

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

MATERNITY SERVICES UPDATE – DECEMBER 2021

Presented by	Sara Hollins, Director of Midwifery		
Author	Sara Hollins, Director of Midwifery		
Lead Director	Karen Dawber, Chief Nurse		
Purpose of the paper	To provide the Regulation Committee/Board with a monthly update on progress with the Maternity Improvement Plan, including CQC Action Plan, monthly stillbirth position and continuity of carer.		
Key control	Identify if the paper is a key control for the Board Assurance Framework		
Action required	For decision		
Previously discussed at/ informed by	Details of any consultation		
Previously approved at:	Academy/Group	Date	

Key Options, Issues and Risks

The Maternity Service was rated as 'Required Improvement' following the November 2019 Care Quality Commission (CQC) inspection. The service has acknowledged the findings and recommendations, and is committed to addressing the issues raised and becoming an 'Outstanding' service.

Following Executive approval, the service have embarked on a significant quality improvement and transformation project, intended to improve the stillbirth rate and other outcomes highlighted by the CQC, and ultimately support the journey towards being an outstanding maternity service.

Bradford is a regional and national outlier for stillbirths and concerns were raised by the CQC in November 2019 that the service had failed to identify a rising trend during 2019. The service has improved the monthly review process and will provide the Board of Directors/Quality Academy with a monthly stillbirth position, in order that they are fully informed and able to scrutinise and challenge as required. The service reported an annual reduction in stillbirths during 2020. However, stillbirth reduction remains a key priority for the service as we continue to work towards the national ambition and 'halve it' trajectory.

The monthly maternity services report presented to Regulation and Assurance Committee/Trust Board/Quality Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Board has an open and transparent oversight and scrutiny of maternity services.

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

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

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

Board is asked to note the midwifery staffing position, particularly the community midwifery pressures described, and is asked to support the temporary pause of Midwifery Continuity of Carer pathways during January.

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 HSIB reportable Serious Incident (SI) declared in December.

To note, there were 3 neonatal deaths in December. Board is asked to request any further information from the Neonatal team directly.

This report includes the Perinatal Mortality Review Tool quarterly update and Board is asked to acknowledge that the service is either already achieving the required standard for some elements, or is within the required timeframe for completion.

Board is asked to approve the updated Midwifery Continuity of Carer plan, agreed with the Board Level Maternity Safety Champion. Progress against the plan will be reported via the monthly maternity update paper.

Board is asked to note that the Maternity Theatre build has been delayed with an expected end date yet to be agreed. Existing mitigation in place remains unchanged.

The Quarterly Maternity Training Compliance report is attached for Board information.

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

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"/>

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: Choose an item.	
Care Quality Commission Fundamental Standard: Choose an item.	
NHS Improvement Effective Use of Resources: Choose an item.	
Other (please state):	

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

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

1 PURPOSE/ AIM

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.

2 BACKGROUND/CONTEXT

Ongoing Impact of Covid-19 pandemic on Maternity Services:

The service has responded to the pandemic in line with local, regional and national recommendations/directives, and has adapted the provision of maternity services to ensure that women, babies and staff are protected whilst maintaining safe, responsive maternity care.

The service is fully compliant with NHS England (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.

In line with the rest of the organisation, the maternity service has implemented evidence of a negative lateral flow test prior to visiting on wards M3/M4/Transitional Care and Neonatal Unit.

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

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

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.

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.

During December, Bradford District Care Trust colleagues were able to resume supporting the service with weekly pop-up vaccination clinics in the maternity unit. This was gratefully accepted. However, the uptake of the pop-up clinics is low and does not justify the amount of staff required to run each session. Pregnant and postnatal women will instead be sign posted to the main vaccination centre as an alternative.

The surveillance of women who are Covid positive in the community setting continues, ensuring that pregnant women from black, Asian and minority ethnic (BAME) and vulnerable communities are monitored and any deterioration in condition is rapidly identified and acted upon.

There were no babies with symptoms of Covid during this time. We do not, to protect our women and staff, move staff from maternity services to the acute main site.

Covid-19 related sickness and absence continued during December, this impacted on the need to escalate and divert services. 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.

The Bed Manager role has also been extended to include weekends and bank holidays on a Temporary Nurse Register (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 received positive feedback on the Ockenden assurance evidence submission on 5 November and was complemented on the quality of the submission. Whilst there are a significant number of 'amber' responses, this is due in part to regional and local maternity system actions

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

beyond our control. In addition, a number of new processes have been put in place and until these are audited and embedded in practice it is not possible to rate them as green.

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.

The vacancy rate for December is 28.51 whole time equivalent (WTE). This is against the revised establishment calculated by Birth Rate Plus, which recommended an increase of 12.52 WTE to maintain safe services based on the acuity of women accessing the existing pathways and models of care, and an overall increase of 32.2 WTE to achieve midwifery continuity of carer (MCoC).

	Original establishment	BR+ safe staffing	BR+ MCoC
December	+3.69 WTE	-8.83 WTE	-28.51

Whilst the current vacancy rate is acknowledged as a significant deficit and the service continues its pro-active recruitment and retention campaign, it must be noted that the larger figure is the Birth Rate Plus calculation to deliver MCoC as a default position for all women. Achieving this remains a priority but the national emphasis from maternity leaders is that safe staffing is the first priority before achieving full continuity. The updated action plan for achieving MCoC is discussed later in this report.

The service is therefore focussing on achieving the 12.52 WTE increase and although there is a deficit of 8.83 WTE, 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.

It is anticipated a further 6.21 WTE new appointments due to start in early 2022 will help to close this gap.

Despite newly qualified midwives finishing initial supernumerary status and being included in the staffing numbers, December staffing remained very challenging and contributed to a number of unit diversions. The number of absences due to Covid remains high, with an increase in the number of staff required to isolate whilst awaiting PCR results or with a positive result.

Community midwifery services were significantly affected during December due to carrying vacancies as a result of internal promotion opportunities, long term sickness and short term absence compounded by Covid. The combined deficit is 14.96 WTE from an establishment of 37.4 WTE. This is significantly impacting on the provision of safe community services, including uncovered antenatal clinics, and is not expected to resolve in January.

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

Immediate actions to improve community staffing have been implemented including:

- Midwifery specialist support secondments have been paused and midwives returned to community teams.
- Specialist Midwife for teenage pregnancy has a small caseload and has capacity to pick up a small caseload in Crystal Team.
- A number of existing MCoC pathways will be paused during January to allow unstaffed clinics and caseloads to be supported. This will be closely monitored and pathways resumed at the earliest opportunity.

Obstetric Staffing

There are currently 20 Consultant Obstetricians and Gynaecologists and 2 locums across the service. On 13th December 2021 we successfully appointed a further Obstetric consultant (who also has Gynaecology laparoscopic skills) to the department. The individual is one of our current locums taking the total number of consultants now to 21. We also appointed a locum consultant Obstetrician and Gynaecologist to replace our other general locum who will be leaving the department in February 2021.

There is 1 pure Consultant Obstetrician in the consultant body and 3 pure Consultant Gynaecologists.

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. However this will improve with our recent Obstetric appointment as cover on the wards and MAC/ ANDU will form part of their job plan and this should be helped with future new appointments. The jobs advertised nationally in October 2021 (2 substantive Obstetric jobs and 1 locum Obstetric post) had very few applications or suitable candidates for interview so we may still struggle to staff these areas appropriately. We intend to advertise again in the New Year.

The junior staffing at present includes 9 Specialist Registrars, and 13 Senior House Officers. On 8th December the college tutors interviewed 4 candidates and offered 2 of the successful candidate's clinical fellow posts who will make a significant difference to filling 2 out of the 3 gaps on the middle grade registrar rota.

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.

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

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. 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.

Appendix 1 is the recently reviewed maternity improvement plan. There has been further progress with the Ockenden assurance action plan, as processes have become embedded in practice and we are able to evidence this. A number of outstanding audits are now in progress.

The Clinical Risk and Governance Lead Midwife is working with the newly appointed Clinical Governance Support Officer to develop an improved tracker for the national benchmarking tab. The service also plans to revisit the CQC action plan in early 2022, to ensure that actions declared compliant remain so.

Stillbirth Position

There were 4 stillbirths in December.

Table 1 is the summary of cases occurring in December.

Gestation	Summary	Outcome
29/40	This is a very sad case of a very early onset fetal growth restriction, in a woman with no significant risk factors, and subsequent intrauterine death (IUD) at 29 weeks gestation. She was appropriately assessed in the AN period, and no risk factors were overlooked. Aspirin was not indicated at booking. There was an early diagnosis of the fetal growth restriction (FGR) and appropriate specialist follow-up and counselling was arranged by a senior multidisciplinary team. Sadly, due to the severity of growth restriction, this baby was never estimated to weigh more than 500g and weighed 440g at birth. Unfortunately baby died in utero before this was achieved. Overall the standard of care delivered was good and despite the bleak prognosis, necessary to help parents deal with such a difficult outlook.	72 hour clinical review completed. No further investigation.

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

31/40	This is a sad case of stillbirth at 31 weeks and 5 days. Evidence of appropriate care and following local and national guidance. There were many confounding factors including a fall during pregnancy and the diagnosis of covid 19 infection. There was no evidence of fetal abnormality or fetal growth restriction. The ultrasound study conducted at 28 weeks suggested a growth between 10th and 50th centile which is normal for this gestational age. This was further confirmed with a birth weight centile which was again between the 10th and 50th centile. This confirms that there was no failure in growth velocity that could have been a contributing factor to this sad event. We are awaiting cytogenetic study and placental histology to enable us to conclude this case review.	72 hour clinical review completed. No further investigation.
32+2/40	The lady was in her second pregnancy, with a normal BMI. She was appropriately assessed as low risk other than having low Papp A. A scan at 32 weeks showed growth to be above the 10th centile. Attended the following day with reduced fetal movements and IUD confirmed. A true knot was evident at birth and the cord was twice wrapped around the baby's neck. On initial review no omissions in care have been identified but the case will undergo a thorough 72 hour review.	Awaiting full clinical review.
37/40	The lady was in her second pregnancy with a BMI of 26.5 she had a history of obstetric cholestasis and treatment was commenced at 36 weeks gestation. A plan was made for delivery at 37 weeks however on the day of induction she presented with abdominal pain and reduced fetal movements. An emergency caesarean section was performed but baby was born with no signs of life, resuscitation was attempted but discontinued after 19 minutes. This case has been referred to HSIB for investigation.	Awaiting full clinical review. Referred to Healthcare Safety Investigation Branch (HSIB) and will be investigated as an SI

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.

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

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
November	1	21	0	Yes- level 1
December	4	25	0	1 x HSIB SI

Ongoing actions to address the stillbirth rate

2021 has seen a reduction of stillbirths compared to 2020 and a slight increase in birth rate. This is extremely positive despite a year filled with the challenges of an ongoing pandemic. It is thought that the rollout of updated guidance for identifying and managing small babies, partnership working with the MVP to disseminate important messages regarding reduced fetal movements, and revisiting and embedding the principles of symphysis fundal height measurement, have contributed to this success.

However, the service does not intend to become complacent, and will continue to improve the stillbirth rate by ensuring that local and national guidance is followed and embedded in practice.

2022 will see further improvement work around smoking cessation, which we hope will reduce the number further.

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 0 babies requiring treatment for HIE in December.

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

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 was 1 HSIB reportable case occurring in December. This is the 37 week intrapartum stillbirth reported earlier. It meets the HSIB criteria as the mother was in established labour when the intrauterine death was diagnosed. The case has been referred to and accepted by HSIB.

There are 7 ongoing maternity SI's, 5 HSIB and 2 Trust level.

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 December.

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	HSIB investigation in progress. Report received in draft. Comments returned to HSIB.

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

		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 Strategic Executive Information System (STEIS). The LMS and CCG have been notified.	HSIB investigation in progress. Report received in draft.
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- ongoing
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 gestational diabetes mellitus (GDM). BMI	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	Internal SI - ongoing

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

	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.	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 Maternal Early Warning Scores (MEWs) rather than National Early Warning Scores (NEWS) for all pregnant women admitted to the trust all need to be addressed in regard to this case.	
October 2021	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. At 39+5, YAS were	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 the unit and do not present.	HSIB investigation in progress- ongoing

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

	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.		
December 2021	This was the neonatal death of a baby born at 38+1 weeks by category 1 caesarean section following identification of placental abruption. The baby was born in poor condition and treatment withdrawn.	An MDT review (anaesthetics, obstetric and neonates) of the case has taken place and excellent elements of care have been identified when the woman attending with the evolving abruption.	Parents declined HSIB investigation therefore Trust investigation

The Ockenden report is clear that neonatal harms should also be visible at Trust Board level. This report already covers monthly neonatal harms regarding care provided during pregnancy and birth, and has not previously featured neonatal harms regarding the care received after birth. This report features a brief description of any neonatal SI's declared in month, including any immediate lessons learned. It must be noted that the responsibility to escalate, investigate and action any learning, sits with the Neonatal Service and not the Maternity Service. The exception will be any case which crosses both specialties.

It also includes the number of Neonatal Deaths (NND) in month and brief description. There was 0 neonatal SI's declared in December.

Ongoing Neonatal SIs

Table 4:

<u>Date of Incident</u>	<u>Brief Description</u>	<u>Immediate Findings</u>	<u>Finalised Key Issues</u>
07/04/2021	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. Baby born at 26 +3 gestation.	Documentation around cannula insertion, monitoring of the site, and decisions to keep / remove the cannula were inadequate. There were also issues	SI declared & investigation commenced Extension agreed

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

	<p>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>	around prescribing which probably did not affect outcome.	
17/04/2021	<p>34/40 infant born to Mum with GDM. Floppy at birth. Identified as having bilateral ventriculomegaly.</p> <p>Management being guided by Leeds neurosurgeons and baby had lumbar punctures to reduce hydrocephalus on 9th of April and 15th of April.</p> <p>Baby became meningitic and septicaemic 48 hours after a second Lumbar Puncture.</p> <p>Baby born with serious intracranial pathology of unknown cause. He has become severely unwell due to meningitis and septicaemia, which has led to additional brain injury. Care is being re-orientated with compassionate extubation.</p>	<p>Possible delay in identifying a deteriorating patient.</p> <p>Possible delay in commencing intravenous antibiotics.</p>	<p>SI declared. Investigation commenced.</p> <p>Extension agreed</p>
November 2021	Klebsiella outbreak including the deaths of 2 very premature		Ongoing

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

	babies.		
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The November Klebsiella outbreak remains contained with 6 babies on unit cohorted into 2 rooms. No further colonised/infected infants outside cohorted areas. Weekly meetings continue with IPC and a further round of swabbing is planned with a view to re-opening the unit cautiously.

Neonatal nurse staffing was very challenging during December due to Covid. Although activity has been kept to a minimum due to Klebsiella, the servicer has operated over capacity at times due to high sickness levels on some shifts. This is a very similar picture in neonatal units across the network who are as bad or worse than us. There are frequent neonatal network discussions on how to manage this situation. There are currently no Newborn Intensive Care Unit (NICU) beds in the region.

Neonatal Deaths (NND)

There were 3 NND's in December:

1 death is the same 38 week gestation baby previously described, that died following placental abruption.

1 term baby was an expected death due to congenital anomalies not compatible with life.

The final baby was a non-viable baby born at 21 weeks gestation.

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
November	4	26	1	1 x level 1 (maternity) 2 cases investigated as Klebsiella SI
December	3	29	2	1 x HSIB

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

Perinatal Mortality Review Tool Quarterly Report:

The Maternity Incentive Scheme, Year 4, Safety Action 1 requires evidence that Trust Boards have received a quarterly Perinatal Mortality Review Tool (PMRT) report. The last report was received as an appendix to the September maternity update paper, presented in October 2021.

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. Appendix 2 provides a summary of the current position and demonstrates that the service is either already achieving the required standard for some elements, or is within the required timeframe for completion.

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 37 week intrapartum stillbirth is the only incident meeting the HSIB criteria in December.

HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with the Trust

The implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

The service can confirm that there have been no such requests to date this year.

Coroner Regulation 28 made directly to Trust

Again, the implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

The service can confirm that there have been no such requests to date this year.

Maternity and Neonatal Bi-Monthly Safety Champion meetings

The Maternity and Neonatal Safety Champions met on 2 December. The standard agenda which includes neonatal and maternity outcomes and harms, staffing, HSIB investigations and SI's, was discussed. A large focus of the discussion was around the Klebsiella outbreak on the neonatal unit and the immediate actions taken to address. This has been reported as a serious incident. Neonatal unit remains closed to external admissions and internal admissions of babies <28/40 (unless unable to transfer out).

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

Ward assurances were discussed. There were occasional missed crash trolley checks on the birth centre when the birth centre has been 'closed'. Birth centre checks are now included on the labour ward handover sheet so that this is picked up.

Missing resuscitaire checks have been noted when the equipment has been loaned to neonatal unit for a period of time. The neonatal unit team will take responsibility for the daily checks when the equipment is in their footprint.

Monthly staff feedback from Safety Champions and walk-rounds

The December meeting was held virtually, hosted by Karen Dawber.

Issues raised:

- Concerns from community midwives feeling they are being used to support the unit excessively.
- Issues regarding the continual breaking down of printers. This impacts on care, discharges and blood requests.
- New starter midwives in the community do not have computers to use, which affects their ability to fulfil their role.

Actions:

- Unfortunately, unit staffing and the requirement to declare unit diverts, has meant that community on call midwives have had to support the unit out of hours. This is not a decision taken lightly but is necessary in extreme circumstances to keep women and babies safe. It is acknowledged that calling the on call in, impacts on provision of routine community care the following day. There is no solution to this at present but concerns are acknowledged. KD will also acknowledge the contribution of the community midwives involved.
- Karen Dawber will escalate the requirement for new printers.
- Karen will also address the lack of community lap tops.

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.

Continued staffing challenges and a high volume of activity and acuity during December resulted in 3 unit diverts and 1 attempted divert.. On 2 of the 3 diverts, the unit continued to accept antenatal women for review and assessment and diverted women in labour only as the pressure was on intrapartum beds. A total of 5 women were diverted to other units in December.

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

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. LMS and regional pressures persisted during November, with multiple areas declaring diverts.

The service has re-written the escalation policy which aligns with the WY&H LMS escalation policy and utilise OPEL. This is currently going through the relevant governance processes.

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
November	3		0		22
December	3		1		25

Midwifery Continuity of Carer (MCoC) Action plan

Achievements and highlights during November:

- Successful visit from the regional/ national team.
- Planning for full implementation underway.
- Positive feedback from service users.

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

TOTAL % booked for MCoC = 24% BAME % = 29%.

The updated continuity of carer action plan (Appendix 3) describing the building blocks and plans to achieve by 2023, was discussed with the Executive Maternity safety Champion in December and agreed. The plan has been submitted to West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) as required and the service asks that Board formally approve the plan. Progress will be monitored and discussed monthly with the Executive Maternity safety Champion, Director of Midwifery and Midwifery Continuity of Care (MCoC) lead midwife, and a monthly update will continue to be provided to Board through this report.

The plan clearly describes our ambition to achieve full implementation by March 2023. However, whilst the service is committed to achieving continuity, this will not be at the expense of unit safety and will be prioritised when safe staffing levels are achieved and maintained. This approach is supported by the National Chief Midwifery Officer.

As previously discussed under midwifery staffing, community midwifery pressures require the service to temporarily pause a number of MCoC pathways, in order that safe care is maintained for all community caseloads. This decision will be closely monitored and pathways will be recommenced at the earliest opportunity.

The Home Birth team will continue to function as intended, in order that choice of place of birth is not compromised.

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. 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.

Phase 1 of the build was due for completion on 24 December 2021. Unfortunately delays with procurement channels and an issue with access to a central gas mains outside of the trust site, for which permission is required to access for the new build, has caused delays to the completion of the build. Completion is now predicted to be in the spring.

The Maternity Theatre Project Board continues to meet on a monthly basis and a further update regarding the delays is expected at the January meeting.

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. Additional mitigation is not required as a result of the build delay.

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

Maternity Dashboard

The service has welcomed a new Clinical Governance Support Officer in November, who is working with Business Intelligence to understand the reporting elements of the role. This has resulted in delays to the publication of the run chart dashboard. Review of the numerical dashboard which contains data up to November 2021, does not reveal any areas of particular concern.

An increase in 3rd/4th degree tears associated with instrumental deliveries was noted in November. However, this increase remains below the regional average, and is not statistically relevant as an isolated month.

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 a copy of the quarterly training compliance. Releasing staff for mandatory training due to the current staffing challenges has been difficult, with some training sessions cancelled or staff postponed to prioritise the filling of clinical shifts.

However, highlights include:

- 97% of midwives were compliant with the full requirements of the K2 Cardiotocography (CTG) training package by 31 December. The remaining 7 midwives have individual plans in place to complete by the end of January or a negotiated time.
- PROMPT training continues to be prioritised and attended.

There has been a drop in basic adult life support. However this is due to no PROMPT session in November and will be recovered by the next compliance report.

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.

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

Work continues where possible in all work streams, despite the staffing challenges previously described.

OMS Board did not sit in December, and a highlight report will be provided in the January update.

Programme Manager, Kate Lavery, left to commence maternity leave in December and will be replaced by Ann-Marie Orr for 12 months.

Service User Feedback

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

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.

Due to the increased staffing pressures due to Covid, the service has significant concerns regarding the ability to facilitate the required level of staff training to enable 'go-live' alongside maintaining safe staffing levels in the clinical areas.

This will be discussed in detail at the January Board meeting and a further update will be provided to Board in February.

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. What are the next steps? Short, medium and long term? Who is involved and what are the arrangements for approval etc.]

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.

Meeting Title	Board of Directors		
Date	20.01.22	Agenda item	Bo.1.22.12

5	RISK ASSESSMENT
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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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Board is asked to note the contents of the Maternity Services Update, December 2021.

Board is asked to note the midwifery staffing position, particularly the community midwifery pressures described, and is asked to support the temporary pause of Midwifery Continuity of Carer pathways during January.

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 HSIB reportable Serious Incident (SI) declared in December.

To note, there were 3 neonatal deaths in December. Board is asked to request any further information from the Neonatal team directly.

This report includes the Perinatal Mortality Review Tool quarterly update and Board is asked to acknowledge that the service is either already achieving the required standard for some elements, or is within the required timeframe for completion.

Board is asked to approve the updated Midwifery Continuity of Carer plan, agreed with the Board Level Maternity Safety Champion. Progress against the plan will be reported via the monthly maternity update paper.

Board is asked to note that the Maternity Theatre build has been delayed with an expected end date yet to be agreed. Existing mitigation in place remains unchanged.

The Quarterly Maternity Training Compliance report is attached for Board information.

7	Appendices
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1. Maternity Improvement Plan version 19 - Appendix 1.
2. Perinatal Mortality Review Tool quarterly report - Appendix 2.
3. Midwifery Continuity of Carer action plan - Appendix 3.
4. Quarterly Maternity Training Compliance - Appendix 4.