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MATERNITY SERVICES UPDATE – JULY 2020

Presented by	Karen Dawber, Chief Nurse	
Author	Sara Hollins, Associate Director of Midwifery	
Lead Director	Karen Dawber, Chief Nurse	
Purpose of the paper	To provide the Executive and Non-Executive Regulation Committee with a monthly update on progress with the Maternity Improvement Plan, including CQC Action Plan, monthly stillbirth position, one to one care in labour, 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:	**Committee/Group**	**Date**
	Executive and Non-Executive Regulation Committee	29.07.20

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.

The service has received Executive approval to embark 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/Executive and Non-Executive Regulation Committee with a monthly stillbirth position, in order that they are fully informed and able to scrutinise and challenge as required.

Failure to achieve adequate rates of one to one care in labour was also raised as a concern by the inspectorate team. However, one to one care has been a regular feature in maternity reports to Quality Committee throughout 2018/19. Reporting monthly until such time that the rates of one to one care are improved and sustained, is intended to provide assurance of on-going improvement work in this area including identifying any barriers and challenges.

Analysis

The current Covid-19 pandemic has resulted in temporary changes to the way that Maternity Services at Bradford are routinely delivered. All outcomes are closely scrutinised by the risk and governance team. No increase in harms to women and babies has been noted during this reporting period, and the service is reviewing the impact of the changes to inform future service development.

The service has acknowledged the recommendations of the CQC 2019 report, and has incorporated them into the existing maternity action plan. The updated action plan demonstrates that steady progress continued during June. 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

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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.

The service presented proposed transformation plans to Trust Board in May, focusing on key areas of improvement identified as necessary to reduce the stillbirth rate. The service would like to assure the Board of Directors, that although the current priority is maintaining safety for women and babies during the pandemic, planning the proposed transformation work and meeting the recommendations of the CQC report remains priority.

Monitoring of the monthly stillbirth rate continues, with every case subject to a 72 hour review and discussion with the Deputy Chief Medical Officer. During June the number of stillbirths was below the agreed trigger for escalation.

During June there was a further significant improvement in the number of women receiving one to one care in labour, which remains a key priority for the Labour Ward Co-ordinators and intrapartum team and will be closely monitored until the rate is sustained.

Recommendation

The Board of Directors are asked to note the progress made on the Maternity Services Action plan, and to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned.

Acknowledgement of the on-going attempts to monitor and develop strategies to improve one to one care in labour and of the continued improvement reported in June.

The service requests that the Board of Directors note the monthly maternity dashboard narrative, including improvements and areas requiring monitoring.

The Board of Directors are also asked to note the progress made with the Continuity of Carer action plan.

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)						

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Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☒	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☒	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☒	☐	☐

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	☒	☐
Quality implications	☒	☐
Resource implications	☐	☒
Legal/regulatory implications	☐	☒
Diversity and Inclusion implications	☒	☐
Performance implications	☐	☒

Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant) ☒Risk Assessment Framework ☒Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: Well Led
Care Quality Commission Fundamental Standard: Good Governance
NHS Improvement Effective Use of Resources:
Other (please state):

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Relevance to other Board of Director's Committee: (please select all that apply)					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
☐	☒	☐	☐	☐	☐

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1 PURPOSE/ AIM

The purpose of this paper is to provide a monthly update on progress with the Maternity Improvement Plan, including the CQC Action Plan, the monthly stillbirth position, one to one care in labour, 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.

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. These measures remained in place during June with appropriate amendments made in line with emerging guidance and evidence.

As a result of increased Covid-19 testing for women accessing maternity services during June, the service has noted a small increase in the number of asymptomatic, positive women. During June there were no women experiencing significant symptoms, who required enhanced or intensive care. There have been no reported cases of positive or suspected Covid occurring in neonates during the same time frame.

During June, the service did not see any significant increase in harms occurring to women and babies, as a result of temporary changes in the way that services are delivered. This continues to be monitored closely by the maternity risk and governance team.

The Home Birth service was suspended in late March and the Home Birth team midwives were redeployed to support staffing in other areas of the service. This has been closely monitored and antenatal care for women requesting home birth resumed in late May, and full service recommenced in June, with the team celebrating three births since suspension in late June.

The service has benefited from the support of an LMS Midwife, who has surveyed both staff and women's views on the positive and negative impact of changes made in response to Covid. The women's surveys will be collated by the Maternity Voices Partnership (MVP), to ensure the service user voice is truly heard and that future service developments are co-designed.

The service has worked closely with the MVP throughout the pandemic to ensure that consistent messages are delivered to pregnant families in the Bradford area, including BAME and vulnerable families with seldom heard voices.

The National Maternity Transformation work streams and agendas, including the Maternity Incentive Scheme and implementation of Saving Babies Lives version 2, remain on hold as reported in the April paper to Regulation Committee. Work continues, within capacity, to ensure that the service is able to quickly resume the national agendas when revised deadlines are announced.

Maternity Action Plan and CQC rating:

Maternity Services received a 'Requires Improvement' rating in the 2019 inspection report published in April. The service has acknowledged the recommendations including monitoring and escalation of stillbirth rates, monitoring and management of infection risks in maternity theatres, and have incorporated 'must, should and could' do's into the existing maternity action plan for immediate attention (Appendix 1).

The 'must, should, could' do actions and recommendations are summarised on the first page of the overarching action plan, with additional tabs providing more detailed descriptions of the actions required to evidence compliance. A number of recommendations will require significant time to complete, as they are intrinsically linked to major maternity transformation plans. For example, the action relating to closely monitoring infection risks in obstetric theatre will be categorised as 'ongoing' until the completion of the planned theatre rebuild in Spring 2021.

The majority of CQC actions are on time with a small number completed and one out of date. This relates to the completion of an audit plan for 2020/21, which is delayed due to the current lack of an obstetric audit lead. A meeting to agree the lead and resolve this action will be held on 9 July.

Good progress has been made on all other tabs. Due to staffing arrangements and capacity during Covid, there are a number of audits which are delayed but it is anticipated that these will be complete and presented within the next month.

Some delays in completing outstanding actions have been incurred as a direct result of the current pandemic, for example, delays in launching additional continuity of carer teams and paused sonographer training required to implement elements of the saving babies' lives scanning regime. The service is now in a position to recommence conversations and engagement with the continuity of carer agenda, with a view to increasing the number of teams in the autumn.

The action plan is reviewed 4-6 weekly by the Associate Director of Midwifery, Clinical Director and Risk and Governance Lead Midwife. The majority of actions are making progress in line with target dates. However, a small number of actions have been impacted by working arrangements due to the pandemic as described.

A separate governance tab has been added to the overarching action plan; to evidence the actions required to demonstrate the CQC 'must do' that the Trust must improve governance and oversight of risk in maternity services.

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Stillbirth position:

There was 1 reported stillbirth in June, below the monthly escalation trigger of 4 cases in month. (Table 1) This is the 4th consecutive month that the service is able to report a position below the escalation trigger of 4 cases in month and the 2nd consecutive quarter below the quarterly escalation figure of 12. (Table 2).The improved position is also reflected in the attached Maternity Dashboard, Appendix 2.

Whilst the service is delighted with the stillbirth position for the first half of the year, it is difficult to pinpoint specific interventions which may have contributed to the improvement. It is likely that improvement work during 2018/19, 2019/20, including 24/7 Maternity Assessment Centre opening, ongoing use of MAMA academy wallets, and consistent messages regarding fetal movements, are now embedded in practice. It is also possible that women's behaviour during the Covid pandemic, and service changes introduced during this period, are also contributing to the overall stillbirth rate but are difficult to prove.

For example, Community Midwives are reporting that it is much easier to make telephone contact with women than pre-Covid, giving opportunities for conversations regarding movements and fetal/maternal wellbeing. The introduction of a dedicated telephone triage line, may also be contributing to continuity and consistency of advice and early attendance.

Table 1:

Gestation	Summary	Review outcome
26 + 4	G2 P1, previous normal birth. Presented at 25 + 4 with reduced fetal movements and IUD confirmed.	72 hour review completed, appropriate antenatal care with clear documented evidence of discussions regarding fetal movements. No care omissions identified. Unexplained stillbirth, awaiting post mortem findings.

Table 2:

Stillbirths 2020			Expected deaths within total number	Further detailed investigation
Month	Number of baby's	Running total	Butterfly baby's	Number of cases
January	4	4	1	2
February	4	8	1	1
March	2	10	0	0
April	1	11	0	0
May	2	13	1	0
June	1	14	0	0

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Ongoing actions to address the stillbirth rate:

Although we are able to report an improved position, the service is far from complacent and remains acutely aware of the need for further improvement work to address the overall stillbirth rate.

The service previously identified and reported themes and trends emerging regarding the identification and management of small for gestational age babies. Review of antenatal care pathways, systems and processes for both low and high risk women, was requested as an urgent transformational work stream, and presented to the Executive team in March.

The Executive team are supportive of the proposed transformation/improvement plans and the service has prioritised the areas which require immediate attention, including a full review of the guidance and tools available used for surveillance of fetal growth.

Full implementation of the Saving Babies' Lives Care Bundle, Version 2, will also contribute towards further reduction of avoidable stillbirths and neonatal deaths. The service are working with radiology colleagues in Unplanned Care, to identify the additional scan capacity, training and resource required to achieve full compliance with the care bundle, which will be presented to Board in the next few months.

One to One care in labour:

One to one care in labour continued to be closely managed by the labour ward co-ordinators during June, with proformas completed for all women who were deemed not to have received the standard. This process has been in place for 2 months and the intention is to collate the data at the end of July, to identify reasons for non-achievement and areas for improvement. This analysis will be included in the August report to the Executive and Non-Executive Regulation Committee.

The rates have improved dramatically over the last 4 months, with 95% of women receiving one to one care during June. This is a slight reduction on the 97% achieved in May but above the target of 90%. There were no changes to the staffing and cohorting arrangements across the intrapartum areas during June, or with the methods of midwife allocation and monitoring by labour ward co-ordinators. However, the area experienced higher activity and acuity in the last weeks of June combined with Covid related staffing pressures, which may account for the small decrease.

	January	February	March	April	May	June
Total	61%	69%	71%	83%	97%	95%

Continuity of Carer Action plan:

As reported in June, the provision of continuity of carer pathways has been affected by Covid-19, with some pathways placed on hold or not commenced. The service reinstated the Home Birth team in June with 3 births in the first few weeks and reports of an increased number of new bookings. Consideration is being given as to when other existing pathways can safely resume.

The service has the additional support of the LMS lead midwife to restart the continuity of carer engagement conversations with staff, due to the ongoing shielding of the lead midwife. Virtual Continuity of Carer forums have been held during June, and expressions of interest to join new teams have been requested this month.

The Continuity of Carer action plan, required to demonstrate compliance with safety action 9 of the temporarily paused Maternity Incentive Scheme, is included in Appendix 1.

Maternity Theatres:

Covid-19 has delayed progression with the maternity theatre rebuild. However, the Maternity Theatre Project team has continued to meet on a regular basis, with plans now approaching the final stages of sign off. A multidisciplinary approach has been applied, with opinion sought from maternity staff, anaesthetic and neonatal colleagues. In addition to this, service users who have had recent experience of caesarean section at BTHFT have also contributed to the design of the new build. It is anticipated that work will commence towards the end of the year, with minimal disruption in the first instance as the modular build will mostly occur off site.

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. This has been robustly implemented and has benefitted from having a dedicated non-clinical midwife who has had the capacity to monitor every case. Consideration will need to be given as to how this is maintained once shielding restrictions are relaxed. Weekly Datix reporting of the frequency of theatre 2 usage is well embedded and consistent.

Maternity Dashboard:

Appendix 2 contains May data and demonstrates consistently positive maternity metrics and outcomes.

As already noted in this report, the stillbirth rate and the provision of one to one care in labour, are particularly reassuring and demonstrate an improved position.

The one metric requiring monitoring is a decrease in the breastfeeding initiation rate for May. This is possibly attributed to the Covid arrangements for visiting, which are encouraging more women to request early discharge home. The dashboard does not reveal any other significant areas of concern requiring escalation to this committee.

Outstanding Maternity Service Programme:

The Outstanding Maternity Service Programme is the working title of the planned maternity transformation programme, intended to improve the service from ‘Requires Improvement’ to ‘Outstanding’.

Tim Gold, Director of Operations for Planned Care, prepared a proposed programme and presented to the Executive team in May for discussion. The programme contains 5 work streams:

- Maternity Pathways and Outcomes.

- Maternity Systems.
- Maternity Theatres and Estates.
- Governance, Risk and Administration.
- Culture, Workforce and ways of Working.

The triumvirate team have started to co-ordinate and prioritise the early stages of the programme, including discussions and engagement with members of the multi-disciplinary team (MDT). A number of meetings with the Consultant Obstetricians and Gynaecologists occurred during May, and a senior Midwifery lead has been identified to support the Maternity Pathways and Outcomes work stream.

Progress during June:

- Positive discussions were held with band 7 ward and department managers and specialist midwives during June, who are committed to utilising their leadership skills to engage and lead their teams during the transformation programme.

- Shortlisting for an interim matron to enable the release of the senior midwifery lead has occurred, with interviews planned for July.

- OMS implementation group established and meets weekly.

- OMS launch date for stakeholders and staff engagement is planned for 26 August at Bradford City Football club.

- The senior team will participate in a team and individual resilience session facilitated by Clive Lewis, on 23 July.

3 PROPOSAL

The service proposes that the Maternity Action Plan, stillbirth rate, one to one care in labour and continuity of carer continue to be presented to Quality Committee on a monthly basis, until sustained improvement is noted in these key areas and the 2019/20 Maternity CQC action plan is complete.

The service also proposes that progress on the Outstanding Maternity Service programme is included in this monthly update.

Any urgent concerns emerging outside of the monthly reporting arrangements will be escalated by the Trust Level Safety Champions to the Board Level Safety Champion.

4 BENCHMARKING IMPLICATIONS

The service will continue to benchmark and monitor performance and position at both regional and national level, using the existing benchmarking tools including the Yorkshire and Humber regional maternity dashboard, MBRRACE-UK publications etc.

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Continuity of Carer is monitored through the West Yorkshire and Harrogate LMS, and reported to the national maternity transformation team although this is temporarily paused due to Covid-19.

5 RISK ASSESSMENT

Stillbirths, One to One care in labour and Continuity of Carer pathways are on the maternity risk register, updated regularly and monitored through Women's Core Governance Group. All risks have been reviewed to reflect any increased risk as a result of changes to the service to maintain safety of women, babies and staff during the pandemic.

6 RECOMMENDATIONS

The Board of Directors are asked to note the Maternity Services Action plan, and to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned.

The service requests that the Board of Directors acknowledge the continued temporary pause of a number of key maternity transformation/national safety initiatives due to the current pandemic.

The Board of Directors are asked to acknowledge the on-going attempts to monitor and develop strategies to improve one to one care in labour, and the service's commitment to addressing the issues raised by the CQC.

The service requests that the Board of Directors note the progress of the Outstanding Maternity Programme during June.

7 Appendices

1. Maternity Improvement Plan – Appendix 1
2. Maternity Dashboard - Appendix 2