

MATERNITY SERVICES UPDATE, INCLUDING QUARTERLY PERINATAL MORTALITY REVIEW TOOL UPDATE AND MATERNITY SERVICES DATA SET ACTION PLAN –APRIL 2021

Presented by	Karen Dawber, Chief Nurse	
Author	Sara Hollins, Director of Midwifery	
Lead Director	Karen Dawber, Chief Nurse	
Purpose of the paper	To provide the Regulation Committee/Board with a monthly update on progress with the Maternity Improvement Plan, including CQC Action Plan, monthly stillbirth position and continuity of carer. This paper also contains the quarterly Perinatal Mortality Review Tool (PMRT) update and Maternity Services Data Set (MSDS) action plan, required to demonstrate compliance with the Maternity Incentive Scheme safety actions.	
Key control	Identify if the paper is a key control for the Board Assurance Framework	
Action required	For information	
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/Quality Academy with a monthly stillbirth position, in order that they are fully informed and able to scrutinise and challenge as required. The service reported an annual reduction in stillbirths during 2020. However, stillbirth reduction remains a key priority for the service as we continue to work towards the national ambition and 'halve it' trajectory.

The monthly maternity services report presented to Trust Board/Quality Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Board has an open and transparent oversight and scrutiny of maternity services.

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 March. Due to the timing of this paper, the plan has not been updated since the March paper was presented to Board. An update will be presented in the May paper to Quality Academy. 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. Significant progress and compliance has been achieved with outstanding actions linked to major maternity transformation plans which are not yet complete.

The service presented proposed transformation plans to Board of Directors in May 2020, focusing on key areas of improvement identified as necessary to reduce the stillbirth rate. The Outstanding Maternity Service Programme continues to attract engagement from staff with progress evident in all 5 work streams during March.

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. This process is well embedded, including the rapid identification and escalation of in-month 'spikes' in the stillbirth rate which are subject to thematic reviews and reporting of any findings and subsequent learning to Trust Board.

Recommendation

The Board/Regulation Committee is asked to note the contents of the Maternity Services Update, March 2021 which was presented and approved by Quality Academy 28 April 2021.

The Board/Regulation Committee is asked to note that due to the timing of the paper submission, the Maternity Services Action plan has not been updated since the March paper was presented to Board. It will be updated and included in the May paper.

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

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

Board/Regulation Committee is asked to acknowledge that there was no Serious Incidents (SI) declared in April in Maternity.

Board/Regulation Committee is asked to note the 3 Neonatal Serious Incidents declared in April, including the immediate lessons learned.

The Board/Regulation Committee is asked to note the quarterly Perinatal Mortality Review Tool (PMRT) position required for Maternity Incentive Scheme compliance.

The service request that Board/Regulation Committee approves the Maternity Services Data Set (MSDS)

Data Quality (DQ) action plan and agree that it can be submitted to the West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) Board to demonstrate compliance with safety action 2 of the Maternity Incentive Scheme.

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

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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Diversity and Inclusion implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Performance implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant) <input checked="" type="checkbox"/> Risk Assessment Framework <input checked="" type="checkbox"/> Quality Governance Framework <input type="checkbox"/> Code of Governance <input type="checkbox"/> Annual Reporting Manual
Care Quality Commission Domain: Well Led
Care Quality Commission Fundamental Standard: Good Governance
NHS Improvement Effective Use of Resources:
Other (please state):

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1	PURPOSE/ AIM
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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. The service reported an annual reduction in stillbirths during 2020. However, stillbirth reduction remains a key priority for the service as we continue to work towards the national ambition and 'halve it' trajectory.

The monthly maternity services report presented to Trust Board/Quality Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Board has an open and transparent oversight and scrutiny of maternity services.

The Board/Regulation Committee is asked to note the contents of the Maternity Services Update, March 2021 (Appendix 1) which was presented and approved by Quality Academy 28 April 2021.

This paper also contains the quarterly Perinatal Mortality Review Tool (PMRT) update and Maternity Services Data Set (MSDS) action plan, required to demonstrate compliance with the Maternity Incentive Scheme safety actions.

2	BACKGROUND/CONTEXT
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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 is fully compliant with NHSE request that woman are supported to have a support person of their choice with them at every stage of the pregnancy and birth journey.

The service is working with Maternity Commissioners to encourage Primary Care colleagues to welcome support partners to attend community midwifery appointments held in Primary Care venues.

The surveillance of women who are Covid positive in the community setting continues, ensuring that pregnant women from BAME and vulnerable communities are monitored and any deterioration in condition is rapidly identified and acted upon.

During March there were 0 women, who experienced significant Covid 19 symptoms and required 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.

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.

Following sign off by Executive Team Meeting (ETM) on 8 February, the service submitted a completed assurance template to the Regional Midwifery Officer on 10 February, ahead of the 15 February deadline. The service was able to demonstrate a high level of compliance with the 7 recommendations, and a statement of commitment to support the implementation of recommendations awaiting further national guidance and information.

A national portal through which to provide the supporting evidence has yet to be opened with no date provided as yet.,

The service also provided the Regional Midwifery Officer with the confirmation that the full Birth Rate Plus acuity tool was commissioned in November 2020, with a draft report expected in March 2021.

The service has received feedback on the assurance template submission from the Regional Midwifery Officer's team, including suggestions as to the type of supporting evidence required when the portal is opened.

We are preparing a submission to bid for a portion of the £95.6 million allocated to support midwifery and obstetric staffing and multi-disciplinary training, to improve maternity safety as a Government response to the Ockenden Report.

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. On-going surveillance of all women who have had a caesarean birth remains in place as part of the risk mitigation until the work is complete.

The action plan is reviewed 4-6 weekly by the Associate Director of Midwifery, Clinical Director and Risk and Governance Lead Midwife.

The action plan was updated in March and significant progress has been made. All of the 'Should Do' recommendations are now complete. Of the 15 'Must Do's' 13 are either 'complete and closed' or 'complete with ongoing monitoring'. The 2 ongoing actions relate to 'Fresh Eyes' audit and staffing incidents. Significant work has already been undertaken. However, further improvement work is in progress.

The Board/Regulation Committee is asked to note that due to the timing of the paper submission, the Maternity Services Action plan has not been updated since the March paper was presented to Quality Academy in April. It will be updated and included in the May paper.

Stillbirth position:

There were 2 stillbirths in April. One baby had a diagnosed fatal condition and died in utero prior to the mother having a termination of pregnancy or deciding to continue her pregnancy on the Butterfly pathway. Although the decision had not been made, this stillbirth has been included in the Butterfly running total.

The second was a Butterfly baby with anencephaly.

Table 1 is the summary of cases occurring in April.

Gestation	Summary	Outcome
24+3	G3 P2. Fetal anatomy scan at 21+4 weeks gestation revealed multiple abnormalities including: Abnormal fetal head and 'banana' shaped cerebellum. Right sided talipes. Possible right sided renal agenesis however this was difficult to ascertain due to fetal position and an enlarged heart. The woman did not attend a number of follow up appointments due to positive Covid in the household. This did not impact on the outcome in anyway. She presented for rescan and counselling regarding continuing/terminating the pregnancy and the foetus was found to have demised already.	72 hour review showed no omissions in care.
37 weeks	G1 P0, 19 years old. Late Booker at 27 weeks from Slovakia. Antenatal diagnosis of anencephaly. Family chose to continue the pregnancy and were cared for on the Butterfly pathway.	No care omissions and some evidence of excellent care including MDT working between maternity/Butterfly Team/Forget-me-not Hospice and continuity of care from the named midwife.

Table 2 is the running total of stillbirths in 2021, including the number of cases requiring further detailed investigation, and the number of butterfly babies whose deaths were expected.

Table 2:

Stillbirths 2021			Expected deaths within total number	Further detailed investigation
Month	Number of babies	Running total	Butterfly babies	Number of cases
January	0	0	0	0
February	1	1	0	Yes- level 1
March	2	3	0	0
April	2	5	2	0

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.

The revised fetal growth guideline including management of small for gestational age babies has been widely reviewed and commented on. Roll out of the guidance commenced 1 February 2021.

Hypoxic Ischaemic Encephalopathy (HIE)

There were 0 babies requiring treatment for HIE in April.

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 0 maternity SI's declared in April.

The Ockenden report is clear that neonatal harms should also be visible at Trust Board level. This report already covers monthly neonatal harms regarding care provided during pregnancy and birth, and has not previously featured neonatal harms regarding the care received after birth. This report will now feature a brief description of any neonatal SI's declared in month, including any immediate lessons learned. It must be noted that the responsibility to escalate, investigate and action any learning, sits with the Neonatal Service and not the Maternity Service. The exception will be any case which crosses both specialties.

There were 3 Neonatal SI's declared in April.

There is 1 ongoing Maternity SI investigations which has been signed off but not yet circulated.

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.	Signed off but not yet circulated.

Neonatal SI's

<u>Date of Incident</u>	<u>Brief Description</u>	<u>Immediate Findings</u>	<u>Finalised Key Issues</u>
<u>14/04/2021</u>	28/40 infant. Emergency LSCS due to reduced fetal movements and abnormal CTG. The baby had an umbilical vein catheter (UVC) inserted for intravenous access, which is routine practice. The baby's condition deteriorated at approximately 3 ½ hours of age. Blood oozing from the UVC noted. Resuscitation measures commenced and management of haemorrhage. The baby sadly died at 3 days of age.	There may have been opportunity to give Vitamin K earlier. There was a delay and then difficulty in obtaining a non-invasive blood pressure. The attempt to insert a second UVC using a "rail-roading" technique is not recommended, but this was done after the initial event at a time where IV access was imperative. Following identification of the event, the baby	SI declared & investigation commenced

		appears to have been managed in accordance with massive haemorrhage protocols.	
07/04/2021	<p>Diagnosis of Osteomyelitis in limb where cannula inserted which is likely to impact on bone development in such a way that function of the right arm/wrist may be affected.</p> <p>Baby born at 26 +3 gestation. 9+ weeks old at the time of the incident.</p> <p>Cannula inserted in right hand to take bloods with potential for blood transfusion. Blood transfusion was not commenced but cannula not removed.</p> <p>Decision to transfuse 2 days later. Cannula still in situ but leaking therefore further cannula sited in left hand.</p> <p>2 days later, right hand noted to be red, hot, tender and tense.</p> <p>Blood cultures grew staph aureus.</p>	<p>Documentation around cannula insertion, monitoring of the site, and decisions to keep / remove the cannula were inadequate.</p> <p>There were also issues around prescribing which probably did not affect outcome.</p>	SI declared & investigation commenced
17/04/21	<p>34/40 infant born to Mum with GDM. Floppy at birth. Identified as having bilateral ventriculomegaly.</p> <p>Management being guided by Leeds neurosurgeons and baby had lumbar punctures to reduce hydrocephalus on 9th of April and 15th of April.</p> <p>Baby became meningitic and septicaemic 48 hours after a second Lumbar Puncture.</p> <p>Baby born with serious</p>	<p>Possible delay in identifying a deteriorating patient.</p> <p>Possible delay in commencing intravenous antibiotics.</p>	SI declared. Investigation commenced.

	intracranial pathology of unknown cause. He has become severely unwell due to meningitis and septicaemia, which has led to additional brain injury. Care is being re-orientated with compassionate extubation.		
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The Neonatal Team has met with the Chief Nurse and the Infection Prevention and Control Nurse Consultant to discuss the cases and agree rapid response immediate actions.

HSIB Cases

Following the Ockenden Report, all cases referred to the Health Safety Investigation Branch (HSIB) will be declared as SI's. There were no cases meeting the HSIB referral criteria in April.

Quarterly Perinatal Mortality Review Tool (PMRT) update

The quarterly PMRT report (Appendix2) has been prepared for Regulation Committee/Board to meet compliance with safety action 1 of the Maternity Incentive Scheme (MIS) year 3, and to provide assurance that the maternity and neonatal services are reviewing the deaths of all eligible babies to the required standard.

The required standard is:

- a)
 - i. All perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.

Current position: All cases to date have been reported to MBRRACE within 7 days. None of the 8 cases have been fully completed but are within timescale for completion within four months of the death.
 - ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to 15 March 2021 will have been started before 15 July 2021.

Current position: This standard has been achieved. All 73 eligible cases have been started. The current compliance is 100%.

b)

At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15 March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021.

Current position: Standard met. 77%, 51/66 eligible cases, have had an MDT review and draft report.

c)

For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trust should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions.

Current position: 86% achieved to date, 62/72 eligible cases. Monitoring will continue to ensure this is achieved within the required timescale of 15 July 2021.

d)

- i. Quarterly reports will have been submitted to the Trust Board from Thursday 1

October 2020 onwards that includes details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.

Current position: This update fulfils the requirement of the revised submission standards. Quarterly reports will continue to be provided until MIS self-declaration on 15 July 2021.

Maternity Unit Diverts

In the 2019 inspection, the CQC commented on the number of times the maternity unit 'diverted' services. Unfortunately there is no national, regional or LMS level benchmarking available which would highlight the service as an outlier.

The NHSI maternity support team have also indicated that they believe that the service 'diverts' more frequently than other organisations. In response, the service agrees that a more robust process is required to review unit diverts, which will identify any themes requiring interrogation.

Moving forwards, maternity unit diverts will be included on the dashboard to demonstrate both the trend and to provide transparency.

There was 1 unit diverts declared in April, a huge improvement on the 6 declared in March. The reason for the divert was acuity and volume of women on the labour ward, compromised by short term staffing challenges and the need to facilitate an inutero transfer to another unit, which required a midwifery escort. The divert occurred at night and although there was some redeployment of staff across the unit, this was limited due to the need to maintain safe staffing levels in other areas.

The senior midwifery leadership team met in March to review the current escalation policy and to agree how diverts are to be reviewed. The OMS programme team will also be supporting a QI piece of work to support the review. This work is ongoing.

MONTH	NUMBER OF DIVERTS	RUNNING TOTAL
JANUARY	1	1
FEBRUARY	0	1
MARCH	6	7
APRIL	1	8

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 January, relates to activity and progress during March which includes:

- New team 'Cherry Blossom' launched with a gradual format. 2 RMs being released 1 day per week each to begin to recruit women and plan the pathway. Starting with previous loss and the existing Butterfly pathway (current poor prognosis/palliative care) with the aim of including previous pre-term in the future. The name of the team was chosen with service user involvement via the MVP.
- There will be some gaps in cover for Clover team on-calls over the coming months due to shielding and upskilling. The team hope to be fully operational by the end of May and plan to recommence GGT antenatal plus sessions in July.
- Willow team are feeling the benefits of being fully staffed, staff are happy and settled in the team with good working processes. The team created a promotional video to introduce the team and remind staff to check when a Willow woman presents in labour.
- On-calls continue to be suspended for Acorn team, one team member due to return from sickness next month and the next team member to join in August which should allow the full pathway to recommence.
- Multiples team are providing 100% antenatal, postnatal and planned intrapartum continuity. They are now offering up to 6/52 postnatal care.
- Homebirth team continue to be busy as ever, caseload size exceeds 36/WTE/annum currently with the team providing day call cover for the city. Next team member to join 1 day per week from August.

TOTAL % booked for CoC in March = 25% of which 29% are from a BAME background

Maternity Theatres

Building work commenced in January, immediately revealing a technical issue of sub-main distribution cables that need to be diverted prior to the project continuing. This essential work was completed in March.

The Maternity Theatre Project Board continues to meet on a monthly basis, and any anticipated delays/challenges will be escalated at that meeting.

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.

Maternity Dashboard

Appendix 3 contains the maternity dashboard including March data.

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

- Bookings were noted to have increased in March. The trend will be observed and is possibly attributed to families who delayed pregnancy during the pandemic as noted in the decline in annual birth rate.
- The total number of births for financial year 2020/21 has shown a downward trend to just below 5,000. Local intelligence informs that neighbouring organisations noted a similar drop in birth rate, also noted at national level. It is thought that this is directly linked to the pandemic.

Due to the timing of this paper, the April maternity dashboard has not yet been updated and will be provided in the next monthly update to Quality Academy/Board.

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.

Due to the timing of this paper, the April highlight paper has not yet been prepared and will be shared in the May update paper to be presented to Quality Academy in June.

However, the April OMS Board meeting described the ongoing engagement of the team and continued progress in our transformation journey.

Maternity Cerner

The Maternity Cerner Project Board took place on 12th April and a high level of confidence was given that the project was on track and within budget. In the last month all the current state review sessions have been successfully completed and a Fetalink project event took place on 13th April. The next phase of the project will include the future state review sessions. Ongoing items under review at the moment include data migration from Medway and the possibility of using the patient portal for our women the access their own maternity records, as well as the communication strategy for the project to move towards better engagement with service users.

The next gateway is due on 28th May, this follows the end of the planning events before we begin the build. This stage looks at our readiness to move into the build process and our readiness to start thinking of future steps such as testing and training. No issues have been raised within any area.

Maternity Services Data Set (MSDS) Data Quality Action plan

In order for the service to be fully compliant with Safety Action 2 of the Maternity Incentive Scheme, we are required to submit an MSDS Data Quality action plan (Appendix 4) to the WY&H LMS Board. The data quality issues relate to 'back end' issues, not user inputting errors. The attached action plan has been reviewed and approved by the Chief Digital and Information Officer. The service asks that Regulation Committee/Board provide the necessary sign off, so that this can be submitted to the LMS Board on 14 May 2021. Submission to the LMS Board means that we will achieve compliance with this safety action in full ahead of the 15 July 2021 Maternity Incentive Scheme, Year 3 submission.

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 service is now in the 'diagnostic' phase of the support programme and 2 site visits took place in February, including attendance at the Women's Core Governance Group meeting. Verbal feedback was extremely positive.

Further site visits took place in April with more planned during May, including a visit by an external Obstetrician. The Maternity Safety Support Programme team have not yet confirmed the next steps, including when the process is likely to be complete. This information has been requested.

3.	PROPOSAL
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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
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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
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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
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The Board/Regulation Committee is asked to note the contents of the Maternity Services Update, March 2021 which was presented and approved by Quality Academy 28 April 2021.

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

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

Board/Regulation Committee is asked to acknowledge that there was no Serious Incidents (SI) declared in April in Maternity.

Board/Regulation Committee is asked to note the 3 Neonatal Serious Incidents declared in April, including the immediate lessons learned.

The Board/Regulation Committee is asked to note the quarterly Perinatal Mortality Review Tool (PMRT) position required for Maternity Incentive Scheme compliance.

The service request that Board/Regulation Committee approves the Maternity Services Data Set (MSDS) Data Quality (DQ) action plan, and agrees that it can be submitted to the West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) Board, to demonstrate compliance with safety action 2 of the Maternity Incentive Scheme.

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

7.	APPENDICES
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1. Maternity Services Update, March 2021- Appendix 1
2. Quarterly PMRT update- Appendix 2
3. Maternity Dashboard - Appendix 3
4. Maternity Services Data Set Data Quality Action Plan- Appendix 4