

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

MATERNITY SERVICES UPDATE – JULY 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.

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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 action plan, with additional tabs providing more detailed descriptions of the actions required to evidence compliance. Significant progress and compliance has been achieved with outstanding actions linked to major maternity transformation plans which are not yet complete.

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

Monitoring of the monthly stillbirth rate continues, with every case subject to a 72 hour review and discussion with the Deputy Chief Medical Officer and Chief Nurse. This process is well embedded, including the rapid identification and escalation of in-month 'spikes' in the stillbirth rate which are subject to thematic reviews and reporting of any findings and subsequent learning to Trust Board.

Recommendation

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

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

Board is asked to acknowledge the national maternity funding award to increase the midwifery and obstetric work force.

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

There is a current 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.

Board is asked to note that a stillbirth declared in June has now been declared as a level 1 investigation and that immediate actions/lessons learned have been addressed.

The service requests that the Board notes that due to the timing of the monthly paper the narrative on the July maternity dashboard is not available and will be presented in the August update.

Board is asked to acknowledge that there was 1 HSIB Serious Incident (SI) declared in July in Maternity.

There was 1 neonatal SI in July relating to a transfusion error which Board is asked to note.

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Board to note that full compliance with against all 10 Maternity Incentive Scheme, Year 3, safety actions was declared in the 22 July submission.

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"/>

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

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

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

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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.

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

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.

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

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.

The service has noted an increase in the number of Covid positive women accessing maternity services during July, and as a result has been unable to step down the Covid area on the Birth Centre. This occasionally impacts on the ability to offer low risk women the opportunity to birth in a low risk environment. However, low risk birth is facilitated within the labour ward environment.

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 parent education midwives have worked closely with the Maternity Voices Partnership (MVP) to co-produce scripts for recent service users who are representative of the diverse, Bradford population to share on social media. A member of the obstetric team has been on local community radio to provide 'myth-busting' information and promote the vaccination to pregnant women.

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 July there was 1 woman, who experienced significant Covid 19 symptoms and required intensive or enhanced care. Both mum and baby are well.

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 has increased during July, particularly due to school children's bubbles bursting and requirements to isolate following track and trace contact. 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.

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.

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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 is currently devising a robust recruitment plan to increase the midwifery workforce between now and the end of the 2021/22 financial year. Any unspent funds will need to be repaid.

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 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 significant progress has been made. See Appendix 1 for further information.

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Stillbirth position:

There was 1 stillbirth in July. There is a 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. An initial notes review and timeline has been prepared and there are no obvious omissions in care.

One of the 2 stillbirths reported in the June update has had a robust clinical review following submission of the paper. The reviewer found that there was a lapse in care regarding an incorrect measurement used during ultrasound scanning and reporting, which led to an incorrect plan of care. The incorrect application of a clinical guideline was identified as an issue, and prompted an immediate review of 1000 scans to ensure that no other woman/baby was at risk of harm. Communication regarding the correct measurements has occurred and the sonography department are assured that all clinicians are now aware of the correct process. This case will be investigated as a level 1 and duty of candour has been completed.

Table 1 is the summary of cases occurring in July.

Gestation	Summary	Outcome
26+3/40	G2 P0, low risk pregnancy. Presented with first episode of reduced fetal movements at 26 weeks and an intrauterine death was sadly diagnosed.	Initial notes review showed no obvious care omissions. 72 hour clinical review is outstanding.

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

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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 2 babies were treated for HIE in July.

1. 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. MRI scan has not yet been performed and the baby remains poorly at the time of writing. 72 hour review completed and identified a possible failure to correctly manage slow progress during the first stage of labour. Duty of candour completed. The case has been referred and accepted by HSIB, declared as an SI on STEIS. The LMS and CCG have been notified.
2. 35+6 gestation baby born by category 1 caesarean section due to a pathological CTG. Initial cord gases did not meet the criteria for cooling but further blood gases and fits led to cooling. Clinical review to be undertaken. This case does not meet the referral criteria for HSIB.

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 July and reported on STEIS and notified to the LMS and CCG. This was the HIE baby 1 reported previously.

There is 1 ongoing maternity SI declared in June which is being investigated by HSIB as described.

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 for twins in last	72 hour review of care found no obvious omissions in either the antenatal or induction period. Examples of	HSIB investigation in progress

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	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.	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.	
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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 was 1 neonatal SI declared in July. This was originally identified as a NNU blood transfusion incident that was initially an Internal Investigation but has been upgraded to an SI as it was felt to be a Never Event. 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.

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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. 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</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</p>	SI declared & investigation commenced

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	<p>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>which probably did not affect outcome.</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>

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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' was presented to Quality Academy in July and described the review processes for all neonatal deaths, a description of the April/May cases, immediate learning and any themes/trends emerging. The Academy was satisfied with the assurance provided and have requested a further update be presented in November.

There were 3 NND in July. All 3 babies were on the Butterfly pathway with death anticipated.

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
July	3	18	3	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 July as already discussed.

The service would also like to inform that they are co-operating with HSIB regarding a case declared by Oldham. This is an HIE case from August 2020, with notification in June 2021. The mother received care from BTHFT between booking and 33 weeks and DNA'd her 35 week appointment as she had

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moved to Oldham. Review of her antenatal care revealed gaps between 11 and 31 weeks. However, this did not affect the outcome. Care and risk assessment were appropriate at 31 and 33 weeks. The identified gaps in care relate to the diabetic pathway and are being urgently reviewed by the OMS workstream.

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:

There was no meeting in July as per Bi-monthly schedule.

Monthly staff feedback from Safety Champions and walk-rounds:

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

Privacy and dignity of women being transferred to the intrapartum areas from the Maternity Assessment Centre (MAC) in established labour, was raised as a concern. MAC staff are exploring innovative ways in which dignity can be maintained, including bespoke trolley covers.

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.

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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 July due to increased activity and acuity of cases, compounded by an increase in short term sickness due to Covid isolation. 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 July, 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.

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

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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 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.

The LMS have since committed to funding a further continuity of carer post for 12 months, which has been advertised with interviews planned in early August.

Data for June was not available at the time of the June this report and is as follows:

Cherry Blossom

Highlights/achievements: Team work well and try to ensure they meet every woman on the caseload. They have made good connections with forget-me-not hospice and have visited the hospice also. They have been able to attend Butterfly meetings with Dr Vasudevan and have made good links with the wider palliative care team.

Barriers/concerns: Clarifications needed with regard team management, clinic space, team visibility and team phone number. PN care is difficult with only work one day each in the team.

Clover

Team functioning well after the restart of on calls at the end of May 2021. Very busy month with 22 births in June! 64% attended by Clover team and this we feel was fantastic considering 13 babies birthed within a 6 day period, 5 being within 24 hours.

Willow

Highlights: Continue to work well together with fantastic communication and teamwork.

Barriers: Busy unit meant they have been pulled from some clinic days and had to pass postnatal visits to community. Lack of admin support can be an issue.

TOTAL % booked for CoC = 23% BAME % = 24%

Whilst Covid has impacted on the progression of further continuity of carer pathways, continuity remains high on the agenda and future plans have been shared with the LMS. A meeting with the regional and national leads for continuity of carer has been arranged for August, to support service design and modelling plans.

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.

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The service have prepared 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 July data. This will be presented with the August dashboard data in the subsequent monthly update. June dashboard data was unavailable at the time of the June paper to Regulation and Assurance Committee and is available to view as Appendix 2.

June data was discussed at the August Women's Core Governance Group and no significant areas of concern were noted.

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.

A detailed update will be provided with the August paper.

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

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The Women's Journey

- BSOTS launched
- Midwife pre triage process trialled
- 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

Service User Feedback

A further 15 step review took place in July. Members of the MVP visited the induction suite and antenatal and postnatal inpatient wards. Feedback will be shared with the relevant teams.

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

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

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- Focus is targeting requirements to support up-coming FSV.
 - Activities continue to focus on building the environment in support of developing and planning the future state validation event.
 - Revised dates currently propose the event is run on Thursday 26th August and Wednesday 1st September.
- Testing:
 - No responses or feedback received for the strategy, expected approval at the next project board on 9th August.
 - Scripts and reviews of patient journeys are under development.
- Training:
 - No responses or feedback received for the strategy, expected approval at the next project board on 9th August.
 - Procurement of eLearning solution underway.
 - Work ongoing to address detailed resource requirements and required funding.
 - Preparation starting to support the development of lesson plans.
 - Archiving and Data Migration work stream.
 - Data Discovery – Medway data – underway.
 - Server and robot preparation/setup requested to support migration automation.
- Reporting:
 - Investigation of existing maternity related reports underway.
 - 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.
 - Pending network configuration setup prior servers being installed. Issues continue to delay the setup. Continues to be chased but becoming a risk.
 - Preparation ongoing to support FSV event.
- Communication
 - Plans continue, moving to continually develop the webpages and ‘Ask Mary’ (FAQ’s and posting queries etc).
 - Next Communications meeting on 16th August.
 - Validation gateway under review and being progressed.
- Key Products Not Delivered
 - None

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

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NHSI Maternity Safety Support Programme

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

The 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 was signed off and submitted ahead of the 22 July deadline, following discussion with the CCG and assurance provided to July Regulation and Assurance Committee. The service has declared compliance with all 10 safety actions.

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

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increased risk as a result of changes to the service to maintain safety of women, babies and staff during the pandemic.

6.	RECOMMENDATIONS
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Board is asked to note the increase in short term absence due to Covid-19 related issues during July.

Board is asked to acknowledge the national maternity funding award to increase the midwifery and obstetric work force.

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

There is a current 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.

Board is asked to note that a stillbirth declared in June has now been declared as a level 1 investigation and that immediate actions/lessons learned have been addressed.

The service requests that the Board notes that due to the timing of the monthly paper the narrative on the July maternity dashboard is not available and will be presented in the August update.

Board is asked to acknowledge that there was 1 HSIB Serious Incident (SI) declared in July in Maternity.

There was 1 neonatal SI in July relating to a transfusion error which Board is asked to note.

Board to note that full compliance with against all 10 Maternity Incentive Scheme, Year 3, safety actions was declared in the 22 July submission.

7.	APPENDICES
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1. Maternity Improvement Plan v15
2. Maternity Dashboard June 2021