

<b>Meeting Title</b>	<b>Board of Directors</b>		
<b>Date</b>	<b>20.01.22</b>	<b>Agenda item</b>	<b>Bo.1.22.12</b>

## MATERNITY SERVICES UPDATE – NOVEMBER 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. 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, November 2021.

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

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

Board is asked to acknowledge that there was 1 HSIB reportable SI declared in November in Maternity but that the family declined HSIB involvement

To note, there were 4 neonatal deaths in November. Board is asked to request any further information from the Neonatal team directly.

Board is asked to support the proposal that with the exception of PROMPT emergency training, all other mandatory training is paused during January to March to release staff to attend essential Maternity Cerner training, prior to the March 'go-live'.

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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)						

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"/>

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

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<b>Regulation, Legislation and Compliance relevance</b>
<b>NHS Improvement: (please tick those that are relevant)</b> <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
<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<b>1</b>	<b>PURPOSE/ AIM</b>
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The purpose of this paper is to provide a monthly update on progress with the Maternity Improvement Plan, including the Care Quality Committee (CQC) Action Plan, the monthly stillbirth position and continuity of carer. It also provides an update on the Outstanding Maternity Service quality improvement/transformation programme, intended to improve key areas of the service and support the journey towards being outstanding.

The paper also provides a brief narrative of the maternity outcomes and metrics reported in the monthly maternity dashboard.

Bradford is a regional and national outlier for stillbirths and concerns were raised by the CQC in November 2019 that the service had failed to identify a rising trend during 2019. This failing contributed to the 'Requires Improvement' rating applied to Maternity Services on 9 April. The service reported an annual reduction in stillbirths during 2020. However, stillbirth reduction remains a key priority for the service as we continue to work towards the national ambition and 'halve it' trajectory.

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

<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 fortnightly Maternity Covid SitRep to confirm the visiting and testing arrangements in place.

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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.

The service continued to collaborate with Bradford District Care Trust colleagues during November to provide opportunities for pregnant women to receive the Covid vaccination. BDCT staffing challenges have meant that pop-up clinics within the maternity setting have not been possible, but the 2 teams remain committed to sign posting and promoting the vaccination to the pregnant Bradford population.

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 continued during November. 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 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 beyond

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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.

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.

In November the service welcomed the majority of the 19.56 WTE newly qualified midwives starting their professional careers at Bradford. The newly qualified midwives have completed Trust and local induction and are working in clinical areas in a supernumerary capacity for 4 weeks. The remaining midwives will commence in post in the New Year, along with a number of Band 6 midwives who were successfully appointed in 'special interest' roles.

National funding has been secured to enable the appointment of a 'Pastoral Support Midwife', who will work alongside new starters in clinical areas to identify any individual learning/training needs and aid the wellbeing and ultimately, the retention of this group of staff.

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

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

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

### **Obstetric Staffing**

There are currently 20 Consultant Obstetricians and Gynaecologists and 2 locums across the service. This includes 1 pure Consultant Obstetrician and 3 pure Consultant Gynaecologists.

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

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consistent consultant cover in MAC and ANDU. This should be helped with future new appointments but the recent jobs advertised nationally in October 2021 had very few applications or suitable candidates for interview so we may still struggle to staff these areas appropriately without a further attempt to advertise again.

The junior staffing at present includes 9 Specialist Registrars, and 13 Senior House Officers. We have significant gaps predicted in the registrar rotas with 2 registrars that have left in November 2021 (OOPE and break in training for family reasons) with another registrar leaving as they have completed training and have secured a consultant post at another unit in the region from January 2022. The gaps have the potential to cause significant strain on the remaining registrars and also negatively affect their training opportunities. The predicted gaps on the on call rota alone are very concerning and jeopardises our ability to keep the unit safe.

Plans are in place to interview 4 suitable applicants to clinical fellow posts which have been advertised. There are 4 candidates for interview in December 2021.

### **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 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 (SIs) and a national benchmarking tab. It is reviewed as a minimum, 4-6 weekly by the Director of Midwifery, Clinical Director and Risk and Governance Lead Midwife.

The improvement plan has not been reviewed since the October Maternity Update to Board and will be included in the December paper.

### **Stillbirth Position**

There was 1 stillbirth in November.



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Table 1 is the summary of cases occurring in November.

Gestation	Summary	Outcome
36 weeks	42 years old with a BMI of 34.6 in her 6 <sup>th</sup> pregnancy. She was high risk with a history of SGA and FGR therefore under shared care and received USS from 32 weeks gestation. The EFW was on the 10th centile. She attended with multiple episodes of RFM and had several assessments. She attended at 35+4 with RFM when IUD was diagnosed. Birth weight was <3rd centile.	72 hour review completed.  Level 1 investigation has been decided even though guidance was followed and no omissions that are likely to have changed the outcome. The clinical review felt a review is required of our local guidance on RFM and assessment of SFGA /FGA to highlight the importance of risk assessment at every clinical encounter and escalation of clinical concerns.

Table 2 is the running total of stillbirths in 2021, including the number of cases requiring further detailed investigation, and the number of butterfly babies whose deaths were expected.

Table 2:

Stillbirths 2021			Expected deaths within total number	Further detailed investigation
Month	Number of babies	Running total	Butterfly babies	Number of cases
January	0	0	0	0
February	1	1	0	Yes- level 1
March	2	3	0	0
April	2	5	2	0
May	1	6	0	0
June	2	8	1	Yes- level 1
July	1	9	0	0
August	5	14	0	0
September	5	19	1	Yes- 1 x SI 1 x HSIB SI
October	1	20	0	1 x HSIB SI
November	1	21	0	Yes- level 1

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### **Ongoing actions to address the stillbirth rate**

The Service has achieved full compliance with implementing all 4 elements of the Saving Babies' Lives Care Bundle, Version 2, confirmed by the Yorkshire and Humber Clinical Network following submission of the latest survey. The improved identification and management of small for gestational age babies continues through the Outstanding Maternity Service (OMS) programme transformational work stream.

### **Hypoxic Ischaemic Encephalopathy (HIE)**

1 baby was treated for HIE in November following placental abruption. Care was withdrawn shortly after birth.

### **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 November. 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. This is the same baby requiring treatment for HIE. HSIB were notified of the case but the parents declined consent for investigation. It has therefore been declared as a level 1 investigation.

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.

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 October.

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.	72 hour review of care found no obvious	HSIB investigation in progress. Report

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	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.	omissions in either the antenatal or induction period. Examples of excellent team work and prompt recognition of the Vasa praevia leading to early blood transfusion for the baby. Case referred to HSIB, duty of candour completed. HSIB declined as did not meet the criteria. However, parents have raised some queries/concerns regarding earlier antenatal contacts and HSIB are investigating these on their behalf.	received in draft.
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

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August 2021	This was a postnatal woman who was admitted to AED. There was a delay in recognising and treating sepsis and the woman required a hysterectomy.		Internal SI
September 2021	G1 P0, Covid positive pregnant woman requiring inpatient respiratory care deteriorated and required emergency CS; baby was IUD at 34+1 week's gestation. A 24 years old in her first pregnancy, diagnosed with GDM. BMI 27.6 and she is a non-smoker. She reported reduced fetal movements at 27, 28, 32 and 33 weeks gestation. At 32+ weeks gestation she was diagnosed with COVID and subsequently was admitted to the Trust on 4 occasions over an 8 day period.	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 rather than NEWS for all pregnant women admitted to the trust all need to be	Internal SI

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		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 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.	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

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 was 1 neonatal SI declared in November relating to the outbreak of Klebsiella.

### **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>
07/04/2021	<p>Diagnosis of Osteomyelitis in limb where cannula inserted which is likely to impact on bone development in such a way that function of the right arm/wrist may be affected.</p> <p>Baby born at 26 +3 gestation. 9+ weeks old at the time of the incident.</p> <p>Cannula inserted in right hand to take bloods with potential for blood transfusion. Blood transfusion was not commenced but cannula not removed.</p> <p>Decision to transfuse 2 days later. Cannula still in situ but leaking therefore further cannula sited in left hand.</p> <p>2 days later, right hand noted to be red, hot, tender and tense.</p> <p>Blood cultures grew staph aureus.</p>	<p>Documentation around cannula insertion, monitoring of the site, and decisions to keep / remove the cannula were inadequate.</p> <p>There were also issues around prescribing which probably did not affect outcome.</p>	<p>SI declared &amp; investigation commenced</p> <p>Extension agreed</p>
17/04/2021	<p>34/40 infant born to Mum with GDM. Floppy at birth. Identified as having bilateral ventriculomegaly.</p>	<p>Possible delay in identifying a deteriorating patient.</p> <p>Possible delay in</p>	<p>SI declared. Investigation commenced.</p> <p>Extension</p>

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	<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>	commencing intravenous antibiotics.	agreed
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### **Neonatal Deaths (NND)**

There were 4 NND's in November:

1 neonatal death following placental abruption as previously described. This baby commenced cooling for HIE before care was withdrawn.

2 premature babies died as a result of Klebsiella pneumoniae sepsis. These cases are being investigated as part of the Klebsiella outbreak SI, in addition to the usual perinatal mortality review tool and child death overview processes. The neonatal team are meeting weekly with infection prevention and initial actions are being worked through.

1 expected death of a baby receiving palliative care for cardiomyopathy and trisomy 21.

During November the Bradford Registrar for Births and Deaths escalated a perceived increase in the number of neonatal deaths reported. On investigation, this increase is partially attributed to an increase in the number of non-viable babies who showed signs of life prior to death within a few hours. Legally, these babies are registered as a live birth and death even though the gestation at birth is non-viable.

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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
October	0	22	0	0
November	4	26	1	1 x level 1 (maternity) 2 cases investigated as Klebsiella SI

**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 SIs. The neonatal death following placental abruption previously described is the only HSIB reportable case occurring in November. The case was reported appropriately but not progressed due to declined consent.

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

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

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



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### **Coroner Regulation 28 made directly to Trust**

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

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

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

The Board and Trust level Maternity Safety Champions did not meet in November. The next meeting is planned for early December.

Non-Executive Director (NED), Jon Prashar, visited the unit in his role as NED Maternity Safety Champion on 5 November, to introduce himself to the maternity and neonatal teams. No safety concerns were escalated during the visit.

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

The November Floor to Board Level Maternity and Neonatal Safety Champion meeting was held virtually and included representatives from maternity. There were no safety concerns raised by the team. However, unconscious racial bias was discussed at length as this has been raised by midwifery students. The University has held an open forum to discuss this issue and this has also been addressed through the Better Births, Act as One work stream. A member of the midwifery team has agreed to raise the profile of this alongside an existing piece of work on civility in the work place.

### **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 November resulted in 3 unit diverts. 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 8 women were diverted to other units in November.

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As previously mentioned in this report, the service completes a daily maternity sitrep for the Regional Chief Midwifery Officer, and the feedback shared by WY&H LMS supports that BTHFT is not an outlier in escalation and closures, with all organisations experiencing similar staffing and activity challenges. 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:

<b>MONTH</b>	<b>NUMBER DIVERTS</b>	<b>OF</b>	<b>NUMBER ATTEMPTED 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
October	0		1		19
November	3		0		22

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

Achievements and highlights during October:

- Continue to provide continuity despite staffing challenges.
- Fantastic feedback from women and families.
- Recruitment underway.
- Willow team currently having a drive in recruiting women on to the pathway.
- Note: Cherry Blossom team currently suspended therefore no bookings. Will be removed from future highlight reports

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TOTAL % booked for MCoC = 26% BAME % = 31%

The service met with the national team in November to discuss progress to date and the 'building blocks' required to achieve continuity of carer as the default position for all women by March 2023. The meeting was positive and demonstrated the ongoing commitment to achieving continuity, particularly for Bradford's most vulnerable women, despite the current staffing challenges.

The updated continuity of carer action plan describing the building blocks and plans to achieve by 2023, will be discussed with the Executive Maternity safety Champion in December and presented to Board for sign off in January 2022.

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.

### **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**

October maternity dashboard data is not available at the time of this report and will be discussed in the December update.

### **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.

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

### **Outstanding Maternity Service Programme**

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

The programme contains 5 work streams:

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

#### Programme Governance

- OMS birthday a huge success
- OMS Board thank you poster to all areas

1. The Women's Journey
  - BSOTS Database finalised and MACU team data collection rep confirmed
  - Midwife scan review training in progress
  - GDM health app for B/P monitoring reviewed
  - Perinatal mental health guideline ratified and Birch clinic commenced
2. Investing In Our Workforce
  - Pastoral Care specialist midwife role out to recruitment
  - Civility in the workplace added to induction for new midwives
  - Staff survey is live, OMS actively supporting
3. A Building Fit For The Future
  - 91% of the Unit has had a 15 step review
  - Architect work ongoing
4. Moving to Digital
  - Digital Maternity Assessment £350,000 bid submitted for language line and upgraded CTGs
  - Cerner Project on track for Go Live date
  - Revised Plan on a Page for 2022 , KPIs and Charter completed
  - Smart phones ordered for all 7 areas to use for language support
5. Linking Learning and Quality Through Our Information
  - Safety huddle subgroup commenced
  - Case reviews in clinical area recommenced and positive feedback received

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### **Service User Feedback**

There have not been any issues or concerns raised by the Maternity Voices Partnership during November. The main MVP meeting took place in November and was attended by representatives from the maternity service. The group were updated on the current staffing pressures and how this is being managed.

Representatives from the maternity service also attended the first face to face, public facing event with service users and were able to hear feedback directly from members of the different communities we serve, including women from the Roma community. The outputs of this event are being collated by the MVP, and will be shared with the service to shape future plans and delivery of care.

### **Maternity Cerner**

The Maternity Cerner Project Board meets monthly and have to date agreed a high level of confidence that the project is on track and within budget.

#### **Key Products Delivered**

- Testing:
- Preparation for IT2 to commence on 20th December.
- **Change Requests**
  - No remaining capacity existing in the project plan to support any further additional change requests without impacting the project in some way. New, critical, CR's must be reviewed /approved by CDAG and the Project board if necessary.
  - Discussions ongoing against Born in Bradford research change request. CCN received from Cerner and under internal review before discussion with Research teams.
- **Training**
  - Booking for Super user training has now opened
  - Rooms for training have been identified, although current proposal may place BAU training at risk.
- **Operational Readiness**
  - Operation Readiness checklist pending completion by Matrons.
  - Focus on training booking and cutover/go-live activities
  - Work ongoing to identified requirements for Smartcard rollout.
- **Archiving and Data Migration work stream**
  - Archive solution being reviewed internally to assess fit for purpose
  - Data Migration trials run, final refinement against 2 fields still pending, awaiting feedback from team.
  - Preparation for MOCK/IT2 data load underway.

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- Reporting
  - Investigation of existing maternity related reports continues, including involvement within scheduling discussions.
  - 835 test environment has been made available to the Business Analysts for down stream mapping.
- Fetalink
  - RDP engaged and planning for rollout has commenced, delivery timeframes are currently at risk for the project and leave little time to build the carts.
  - Estates work for network points progressing but still at risk.
    - ☐ Initial asbestos survey booked expected to be complete.
    - ☐ Change approved for Comms room reorganisation
    - ☐ Preparation for network points tender underway.
- Cutover
  - Dress Rehearsal plans being developed.
  - Cutover Plans being developed.
  - Requirements for Cutover Command Centre underway. Initially to assist in locating a viable location.
- Key Products Not Delivered
  - None

The service have identified that continued staffing pressures and a lack of midwives available nationally to recruit, coupled with the essential training required to roll out maternity Cerner, will impact on the ability to maintain safe staffing levels during January to March 2022.

The service proposes that with the exception of PROMPT emergency training, Fire and Trust induction, all other mandatory training is paused during January to March, in order to release staff to attend Cerner training only. Board is asked to support this proposal.

<b>3.</b>	<b>PROPOSAL</b>
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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.

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<b>4.</b>	<b>BENCHMARKING IMPLICATIONS</b>
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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.

<b>5.</b>	<b>RISK ASSESSMENT</b>
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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.

<b>6.</b>	<b>RECOMMENDATIONS</b>
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Board is asked to note the contents of the Maternity Services Update, November 2021.

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

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

Board is asked to acknowledge that there was 1 HSIB reportable SI declared in November in Maternity but that the family declined HSIB involvement.

To note, there were 4 neonatal deaths in November. Board is asked to request any further information from the Neonatal team directly.

Board is asked to support the proposal that with the exception of PROMPT emergency training, all other mandatory training is paused during January to March to release staff to attend essential Maternity Cerner training, prior to the March 'go-live'.

<b>7.</b>	<b>APPENDICES</b>
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