete PMRT activities. This has been raised as a concern with the Director of Planned Group, and the Paediatric/Neonatal Clinical Business Unit is discussing solutions. Until a resolve is agreed, this jeopardises the likelihood of the service achieving full compliance with the incentive scheme.

### **Monitoring of monthly stillbirth trends:**

During the November 2019 inspection, the CQC were not assured that the service understood the current stillbirth position, including reasons for the in- year increase and a subsequent lack of escalation to Board Level.

In response to the concerns raised, the service have been able to demonstrate that individual deaths have been robustly reviewed using the PMRT and that this information has been shared with Quality Committee on a quarterly basis. The service has acknowledged that the monthly monitoring of stillbirth numbers, and any immediately identified emerging themes and trends has been overlooked and has considered ways in which this can be addressed.

It has been agreed that in addition to discussing all stillbirths at the monthly Perinatal Mortality meetings and Women's Core Governance Group meeting, an exception report will be produced in the event that the monthly stillbirth number is greater than 5 or the quarterly number is greater than 12. This report will be escalated to the Chief Nurse and Chief Medical Officer, Patient Safety Sub Committee and Quality Committee.

Quarter 3 Stillbirth position:

There were 10 stillbirths during Quarter 3:

- October = 6: 1 x congenital anomaly, 1 x suspected congenital anomaly, 1 x placental abruption, 1 x chorioamnionitis, 1 x suspected placental insufficiency, 1 x unknown(awaiting results).
- November = 2: 2 x unknown cause awaiting results.
- December = 2: 1 x unknown cause awaiting results, 1 x coroners case (concealed pregnancy, unwitnessed birth).

## **3.2 Key Challenges**

### **3.2.1 Suspension of service:**

During Quarter 3, 11 suspensions of the maternity service were reported. The main reason for suspension of services on all occasions was increased activity and acuity of cases, with staffing being an additional factor in the majority of cases. There was no requirement to transfer women to other units during 6 of the 11 suspensions, and 1 occasion where no women were transferred elsewhere due to no neighbouring units within the West Yorkshire and Harrogate LMS being in a position to accept.

### **3.2.2 One to One Care in Labour**

Consistently achieving one to one care for >90% of women in established labour is a key challenge for the service.

The contributory factors identified in Quarter 3 include:

- Increased staff sickness resulting in the need to redeploy midwives from other areas to maintain safe staffing levels on Labour Ward. This particularly impacts on the Birth Centre, who historically achieved high levels of one to one care, as they increasingly close beds from 7 to 5 and work with 2 rather than 3 midwives.

- Labour Ward Co-ordinators achieve almost 100% supernumerary status and do not act as the main care giver for women in labour, even when intrapartum activity is high. The rationale for this is to ensure that there is a focus on acuity and activity by a senior practitioner at all times, to maintain the safety of all women on the unit.
- Current Labour Ward environment does not have an area to cohort women who require increased observation/care but are not in labour.
- Possibility that there is an inconsistent application of the one to one care in labour definition.

Existing mitigation in place includes completion of the amber escalation paper work, when there are concerns that staffing levels are insufficient to provide safe care to the number of women on the labour ward. Failure to achieve one to one care in labour has been included as a trigger to consider escalation in the updated escalation guideline.

One to one care for women in active labour is often not achieved due to the competing need to provide one to one care to high acuity, sick women who are not in labour. The designs for the planned maternity theatre rebuild include a 4 bedded area which will provide the ability to cohort women who have a clinical need to be on Labour Ward, but who do not require one to one care or are in labour. Building work is due to commence in Spring 2020.

Birth Centre staff are frequently used to cover staffing shortfalls in other areas. Three midwives plus one maternity support worker is the current requirement for every shift, however the birth centre is generally the first area from where staff are redeployed to support other clinical areas. When the birth centre is taken down to two midwives, two rooms are closed; however this significantly affects the opportunity to provide one to one care if more than two women are in established labour. The agreed increase to the midwifery establishment of 5.22 WTE to provide an additional midwife per shift on the Birth Centre, is fully anticipated to further improve the ability to provide one to one care and maintain safety across the intrapartum areas.

The one to one care in labour definition was re-launched in December 2019, in an attempt to encourage all midwives caring for women in labour to use a consistent definition. This has been communicated at safety huddles and handovers. An audit of intrapartum notes will be undertaken in March 2020 to assess whether the definition has been embedded in practice. A maternity 'Work As One' week is planned in March 2020, with a focus on one to one care in labour.

Table 1 is the one to one care rate taken from Medway and demonstrates an improvement in the provision of one to one care during December which can be attributed to an improved long term sickness position, increased staffing over the festive period to counter balance anticipated short term absence, and a slight reduction in elective activity over the festive/Bank Holiday period.

Of note, there have been no complaints from women reporting that they felt they were left alone during labour or at a time when they were concerned during the last 6 months. Equally, there has been no indication that failure to provide one to one care in labour is a contributory factor in clinical incidents relating to Labour Ward.

	Quarter 2			Quarter 3		
	Jul	Aug	Sep	Oct	Nov	Dec
<b>LW</b>	78%	62%	56%	63%	65%	72%
<b>BBC</b>	77%	69%	65%	69%	64%	71%
<b>Overall</b>	78%	64%	57%	64%	64%	72%

Table 1:

### **3.2.3 Achieving 35% Continuity of Carer**

The national mandated target for women booked on a Continuity of Carer pathway in March 2020 is 35% and is not anticipated to be achieved despite progress being made during 2019 and further teams planned for 2020. All teams created so far are from within the current midwifery establishment and involve the same midwives caring for the same groups of women in a different way, with the exception of the Clover Team which is funded through the Big Lottery Fund.

Continuity of Carer teams currently in place:

- Clover Personalised Midwifery case loading team (Funded by Better Start Bradford).
- Home Birth team.
- Gold Star (HIV)/Bradford Butterfly Pathway.
- Teens.

The teams above have achieved 7.7% of women booked on a Continuity of Carer pathway in the last 6 months, against a target of 20%.

The following are further teams who have formed in the last month or are due to commence in early 2020, and who are anticipated to generate 16.5% against the 35% target.

- Willow Team (Birth Centre model).
- Acorn (Vulnerable women).
- Multiples.

A service redesign is essential to deliver the 35% and subsequent 51% and will have significant implications for the midwifery workforce, as well as a likely financial implication providing the evidence based community caseload model of 1:36 against the current caseload of around 1:90-100. A paper will be presented to Workforce Committee in Quarter 4 describing the anticipated impact of the proposed continuity of carer plans on the midwifery workforce.

The conditions of Safety Action 9 of the Maternity Incentive Scheme, Year 3, require an action plan relating to a minimum of 51% of women being placed onto a Continuity of Carer pathway, to be shared with the Board safety champion by 30 January 2020. Thereafter, there is a monthly requirement to share progress in meeting the action plan with the board. Appendix 4 is a copy of the Continuity of Carer action plan, shared and discussed with the Board Level Maternity Safety, Karen Dawber on 29 January 2020. Monthly updates on progress against the action plan will be presented to Quality Committee as a subsidiary of Trust Board, from March 2020.

## **4.0 Maternity Assurance Tracker including CQC actions**

In direct response to comments and concerns raised by the CQC during the November inspection, the service has reviewed and significantly revised the Maternity Action Plan, incorporating the points raised during the informal feedback stage.

The overarching action plan consists of multiple tabs and provides a more robust and comprehensive tracking system. The action plan is reviewed monthly at Women's Core Governance Group, and progress will be presented to Quality Committee on a monthly basis

including progress on the Continuity of Carer action plan and progress on implementation of the Saving Babies Lives Care Bundle version 2.

## **5.0 Board Level Maternity Safety Champion**

The Trust Maternity Safety Champions have met with the Board Level Champion bimonthly during Quarter 3. A standard agenda is followed covering safety issues including staffing, clinical incidents and any emerging safety concerns or issues are discussed and escalated as appropriate.

The Board Level safety Champion has continued to meet with members of the maternity and neonatal staff every month during Quarter 3 and there have been no significant safety issues raised during this reporting period.

Midwifery staffing levels are regularly raised as a concern. However, staff are able to articulate the actions taken to keep the unit safe on a daily basis, and are aware of recruitment plans which will improve the position, including the recently agreed increase to the midwifery establishment.

In direct response to concerns raised by the CQC regarding the monthly stillbirth overview and subsequent escalation processes to Board, stillbirth numbers will be a standing agenda item at the bi-monthly safety champion meetings from January 2020. This is in addition to discussion of the quarterly PMRT reports as directed by the conditions of the Maternity Incentive Scheme, Year 3.

## **6.0 Priorities**

Priorities for Quarter 3 and beyond include:

- Improved delivery of one to one care in labour.
- Continued development of Continuity of Carer pathways to meet the 35% 2020 trajectory.
- Improved oversight and thematic review of stillbirths on a monthly basis.
- Launch of planned work to move Bradford Maternity Services to outstanding.

## **7.0 Good News Stories**

- The service held its first 'Open Day' in December which was a huge success and well attended by antenatal service users and women who had recently had a baby at Bradford. The event was supported by maternity focussed groups from the community and voluntary sectors and showcased both the services available at BTHFT and in the wider community.
- The Maternity Assessment Centre celebrated its first year as a 24 hour service and reported seeing an additional 2000 women during the year, a key feature being women presenting with reduced fetal movements.

### **7.1 Patient Feedback**

The Bradford Maternity Services Facebook page, Bradford Antenatal, Birth and Beyond, continues to generate positive service user feedback on a weekly basis.

The WY&H LMS induction of labour audit has revealed extremely positive feedback from Bradford women utilising the induction suite. Women reported feeling listened to and well cared for, and appreciated the continuity of carer provided.

## **8.0 Conclusions**

The CQC inspection of Maternity Services during Quarter 3 was an extremely challenging period. The service has reflected and responded positively to the comments and concerns raised and are committed to developing a structured improvement programme with the ambition of moving towards 'Outstanding'. The CQC verbally acknowledged improvements made by the service in response to previous inspections and following the 2016 quality summit, which are now embedded in practice. The service will ensure that this work is sustained and that continued assurance is provided, whilst simultaneously embarking on Quality Improvement and transformation.

The service is extremely grateful for the support received from executive and non-executive colleagues during this challenging time.