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| <b>Meeting Title</b> | <b>Quality and Patient Safety Academy</b> |                    |                   |
| <b>Date</b>          | <b>27.10.2021</b>                         | <b>Agenda item</b> | <b>QA.10.21.6</b> |

## MATERNITY SERVICES UPDATE – SEPTEMBER 2021

|  |  |             |  |
|--|--|-------------|--|
| <b>Presented by</b>                        | Sara Hollins, Director of Midwifery  |             |  |
| <b>Author</b>                              | Sara Hollins, Director of Midwifery  |             |  |
| <b>Lead Director</b>                       | Karen Dawber, Chief Nurse  |             |  |
| <b>Purpose of the paper</b>                | 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. |             |  |
| <b>Key control</b>                         | Identify if the paper is a key control for the Board Assurance Framework   |             |  |
| <b>Action required</b>                     | For decision   |             |  |
| <b>Previously discussed at/informed by</b> | Details of any consultation  |             |  |
| <b>Previously approved at:</b>             | <b>Committee/Group</b>   | <b>Date</b> |  |
|  |  |             |  |
|  |  |             |  |

### 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. 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 Quality Academy/Board is asked to note the contents of the Maternity Services Update, September 2021.

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

Quality Academy/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 September generated a table top review to identify any emerging themes or trends.

Quality Academy/Board is asked to note that there were 3 maternity Serious Incidents (SI) declared in September which was notified to the CCG and WY and H LMS and HSIB as appropriate.

Quality Academy/Board is asked to acknowledge that there were 2 HSIB reportable SIs declared in September in Maternity.

There were three neonatal deaths in September.

Quality Academy/Board is asked to approve the Quarter 2 ATAIN report, appendix 1.

Quality Academy/Board is asked to note appendix 2, GMC trainee survey, and that the service achieved 87% in relation to the quality of clinical supervision out of hours.

Quality Academy/Board is asked to note the quarterly PMRT report and that a position on the Maternity Incentive Scheme will be provided in November.

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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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|--|
| <b>Regulation, Legislation and Compliance relevance</b>  |
| <b>NHS Improvement: (please tick those that are relevant)</b><br><div style="display: flex; justify-content: space-between;"> <div> <input checked="" type="checkbox"/> Risk Assessment Framework<br/> <input type="checkbox"/> Code of Governance         </div> <div> <input checked="" type="checkbox"/> Quality Governance Framework<br/> <input type="checkbox"/> Annual Reporting Manual         </div> </div> |
| <b>Care Quality Commission Domain: Well Led</b>  |
| <b>Care Quality Commission Fundamental Standard:</b>   |
| <b>NHS Improvement Effective Use of Resources:</b> Choose an item.   |
| <b>Other (please state):</b>   |

| <b>Relevance to other Board of Director's academies: (please select all that apply)</b> |                                     |                          |                          |
|---|-------------------------------------|--------------------------|--------------------------|
| 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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| <b>1</b> | <b>PURPOSE/ AIM</b> |
|----------|---------------------|

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.

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| <b>2</b> | <b>BACKGROUND/CONTEXT</b> |
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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 September 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 3<sup>rd</sup> trimester of pregnancy. In response to 1 case, which has been escalated as a Serious Incident (SI), the maternity service is reviewing the standard operating procedures (SOP) specifically regarding the management of pregnant Covid positive inpatients on the main site, to improve the multidisciplinary team (MDT) review and maternity outreach care provided.

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

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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. The pop-up clinics have continued on a weekly basis during September and a further 'push' to promote uptake is planned during October.

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 September. This was escalated to the Chief Nurse and prompted a risk assessment approach supporting staff with a positive household contact to return to work before the end of the 10 day isolation period. This was in direct response to critical staffing levels. The service continues to see 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. 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. This has been well received and will continue as a pilot for 3 months.

### **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 has been reviewed by the Regional Chief Midwifery Officer's team. No further feedback has been received during September. However, feedback is expected from October onwards, including site visits. The Board will be updated following this visit.

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### **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.

### **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.

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. There have been challenges in reviewing the action plan over the last 3 months as a result of increased clinical commitments and work load. Equally, this has also impacted on the completion of audits and guidelines linked to the action plan, as clinical staff have not had any capacity to do this alongside prioritising clinical care. It is anticipated that this position will improve over the next few months and when additional Consultants have been appointed.



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### **Stillbirth position**

There were 5 stillbirths in September which again 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, although this has improved slightly during September. However, all 5 cases have had a thorough review and timeline completed by a member of the maternity risk and governance team.

Thematic review of the 5 cases revealed distinctly different scenarios, with no emerging themes or trends. During October, the 5 stillbirths occurring in August will be thematically reviewed alongside the 5 September cases, with findings presented at the next speciality meeting.

Of note, the West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) have reported an increase in stillbirths across the system. This will be escalated to the Yorkshire and Humber Stillbirth Steering Group, and an LMS wide approach to review all cases within the system is planned. The aim of this review is that whilst individual Trusts are not identifying specific themes and trends, a wider review may reveal this.

The table below describes the cases and immediate lessons learned from September.

Table 1 is the summary of cases occurring in September.

| Gestation | Summary   | Outcome   |
|-----------|---|---|
| 25+6      | <p>G4 P2+2, BMI 35.6, PET in previous pregnancies, history of stillborn twins at 25 weeks.</p> <p>She was high risk due to previous obstetric history and seen early in pregnancy by the obstetric consultant. She was commenced aspirin and folic acid and the importance of taking aspirin was reiterated at the consultant clinic. She reported she was going to Slovakia at this appointment. A plan was made for dopplers and growth scans however acknowledged that she may be in Slovakia at the FAS time.</p> <p>She was diagnosed with PIH at 18+6 weeks gestation, commenced labetalol and given home BP machine. Reviews regarding BP were arranged and attended by the patient. Travelled to Slovakia (received antenatal care as advised there) on the 30/8/21 and did not return until September therefore DNA'd appointments on the 19+6 and 21+6 weeks. She attended with an IUD at 25+4 weeks gestation.</p> | <p>No omissions in care identified that would have changed outcome.</p> <p>Clinical review completed.</p> |



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| 29+1 | <p>G5 P3, BMI 33, smoker. Previous FGR baby with a BW 1.7kg at 35/40. She has a history of chronic renal disease under renal consultant and chronic hypertension. Her VTE score 4 (declined tinzaparin). She was seen regularly in the antenatal clinic. She was next seen by the community midwife at 26 weeks, blood pressure was normal and fetal movements were reported as normal. No SFH assessment as having growth scans. DNA ANC appointment at 23+ weeks and 27+ weeks. The next ANC and USS appointment was attended and unfortunately an IUD was confirmed.</p> <p>Breech SB at 29+1 weeks<br/>BW 0.725kg (severely growth restricted well below 3rd centile)</p>   | No omissions in care identified.<br>Clinical review completed.        |
| 41   | <p>G1 P0, low risk, attended with a PV bleed at 40 weeks gestation, SFH 37. She was reviewed and discharged home.</p> <p>At 40+6 weeks she attended in spontaneous labour and an IUD was diagnosed. Birth weight was 3.665kg (50th centile).</p> <p>IOL or admission to the antenatal ward should have been offered following the admission at 40 weeks gestation.</p>  | This case has been referred to HSIB (SI)<br>Clinical review completed |
| 34+1 | <p>G1 P0, Covid positive pregnant woman requiring inpatient respiratory care deteriorated and required emergency CS, baby was IUD at 34+1 weeks gestation.</p> <p>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 COVID and subsequently was admitted to the Trust on 4 occasions over an 8 day period.</p> <p>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) 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</p> | SI declared   |

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|    | rather than NEWS for all pregnant women admitted to the trust all need to be addressed in regard to this case. |                                       |
| 34 | IUD at 34/40 with known anencephaly on the Butterfly pathway.  | No omissions in care. Death expected. |

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:

| <b>Stillbirths 2021</b> |                         |                      | <b>Expected deaths within total number</b> | <b>Further detailed investigation</b> |
|-------------------------|-------------------------|----------------------|--|---------------------------------------|
| <b>Month</b>            | <b>Number of babies</b> | <b>Running total</b> | <b>Butterfly babies</b>                    | <b>Number of cases</b>                |
| 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<br>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 was 1 baby treated for HIE in September. This was a term baby born to a low risk mother. There was a failure to identify a delay in the first stage of labour which resulted in a delay in commencing cardiotocograph (CTG) monitoring. The baby required extensive resuscitation at birth and immediate cooling. The case was referred to and accepted by HSIB.

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### **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).

There were 3 maternity SI declared in September and reported on STEIS and notified to the LMS and CC&.

There are three ongoing maternity SIs.

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. There were 4 moderate harms reported in September (1 case was reported twice). The 3 cases are the SI's as already described.

Table 3: Ongoing Maternity SIs:

| <b>Date of Incident</b> | <b>Brief Description</b>   | <b>Immediate Findings</b>   | <b>Finalised Key Issues</b>    |
|-------------------------|--|---|--------------------------------|
| 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 | HSIB investigation in progress |

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|             |   | regarding earlier antenatal contacts and HSIB are investigating these on their behalf.  |                                |
| 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 accepted by HSIB, declared as an SI on STEIS. The LMS and CCG have been notified. | HSIB investigation in progress |
| 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                    |

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.

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

There were no neonatal SI's declared in September.

### **Ongoing Neonatal SIs**

Table 4:

| <b><u>Date of Incident</u></b> | <b><u>Brief Description</u></b>  | <b><u>Immediate Findings</u></b>  | <b><u>Finalised Key Issues</u></b>                                       |
|--------------------------------|--|---|--|
| 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 &amp; 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>Documentation around cannula insertion, monitoring of the site, and decisions to keep / remove the cannula were inadequate.</p>  | <p>SI declared &amp; investigation commenced</p> <p>Extension agreed</p> |

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|------------|--|--|--|
|            | <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>There were also issues around prescribing 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</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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|         |   |  |          |
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|         | extubation.   |  |          |
| 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. |  | Complete |

### **Neonatal Deaths (NND)**

There were 3 NND's in September:

Baby born at 24/40 who presented to paediatrics with bronchiolitis 4 weeks post-discharge.

23/40 twin who died at day 2 of life following a pulmonary haemorrhage.

22/40 delivery room death (comfort care), extreme prematurity.

Table 5:

| <b>NND 2021</b> |                         |                      | <b>Expected deaths within total number</b>                           | <b>Further detailed investigation</b> |
|-----------------|-------------------------|----------------------|--|---------------------------------------|
| <b>Month</b>    | <b>Number of babies</b> | <b>Running total</b> | <b>Extreme preterm/congenital anomalies/life limiting conditions</b> | <b>Number of cases</b>                |
| 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                                     |

### **Avoiding Term Admissions into Neonatal units (ATAIN)**

Safety Action 3 of the Maternity Incentive Scheme, Year 4, requires that ATAIN review findings are shared quarterly with the maternity and neonatal safety champions and Board level safety champions, LMNS and ICS quality surveillance meeting. The quarter 2 report attached as appendix 1 was



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discussed at the October bi-monthly maternity/neonatal safety champion meeting. The data is shared at the West Yorkshire and Harrogate Local Maternity System, ATAIN meetings, who subsequently feed into the ICS quality surveillance meeting.

The quarter 2 data shows an ATAIN rate for BTHFT of 3.42% which is below the agreed target rate of 5%. During this quarter there was only 1 baby who could have been cared for on transitional care (TCU) rather than admission to neonatal unit. This was due to staffing challenges on TCU and is not an area of concern.

Following review of the 43 cases in quarter 2, only 1 baby was classed as being an 'avoidable' admission. This was due to a failure to follow the hypoglycaemia pathway adequately, and learning has been shared with the relevant teams.

The updated ATAIN action plan has been prepared and will be reviewed by the maternity/neonatal safety champions prior to being presented to Board for sign off in November.

**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. Two cases were referred to and accepted for investigation by HSIB in September. 1 case is the 41 week stillbirth reported in Table 1. This case met the HSIB referral criteria as the mother was in established labour when fetal death was diagnosed.

The 2<sup>nd</sup> case is the baby requiring cooling for HIE previously mentioned.

**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.

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### **Maternity and Neonatal Bi-Monthly Safety Champion meetings**

There was no planned meeting in September. Details of the October meeting will be provided in the next monthly update.

### **Monthly staff feedback from Safety Champions and walk-rounds**

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

Concerns were raised regarding the ongoing local/LMS/Regional staffing pressures and increased acuity and capacity experienced by both maternity and neonatal services. This concern was escalated to the Chief Executive and to the Board in September. An update on current pressures was also provided to the CQC liaison team in September.

### **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.

Appendix 2 details the 2021 GMC trainee results alongside the results for the previous 3 years. The service scored 87% for the quality of clinical supervision out of hours, which is within the acceptable threshold.

Here is the spread sheet explaining the GMC trainee survey for 2021 and includes last 3 years as well. Overall the other results are satisfactory with some areas requiring attention including workload and handover process. The current survey was completed prior to the OMS led implementation of an improved multidisciplinary handover process, and it is anticipated that this element will show an improved position next year.

Regarding workload, the service have recruited 2 specialty doctors to add resilience to the middle grade rotas , however this has still not helped as BTHFT received less trainees from the deanery than required so currently these staff are filling the gaps created by lack of Obstetrics and Gynaecology trainees.

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## **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.

The divert position reported in August needs updating following Datix and amber risk assessment reconciliation. There were actually 5 diverts not 2 divert as first reported, due to increased activity and acuity of cases, compounded by an increase in short term sickness due to Covid isolation. There were a further 5 attempted diverts, not 3, with no neighbouring units able to accept. A total of 8 women were affected although some only required assessment and returned to BTHFT for further care at a later point.

Staffing challenges and a high volume of activity and acuity continued during September with 3 diverts declared and 1 attempted divert.

Specialist Midwives with appropriate clinical skills, were redeployed frequently to clinical areas during August and September in an attempt to prevent diversions and maintain safe staffing levels. This has impacted on their individual workloads, specifically the clinical risk and governance team, resulting in delays to clinical investigation processes and dissemination of lessons learned.

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.

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 acknowledges the high number of diverts and attempted diverts, but remain confident that BTHFT is not an outlier in the current climate. However, other organisations within the LMS have very different approaches to how they manage unit escalations and whilst they do not declare 'divert' they frequently request neighbouring organisations support with induction of labour cases, or if multi-site, divert women between their own sites.

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 October/November.

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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:

| <b>MONTH</b> | <b>NUMBER<br/>DIVERTS</b> | <b>OF</b> | <b>NUMBER<br/>ATTEMPTED<br/>DIVERTS</b> | <b>OF</b> | <b>RUNNING TOTAL</b> |
|--------------|---------------------------|-----------|---|-----------|----------------------|
| 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                   |

### **Continuity of Carer (CoC) Action plan**

September continuity of carer progress.

#### **Highlights:**

- Teenage: offering PN implants, 100% AN care at home
- Amber: trying a different roster model which is working well
- Acorn: recommenced on-calls
- Willow: Consistently receiving positive feedback from the women and have recruited a new team member so will be back up to capacity
- CoC lead now in post
- The percentages of women both booked on a pathway and from a BAME background has increased during September. This is a great achievement given the gaps that persist in the existing teams.

#### **Barriers:**

- Reported barriers for all teams are lack of admin support

TOTAL % booked for CoC = 28% BAME % = 35%

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

Appendix 3 is the maternity dashboard including August data.

- 1:1 care in labour 90%. This is a significant achievement considering the staffing challenges during August
- The increase in induction of labour continues during August to 34%. This does fluctuate but is likely associated with improved application of the fetal growth guideline and better identification of small babies.

## **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.

Appendix 4 is the current mandatory training compliance position. There are a number of 'red' areas where compliance is below expected, including FIT testing and blood competence.

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The service continues to promote the requirement to FIT test and provides regular opportunities for staff to be tested within the service. The true position is higher, as there is a backlog of tests that have not been uploaded to ESR due to technical difficulties.

There is a lack of trainers available within maternity to provide the organising receipt of blood and preparing to administer blood. This position is being reviewed.

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

Table 5 demonstrates the current position for emergency training. The aim is that 90% of all staff groups will have received MDT training by 30 June 2022 when MIS year 4 is submitted.

| <i>MDT training for all staff working in maternity services</i>  | <b>Aug-21</b> | <b>Sep-21</b> | <b>Oct-21</b> |
|--|---------------|---------------|---------------|
| % of staff who have participated in MDT training (actuals)       | 93%           |               |               |
| % of staff who will have participated in MDT training (forecast) |               | 83%           | 87%           |

### **Outstanding Maternity Service Programme**

The Outstanding Maternity Service (OMS) Programme is a transformation programme, intended to improve the service from 'Requires Improvement' to 'Outstanding'.

The programme contains 5 work streams:

- The Woman's Journey and Clinical Excellence.
- Moving to Digital.
- Streamlining Systems.
- A Building Fit for the Future.
- Investing In Our Workforce.

#### The Women's Journey

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

#### Investing In Our Workforce

- Midwifery Workstream Lead role filled
- 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

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- Midwifery workstream role filled

#### 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 September. The next main MVP meeting is in November.

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. This issue has persisted during September.

### **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.
  - Planned for the afternoon of Tuesday 5<sup>th</sup> October for the future state validation event covering Fetalink.
- Testing:
  - System Testing
    - Cycle 1 complete, with 55% pass rate, but 19% blocked predominantly by components not yet built.
    - Cycle 2: 71% complete, with 66% pass rate, 21% fail and 13% blocked.
- Change Workshop
  - Total of 37 changes continue to be reviewed on a weekly basis, including both Cerner and BAU requested changes.
  - Current focus is against the 'Major' changes still requiring further information.
- Training:
  - Development continues with lesson plans, but limited progress this week due to annual leave.
  - Work ongoing to address detailed resource requirements and required funding.
  - Course outline reviewed internally, to be shared to wider audience once updated next week.
- Operational Readiness



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- Meeting expected to collate training and change work stream, to be setup from October running at regular intervals, expected to become more frequent closer to go live.
  - Inaugural meeting setup for 26<sup>th</sup> October.
- 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 - development on-plan.
- Fetalink
  - Procurement exercise coming to a close for the CTG Carts.
  - FSV event planned for Tuesday 5<sup>th</sup> October in the afternoon in the Sovereign Lecture Theatre.
- 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

### **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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#### **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.

#### **Perinatal Mortality Review Tool Quarterly Report:**

The Maternity Incentive Scheme, Year 4, Safety Action 1 requires evidence that Trust Boards have received a quarterly PMRT report.

Using the national PMRT to review perinatal deaths to the required standard has been a condition of the incentive scheme for the last 3 years. However, the timeframes have been amended in year 4 and are significantly shorter.

Appendix 5 provides a summary of the current position. Changes to the requirement for surveillance information to be completed within 1 month of the death instead of 4 months, has resulted in 2 cases not meeting the standard. The cases were completed a few days after the month deadline. The service has contacted MBRRACE-UK to ask if there is any chance of these cases being accepted. If the response is no, this means that the safety action is non-compliant which would mean the whole of the Incentive Scheme is an overall fail.

An update will be provided to Board in November.

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### 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 Quality Academy/Board is asked to note the contents of the Maternity Services Update, September 2021.

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

Quality Academy/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 September generated a table top review to identify any emerging themes or trends.

Quality Academy/Board is asked to note that there were 3 maternity Serious Incidents (SI) declared in September which was notified to the CCG and WY and H LMS and HSIB as appropriate.

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Quality Academy/Board is asked to acknowledge that there were 2 HSIB reportable SIs declared in September in Maternity.

There were three neonatal deaths in September.

Quality Academy/Board is asked to approve the Quarter 2 ATAIN report, appendix 1.

Quality Academy/Board is asked to note appendix 2, GMC trainee survey, and that the service achieved 87% in relation to the quality of clinical supervision out of hours.

Quality Academy/Board is asked to note the quarterly PMRT report and that a position on the Maternity Incentive Scheme will be provided in November.

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| <b>7.</b> | <b>APPENDICES</b> |
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1. Quarter 2 ATAIN report- Appendix 1
2. GMC trainee survey- Appendix 2
3. Maternity Dashboard- Appendix 3
4. Mandatory training compliance- Appendix 4
5. PMRT Quarterly Report- Appendix 5