

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

MATERNITY SERVICES UPDATE – JUNE 2021

Presented by	Sara Hollins, Director of Midwifery		
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 Regulation and Assurance Committee/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 May. Due to the timing of this paper, the next update will be provided in the July paper. The 'must, should, could' do actions and recommendations are summarised on the first page of the overarching

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

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 Regulation and Assurance Committee/Board is asked to note the contents of the Maternity Services Update, June 2021.

Regulation and Assurance Committee/Board is asked to note the contents of the May 2021 Maternity Services Update (appendix 1) presented and discussed at May Quality Academy.

Regulation and Assurance Committee/Board is asked to note that the Ockenden Assurance evidence was successfully submitted to the national portal by the 30 June deadline.

Board/Regulation and Assurance 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 and Assurance Committee notes that due to the timing of the monthly paper the narrative on the June maternity dashboard is not available and will be presented in the July update.

Board/Quality Academy is asked to acknowledge that there was 1 HSIB Serious Incident (SI) declared in June in Maternity.

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

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"/>

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

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

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

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. 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 Regulation and Assurance Committee/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.

Appendix 1 is a copy of the May Maternity Update presented to Quality Academy in June. Regulation and Assurance Committee and Trust Board are asked to note the contents.

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 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.

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

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 June 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 can confirm that the Ockenden assurance evidence was submitted to the national portal by the 30 June deadline. This is now being reviewed by the Regional Chief Midwifery Officer's team. The West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) have also acknowledged the submission and commented on the quality and comprehensive structure of the submission.

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.

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

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 as a minimum, 4-6 weekly by the Director of Midwifery, Clinical Director and Risk and Governance Lead Midwife.

The action plan was last updated in May and significant progress has been made. Due to the timing of this paper, the next update will be provided in the July paper. 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 were 2 stillbirths in June. . A 72 hour review has been completed for the Butterfly baby and is in progress for the 2nd case and a clinical review in progress.

Table 1 is the summary of cases occurring in June.

Gestation	Summary	Outcome
26+2/40	Antenatal diagnosis of megacystitis Mum cared for on the Butterfly pathway. Presented with no fetal heart.	72 hour review showed no omissions in care.
34+6/40	A 44 year old presented with RFM, PET and an IUD at 34+6. At booking a plan was made for serial growth scans and delivery at term due to history of a previous LSCS for abnormal dopplers at 33weeks, she was also commenced on aspirin. She was diagnosed with GDM and was commenced on metformin. The last scan following 2 admissions for RFM showed normal growth with EFW between 10-20th centile. At 35+1 a female infant delivered stillborn.	72 hour review in progress. No obvious omissions in care evident from the review of the timeline.

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

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

March	2	3	0	0
April	2	5	2	0
May	1	6	0	0
June	2	8	1	0

Ongoing actions to address the stillbirth rate

The Service has achieved full compliance with implementing all 4 elements of the Saving Babies' Lives Care Bundle, Version 2, confirmed by the Yorkshire and Humber Clinical Network following submission of the latest survey. The improved identification and management of small for gestational age babies continues through the Outstanding Maternity Service (OMS) programme transformational work stream.

Hypoxic Ischaemic Encephalopathy (HIE)

1 baby was treated for HIE in June. This was a term baby who was born via category 1 caesarean section following massive obstetric haemorrhage. The baby had a normal MRI scan and was discharged home with mum after a few days. The case was referred to HSIB but declined as it did not meet the clinical criteria. However, this case is now being investigated by HSIB as an SI due to parental concerns raised.

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 was 1 maternity SI declared in June and reported on STEIS and notified to the LMS and CCG. This was the HIE baby reported previously. A 72 hour review of the care found no omissions in care. Indeed, the management of the obstetric haemorrhage demonstrated positive learning for both the obstetric and neonatal teams, including prompt recognition and response and early blood transfusion for the baby.

HSIB declined the case on clinical grounds as it did not meet the criteria. However, the family raised some concerns regarding antenatal care which they believe if managed differently, may have prevented the emergency situation. The case is now being investigated as an SI under the HSIB framework.

Table 3: Ongoing Maternity SI's:

Date of Incident	Brief Description	Immediate Findings	Finalised Key Issues
June 2021	G5 P5 (Twins) 40 weeks. Smoker. Induction of Labour due to previous LSCS	72 hour review of care found no obvious omissions in either the antenatal or induction	HSIB investigation in progress

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

	for twins in last pregnancy. Major obstetric haemorrhage occurred during routine artificial rupture of membranes procedure. Vasa praevia confirmed at emergency caesarean section. Baby cooled. Normal MRI scan. Discharged home with mum a few days later.	period. Examples of excellent team work and prompt recognition of the Vasa praevia leading to early blood transfusion for the baby. Case referred to HSIB, duty of candour completed. HSIB declined as did not meet the criteria. However, parents have raised some queries/concerns regarding earlier antenatal contacts and HSIB are investigating these on their behalf.	
--	---	---	--

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 features 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.

It also includes the number of Neonatal Deaths (NND) in month and brief description.

There were 0 Neonatal SI's declared in June.

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

Ongoing Neonatal SI's

Table 4:

<u>Date of Incident</u>	<u>Brief Description</u>	<u>Immediate Findings</u>	<u>Finalised Key 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.</p> <p>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>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</p>	SI declared & investigation commenced

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

	<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>	affect outcome.	
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>	SI declared. Investigation commenced.

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

Neonatal Deaths (NND)

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 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 July 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.

There was 1 NND in June. This was a baby born in Calderdale at 36 weeks and transferred to BTHFT Neonatal Unit following an unexpected collapse/probable sepsis. Sadly the baby died 8 hours after admission to the neonatal unit. The case has been referred to the coroner.

Table 5 includes the number of NND by month including babies expected to die and any further investigation required.

Table 5:

NND 2021			Expected deaths within total number	Further detailed investigation
Month	Number of babies	Running total	Extreme preterm/congenital anomalies/life limiting conditions	Number of cases
January	2	2	Not available	
February	2	4	Not available	
March	1	5	Not available	
April	5	10	Not available	3 SI's
May	4	14	Not available	
June	1	15	0	0

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 was 1 HSIB case in June as already discussed.

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

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

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 June. 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:

The June Floor to Board Level Maternity Safety Champion meeting was held virtually and included representatives from maternity and neonatal services.

Staff from the Birth Centre raised an issue regarding a lack of working sonic aids to be actioned by the Matron for the area with medical electronics.

Neonatal Unit staff raised concerns about the current location of the isolation room and a lack of electrical plug socket points. The staff is asked to complete a risk assessment tool, including any mitigation in place to escalate through the CBU governance process.

A further safety escalation occurred outside of the planned meeting in June, providing assurance that the mechanisms for staff to escalate concerns are known and embedded. The concern is in relation to challenges maintaining social distance in the antenatal clinic/MAC waiting area and reduced visibility of women waiting due to pods. A risk assessment of the area has again been requested and will be managed through the CBU governance process.

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 have not yet been reviewed and will be presented in a future paper.

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

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.

Table 4 has been amended to reflect that the service did not divert in May, although an attempt was made.

There was 1 divert declared in June due to increased activity and acuity of cases and a further attempted divert, again due to increased acuity and activity with no neighbouring units in a position to accept Bradford women. 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:

MONTH	NUMBER DIVERTS	OF	NUMBER ATTEMPTED DIVERTS	OF	RUNNING TOTAL
JANUARY	1		X		1
FEBRUARY	0		X		1
MARCH	6		X		7
APRIL	1		X		8
MAY	0		1		8
JUNE	1		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. The LMS funded

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

role came to an end in May and coincided with the post holder securing a secondment with the Better Births, Act as One programme.

This leaves a current reporting gap which will be picked up temporarily by the Matron for Community Services and the OMS team. Data for June is not available at the time of this report and will be included in the July update.

The LMS have since committed to funding a further continuity of carer post for 12 months, which is out to advert and due to close in early July.

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. Progress with the build remains on track.

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

Due to the timing of this paper the Maternity Dashboard has not yet been updated to include June data. This will be presented with the July dashboard data in the subsequent monthly update.

Training Compliance

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.

Appendix 2 is a copy of the compliance for PROMPT MDT emergency training and Trust Mandatory sessions.

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:

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

- 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 launched
- Midwife pre triage process trialed
- Diabetic Pathway sub group launch
- Perinatal Mental Health Pathway work progressing
- Business case in progress for Diabetic Pathway resource requirements re nursing, dietetics and GDM health app funding

Investing In Our Workforce

- Midwifery Workstream Lead role filled – Easher Quinlan
- Staff survey task and finish group launched
- Vision shared with new Head of OD
- Labour Ward Proud Cloud launched
- Exit interview proposed process has been reviewed by all managers

A Building Fit For The Future

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

Moving to Digital

- "The Perfect Clinic Room" complete
- Midwifery Workstream Lead role filled – Gemma Sykes
- Obstetric Website development underway
- 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

Update on the 'culture' in the Maternity Unit:

The service has been requested by Regulation and Assurance Committee to provide an update regarding the current 'culture' within the maternity unit.

Staff behaviours, working effectively together and promoting a positive culture are central features of the OMS, 'Investing in our workforce' work stream. Representatives from a variety of staff groups are working together to improve staff morale and well-being. There has been an extremely positive response from staff self-nominating to become 'well-being champions' for their clinical areas.

Staff remain engaged with the OMS programme and are embracing the resulting changes including:

- Launch of BSOTS

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

- Improved Labour Ward Handover
- Labour Ward 'Proud Cloud'

A recent 'Floor to Board' maternity safety champion walk round demonstrated that staff are able to directly link service change and development to lessons learned from clinical incidents and poor outcomes. This shows a level of maturity and learning from incidents that did not previously exist within the unit.

Other examples of how the culture has improved over the last 12-18 months include:

- Sustained rate of 1:1 care in labour, driven by the labour ward co-ordinators
- 100% compliance with administration of the Tommy's fetal movement leaflet
- Staff have embraced the opportunity to refresh skills in symphysis fundal height measurement and are following the revised guideline
- The last 2 points are contributory factors in the improved monthly stillbirth position

Service User Feedback

Further '15 steps' reviews are scheduled over the coming months and the service continues to address feedback provided in the reviews already undertaken.

There have not been any issues or concerns raised by the Maternity Voices Partnership during June.

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.

Key Products Delivered

- Current/Future State Review sessions
 - Week 10 of the data collection workshops completed.
- Testing:
 - Testing approach/strategy is being reviewed with Cerner, ready for Project Board presentation on 5th July.
- Training:
 - Training Approach ready for Project Board presentation on 5th July.
- Archiving and Data Migration workstream.
 - Server creation completed.
 - Medway show-and-tell session completed.
 - Timeline planning in progress to align with overall project plan.
- Reporting:
 - Investigation of existing maternity related reports underway.
 - Timeline planning in progress to align with overall project plan.
- Fetalink
 - Procurement exercise starting for the CTG Carts.
 - Pending network configuration setup prior servers being installed.
 - Data Collection Worksheets being progressed.

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

- Communication
 - Plans continue, moving to development of webpages and 'Ask Mary' (FAQ's and posting queries etc..)
- Validation gateway under review and being progressed.

Key Products Not Delivered

- None

A detailed update will be presented to Quality Academy in September.

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 service is preparing for a final site visit with the Maternity safety Support Programme team in August when it is anticipated that we will exit the programme. To date, there have been no actions that we have been asked to address.

Maternity Incentive Scheme Year 3:

The Maternity Incentive Scheme, Year 3, self-declaration form is due for sign off and submission by the recently revised date of 12 noon on Thursday 22 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.

It is anticipated that full compliance with all 10 safety actions will be declared, subject to neonatal medical and nursing staffing papers being approved by ETM on 12 July.

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.

Meeting Title	Regulation and Assurance Committee		
Date	13.07.21	Agenda item	RC.7.21.11a

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
-----------	------------------------

7.	APPENDICES
-----------	-------------------

1. Appendix 1 Maternity Services Update, May 2021
2. Appendix 2 Mandatory Training 06.07.21