Meeting Title	Board of Directors (Open)		
Date	27.05.20	Agenda item	Bo.5.20.16

MATERNITY SERVICES UPDATE – MAY 2020

Presented by	Karen Dawber, Chief Nurse	
Author	Sara Hollins, Associate Director of Midwifery	
Lead Director	Karen Dawber, Chief Nurse	
Purpose of the paper	To provide the Board of Directors with a monthly update on progress with the Maternity Improvement Plan, including CQC Action Plan, monthly stillbirth position, one to one care in labour, and continuity of carer.	
Key control	Identify if the paper is a key control for the Board Assurance Framework	
Action required	For decision	
Previously discussed at/ informed by	Details of any consultation	
Previously approved at:	**Committee/Group**	**Date**

Key Options, Issues and Risks

The Maternity Service was rated as 'Required Improvement' following the November 2019 Care Quality Commission (CQC) inspection. The service has acknowledged the findings and recommendations, and is committed to addressing the issues raised and becoming an 'Outstanding' service.

The service has received executive approval to embark on a significant quality improvement and transformation project, intended to improve the stillbirth rate and other outcomes highlighted by the CQC, and ultimately support the journey towards being an outstanding maternity service.

Bradford is a regional and national outlier for stillbirths and concerns were raised by the CQC in November 2019 that the service had failed to identify a rising trend during 2019. Quality Committee receive a quarterly report which includes an update on the use of the Perinatal Mortality Review Tool (PMRT) and provides assurance that each stillbirth and neonatal death receives an appropriate investigation and identifies lessons learned. The service has improved the monthly review process and will provide the Board of Directors/ Quality Committee with a monthly stillbirth position, in order that they are fully informed and able to scrutinise and challenge as required.

Failure to achieve adequate rates of one to one care in labour was also raised as a concern by the inspectorate team. However, one to one care has been a regular feature in maternity reports to Quality Committee throughout 2018/19. Reporting monthly until such time that the rates of one to one care are improved and sustained, is intended to provide assurance of on-going improvement work in this area including identifying any barriers and challenges.

Analysis

The current Covid 19 pandemic has resulted in temporary changes to the way that Maternity Services at Bradford are routinely delivered. All outcomes are closely scrutinised by the risk and governance team. No increase in harms to women and babies has been noted during this reporting period, and the service is reviewing the impact of the changes to inform future service development.

The service has acknowledged the recommendations of the CQC 2019 report, and has incorporated them into the existing maternity action plan. The updated action plan demonstrates that steady progress

Meeting Title	Board of Directors (Open)		
Date	27.05.20	Agenda item	Bo.5.20.16

continued during April, with a number of actions closed. The 'must, should, could' do actions and recommendations are summarised on the first page of the overarching action plan, with additional tabs providing more detailed descriptions of the actions required to evidence compliance. A number of recommendations will require significant time to complete, as they are intrinsically linked to major maternity transformation plans.

The service presented proposed transformation plans to Trust Board in March, focusing on key areas of improvement identified as necessary to reduce the stillbirth rate. The service would like to assure the Board of Directors, that although the current priority is maintaining safety for women and babies during the pandemic, planning the proposed transformation work and meeting the recommendations of the CQC report remains priority.

Monitoring of the monthly stillbirth rate continues, with every case subject to a 72 hour review and discussion with the Deputy Medical Director. During April the number of stillbirths was below the agreed trigger for escalation.

During April there was a significant improvement in the number of women receiving one to one care in labour, which remains a key priority for the Labour Ward Co-ordinators and intrapartum team and will be closely monitored until the rate is sustained.

Recommendation

The Board of Directors are asked to note the progress made on the Maternity Services Action plan, and to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/ lessons learned.

Acknowledgement of the on-going attempts to monitor and develop strategies to improve one to one care in labour and of the improvement reported in April.

The service requests that Board note the monthly maternity dashboard narrative, including improvements and areas requiring monitoring.

The Board of Directors are also asked to note the progress made with the Continuity of Carer action plan.

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					

Meeting Title	Board of Directors (Open)		
Date	27.05.20	Agenda item	Bo.5.20.16

Explanation of variance from Board of Directors Agreed General risk appetite (G)	

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☐	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☐	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☐

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

Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant) ☐Risk Assessment Framework ☐Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain:
Care Quality Commission Fundamental Standard:
NHS Improvement Effective Use of Resources:
Other (please state):

Relevance to other Board of Director's Committee: (please select all that apply)					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
☐	☒	☐	☐	☐	☐

Meeting Title	Board of Directors (Open)		
Date	27.05.20	Agenda item	Bo.5.20.16

1 PURPOSE/ AIM

The purpose of this paper is to provide a monthly update on progress with the Maternity Improvement Plan, including the CQC Action Plan, the monthly stillbirth position, one to one care in labour, and continuity of carer. It also provides an update on the quality improvement/transformation programme, intended to improve key areas of the service and support the journey towards being outstanding.

The paper also provides a brief narrative of the maternity outcomes and metrics reported in the monthly maternity dashboard.

Bradford is a regional and national outlier for stillbirths and concerns were raised by the CQC in November 2019 that the service had failed to identify a rising trend during 2019. This failing contributed to the 'Requires Improvement' rating applied to Maternity Services on 9 April.

Failure to achieve adequate rates of one to one care in labour was also raised as a concern by the inspectorate team. However, one to one care has been a regular feature in maternity reports to Quality Committee throughout 2018/19 and 2019/20.

2 BACKGROUND/CONTEXT

Ongoing Impact of Covid 19 pandemic on Maternity Services:

The service has responded to the pandemic in line with local, regional and national recommendations/directives, and has adapted the provision of maternity services to ensure that women, babies and staff are protected whilst maintaining safe, responsive maternity care. These measures remained in place during April, with appropriate amendments made in line with emerging guidance and evidence.

There has been a low incidence of women presenting to the maternity service who were Covid 19 positive during April, with no women experiencing significant symptoms requiring enhanced or intensive care. There have been no reported cases of positive or suspected Covid occurring in neonates during the same time frame.

During April, the service did not see any significant increase in harms occurring to women and babies, as a result of temporary changes in the way that services are delivered. However, there was one reported 'near miss' with no harm occurring to mother or baby, but where care in labour fell below the accepted standard as a direct consequence of Covid cohorting arrangements. The case was reviewed as a round table discussion with members of the team involved, with a number of lessons learned emerging. This continues to be monitored closely by the maternity risk and governance team.

The service is in the process of engaging with staff and women to understand the impact of changes made in response to managing the pandemic, and how this influences future planning.

The National Maternity Transformation work streams and agendas, including the Maternity Incentive Scheme and implementation of Saving Babies Lives version 2, remain on hold as reported in the April paper to Regulation Committee. Work continues, within capacity, to ensure that the service is able to quickly resume the national agendas when revised deadlines are announced.

Maternity Action Plan and CQC rating:

Maternity Services received a 'Requires Improvement' rating in the 2019 inspection report published in April. The service has acknowledged the recommendations including monitoring and escalation of stillbirth rates, monitoring and management of infection risks in maternity theatres, and have incorporated 'must, should and could' do's into the existing maternity action plan for immediate attention (Appendix 1).

The 'must, should, could' do actions and recommendations are summarised on the first page of the overarching action plan, with additional tabs providing more detailed descriptions of the actions required to evidence compliance. A number of recommendations will require significant time to complete, as they are intrinsically linked to major maternity transformation plans. For example, the action relating to closely monitoring infection risks in obstetric theatre will be categorised as 'ongoing' until the completion of the planned theatre rebuild in spring 2021.

Some delays in completing outstanding actions have been incurred as a direct result of the current pandemic, for example, delays in launching additional continuity of carer teams and paused sonographer training required to implement elements of the saving babies' lives scanning regime.

Progress has been made on the MBRRACE action plan, with actions relating to perinatal mental health now closed. Staffing actions, particularly relating to the provision of one to one care in labour, have been updated to reflect the additional actions taken to improve this.

A separate governance tab has been added to the overarching action plan, to evidence the actions required to demonstrate the CQC 'must do' that the Trust must improve governance and oversight of risk in maternity services.

Stillbirth position:

There were 10 stillbirths in total during Quarter 4, January-March 2020, below the agreed escalation trigger of 12.

In April we reported 1 stillbirth of a Covid positive woman who presented to hospital following a 3 day episode of reduced fetal movements at 27 weeks. The woman had no other risk factors and there was good documentation of discussions regarding the need to present with

reduced movements. 72 hour review revealed care to be appropriate with no lessons learned.

The woman had experienced Covid related bereavement a few days earlier and was symptomatic on presentation at the unit.

Delay in presenting with reduced fetal movements due to Covid was identified as a potential risk at the onset of the pandemic. The service have proactively increased the frequency with which reduced fetal movement advice is shared with women, both at routine contacts and through other mediums including the website and Facebook page. A brief video was also produced and shared widely.

Ongoing actions to address the stillbirth rate:

The service previously identified and reported themes and trends emerging regarding the identification and management of small for gestational age babies. Review of antenatal care pathways, systems and processes for both low and high risk women, was requested as an urgent transformational work stream, and presented to the executive team in March.

The executive team are supportive of the proposed transformation/improvement plans and the service has prioritised the areas which require immediate attention, including a full review of the guidance and tools available used for surveillance of fetal growth.

Steps taken so far include:

- 2 meetings with Deputy Medical Director and Quality Improvement Lead
- Comparison of growth charts used to plot symphysis fundal height and estimated fetal weight and review of current evidence
- Engagement with Consultant Obstetric team including presentation of the above
- Identification of members of the MDT to participate in process mapping
- Ongoing 72 hour reviews and discussion with Deputy Medical Director of any new cases
- Continued focus on reiterating the importance of attending with reduced fetal movements, particularly during the pandemic

One to One care in labour:

Failure to improve the rate of women receiving one to one care in labour over the last 2 years was highlighted by the CQC in the November 2019 inspection. The actions taken to address one to one care and the associated challenges were regularly reported to Quality Committee throughout 2019.

Following the reported slight increase in women receiving one to one care in March, the service is delighted to report a significant improvement in April with a total of 83% of women receiving one to one care.

Meeting Title	Board of Directors (Open)		
Date	27.05.20	Agenda item	Bo.5.20.16

	January	February	March	April
Total	61%	69%	71%	83%

Despite the impact of Covid 19 on midwifery staffing and different ways of working, the concerted focus of the Labour Ward Co-ordinator team has contributed to the improved position.

Actions taken in April to support improvement:

- Focus Group held with Labour Ward Co-ordinators, Associate Director of Midwifery and Matron for Labour Ward. CQC report discussed including the role and accountability of the senior team in improving standards of care.
- Group identified barriers and enablers.
- Nominated lead and collective acknowledgement of responsibility.
- Proforma designed and completed for every woman in labour, including reason why one to one care not achieved.

The co-ordinators also report that combining staff from the Birth Centre and Labour Ward, introduced to manage staffing and cohorting of Covid women, has improved the ability to appropriately allocate midwives to women requiring one to one care.

Next Steps:

- Continue daily focus throughout May and June.
- Evaluate the proformas in July, including reasons why one to one not achieved.
- Devise action plan following evaluation.
- Consideration to be given to continuing central allocation of intrapartum staff post Covid.

Continuity of Carer Action plan:

The requirement to submit March 2020 Continuity of Carer figures to the National Maternity Transformation team via the LMS was postponed due to Covid 19 as reported in April.

However, the service is delighted to report that the 35% target was exceeded with 45% of women on a continuity of carer pathway in March. This contributed to the West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) overall position of 36%. This is an incredible achievement for BTHFT and for the system as a whole.

As reported in April, the provision of continuity of carer pathways has been affected by Covid 19, with some pathways placed on hold or not commenced. The service is currently looking at how the pathways can safely resume at the earliest possibility, as part of the specialty

future state plans. It is anticipated that the Home Birth service will resume on a reduced scale with the provision of antenatal care in late May, working towards reinstating on call arrangements in June.

The updated Continuity of Carer action plan, required to demonstrate compliance with safety action 9 of the temporarily paused Maternity Incentive Scheme, is included in Appendix 1.

Maternity Dashboard:

Outcomes and performance for April can be reviewed in Appendix 3, Maternity Dashboard.

There are no immediate triggers for concern noted during April.

- 3rd and 4th degree tears noted to have increased in March, but are within normal range in April.
- Bookings under 13 weeks reported consistently around 80% in March, has improved to 90% in April. This is possibly a positive consequence of Covid-19 antenatal arrangements where women receive a telephone booking rather than face to face. This will continue to be monitored.
- Planned home births dropped to 0 in April due to suspension of the service to support staffing challenges during the pandemic.
- Stillbirth rate showing a downward trajectory for the 3rd consecutive month and continues to be closely monitored.
- Increase in caesarean section rate in April to the national average of 25%, particularly emergency caesareans. No cause for concern at present but trend will be monitored.

The service have asked for support from the informatics team to pick out 5 key areas of the dashboard and look at how the data can be made more meaningful for staff. The intention is then to upload this information onto the Trust intranet site so that staff can understand and be more conversant with maternity data and metrics. Metrics suggested are:

- Still births.
- Small babies.
- Bookings < 13 weeks.
- 1:1 care in labour.
- Caesarean sections.

The service is also considering the inclusion of other metrics:

- Number of HIE cases.
- MAC attendances particularly reduced fetal movements.

Meeting Title	Board of Directors (Open)		
Date	27.05.20	Agenda item	Bo.5.20.16

Outstanding Maternity Service Programme:

The Outstanding Maternity Service Programme is the working title of the planned maternity transformation programme, intended to improve the service from 'Requires Improvement' to 'Outstanding'.

Tim Gold, Director of Operations for Planned Care, has prepared a proposed programme for presentation to the executive team in May for discussion. The programme contains 5 work streams:

- Maternity Pathways and Outcomes.
- Maternity Systems.
- Maternity Theatres and Estates.
- Governance, Risk and Administration.
- Culture, Workforce and ways of Working.

The triumvirate team have already started to co-ordinate and prioritise the early stages of the programme, including discussions and engagement with members of the multi-disciplinary team (MDT).

As discussed in 'Actions to address the stillbirth rate', fetal growth and surveillance have been identified as a priority and initial preparation work is underway.

The planned Maternity Theatre building work has been one of the established work streams to continue during the pandemic. In May, design plans were shared with the wider MDT and also with service users, who have provided valuable feedback.

3 PROPOSAL

The service proposes that the Maternity Action Plan, stillbirth rate, one to one care in labour and continuity of carer continue to be presented to Board of Directors on a monthly basis, until sustained improvement is noted in these key areas and the 2019/20 Maternity CQC action plan is complete.

Any urgent concerns emerging outside of the monthly reporting arrangements will be escalated by the Trust Level Safety Champions to the Board Level Safety Champion.

4 BENCHMARKING IMPLICATIONS

The service will continue to benchmark and monitor performance and position at both regional and national level, using the existing benchmarking tools including the Yorkshire and Humber regional maternity dashboard, MBRRACE-UK publications etc.

Meeting Title	Board of Directors (Open)		
Date	27.05.20	Agenda item	Bo.5.20.16

Continuity of Carer is monitored through the West Yorkshire and Harrogate LMS, and reported to the national maternity transformation team although this is temporarily paused due to Covid 19.

5 RISK ASSESSMENT

Stillbirths, One to One care in labour and Continuity of Carer pathways are on the maternity risk register, updated regularly and monitored through Women's Core Governance Group. All risks have been reviewed to reflect any increased risk as a result of changes to the service to maintain safety of women, babies and staff during the pandemic.

6 RECOMMENDATIONS

The Board of Directors are asked to note the progress made on the Maternity Services Action plan, and to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned.

The service requests that the Board of Directors acknowledge the continued temporary pause of a number of key maternity transformation/national safety initiatives due to the current pandemic.

The Board are asked to acknowledge the on-going attempts to monitor and develop strategies to improve one to one care in labour, and the service's commitment to addressing the issues raised by the CQC.

The service requests that Board note the monthly maternity dashboard narrative, including improvements and areas requiring monitoring.

The Board of Directors are also asked to note the progress made with the Continuity of Carer action plan.

7 Appendices

1. Maternity Action Plan – Appendix 1
2. Maternity Dashboard - Appendix 2