Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	20 January 2021	Agenda item	Bo.1.21.12

MATERNITY SERVICES UPDATE –DECEMBER 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 Quality Academy/Board with a monthly update on progress with the Maternity Improvement Plan, including CQC Action Plan, monthly stillbirth position 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.

Following Executive approval, the service have embarked on a significant quality improvement and transformation project, intended to improve the stillbirth rate and other outcomes highlighted by the CQC, and ultimately support the journey towards being an outstanding maternity service.

Bradford is a regional and national outlier for stillbirths and concerns were raised by the CQC in November 2019 that the service had failed to identify a rising trend during 2019. The service has improved the monthly review process and will provide the Board of Directors/Regulation 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, the service has reported 6 consecutive months of a rate above 90%. October 2020 Regulation Committee therefore agreed that this metric can be reported by exception if it falls below 90%.

Analysis

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 reflects progress and the position during November and December. 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 Board of Directors in May, focusing on key areas of improvement identified as necessary to reduce the stillbirth rate. The Outstanding Maternity Service Programme is now launched and embedded within the unit and continued staff engagement and progress has been made during December.

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Monitoring of the monthly stillbirth rate continues, with every case subject to a 72 hour review and discussion with the Deputy Chief Medical Officer and Chief Nurse.

Recommendation

The Board/Quality Academy is asked to note the updated Maternity Services Action plan.

Board/Quality Academy is asked to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned.

Board/Quality Academy is also asked to note that the December stillbirth rate has triggered the agreed escalation process.

The service requests that the Board/Quality Academy notes the narrative on the November maternity dashboard and notes that the December data is not available due to the timing of the paper submission, and will be provided at the next monthly update. However, the December stillbirth position is included within this report.

Board/Quality Academy is asked to acknowledge that there was no Serious Incidents (SI) declared in December.

The service requests that the Board/Quality Academy note the progress of the Outstanding Maternity Programme during December.

The Board/Quality Academy is also asked to note the progress made with the Continuity of Carer action pathways.

Board/Quality Academy is asked to note the feedback from the NHSI Maternity Safety Support Programme visit in December.

The Board/Quality Academy is asked to note the immediate response to the Ockenden Report including that the Birth Rate Plus acuity tool has been commissioned and is in progress.

Board/Quality Academy is asked to note that the revised submission date for the Maternity Incentive Scheme, Year 3, is now 15 July 2021 at 12 noon.

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

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

Risk Implications (see section 5 for details)	Yes	No
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: Well Led
Care Quality Commission Fundamental Standard: Good Governance
NHS Improvement Effective Use of Resources: Choose an item.
Other (please state):

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Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
☐	☒	☐	☐

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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 and continuity of carer. It also provides an update on the Outstanding Maternity Service quality improvement/transformation programme, intended to improve key areas of the service and support the journey towards being outstanding.

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

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

2 BACKGROUND/CONTEXT

Ongoing Impact of Covid-19 pandemic on Maternity Services:

The service has responded to the pandemic in line with local, regional and national recommendations/directives, and has adapted the provision of maternity services to ensure that women, babies and staff are protected whilst maintaining safe, responsive maternity care.

The service continues to return a weekly maternity 'sitrep' which includes questions about partner access to the unit. Following the installation of 'pods/booths' in antenatal clinic waiting area in December, women are now able to have the support of a partner at all antenatal appointments. Further booths will be installed in the Early Pregnancy Unit and in Antenatal Ultrasound department on 18 January, which will enable partners to accompany pregnant women at all scans and for suspected pregnancy loss.

Further guidance was produced by NHSE in December 2020, regarding lateral flow testing for women and their partners at specific appointments and during all inpatient admissions. This is a large piece of work which is likely to involve support from Estates, Performance and Pathology department, which the service is currently working through how to operationalise.

During December there were no women who experienced significant Covid 19 symptoms requiring intensive or enhanced care. There were no babies with symptoms of Covid during this time. We do not, to protect our women and staff, move staff from maternity services to the acute main site.

During December the service received further, formal notification of the revised submission dates for the Maternity Incentive Scheme (MIS) Year 3. Trust Boards are now required to submit the self-declaration form to NHS Resolution by 12 noon on Thursday 15 July 2021, rather than the original revised date of Thursday 20 May 2021. The service has reviewed the revised standards and is working towards compliance with the 10 maternity safety actions.

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Ockenden Report of Maternity Services at Shrewsbury and Telford NHS Trust

The Ockenden report of Maternity Services at Shrewsbury and Telford NHS Trust was published on 10 December 2020. The report looked at maternal and neonatal harms occurring between 2000-2019 at Shrewsbury and Telford Hospital and resulted in 27 recommendations for the named Trust with a further 7 early recommendations, referred to as immediate and essential actions (IAE's) to be implemented by all NHS Maternity services.

The service responded promptly to the report, completing initial benchmarking within 3 days and provided assurance of implementation of the 7 IAE's to NHSE by the 15 December submission deadline.

A further assurance template and evidence is being prepared for submission to the Regional Midwifery Officer on 15 February.

A presentation on the Ockenden Report and Trust position will go to Open Board on 20 January along with the assurance that BTHFT Maternity Services have commissioned the Birth Rate Plus acuity tool as requested by NHSE and the analysis is expected in late February/early March.

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

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 which is approximately 6 weeks behind schedule.

The action plan is reviewed 4-6 weekly by the Associate Director of Midwifery, Clinical Director and Risk and Governance Lead Midwife. The majority of actions are making progress in line with target dates. However, a small number of actions have been impacted by working arrangements due to the pandemic as described.

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.

The action plan was updated in December and can be reviewed in Appendix 1.

Stillbirth position:

There were 6 reported stillbirths in December (Table 1). This number triggers the agreed escalation reporting. A table top review of the 6 cases took place on 7 January, to look at

any emerging themes and trends. This was in addition to the individual 72 hour review of each case. All 6 cases were very different and included 1 Butterfly baby and 1 baby expected to have a poor outcome due to ruptured membranes at a very early stage of pregnancy.
2 cases which involved a late booker and a woman, who transferred care from another hospital, have revealed areas for improvement that have some similarities but otherwise no themes and trends were identified.
Reassuringly, the themes around late presentation with reduced fetal movements which were identified in the September 2020 cluster were not evident in this review and good practice regarding provision of the Tommy's leaflet was evident in all cases.

Table 2 is the running total of stillbirths in 2020, including the number of cases requiring further detailed investigation, and the number of butterfly babies whose deaths were expected. The final total of stillbirths for 2020 is 35, including 6 Butterfly babies. This is an overall reduction of 11, on the 46 stillbirths reported in 2019.

Table 1:

Gestation	Summary	Review outcome
41	G1 P0 booked at approximately 30 weeks gestation as recently moved from Pakistan. A scan had been performed in Pakistan at 23 weeks which was used to date this pregnancy. An appropriate risk assessment was completed at the booking appointment and notable care referring for scan and review following an abnormal SFH trajectory. The estimated fetal weight at scan was above 10th centile therefore she was appropriately referred back to midwifery led care. She was seen in the consultant antenatal clinic at 40+2 weeks and a plan was made for induction of labour at 40+12 weeks gestation. An admission at 41 weeks to the Maternity Assessment Unit reporting signs of labour diagnosed an intrauterine death. There is a possible spread of gestation around the 50th centile for estimated fetal weight and head circumference. It is, therefore possible, that this baby was, in actual fact, more than 2 weeks post mature. It may therefore be pragmatic to advise induction at 40 weeks for late booking women in whom a reliable CRL measurement between 9+6 and 13+6 or an HC at 20	Case referred to HSIB. 72 hour review found care to be appropriate overall. However, the accuracy of the 23 dating scan is variable and it is suggested that if induction had been offered at 40 weeks rather than 40+12, this stillbirth may have been avoided.

	weeks is not available, induction should be offered at 40 weeks.	
33	G1 PO with a BMI of 30 was diagnosed with an intrauterine death at 33 weeks gestation. The woman transferred her care from another Trust at 26 weeks and did not have a SFH measurement taken at her first BTHFT appointment. The likely cause at initial review is severe fetal growth restriction secondary to pre-eclampsia. It may have been possible to identify a static SFH if an initial SFH measurement was taken around the time of booking. It may also have been possible to identify the patient's pre-eclampsia if the systolic BP of 140 had been escalated. However, given the inherent inaccuracy of SFH and the patient's BMI, it is probable that this would not have diagnosed a significant discrepancy warranting further investigation. Similarly, the patients pre-eclampsia diagnosed around the time of induction, labour and delivery required treatment but settled soon after birth and discharge, raising a possibility that a more detailed assessment of blood pressure at 31 weeks would not have revealed a persistent anomaly. Lessons therefore to be learnt which are unlikely to have effected outcome.	72 hour review revealed lessons learned which were unlikely to have altered the outcome. The woman transferred care at 26 weeks and was treated as a routine booking appointment and not seen again until 31 weeks. It is possible that if an SFH measurement had been performed at 26 weeks, static growth may have been identified. However, the raised BMI may not have revealed this.
29	G4 P3 with history of safeguarding issues and substance misuse was diagnosed with an intrauterine death at 29 weeks gestation. The safeguarding team was involved in this lady's care. All care reviewed appears appropriate on brief review.	72 hour review Poor engagement with maternity services. No care omissions identified.
37	G1 PO with a fetal diagnosis of trisomy 13 was supported on the Butterfly pathway throughout her pregnancy. At 37 weeks gestation she attended the Maternity Assessment Unit in labour reporting reduced fetal movements and a diagnosis of an intrauterine death was made. No omissions in care identified on initial review.	72 hour review No care omissions identified. Baby on Butterfly Pathway,
34+1	G5 P4, age 38 with a BMI of 29 was having ultrasound scans due to intrauterine growth restriction due to	72 hour review

	placental insufficiency. She was seen by the Obstetric Consultant at 33 weeks and a plan made for weekly liquor and Doppler monitoring and 2 weekly growth scans. A scan was arranged 7 days later but cancelled by the lady. At 34+1 weeks gestation she presented with an intrauterine death.	No care omissions identified.
24+6	G8 P2 with a history of anorexia nervosa and mental health issues had a premature rupture of membranes at 16 weeks gestation. Her pregnancy continued with persistent anhydramnios until 24+6 weeks gestation when she was admitted by ambulance with a small loop of cord noted at the introitus, a diagnosis of intrauterine death was made and a stillborn male infant was born the following day	72 hour review Anticipated poor outcome due to prolonged, premature rupture of membranes since 16 weeks. No care omissions identified.

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Table 2:

Stillbirths 2020			Expected deaths within total number	Further detailed investigation
Month	**Number of baby's**	**Running total**	**Butterfly baby's**	**Number of cases**
January	4	4	1	2
February	4	8	1	1
March	2	10	0	0
April	1	11	0	0
May	2	13	1	0
June	1	14	0	0
July	2	16	0	0
August	2	18	1	1
September	5	23	0	0
October	2	25	0	0
November	4	29	1	1 (SI)
December	6	35	1	1 (HSIB)

Ongoing actions to address the stillbirth rate

The Service continues to work towards full implementation of the Saving Babies' Lives Care Bundle, Version 2 and the improved identification and management of small for gestational age babies through the Outstanding Maternity Service (OMS) programme transformational work stream.

A revised fetal growth chart has been agreed, which includes the 3rd centile. The chart is in use in paper format and work continues to incorporate it into EPR.

Hypoxic Ischaemic Encephalopathy (HIE)

There were no babies requiring treatment for HIE in December.

Serious Incidents (SI's)

The December 2020 Ockenden Report, independent review of Maternity services at the Shrewsbury and Telford Hospital NHS Trust, contained 7 immediate and essential actions (IAE) to improve care and safety in maternity services for all Trusts.

IAE 1: Enhanced Safety, recommends that all maternity SI reports and a summary of the key issues, must be sent to the Trust Board and the Local Maternity System (LMS).

There were no maternity SI's declared in December.

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There are 2 ongoing SI investigations, 1 declared in November and reported to Regulation Committee in December and 1 declared in July which has been completed to draft final report stage.

Date of Incident	Brief Description	Immediate Findings	Finalised Key Issues
November 2020	A lady in her third pregnancy who is a type 2 diabetic requiring metformin booked her antenatal care with the midwife over the telephone. The woman's husband was used to interpret and information about her diabetes was not established by the midwife. The woman was treated as low risk throughout her pregnancy despite significantly raised SFH measurements. At 39+1 week's gestation an IUD was diagnosed.	Failure to utilise interpreting services appropriately. 72 hour review revealed the lack of a robust follow up process for women who failed to attend glucose tolerance testing appointments.	Investigation still in progress
July 2020	5 weeks Postnatal woman with complex medical and mental health issues, commit suicide at home shortly after being discharged from AED.		Final report in draft format

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HSIB Cases

Following the Ockenden Report, all cases referred to the Health Safety Investigation Branch (HSIB) will be declared as SI's.

There was 1 case meeting the HSIB criteria for referral for investigation during December. Stillbirth at 41 weeks as previously described. This case was escalated to HSIB before the changes resulting from the Ockenden review, discussed later in this report.

Continuity of Carer Action plan

The Specialist Midwife for Continuity of Carer Pathways produces a monthly highlight report shared with the LMS and the Chief Nurse, in her capacity as Board Level Safety Champion. The report presented in December, relates to activity and progress during November which includes:

• Acorn commenced on-calls on the 6th of December.

• Birthrate+ review currently being undertaken with consideration of CoC teams included in the assessment.

• Multiples team now staffed and both team members working all of their hours in the team. Twins Trust action QI action plan complete.

• Amber team set to commence with full team from January, however one team member no longer joining due to getting a secondment.

• Vacancies due in Acorn and Willow team due to movement of staff to other trusts.

• Clover clone "Heather Team" due March 2021.

• Meeting with the Chief Executive to update on CoC plans. CoC will be featured in her vlog and she plans to spend a day shadowing Clover Team in the New Year.

22% of women were booked on a Continuity of Carer pathway (target 35%) with 24% of women being from a BAME background.

Maternity Theatres

Covid-19 has delayed progression with the maternity theatre rebuild and a further small delay has been incurred as a result of changes to the procurement process and an essential review of the project build. No further delays have been incurred since the last update, and the project remains 6 weeks behind schedule. First 'spade in the ground' is anticipated week commencing 5 January 2021.

Mitigation of the current maternity theatre has continued throughout the pandemic, including the use of the Public Health England, surgical site infection surveillance tool, for all women who have had a caesarean birth. Weekly Datix reporting of the frequency of theatre 2 usage is well embedded and consistent.

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Maternity Dashboard

Appendix 2 contains the maternity dashboard including November data.

The metrics reported on the November dashboard continue to demonstrate consistently positive outcomes. There are currently no areas of significant concern to report.

- One to one care in labour remains consistently above 90%
- The rolling stillbirth rate continues to demonstrate a positive downward trajectory

Following the Ockenden report, Trusts have been asked to provide a statement of commitment that they will implement a revised perinatal mortality surveillance model, which gives clear direction on the maternity metrics and information which must be presented to the Board of Directors on a monthly basis. The service will meet with the Chief Nurse in her capacity as Maternity Safety Champion, to agree the format of this monthly update and the maternity and neonatal dashboards moving forwards.

Due to the timing of this paper, the December maternity dashboard has not yet been updated and will be provided in the next monthly update to Regulation Committee.

Outstanding Maternity Service Programme

The Outstanding Maternity Service (OMS) Programme is a transformation programme, intended to improve the service from 'Requires Improvement' to 'Outstanding'.

The programme contains 5 work streams:

- The Woman's Journey and Clinical Excellence.
- Moving to Digital.
- Streamlining Systems.
- A Building Fit For The Future.
- Investing In Our Workforce.

Progress during December:

The Women's Journey

- Twins Trust Multiples Audit circulated to team and meeting arranged for Jan 2021 to do QI plan
- PN contraception working group in place, linking with LMS
- Preterm Pathway review commenced
- Fetal Growth pathway Review commenced
- MeAcc Pathway document-gone to print
- GTT process mapping completed
- Ambulatory Pathways creation work commenced-RFM first priority to test approach
- BSOTS implementation commencing in MAC/ANDU

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Investing In Our Workforce

- Labour Ward Handover observations and PDSAs initiated and ongoing
- Birth rate Plus workforce modelling ongoing
- Medical staffing review ongoing
- Trust and Maternity Greatix review and agreement to merge
- MSW week completed
- Linked to #embeddingkindness project

A Building Fit For The Future

- 15 steps planned timescale for all areas with the MVP, first review 18.12.2020 (ANC/ANDU/MAC/waiting area)
- Implemented changes to unit signage and lift configuration
- Ambulatory Care Unit requirements staff views collated
- Project Initiation Document for Ambulatory Care Unit in progress

Moving to Digital

- IT equipment gap audit completed for admin and clinical areas

Linking Learning and Quality Through Our Information (Streamlining systems)

- Workstream title revised
- Midwifery champion confirmed
- Reviewed Datix trigger list
- Digital platform work started

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NHSI Maternity Safety Support Programme

The organisation received notification from NHSI in July 2020, that maternity services at BTHFT had been entered onto the Maternity Safety Support Programme, triggered by the CQC 'requires improvement' rating.

The programme was paused due to Covid-19, but has now formally recommenced with notification received on 23 November 2020.

The first support visit took place virtually on 15 December. The service shared a presentation outlining the journey and progress made during the 12 months following the CQC visit, including the immediate response to the Ockenden Report.

The NHSI team gave extremely positive feedback, and the National Chief Midwifery Officer, Professor Jacqueline Dunkley-Bent, said she was 'blown away' by the presentation and progress made.

The service is now in the 'diagnostic' phase of the support programme and is anticipating a site visit from members of the team in the early part of 2021.

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3 PROPOSAL

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

The service also proposes that progress on the Outstanding Maternity Service programme is included in this monthly update

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

4 BENCHMARKING IMPLICATIONS

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

Continuity of Carer is monitored through the West Yorkshire and Harrogate LMS.

5 RISK ASSESSMENT

Stillbirths and Continuity of Carer pathways are on the maternity risk register, updated regularly and monitored through Women's Core Governance Group. All risks have been reviewed to reflect 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/Quality Academy is asked to note the updated Maternity Services Action plan.

Board/Quality Academy is asked to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned

Board/Quality Academy is also asked to note that the December stillbirth rate has triggered the agreed escalation process.

The service requests that the Board/Quality Academy notes the narrative on the November maternity dashboard and notes that the December data is not available due to the timing of the paper submission, and will be provided at the next monthly update. However, the December stillbirth position is included within this report.

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The service requests that the Board/Quality Academy note the progress of the Outstanding Maternity Programme during December.

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Board/Quality Academy is asked to note the feedback from the NHSI Maternity Safety Support Programme visit in December.

The Board/Quality Academy is asked to note the immediate response to the Ockenden Report including that the Birth Rate Plus acuity tool has been commissioned and is in progress.

Board/Quality Academy is asked to note that the revised submission date for the Maternity Incentive Scheme, Year 3, is now 15 July 2021 at 12 noon.

7 Appendices

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