

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

MATERNITY SERVICES UPDATE – AUGUST 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	To note		
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.

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

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 July and was submitted as an appendix to the July Maternity update paper. Due to the timing of this paper, the next update will be provided in the September paper. 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

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)						

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

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:	
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 checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

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:

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	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

The Regional Chief Midwifery Officer's team have also requested that a daily maternity sitrep be returned to them Monday to Friday, to capture the current pressures faced by maternity services in the North East and North West, including unit escalations, staffing pressures, neonatal unit status and delays in care. This process commenced in late July and continued throughout August. Review of the West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) demonstrates that Bradford is not an outlier and is facing the same capacity, demand and staffing challenges as neighbouring organisations at the present time.

A daily LMS Heads and Directors of Midwifery call was initiated in August, in order that the 6 organisations have an overview of the challenges faced within the LMS and are able to consider any mutual support which can be offered.

An increase in the number of Covid positive women accessing maternity services continued during August with a small number of women requiring intensive care or care on the main hospital site.

The service has responded to the national information that 58% of the pregnant population are unvaccinated, by increasing public awareness of the importance and benefits.

The service collaborated with Bradford District Care Trust colleagues during August and launched a series of 'pop up' maternity vaccination clinics within the Women's and Newborn unit. This has meant that pregnant women, new mums, partners and other family support members have been able to have the vaccination in a maternity setting, with midwives and obstetricians available to answer any questions or concerns and provide reassurance that the vaccine is safe to use in pregnancy and the postnatal period.

This approach attracted local and national interest, including other organisations approaching us for information in how to establish a similar service.

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.

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.

Covid-19 related sickness and absence remained high during August, compounded by peak holiday season. The service saw a positive response to the Trust wide enhanced pay rates. Staffing gaps have been managed daily by the Matron's and maternity bed managers, redeploying staff within the unit where required, utilising non-clinical/specialist midwives to support in clinical areas, closing beds to maintain safe staffing ratios in all areas.

In direct response to staff concerns regarding the safety of the unit out of hours, the senior leadership team have provided on call back up to the existing senior midwife on call rota. The Bed Manager role has also been extended to include weekends and bank holidays on a TNR basis, to provide support with flow and staff redeployment which usually falls to the labour ward co-ordinator. This has been well received and will continue as a pilot for 3 months.

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

Ockenden Report of Maternity Services at Shrewsbury and Telford NHS Trust

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

The service 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. No further feedback has been received during July.

As a direct result of the Ockenden report, the Government pledged a significant financial commitment to improve midwifery and obstetric staffing and multi-disciplinary training, to improve safety within maternity services. Following the national submission in May, the service have now been informed that they have been awarded national funding for:

1.9 Whole Time Equivalent (WTE) Consultant Obstetricians.
33.6 WTE Midwives.

The Regional Chief Midwifery Officer informed that the National team had acknowledged that Bradford was receiving support from the NHSE/I Maternity Safety Support Programme, and the levels of social deprivation, vulnerabilities and large BAME communities accessing care.

The Director of Midwifery and senior team are considering a variety of strategies to recruit the increase to the midwifery establishment. This includes international recruitment, special interest posts; return to practice incentives.

A further Birth Rate Plus report and recommendations has also been submitted to September Board.

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	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

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 now incorporates the Ockenden assurance actions and outstanding actions from Serious Incidents (SI's) and a national benchmarking tab. It 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 reviewed in early August and submitted as an appendix to the July Maternity update paper. The next updated plan will be shared with the September paper.

Stillbirth position

There were 5 stillbirths in August which triggered the agreed escalation process, including a table top review of the cases. There is continued delay in completion of the 72 hour reviews at the present time due to increased sickness and absence within the consultant body. This is a short term pressure and there is a plan in place to improve. However, all 5 cases have had a thorough review and timeline completed by a member of the maternity risk and governance team, with all now having had a completed 72 hour review. The cases have been discussed collectively as a table top review and the findings/learning will be presented at the October speciality governance meeting.

Thematic review of the 5 cases revealed no commonality, with the exception that the reason for presentation to hospital for 4 of the 5 women was reduced fetal movement. The 5 cases were distinctly different, with no emerging themes or trends. The table below describes the cases and immediate lessons learned.

Table 1 is the summary of cases occurring in August.

Gestation	Summary	Outcome
29+4	G1 P0, low risk pregnancy, 29+4 weeks. Presented with 1 st episode of reduced fetal movements. Appropriate antenatal care and management, she was given written and verbal information regarding fetal movements. There was normal growth velocity on her symphysis fundal height chart. Baby just above 10 th centile.	No omissions in care
36+5	G1 PO, Continuity of Carer pathway, presented with reduced fetal movements. She had been found to have gestational proteinuria with normal BP and U&Es during pregnancy but found to have a raised ALT when she presented with the IUD. She had received the Tommy's leaflet in Urdu and had presented previously to MAC with reduced movements which had prompted growth scans. Two growth scans showed normal growth, lv and dopplers with growth just below the 50th centile. She did have another departmental scan to confirm the IUFD and this showed growth just	Immediate learning: Her second PCR result was not escalated to a doctor by the midwife checking it, it showed a level that was increasing and should have been discussed with a doctor. Action: Consider developing a gestational proteinuria care pathway to ensure consistent care.

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

	<p>above 10th centile which corresponded very closely to the birthweight of the baby. This shows that there was likely fetal growth restriction and with the presence of gestational proteinuria and the finding of raised LFTs then pre-eclampsia does need to be considered despite normal blood pressures. Overall her gestational proteinuria was managed well with a plan for regular blood pressure measurements. Placental histology result may provide more clarity.</p>	Continue to progress the business case for PLGF testing
34+3	<p>G6 P3, presented with a history of no fetal movements for 48 hours. Covid positive on admission.</p> <p>2 previous term deliveries where both babies were small for gestational age and then a LSCS at 31 weeks for severe fetal growth restriction where the baby weighed only 800g. This pregnancy had been managed at another hospital with input from fetal medicine.</p> <p>This pregnancy she was not commenced on Aspirin, our guideline states Aspirin should be started if evidence of previous placental insufficiency on placental histology. She had delivered in another hospital and we did not have immediate access to information including a placental histology result. There was sufficient evidence to assume that there had been placental insufficiency where an 800g baby was delivered at 31 weeks and Aspirin should have been commenced by the Obstetrician though this would have been after the optimal time as she would have been >16 weeks gestation. There also should have been an attempt to gain further information from the previous hospital as placental histology results would have guided pregnancy management.</p> <p>Her growth scans did show normal growth velocity just above the 10th centile, she was given written and verbal information regarding fetal movements. Uterine artery dopplers were requested as were scans starting from 24 weeks. It should also be acknowledged that this woman was found to be covid positive from a swab performed on the admission where she diagnosed with an IUFD and this may have had a role in the outcome for this pregnancy. Placental histology will be key for determining the cause for this stillbirth.</p>	<p>Immediate lessons learned/recommendations:</p> <ul style="list-style-type: none"> • Discussions should be held regarding consideration of changing the Aspirin risk assessment to include a category for women who have had previous severe fetal growth restriction requiring preterm delivery in the absence of a placental histology result. • Women with a previous history of severe fetal growth restriction requiring preterm delivery should be seen at 12 weeks gestation for a consultant newside

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

32+5	<p>G2 P1, MCDA twin pregnancy confirmed at 12 weeks. Continuity of care under the multiples pathway.</p> <p>Twin to Twin transfusion identified at 22 weeks. Appropriately referred to Leeds fetal medicine in first instance prior to undergoing laser ablation in Birmingham.</p> <p>Care returned to BTHFT at 27 weeks. Appropriately managed with fortnightly growth scans and dopplers.</p> <p>Scan and Doppler at 30 weeks within normal limits. Attended at 32 weeks as planned, unexpected death of twin 1 identified on routine scan. Twin 2 well, but reduced liquor. Delivery options discussed and agreed for planned caesarean section following steroids and magnesium sulphate for the surviving twin. Section at 32+5 as planned.</p>	<p>72 Hour review delayed but now completed.</p> <p>No omissions in care identified.</p> <p>Appropriate management of multiple pregnancy, prompt identification and referral following diagnosis of twin to twin transfusion.</p> <p>Appropriate scan and Doppler regime following laser ablation.</p>
28+5	<p>G2 P1, previous SGA baby, previous emergency LSCS for hypertension. Risk assessment at booking correctly triggered need for aspirin but did not recognise the need for serial growth scans and umbilical artery dopplers.</p> <p>Further missed opportunities to identify placental insufficiency as estimated fetal weights were not plotted following growth scans which would have identified a baby below the 3rd centile.</p> <p>Attended routine antenatal appointment at 28+5 days. Reported normal fetal movements. Unable to auscultate fetal heart. Scan confirmed IUD.</p> <p>Normal delivery of stillborn baby weighing 400g.</p>	<p>72 hour review delayed but now completed.</p> <p>Immediate learning/recommendations:</p> <ol style="list-style-type: none"> 1. Risk assessment at every clinical encounter using appropriate tools including SBLV2 (risk assessment tool at booking and at anomaly scan). 2. Develop an EFW chart in values for gestations between 18 and 20+6 weeks to enable sonographers to accurately assess growth at anomaly scan. 3. Review communication tool to ensure timely commencement and continuation of aspirin supply when indicated. 4. Review local process on documentation and description of examination of stillborn foetus at birth. <p>Case referred to QUOC</p>

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

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
June	2	8	1	Yes- level 1
July	1	9	0	0
August	5	14	0	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)

There were no babies treated for HIE in August.

Serious Incidents (SIs)

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 one maternity SI declared in August and reported on STEIS and notified to the LMS and CCG. This was a postnatal woman who was admitted to A&E. There was a delay in recognising and treating sepsis and the woman required a hysterectomy.

There are two ongoing maternity SIs.

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

Table 3: Ongoing Maternity SIs:

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 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.	72 hour review of care found no obvious omissions in either the antenatal or induction 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.	HSIB investigation in progress
July 2021	This was a term baby, low risk pregnancy and birth, born on the birth centre in poor condition following vaginal birth. Transferred to neonatal unit for cooling and noted to be fitting.	72 hour review completed and identified a possible failure to correctly manage slow progress during the first stage of labour. Delay in commencing CTG after identifying bradycardia. Neonatal crash team not called in a timely way. Duty of candour completed. The case has been referred and	HSIB investigation in progress

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

		accepted by HSIB, declared as an SI on STEIS. The LMS and CCG have been notified.	
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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 no neonatal SI's declared in August.

Ongoing Neonatal SIs

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. Resuscitation measures commenced and management of haemorrhage.</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</p>	<p>SI declared & investigation commenced</p> <p>Extension agreed</p>

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

	The baby sadly died at 3 days of age.	was imperative. Following identification of the event, the baby 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>	<p>SI declared & investigation commenced</p> <p>Extension agreed</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</p>	<p>Possible delay in identifying a deteriorating patient.</p> <p>Possible delay in commencing</p>	<p>SI declared. Investigation commenced.</p> <p>Extension</p>

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

	<p>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>	intravenous antibiotics.	agreed
07/2021	The laboratory issued the wrong fresh frozen plasma (FFP) for a neonate and the neonatal unit did not identify that it was incorrect and proceeded to transfuse. Most of the actions are with Transfusion although there was some education / guideline modification.		Investigation completed and written but not yet submitted.

Neonatal Deaths (NND)

There was one NND in August of a 21 week gestation baby who lived for a couple of hours

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	

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

March	1	5	Not available	
April	5	10	Not available	3 SI's
May	4	14	Not available	
June	1	15	0	0
July	3	18	3	0
August	1	19	4	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 were no HSIB reportable cases in August.

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 and Neonatal Bi-Monthly Safety Champion meetings

The Maternity and Neonatal safety champions met in August. Meeting notes and action log are attached as Appendix 1 for information. The group agreed that there were no issues requiring escalation to Board. The action log acknowledges the delay in completing 72 hour clinical reviews as already highlighted within this paper, and the plans in place to resolve this. The culture on the neonatal unit was also discussed and the action was to extend the membership of the safety champion group to a neonatal nursing colleague, in order that this group are represented.

The August meeting was the final meeting attended by Non-Executive Director (NED), Selina Ullah. The service would formally like to recognise and thank Selina for her support and contribution to the

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

maternity and neonatal safety agenda. We are delighted to welcome Jon Prashar as the incoming NED safety champion.

Monthly staff feedback from Safety Champions and walk-rounds

The August Floor to Board Level Maternity and Neonatal Safety Champion meeting was held virtually and included representatives from maternity.

Staffing pressures were discussed including the planned increase to M3/M4 night time numbers and the intention to ring fence this. Good uptake of bank shifts with the current incentive applied. Junior Doctors raised the overwhelming work load in antenatal clinic. This has been acknowledged and there is a plan in place to improve delegation.

Concerns raised regarding the short notice change to all day theatre lists due to Consultant Anaesthetist availability. This was a planned change but needed to be expedited due to Trust wide pressures. This has been raised with the executive team.

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.

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.

There were 2 diverts declared in August due to increased activity and acuity of cases, compounded by an increase in short term sickness due to Covid isolation. There were a further 3 attempted diverts during August, with no neighbouring units able to accept. As previously mentioned in this report, the service completes a daily maternity sitrep for the Regional Chief Midwifery Officer, and the feedback shared by WY&H LMS supports that BTHFT is not an outlier in escalation and closures, with all organisations experiencing similar staffing and activity challenges.

Regional neonatal cot pressures are also contributing to the need to divert women.

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

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 service has completed multiple amber risk assessments during August, but have managed to avoid divert due to the redeployment of staff, use of non-clinical midwives and closure of beds on the antenatal/postnatal wards to maintain safe staffing levels. The increase in escalations has been driven by the challenging staffing position as previously described.

Staffing challenges due to Covid persist, but it is anticipated that staffing will improve over the next few weeks as peak holiday season draws to a close, further uptake of incentivised bank shifts and the arrival of newly qualified midwives in September/October.

The senior midwifery team have responded to the additional pressures and concerns raised by staff and have provided additional support out of hours to manage escalation and unprecedented challenges.

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
JULY	2		X		11
AUGUST	2		3		13

Continuity of Carer (CoC) Action plan

The Team Leader for Vulnerable Women Continuity of Carer pathways, with LMS reporting responsibilities, was appointed in August and will take up post in the next few months. This role is funded by the LMS this year and replaces the Specialist Midwife for Continuity of Carer Pathways. It is intended that the existing community midwifery managers will change their titles to 'Team Leader for Geographical Continuity of Carer pathways' and a 3rd Team Leader will be appointed to cover the

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

remaining areas of the city. This approach will support the embedding and sustainability of continuity of carer as the default model of care for all women.

Continuity of Carer data is one month behind and the information supplied is in relation to progress and achievements during July:

Highlights:

- Acorn new recruit and restarting intrapartum care in August.
- Homebirth recruitment for additional team members in progress.
- Diabetic Pathway starting with bespoke model-booking numbers next month.

Barriers:

- Covid pressures/staff shortages delaying expansion plans.
- Willow clinic room disrupted/relocated, due to space use for pop-up covid vaccination one day a week.

TOTAL % booked for CoC = 23% BAME % = 30%

A meeting with the regional and national leads for continuity of carer took place in August, to support service design and modelling plans. The priority, agreed at National level, is that whilst continuity of carer remains a key priority, the focus is on all units maintaining safe staffing during the heightened staffing pressures and shortage of midwives.

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 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 August data. This will be presented with the September monthly update.

Appendix 2 is the maternity dashboard including July data.

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

- New metrics included to monitor the implementation of the Saving Babies Lives Care Bundle Version 2: Babies below the 3rd centile at 38 weeks, including missed identification and babies below the 10th centile at >40 weeks, including missed identification.
- Improved CO monitoring at booking following the pause during the pandemic.
- Increased induction of labour 30%. This does fluctuate but is likely associated with improved application of the fetal growth guideline and better identification of small babies.
- PPH rate noted to be increased for BTHFT but as it is only an isolated month, this will be monitored.

July data was discussed at the September Women's Core Governance Group.

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. This work is ongoing.

The staffing challenges during July and August have resulted in the cancellation of maternity training days, with the exception of PROMPT emergency training which is always prioritised.

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 OMS Board did not meet in August due to peak holidays; therefore an update is not available. The next update will be provided in the September paper.

The OMS team are due to present at the September Quality Academy, deferred from August due to lack of time in the agenda.

Service User Feedback

The service has worked with the MVP to promote the pop up Maternity Covid vaccination hubs during August.

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

There have not been any issues or concerns raised by the Maternity Voices Partnership during August. The next main MVP meeting is in September.

There have been some issues with Friends and Family cards, resulting in a zero submission rate for some clinical areas within maternity. This is due to incorrect cards sent to the areas, which the Patient Experience team have then been unable to process. Although we are unable to provide a submission, the cards and comments are being collated at CBU level, so that the feedback is captured.

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

- Future State Validation.
Pending Fetalink confirmation of dates. To be confirmed end of next week.
- Testing:
 - System Testing has commenced.
Cycle 1 progress at 40% run, with 57% pass rate.

○ Issue Status:

Defect Severity	Closed	Open
P1	0	1
P2	0	2
P3	2	13
P4	0	0
Total	2	18

- Change Workstream
 - Currently being setup.
- Training:
 - Use of eLearning is being balanced with the timeframes for delivery of the lesson plans. This continues to be assessed and may require reconsideration of a higher use of Classroom training that originally anticipated.
 - Dedicated Training workstream to be setup to continually monitor the progress.
 - Procurement of eLearning solution continues.
 - Work ongoing to address detailed resource requirements and required funding.
 - Development continues in support of the development of lesson plans.
- Operational Readiness
 - Meeting expected to collate training and change workstream, to be setup from October running at regular intervals, expected to become more frequent closer to go live. (Will be operationally driven).
- Archiving and Data Migration work stream.
 - Data Discovery – Medway data – progressing.
 - Preparation for robot script development to start, against the BUILD environment.
- Reporting:
 - Investigation of existing maternity related reports underway.

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

- MSDS Data Collection Workbook under development between Cerner and the Trust.
- Coding and 3M solution engaged under the reporting workstream.
- Fetalink
 - Procurement exercise continuing for the CTG Carts.
 - FSV even targeting week commencing 27th September to be confirmed end of next week.
 - Work ongoing to provide the revised date for the Future State Validation of the Fetalink solution, this will also be reviewed against the project plan and timeline to evaluate any potential impact and re-planning should it be needed.
- Communication
 - Plans continue, moving to continually develop the webpages and 'Ask Mary' (FAQ's and posting queries etc).
 - Ask Mary being published more widely and was shared at the FSV events.
- Validation gateway have now been passed. Workoff items have been identified and will continue to be progressed.

Key Products Not Delivered

- Fetalink Future State Validation – Under revision now for replanning.

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 (MSSP), triggered by the CQC 'requires improvement' rating.

The Maternity Safety Support Programme team attended a site visit in August and received an update from the triumvirate and executive team members, on the progress made since the presentation in December 2020.

The visit was positive and significant progress was acknowledged. Unfortunately, it is not within the remit of the MSSP team to exit us from the programme. This is the CQC decision following re-inspection and an improved rating. However, the comments and findings of the MSSP will inform the CQC.

Maternity Incentive Scheme Year 4:

The Maternity Incentive Scheme, Year 4, was published on 8 August with a submission date of 30 June 2022. The 10 safety actions remain unchanged, although there are a number of changes to the evidence required to demonstrate compliance.

There are some early concerns regarding the Trust's ability to meet Safety Action 2, regarding the Maternity Services Data Set requirements. A regional meeting to discuss this standard is planned for September and a further update will be provided to Board in October.

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

3. PROPOSAL

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

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

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

4. BENCHMARKING IMPLICATIONS

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

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

5. RISK ASSESSMENT

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

6. RECOMMENDATIONS

The Board is asked to note the contents of the Maternity Services Update, August 2021.

Board is asked to note the continued increase in short term absence due to Covid-19 related issues during August.

Board is asked to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned and that 5 reported cases in August generated a table top review to identify any emerging themes or trends.

There is a continued challenge completing the 72 hour reviews on stillbirths due to obstetric staffing issues. Board is asked to note that a plan is in place to address this.

Meeting Title	Board of Directors		
Date	23.09.21	Agenda item	Bo.9.21.15

Board is asked to note that there was 1 maternity Serious Incident (SI) declared in August which was notified to the CCG and WY and H LMS.

Board is asked to acknowledge that there were no HSIB reportable SIs declared in August in Maternity.

There was one neonatal death in August of an extremely premature baby.

7.	APPENDICES
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1. Appendix 1: Draft Maternity and Neonatal Safety Champion meeting notes and action log, August 2021.
2. Appendix 2 Maternity Dashboard July 2021.