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MATERNITY SERVICES UPDATE – OCTOBER 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 and approve		
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 '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. The overarching improvement plan has been updated to include the Ockenden Assurance action plan. Significant progress and compliance has been achieved with outstanding actions linked to major maternity transformation plans which are not yet complete. An increase in 'red' was raised at September Board of Directors. This has been reviewed and relates to outstanding audits and guidelines which have been delayed due to increased clinical activity and staffing challenges.

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 and associated appendices, September 2021 (Appendix 1), presented to Quality Academy in October.

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

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

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

Board is asked to acknowledge that there was 1 HSIB reportable SI declared in October in Maternity.

To note, there were 0 neonatal deaths in October.

Board is asked to note and approve the updated ATAIN action plan (Appendix 3).

Board is asked to provide final sign off for the MSDS action plan (Appendix 5).

Board is asked to formally note Jon Prashar's appointment as Non-Executive Director Maternity Safety Champion.

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Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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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"/>

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 Care Quality Committee (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.

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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.

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 continues until further notice. . 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 October with a small number of women requiring intensive care or care on the main hospital site. Some of the women have been very unwell, and it is noted that they were all unvaccinated and in the 3rd trimester of pregnancy.

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 continued to collaborate with Bradford District Care Trust colleagues during October to provide '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

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questions or concerns and provide reassurance that the vaccine is safe to use in pregnancy and the postnatal period.

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. The service is in the process of reviewing the recent guidance regarding outpatient pulse oximetry for Covid positive women in the community.

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 October. 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. This continues on an ad hoc basis. 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.

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 will receive feedback on the Ockenden assurance evidence submission on 5 November and will include the outcome in the November update paper.

Maternity Staffing

Safety Action 9 of the Maternity Incentive Scheme, Year 4, requires that there is evidence that discussions regarding safety intelligence, including minimum staffing in maternity services are taking place at Board level.

As already reported, the ongoing impact of the pandemic continues to affect maternity staffing levels, in addition to the expected annual attrition position. The service mitigates maternity staffing on a daily basis, by redeploying staff across the service, utilising specialist midwives and senior leaders to work clinically where appropriate, closing beds to maintain safe staffing levels and utilising the escalation policy to 'divert' services if activity and acuity outweigh the number of staff available.

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19.56 WTE newly qualified midwives will start their midwifery careers at Bradford in November. There are a number of band 6 midwives due to start in the next few months and there has been a positive response to recruitment plans to appoint midwives with special interest in a number of specific areas.

The service has submitted an expression of interest to Health Education England, for the recruitment of international midwives during financial year 2022/23.

Whilst recruitment has been positive, the Director of Midwifery has escalated concerns that due to the national shortage of midwives, the service is likely to meet the Birth Rate Plus recommendation for safe staffing based on current models of care, but will not achieve the number required to provide continuity of carer as a default position for all women. It must also be noted that whilst the increased establishment figure will likely be achieved, the lack of midwives at national level means that unlike previous years, there is no buffer for annual attrition and a high level of maternity leave.

The roll out of Cerner Maternity in March 2022 will place an additional staffing pressure on the service as staff are released for essential training.

Obstetric Staffing

There are currently 20 Consultant Obstetricians and Gynaecologists and 2 locums across the service. This includes 1 pure Consultant Obstetrician and 3 pure Consultant Gynaecologists. The junior staffing at present includes 11 Specialist Registrars, and 13 Senior House Officers.

Labour ward is always covered by a consultant and there are no exceptions to report. At present we are still unable to provide consistent daily consultant led ward rounds of the antenatal wards or consistent consultant cover in MAC and ANDU. This should be helped with future new appointments but the recent jobs advertised nationally in October 2021 had very few applications or suitable candidates for interview so we may still struggle to staff these areas appropriately without a further attempt to advertise again.

We have significant gaps predicted in the registrar rotas with 3 registrars leaving in the next 2 months which will leave huge gaps on the on call rotas which if not filled, will cause significant strain on the remaining registrars and also negatively affect their training opportunities. The predicted gaps on the on call rota alone is very concerning and jeopardises the ability to keep the unit safe. Further registrar appointments will be advertised to try and fill some of the gaps but the concern again is that there may not be suitable candidates to interview or appoint to posts.

Maternity Action Plan and CQC rating

Maternity Services received a 'Requires Improvement' rating in the 2019 inspection report published in April 2020. 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.

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The 'must, should, could' do actions and recommendations are summarised 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 improvement plan was reviewed in October and early November and can be viewed as Appendix 2. The NED Maternity Safety Champion raised some concerns regarding the amount of 'red' actions at September Board. This was explained as outstanding assurance audits in the main, linked to clinical work load pressures, anticipated improving with the agreed appointment of additional Consultants. There have been a number of closed actions on the Ockenden assurance tab, following September Board approval of the Birth Rate Plus staffing review, provided as an appendix to the Nursing and Midwifery staffing review.

Stillbirth Position

There was 1 stillbirth in October. This case is HSIB and SI reportable.

Table 1 is the summary of cases occurring in October.

Gestation	Summary	Outcome
39+5	<p>G2 P1. Vulnerable woman booked with the Acorn continuity team. History of reduced fetal movements at 38 weeks, appropriate review and management. Further report of reduced fetal movements at 38+6 and again at 39+5. On both occasions she was advised to attend MAC for review but DNA on either occasion.</p> <p>At 39+5, YAS were requested to attend due to labour. On arrival the baby had been born and was blue, floppy, and unresponsive. Resuscitation was attempted but unsuccessful. Initial post mortem findings suggest the baby was stillborn.</p> <p>Some evidence of great continuity and compassionate care from the Acorn team throughout pregnancy. Immediate learning includes that there is no current process in place for following up women who are advised to attend</p>	<p>72 hour review</p> <p>Case referred to HSIB and accepted as an SI.</p> <p>Reported on STEIS. LMS and CCG informed.</p> <p>Out of hospital stillbirth and meets the CDOP criteria</p>

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	the unit and do not present.	
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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
September	5	19	1	Yes- 1 x SI 1 x HSIB SI
October	1	20	0	1 x HSIB SI

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 October.

Serious Incidents (SIs) and serious harms

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).

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The HSIB reportable still birth is the only maternity SI declared in October. The LMS and CCG have been informed of the incident.

There are four ongoing maternity SI's.

Safety Action 9 of the Maternity Incentive Scheme, Year 4, requires that there is evidence that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues, are taking place at Board level.

The same stillbirth/HSIB/SI case is the only moderate harm reported in October.

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.	72 hour review completed and identified a possible failure to correctly manage slow progress during the first stage	HSIB investigation in progress

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	Transferred to neonatal unit for cooling and noted to be fitting.	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 accepted by HSIB, declared as an SI on STEIS. The LMS and CCG have been notified.	
August 2021	This was a postnatal woman who was admitted to AED. There was a delay in recognising and treating sepsis and the woman required a hysterectomy.		Internal SI
September 2021	G1 P0, Covid positive pregnant woman requiring inpatient respiratory care deteriorated and required emergency CS; baby was IUD at 34+1 week's gestation. A 24 years old in her first pregnancy, diagnosed with GDM. BMI 27.6 and she is a non-smoker. She reported reduced fetal movements at 27, 28, 32 and 33 weeks gestation. At 32+ weeks gestation she was diagnosed with	There were 3 missed opportunities to perform an USS and Doppler. Issues relating to the escalation of pregnant women in the main hospital to the obstetric team and following the guidance on the trust intranet (pregnant and postnatal women being seen through ED and escalation to the Obstetric team as well as the intranet Covid 19 guidance for managing pregnant women with Covid)	Internal SI

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	COVID and subsequently was admitted to the Trust on 4 occasions over an 8 day period.	and communication between clinical teams, Multidisciplinary (obstetric, medical and anaesthetic) reviews and decision making around delivery of complex high risk Covid pregnant patients, and use of MEWs rather than NEWS for all pregnant women admitted to the trust all need to be addressed in regard to this case.	
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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 SIs declared in October.

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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>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>	<p>SI declared & investigation commenced</p> <p>Extension agreed</p>
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</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>

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	<p>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>		
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> <p>Extension agreed</p>

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Neonatal Deaths (NND)

There were 0 NND's in October:

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
August	1	19	4	0
September	3	22	1	0
October	0	22	0	0

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

Following the Ockenden Report, all cases referred to the Health Safety Investigation Branch (HSIB) will be declared as SI's. The stillbirth case already mentioned is the only HSIB reportable case occurring in October

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.

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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 Board and Trust level Maternity Safety Champions met in October and welcomed Non-Executive Director (NED), Jon Prashar, to his first meeting as the NED Maternity Safety Champion.

The group discussed the increased stillbirths noted in August and September and the actions taken to review the combined months for any themes and trends.

An update was provided regarding the ATAIN quarterly report and the updated action plan was agreed (appendix 3) and is now presented for Board sign off before 30 November. There are a number of red actions which are expected to improve to amber rapidly. Progress will be monitored through the Bi-monthly safety champion meetings and also through the LMS ATAIN group.

There were no issues requiring escalation to Board level that are not already included within the monthly updates.

Monthly staff feedback from Safety Champions and walk-rounds

The October Floor to Board Level Maternity and Neonatal Safety Champion meeting was held virtually and included representatives from maternity. There was nothing requiring escalation to Board.

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.

Despite continued staffing challenges and a high volume of activity and acuity during October, there were 0 diverts declared and 1 attempted divert where no neighbouring units could support.

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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.

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	5		5		16
September	3		1		19
October	0		1		19

Continuity of Carer (CoC) Action plan

Due to the timing of November Board, the October update has not yet been completed and will be included in the November paper.

The newly appointed Team Leader for Continuity of Carer/ Vulnerable Women has commenced in post and is beginning to review the existing plans and progress, and update the action plan to reflect next steps. This will be discussed with the Board Level Maternity Safety Champion prior to being presented in a paper to Board for sign off by 31 January 2022.

The service will be meeting with the national team in November to discuss progress made to date and the 'building blocks' in place to achieve continuity of carer as the default position for all women by March 2023. This meeting will inform the updated action plan.

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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.

Internal building work commenced in August and during September, resulting in the loss of the original recovery area and another birthing room. Mitigation to protect flow includes the use of rooms on the Birth Centre for the lower acuity, high risk women.

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 October data. This will be presented with the November monthly update.

Appendix 4 is the maternity dashboard including September data.

There are no areas of concern on the dashboard which have not been discussed elsewhere in this paper. This includes the in- month rise in stillbirths, although the rolling annual stillbirth rate remains on a decreasing trajectory.

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.

Training compliance was reported in the September update paper and Board will be updated quarterly with exception reporting as required.

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.

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- Streamlining Systems.
- A Building Fit for the Future.
- Investing In Our Workforce.

Programme Governance

- OMS birthday planning well underway.
- Initial feasibility meeting completed.
- Supported BSOTS data collection.
- Life QI guru training delivered for workstream leads and project leads.
- OMS and OTS collaborative working – Angela McMillan presented at OTS Launch event.
- Candour TV award.

The Women's Journey

- BSOTS retrospective data collection completed.
- Midwife scan review competency document development.

Investing In Our Workforce

- Midwifery Workstream Lead role filled – Easher Quinlan.
- Staff survey is live, OMS actively supporting.

A Building Fit For The Future

- 67% of the Unit has had a 15 step review.
- Welcome sign up in the Unit.
- Feasibility meeting completed.

Moving to Digital

- "The Perfect Clinic Room" complete.
- Obstetric Website complete and live.
- Cerner Project in Future State stage - currently Amber due to dates moving to September.
- Midwifery workstream role filled- Gemma Sykes.

Linking Learning and Quality Through Our Information

- Safety huddle subgroup commenced.
- Case reviews in clinical area recommenced and positive feedback received.
- World patient safety day – 17th September.

Service User Feedback

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

There continues to be 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. The maternity matrons are working with the Patient Experience team to resolve.

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Further 15 Steps maternity reviews took place in October. Members of the MVP and the midwifery trust level maternity safety champion reviewed maternity ultrasound department and the birth centre. Immediate feedback was provided to the teams ahead of the formal report which will include suggestions for improvements.

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

- **Testing:**
 - Integration Testing has started as planned.
No P1's raised against IT1 to date. Those issues that have been raised have been predominantly around Dynamic Documentation.
- **Change Workshop**
 - No remaining capacity existing in the project plan to support any further additional change requests without impacting the project in some way. Existing CR list has been reviewed by CDAG to confirm items identified as Critical for go-live. New critical CR's must be reviewed /approved by CDAG and the Project board if necessary.
 - Current focus is against the 'critical' changes that are 'must have' for a go-live.
 - Regular meetings are now progressing the BAU change requests.
 - A separate discussion is still pending with regards to the changes needed for the Maternity Whiteboard that has yet to be organised.
- **Training:**
 - Discussions continue to determine options around delivery of training over 6, 7 and 8 week period.
 - Initial assessment proposes that Midwives will require a half day eLearning and a full day on classroom training, to be delivered over a 6 week period.
 - Work ongoing to address detailed resource requirements and required funding.
 - Community Scheduling training is still awaiting confirmation of the workflow.
- **Operational Readiness**
 - Inaugural meeting held, Tuesday 26th October.
 - Operation Readiness checklist reviewed for future approval/finalisation.
 - Focus on training resources and rostering.
- **Archiving and Data Migration work stream.**
 - Data Discovery – Medway data – on plan.
 - Data collection for mapping of selection fields from Medway to EPR.
- **Reporting:**
 - Investigation of existing maternity related reports continues.
 - 835 test environment expected to be available in November.
 -

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- Fetalink
 - Test scripts developed in preparation for integration testing.
 - CTG Cart Procurement concluded. Final quote requested prior to PO being raised. RDP engaged and planning for rollout has commenced.
 - Estates work for network points continues to be chased, but progress is slow due to the network team being focussed on Telephony go-live.
- 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.
- Recruitment of Cutover manager being progressed.

Key Products Not Delivered

- None.

Maternity Services Data Set (MSDS) action plan update

Appendix 5 is a copy of the updated MSDS action plan. The plan was agreed at Executive Team Meeting (ETM) on 1 November, presented by the Chief Digital and Information Officer, and submitted to the West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) by the 5 November deadline. Board is asked to approve the action plan for final sign off.

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.

There are no further updates to report since the August visit.

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Perinatal Mortality Review Tool Quarterly Report:

The September maternity services update to Board, presented to Quality Academy, highlighted that 2 cases missed the surveillance information completion deadline by a couple of days. An informal conversation with MBRRACE-UK, reassures that completion a few days after the deadline is not a cause for concern. However, MBRRACE-UK have advised that recurrent failures to miss the deadline would be considered non-compliant.

An alert system has now been added to the list of cases, which triggers when an individual case is 2 weeks away from the completion deadline. This is closely monitored by the PMRT administrator.

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

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The Board is asked to note the contents of the Maternity Services Update and associated appendices, September 2021 (Appendix 1), presented to Quality Academy in October.

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

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

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

Board is asked to acknowledge that there was 1HSIB reportable SI declared in October in Maternity.

To note, there were no neonatal deaths in October.

Board is asked to note and approve the updated ATAIN action plan (Appendix 3).

Board is asked to provide final sign off for the MSDS action plan (Appendix 5).

Board is asked to formally note Jon Prashar's appointment as NED Maternity Safety Champion.

7.	APPENDICES
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1. Maternity Services Update September 2021 and associated appendices.
2. Maternity Improvement Plan version 18.
3. ATAIN action plan October 2021.
4. Maternity Dashboard September 2021.
5. MSDS action plan.