

Meeting Title	Quality Academy		
Date	30 June 2021	Agenda item	QA.6.21.XX

MATERNITY SERVICES UPDATE, MAY 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.		
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/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

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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 Quality Academy/Board is asked to note the contents of the Maternity Services Update, May 2021. This paper will then be presented to Trust Board for noting as an appendix to the June update.

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

Board/Quality Academy 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/Quality Academy notes the narrative on the April and May maternity dashboard.

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

Board/Quality Academy is asked to note the request for a 'deep dive' into neonatal deaths occurring in the last 12 months. This information will be presented to Board/Quality Academy as an appendix to the June Maternity Services Update paper in July.

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

Quality academy/ Board are asked to note that the organisation meets the Anaesthesia Clinical Services Accreditation (ACSA) standards for maternity services in full; therefore an action plan is not required.

Trust Board/Quality Academy is also asked to note that Neonatal services have prepared a neonatal medical and nursing workforce paper has been prepared and will be presented to the Executive Team Meeting (ETM) in June by the Chief Nurse.

Quality Academy/Trust Board are asked to acknowledge that the service has achieved full compliance

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with implementation of the Saving Babies Lives Care Bundle version 2.

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"/>

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Relevance to other Board of Director's academies: (please select all that apply)			
<input checked="" type="checkbox"/> Risk Assessment Framework	<input checked="" type="checkbox"/> Quality Governance Framework	<input checked="" type="checkbox"/> Quality Improvement Framework	<input type="checkbox"/> Other (please state)
<input type="checkbox"/> Code of Governance	<input checked="" type="checkbox"/> Annual Reporting Manual	<input type="checkbox"/> Annual Reporting Manual	<input type="checkbox"/>
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):			

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.

2	BACKGROUND/CONTEXT
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Ongoing Impact of Covid-19 pandemic on Maternity Services:

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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 also meets the recommendations in the NHSE Frequently Asked Questions relating to Maternity services and Covid, and has a process in place to request that women and their birth support partners access the government lateral flow testing scheme, and are requested to perform a lateral flow test prior to attending any routine antenatal appointments including scans.

The service continues to submit the weekly Maternity Covid SitRep to confirm the visiting and testing arrangements in place.

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 May there were 2 women, who experienced significant Covid 19 symptoms and required intensive or enhanced care. Both required early delivery to improve maternal condition and both mums and both babies are making a good recovery.

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.

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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 prepared the assurance evidence for submission to the national portal by 30 June 2021. Full compliance has been achieved and demonstrated in a number of the immediate and essential actions. The remaining areas are amber, in the majority this is due to an outstanding audit completion. All outstanding audits have been added to the 2021/22 audit schedule and will be prioritised. All outstanding actions are achievable and there are no current safety concerns.

The evidence has been reviewed and authorised by the Chief Nurse/Board Level Maternity Safety Champion and a summary of the evidence submitted will be presented to Executive Team Meeting before the portal closes on 30 June.

The service are awaiting the outcome of the 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. This has been delayed due to a national request for further information from Trust's to support the bid applications. BTHFT have clarified and submitted the additional information requested.

One of the Ockenden recommendations is that Trusts should fully implement a revised Perinatal Quality Surveillance Model by June 2021. To be compliant with implementation of this model, Quality Academy/Trust Board will note that there are a number of new additions to this paper to fulfil the minimum data measures that Trust Boards are expected to have an overview of. The minimum data measures have been populated and can be viewed in Appendix 1.

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 of which the first stage of completion is expected by 24 December 2021. 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 (Appendix 2) is reviewed as a minimum, 4-6 weekly by the Director of Midwifery, Clinical Director and Risk and Governance Lead Midwife.

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The action plan was updated in May 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 action plan has also been refreshed to include the Ockenden assurance actions and outstanding actions from Serious Incidents (SI's) and a national benchmarking tab.

Stillbirth position:

There was 1 stillbirth in May. A 72 hour review has been completed and a clinical review in progress.

Table 1 is the summary of cases occurring in May.

Gestation	Summary	Outcome
28/40	Primigravida. BMI 17 referred for shared care. UTI in early pregnancy treated and repeat MSU sent and was normal (notable practice). Attended routine midwife appointment at 28 weeks reporting reduced fetal movements. Referred to MAC and IUD confirmed. Baby FGR <1st centile. No omissions in care which would have changed the outcome	72 hour review showed no omissions in care.

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
May	1	6	0	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.

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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 May.

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 May.

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 0 Neonatal SI's declared in May.

There are no ongoing Maternity SI investigations.

Ongoing Neonatal SI's

Table 3:

<u>Date of Incident</u>	<u>Brief Description</u>	<u>Immediate Findings</u>	<u>Finalised Key</u>
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			<u>Issues</u>
14/04/2021	<p>28/40 infant.</p> <p>Emergency LSCS due to reduced fetal movements and abnormal CTG.</p> <p>The baby had an umbilical vein catheter (UVC) inserted for intravenous access, which is routine practice.</p> <p>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.</p> <p>The baby sadly died at 3 days of age.</p>	<p>There may have been opportunity to give Vitamin K earlier.</p> <p>There was a delay and then difficulty in obtaining a non-invasive blood pressure.</p> <p>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.</p> <p>Following identification of the event, the baby appears to have been managed in accordance with massive haemorrhage protocols.</p>	SI declared & investigation commenced
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</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

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	<p>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>		
17/04/2021	<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 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.</p>	<p>Possible delay in identifying a deteriorating patient.</p> <p>Possible delay in commencing intravenous antibiotics.</p>	<p>SI declared. Investigation commenced.</p>

Neonatal Deaths

The June 2021 bi-monthly Maternity Safety Champion meeting noted an increase in the number of neonatal deaths reported in April and May 2021, 7 in total. All babies have been robustly reviewed through the Perinatal Mortality Review Tool (PMRT) process, but it was agreed that a 'deep dive' and

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thematic review of neonatal deaths occurring in the last 12 months should be undertaken. It was also agreed that following the 'deep dive', the neonatal team should agree an escalation to Board trigger in the same way as the maternity service escalates monthly stillbirths.

The 'deep dive' will be included as an appendix to the June 2021 Maternity Services Update paper, and a member of the Neonatal team will attend Board/Quality Academy to answer any executive and non-executive questions regarding the information.

HSIB Cases and Progress in achieving Maternity Incentive Scheme Safety Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

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 May.

The service can confirm that all eligible 2019/20 births were reported to NHS Resolution's Early Notification Scheme.

HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with the Trust:

The implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

The service can confirm that there have been no such requests to date this year.

Coroner Regulation 28 made directly to Trust

Again, the implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

The service can confirm that there have been no such requests to date this year.

Maternity Bi-Monthly Safety Champion meetings:

The Board and Trust level Maternity Safety Champions met in April and June meeting notes are attached as Appendices 3 and 4. There were no areas of concern for escalation to Board in April and the deep dive into neonatal deaths as previously mentioned is the only escalation from the June meeting.

Monthly staff feedback from Safety Champions and walk-rounds:

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The Board level Maternity Safety Champion walked round the unit in May and had an overwhelmingly positive response from staff with no safety concerns requiring escalation to the Board raised. Staff in the Maternity Assessment Centre (MAC) demonstrated particular enthusiasm in relation to the launch of the Birmingham Symptom Specific Obstetric Triage (BSOTS) process which is due for formal launch in June. The Board champion was particularly pleased to note that staff articulated that the reason for the change was as a direct result of lessons learned from a recent level 1 investigation and the last maternity SI.

Staff Survey:

The implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on the number of midwives who would recommend the organisation as a place to work or receive treatment is an annual minimum data measure for Trust Board overview.

The 2020 breakdown of staff survey results does not detail response by staff group; therefore it is not possible to report on the number of midwives. 68% of staff responding would recommend BTHFT as a place to work and 82% of staff responding would be happy for a family member or friend to receive treatment here.

Specialty Trainee survey:

The implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations also asks for an annual report of the number of speciality trainees who respond with 'excellent or good' on how they would rate the quality of clinical supervision out of hours.

The 2020 survey results will be reviewed and presented in the June paper.

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 divert declared in May due to increased activity and acuity of cases. However, although divert was declared, no neighbouring units were able to accept any women on our behalf, therefore we

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remained open to new admissions. There were no reported incidences of harms during the time that the unit declared the need to divert, and as yet, no complaints received relating to that time period.

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.

Table 4 is the running total of diverts to date.

Table 4:

MONTH	NUMBER OF DIVERTS	RUNNING TOTAL
JANUARY	1	1
FEBRUARY	0	1
MARCH	6	7
APRIL	1	8
MAY	1	9

Continuity of Carer (CoC) 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.

Abbie Wild, Specialist Midwife for Continuity of Carer, will be leaving her post to commence her role as Project Lead for the Better Births strand of the Act as One programme. The service wishes to formally acknowledge Abbie for her passion, leadership and commitment to supporting the CoC agenda at BTHFT and we look forward to working with her during her seconded post.

Her departure coincides with the end of the LMS funding for the specialist midwife post. The service is currently awaiting the outcome of the national maternity funding bid before seeking vacancy approval for a replacement post. In the interim, an individual will be identified to continue the reporting elements of the role and further CoC pathway development will be picked up through the Outstanding Maternity Services (OMS) programme.

The report relates to activity and progress during May which includes:

- iPiP CoC training completed and was well attended with representation from all areas of maternity.
- Willow team continue to work well, achieving a good level of intrapartum CoC and report good teamwork and a strong level of commitment to the team. Willow continues to find the lack of admin support a barrier and a challenge.
- The homebirth team have had an unusually quiet month but probably a welcome relief for them!

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- Cherry Blossom are continuing to recruit women to the caseload slowly. One of the midwives planning to be in the team has been successful in being recruited to the Specialist Bereavement Midwife post and will start next month. Although this leaves a gap in the team it will be great to have a midwife who is passionate about continuity to lead the team.
- Clover team recommenced on-calls at the end of May and are in a good position, feeling upskilled and ready to provide intrapartum care.
- Acorn team are on track to recommence on-calls from September.
- A meeting was held to discuss the barriers leading to births missed by Amber team. This was a productive meeting and the team have already reported an increase in levels of intrapartum CoC.

TOTAL % booked for CoC in May = 24% of which 36% 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 build remains on target and the first stage is due for completion on 24 December 2021.

The service is preparing a risk assessment in relation to the loss of labour rooms between August and December and the impact that this will have on service delivery.

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 5 contains the maternity dashboard including April and May data. April data is included as it was unavailable at the time of the April update to Board, presented in May. A narrative/numerical dashboard is also provided (Appendix 6).

The metrics reported on the April and May dashboards continue to demonstrate consistently positive outcomes. There are currently no areas of significant concern to report.

- Stillbirths continue to demonstrate a positive downward annual trajectory. Of note there have been 6 stillbirths to date compared to 13 in the same time period last year. In addition there have been 2 stillbirths at term compared to 5 in the same period last year. 1 of the 2 this year was to a woman who had care in another organisation.

Training Compliance

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The revised Perinatal Quality Surveillance Model minimum data set for Trust Board's, requires oversight of the training compliance of all staff groups in maternity related to the core competency framework and wider job essential training.

The service will work with Business Intelligence colleagues, to look at a comprehensive way for this to be shared at Board level as an appendix to this paper.

For the purpose of this report, the service can report that they remain on trajectory to exceed 90% of all staff groups in receipt of multi-disciplinary emergency maternity training. The 90% denominator previously required for Maternity Incentive Scheme compliance has been removed for this year, and we are proud that we have maintained this standard which will no doubt resume next year.

The service can also report an improved position with level 3 safeguarding compliance, achieving over the 85% target.

The service is experiencing challenges with the percentage of staff compliant with collecting blood, organising receipt of blood and preparing to administer blood competencies. This is monitored through the monthly Women's Clinical Business Unit (CBU) Business meeting and managed by the ward and department managers. A recovery plan for mandatory training compliance which falls below the acceptable standard is in the process of being written.

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

The Women's Journey

- BSOTS planning and training completed
- Perinatal Mental Health Pathway work progressing
- Business case in progress for Diabetic Pathway resource requirements re nursing, dietetics and Gestational Diabetes Mellitus (GDM) health app funding

Investing In Our Workforce

- Revised Labour Ward handover in place
- Wellbeing sub group initiated

A Building Fit For The Future

- The Perfect Labour Room setup
- 15 steps for M4 completed

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Moving to Digital

- “ The Perfect Clinic Room” complete
- Obstetric Website development underway
- Workforce survey distributed to understand current training gaps relating to Cerner
- Cerner project Testing phase
- Linking Learning and Quality Through Our Information
- Digital platform has a firm foundation to build upon
- Survey to understand learning preferences has been circulated
- Datix access has been provided for all consultants and coordinators

Service User Feedback

Positive engagement continues with our local Maternity Voices Partnership with another ‘15 steps’ review undertaken in Labour Ward during April. The Labour Ward team reviewed the feedback and have made positive alterations to the physical environment during May and early June, including the layout and less clinical appearance of the labour rooms.

Maternity Cerner

The Maternity Cerner Project Board meets monthly and have to date agreed a high level of confidence that the project is on track and within budget. All criteria was met to pass through the gateway on 28th May, this confirmed our readiness to move into the build process and our readiness to start thinking of future steps such as testing and training.

The project team are currently undertaking a 10 week programme of data collection workshops. The Training team is engaged and the training approach is under development. The team has recently welcomed a Project Test Manger who is progressing the test approach strategy. Fetalink, the electronically stored Cardiotocograph (CTG) module project is progressing well.

The patient portal forms part of the Healthy Life project, they are currently looking to simplify the registration process enabling women to sign up to the patient portal to access their own maternity records and support us in sending out pregnancy and parenting information and personalised care plans. Cerner report that good progress is being made with the offline mode functionality, not just for the Maternity module, but the system as a whole.

Regular communication work stream meetings are ongoing to ensure timely delivery of comms to our staff within the maternity service, the wider Trust and to women and service users.

It has been agreed that quarterly progress and achievement reports will be provided to the Trust Board via the Quality Academy.

NHSI Maternity Safety Support Programme

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Date	30 June 2021	Agenda item	QA.6.21.XX

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.

The Consultant Obstetricians had a very positive virtual meeting with the external Obstetrician specialist advisor, who complemented the team on the progress made. 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.

Maternity Incentive Scheme Year 3:

The Maternity Incentive Scheme, Year 3, self-declaration form is due for sign off and submission by 12 noon on Thursday 15 July 2021. A paper confirming the final position and any outstanding evidence required prior to submission will be presented to ETM on 12 July and Regulation Committee on 13 July.

As part of the submission evidence, Quality academy/Trust Board are asked to note appendix 7 which demonstrates that the organisation meets the Anaesthesia Clinical Services Accreditation (ACSA) standards for maternity services in full, therefore an action plan is not required.

Trust Board/Quality Academy is also asked to note that Neonatal services have prepared a neonatal medical and nursing workforce paper has been prepared and will be presented to ETM in June by the Chief Nurse.

Appendix 8 provides Quality Academy/Trust Board with the assurance that the service has achieved full compliance with implementation of the Saving Babies Lives Care Bundle version 2.

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.

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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 Quality Academy/Board is asked to note the contents of the Maternity Services Update, May 2021. This paper will then be presented to Trust Board for noting as an appendix to the June update.

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

Board/Quality Academy 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/Quality Academy notes the narrative on the April and May maternity dashboard.

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

Board/Quality Academy is asked to note the request for a 'deep dive' into neonatal deaths occurring in the last 12 months. This information will be presented to Board/Quality Academy as an appendix to the June Maternity Services Update paper in July.

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

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Quality academy/ Board are asked to note that the organisation meets the Anaesthesia Clinical Services Accreditation (ACSA) standards for maternity services in full, therefore an action plan is not required.

Trust Board/Quality Academy is also asked to note that Neonatal services have prepared a neonatal medical and nursing workforce paper has been prepared and will be presented to ETM in June by the Chief Nurse.

Quality Academy/Trust Board are asked to acknowledge that the service has achieved full compliance with implementation of the Saving Babies Lives Care Bundle version 2.

7.	APPENDICES
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1. Perinatal Quality Surveillance Model Minimum Data Sets for Trust Boards- Appendix 1
2. Maternity Improvement Plan- Appendix 2
3. Bi-Monthly Maternity Safety Champions meeting notes April 2021- Appendix 3
4. Bi-Monthly Maternity Safety Champions meeting notes and action log June 2021- Appendix 4
5. Maternity Dashboard- Appendix 5
6. Maternity Narrative Dashboard- Appendix 6
7. ACSA Compliance- Appendix 7
8. SBLCB Survey- Appendix 8