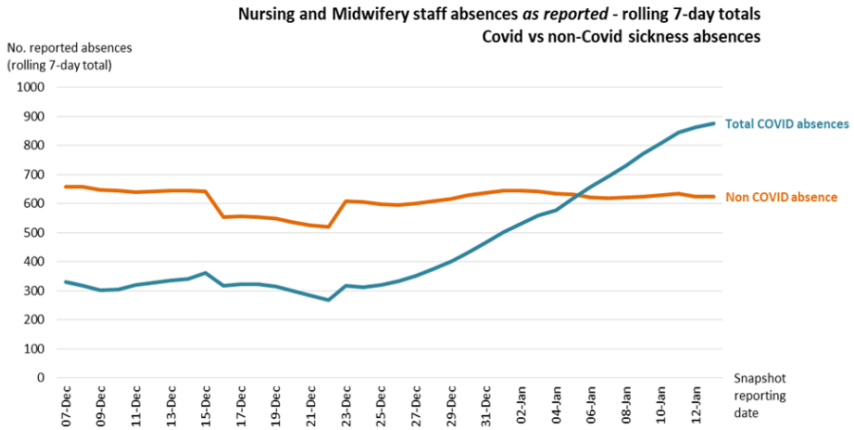
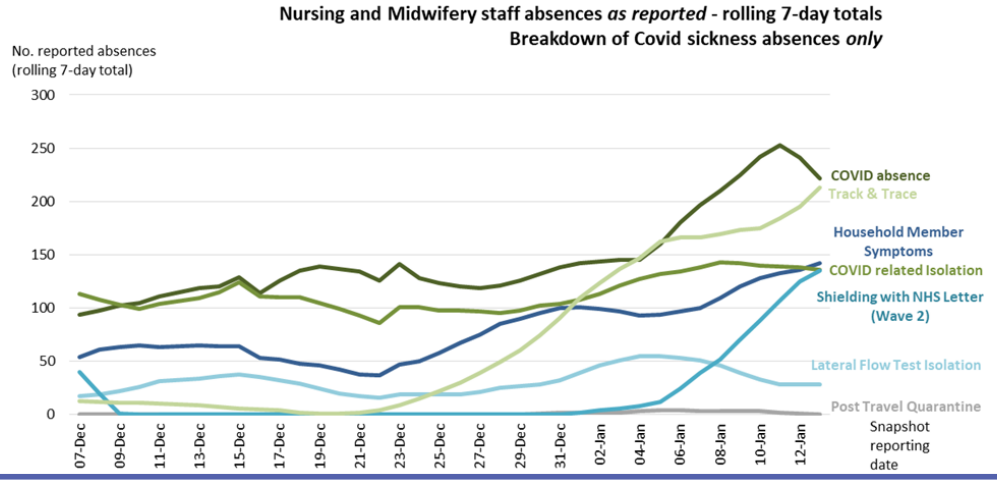
Staff absence

With the increase in community prevalence from Covid 19 infections we saw associated nursing and Midwifery staff absences through December in to January as illustrated in the graphs below.





We have been acutely aware of the fact that staff absences and high acuity, bed occupancy has resulted in a two-fold impact:

- potential impact on quality of care
- potential impact on staff moral, health and wellbeing.

Actions taken:

- re visit staff awareness of the offer for support and to encourage they prioritise their own health and wellbeing offers of flexible working arrangements
- Reinstated use of the dynamic trigger tool in safety huddles with weekly auditing care provision
- redeployment of staff, use of a blended model* of staffing facilitated by buddy system and meet and greet model at start and end of shifts in CC
- Increased visibility of leadership nursing team., reinstated Covid responsive site leadership team

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 February 2021
Paper number	F1

Midwifery Safe Staffing Report Oct - Nov 2020

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Vicky Morris, Chief Nursing Officer		
Presented by	Justine Jeffery, Divisional Director of Midwifery & Gynaecology Nursing	**Author /s**	Justine Jeffery, Divisional Director of Midwifery & Gynaecology Nursing

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
Maternity Governance	February 2021	
TME	20 January 2021	Report noted

Recommendations	The Board is asked to note how safe staffing is monitored and actions taken to mitigate any shortfalls.

Executive summary	A monthly report is provided to Board outlining how safe staffing in maternity is monitored to provide assurance. Safe midwifery staffing is monitored monthly by the following actions: • Completion of the Birthrate plus acuity tool (4 hourly) • Monitoring the midwife to birth ratio • Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' • Daily staff safety huddle • COVID SitRep (re -introduced during COVID 19 wave 2) October and November was a challenging period of time to maintain safe staffing levels. Actions taken did provide appropriate mitigation however delays in care were noted and the increased utilisation of the community midwifery team to support the maintenance of safe staffing levels was noted. The directorate has recently recruited into all vacancies and further adverts will be placed to recruit into 10 WTE additional funded posts to support the team during the challenges of COVID. This is expected to have a positive impact on the Directorates ability to maintain above 90%

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 February 2021
Paper number	F1

	fill rates.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	

Assurance Level (x)	0		1		2		3		4		5		6	x	7		N/A	
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	**3 months**					

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	11 February 2021
Paper number	F1

Introduction/Background

The Directorate is required to provide a monthly report to Board outlining how Safe midwifery staffing in maternity is monitored to provide assurance.

Safe staffing is monitored monthly by the following actions:

- Completion of the Birthrate plus acuity tool (4 hourly)
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- Daily staff safety huddle
- COVID SitRep (re -introduced during COVID 19 wave 2)

The biannual report (published in June and December) also includes the results of the 3 yearly Birthrate Plus audit or the 6 monthly 'desktop' audits. The Trust is required to complete a full Birthrate plus audit in Spring 2021.

Issues and options

Completion of the Birthrate plus acuity tool (4 hourly)

The Birthrate Acuity Tool summary for October – November is presented below and also the documented shortfalls and actions taken to mitigate any risks identified and demonstrate that acuity was higher than the actual staffing in 48% of the time. This % is documented **prior to any actions taken** and it is noted that in the majority of cases this is due to a staff member undertaking scrub duties in theatre. Recent meetings have been undertaken with SCSD to discuss the opportunity to transfer this service and remove the requirement for midwives to scrub in theatre.

The second recorded reason for a shortfall is sickness which is due to both COVID and non-COVID related sickness. Non COVID related sickness is being managed in line with the Trust Policy with the support of HR colleagues.

Monitoring the midwife to birth ratio

The birth to midwife ratio is recorded on the dashboard and monitored at Maternity Governance meeting. The ratio in October (1:28) & November (1:24) was within the agreed midwife to birth ratio as outlined in Birthrate Plus Audit (1:29).

Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'

No red flags affecting care have been reported via Datix during this time and it has been noted that 'red flags' are poorly reported via this mechanism. Lower than expected staffing levels have been reported. The Directorate has worked with the E Roster team to develop a module within 'Safe care' to record 'red flags'. Training has been arranged for the unit managers to ensure that the flags are recorded consistently.

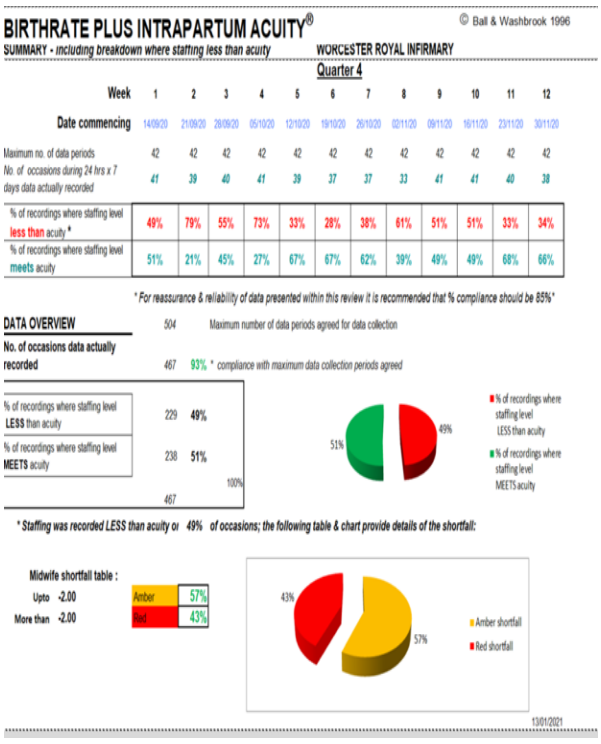
Meeting	Trust Board
Date of meeting	11 February 2021
Paper number	F1

Daily staff safety huddle

Daily staffing huddles have been completed each morning within the maternity department. In addition to this huddle a second daily huddle (attended by HoM) has been in place when it was noted that minimum staffing levels were not achieved or acuity was high and escalation required. Senior oversight and professional judgement has been utilised to undertake appropriate actions to ensure safe staffing.

COVID SitRep (re-introduced during COVID 19 Wave 2)

The Divisional Management team complete a daily COVID huddle with all directorates to share information about the current COVID position and identify any risks to the service which includes a focus on safe staffing and is a forum for Matrons and Ward Managers to raise concerns about staffing levels.


BIRTHRATE PLUS INTRAPARTUM ACUITY®

© Ball & Washbrook 1996

SUMMARY - *including breakdown where staffing less than acuity* WORCESTER ROYAL INFIRMARY

Quarter 4

Week	1	2	3	4	5	6	7	8	9	10	11	12
Date commencing	14/09/20	21/09/20	28/09/20	05/10/20	12/10/20	19/10/20	26/10/20	02/11/20	09/11/20	16/11/20	23/11/20	30/11/20
Maximum no. of data periods	42	42	42	42	42	42	42	42	42	42	42	42
No. of occasions during 24 hrs x 7 days data actually recorded	41	39	40	41	39	37	37	33	41	41	40	38
% of recordings where staffing level less than acuity *	49%	79%	55%	73%	33%	28%	38%	61%	51%	51%	33%	34%
% of recordings where staffing level meets acuity	51%	21%	45%	27%	67%	67%	62%	39%	49%	49%	68%	66%

* *For reassurance & reliability of data presented within this review it is recommended that % compliance should be 85%*

DATA OVERVIEW

504 Maximum number of data periods agreed for data collection

No. of occasions data actually recorded 467 93% * *compliance with maximum data collection periods agreed*

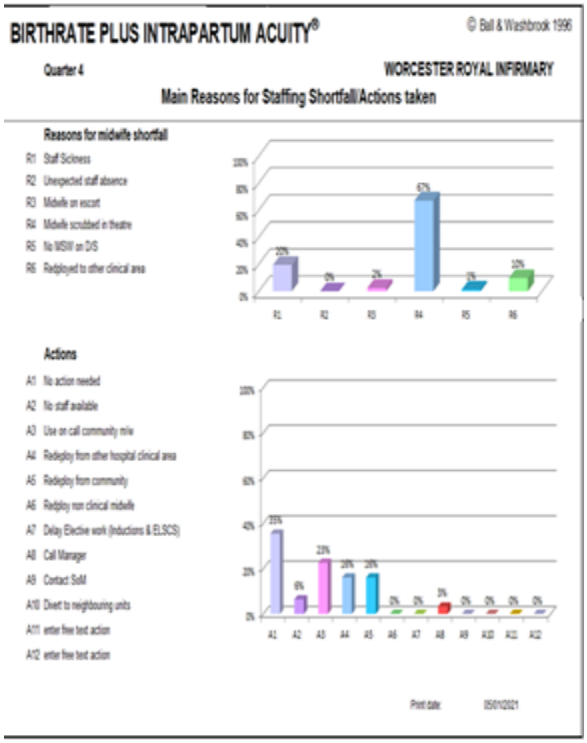
% of recordings where staffing level LESS than acuity	229	49%
% of recordings where staffing level MEETS acuity	238	51%
	467	100%

* *Staffing was recorded LESS than acuity on* 49% *of occasions; the following table & chart provide details of the shortfall:*

Midwife shortfall table :

Upto -2.00	Amber 57%
More than -2.00	Red 43%

13/01/2021


BIRTHRATE PLUS INTRAPARTUM ACUITY®

© Ball & Washbrook 1996

Quarter 4 WORCESTER ROYAL INFIRMARY

Main Reasons for Staffing Shortfall/Actions taken

Reasons for midwife shortfall

R1 Staff Sickness
R2 Unexpected staff absence
R3 Midwife on escort
R4 Midwife scrubbed in theatre
R5 No MSW on D/S
R6 Redployed to other clinical area

Actions

A1 No action needed
A2 No staff available
A3 Use on call community mw
A4 Redeploy from other hospital clinical area
A5 Redeploy from community
A6 Redploy non clinical midwife
A7 Delay Elective work (Inductions & ELSCS)
A8 Call Manager
A9 Contact SoM
A10 Divert to neighbouring units
A11 enter free text action
A12 enter free text action

Print date: 05/01/2021

In October staff raised their concerns regarding the level of staff on shift.

Actions taken

The Divisional Management Team met with staff to discuss their concerns and to provide assurance as outlined below:

- It was established that whilst acknowledging expected levels of staffing had not been met on certain occasions, minimum safe staffing levels were achieved and patient safety maintained.

- The increased episodes of escalation and the reliance on support from the on-call community midwife were also acknowledged and staff assured that this was a result of COVID related absence. Daily safe staffing huddles continued to monitor and plan mitigations.
- The delays in Induction of Labour continued in October: each delay was managed through continuous risk assessment with the multi-professional team and some women were transferred within the LMNS supported by Wye Valley Trust.
- No adverse clinical incidents were reported which related to staffing or delays in care however it is acknowledged that some women had a poor experience. Daily discussions with the Consultant / midwife in charge were undertaken and further support offered by the named lead midwife following discharge.
- All non-essential training and non - clinical working days were cancelled and all of the matrons ward managers and specialist midwives were deployed to the clinical areas to support safer staffing levels as required throughout this period.

Conclusion

October and November was a challenging period of time to maintain safe staffing levels. Actions taken did provide appropriate mitigation however delays in care were noted and the utilisation of the community midwifery team to support the maintenance of safe staffing levels was increased and the impact of this was noted.

The directorate has recently recruited into all vacancies and further adverts will be placed to recruit into 10 WTE additional funded posts to support the team during the challenges of COVID. This is expected to have a positive impact on the Directorates ability to maintain above 90% fill rates.

Human resources continue to support ward managers/Matrons to manage sickness absence in line with the Trust Policy.

Recommendations

The Board is asked to note how safe staffing is monitored and actions taken to mitigate any shortfalls.

Appendices

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11th February 2021
Paper number	Enc F2

Ockenden Report - Review Gap Analysis

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Vicky Morris, Chief Nursing officer		
Presented by	Justine Jeffery, Divisional Director of Midwifery & Gynaecology Nursing	**Author**	Justine Jeffery, Divisional Director of Midwifery & Gynaecology Nursing

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	20th January 2021	Report noted
QGC	28th January 2021	Report noted

Recommendations	Trust Board is asked to note the gap analysis; the actions identified and support the Division to demonstrate compliance.

Executive summary	The Ockenden report was published in December 2020 following an investigation into the safety of the maternity services at Shrewsbury and Telford NHS Trust. Following the publication of this report Trusts were asked to provide assurance against 8 categories outlining 14 immediate safety actions. The categories are: 1. Enhanced safety 2. Listening to Women and their Families 3. Staff Training and working together 4. Managing complex pregnancy 5. Risk Assessment throughout pregnancy 6. Monitoring Fetal Wellbeing 7. Informed Consent 8. Workforce A gap analysis was completed and the Division were able to demonstrate compliance with 7 of the 14 immediate actions. In a further 6 areas a gap had been noted and actions identified to meet the standard outlined in the report. At the time of initially completing the gap analysis one action 'Perinatal Clinical Quality Surveillance Model' had not been launched. This has now been received by the Trust and the Division is in the process of reviewing

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11th February 2021
Paper number	Enc F2

	the model.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	

Assurance Level (x)	0		1		2		3		4		5		6	x	7		N/A	
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	**Y**	**X**	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	**Y**	**X**	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11th February 2021
Paper number	Enc F2

Introduction/Background

The Ockenden report was published in December 2020 following an investigation into the safety of the maternity services at Shrewsbury and Telford NHS Trust.

Issues and options

Following the publication of this report Trusts were asked to provide assurance against 7 categories with 14 immediate safety actions. The categories are:

1. Enhanced safety
2. Listening to Women and their Families
3. Staff Training and working together
4. Managing complex pregnancy
5. Risk Assessment throughout pregnancy
6. Monitoring Fetal Wellbeing
7. Informed Consent
8. Workforce

A gap analysis is presented in the appendix.

The Trust has now received a request for the completion of an assurance tool for the remainder of the reports' recommendations which is due for submission to NHSE/I on 15th February 2021. Evidence to support this submission will be expected in March 2021.

Conclusion

On review of the actions the Division were able to demonstrate compliance with 7 of the 14 immediate actions. In a further 6 areas a gap had been noted and actions identified to meet the standard outlined in the report.

At the time of initially completing the gap analysis one action 'Perinatal Clinical Quality Surveillance Model' had not been launched. This has now been received by the Trust and the Division is in the process of reviewing the model.

Recommendations

Trust Board is asked to note the gap analysis; the actions identified and support the Division to demonstrate compliance.

Appendices - Gap Analysis

Worcestershire Acute Hospitals NHS Trust

Women & Children's Division

Gap analysis Ockenden Report Immediate Actions 15th December 2020

RAG Rating Key:

Completion Status	
	Unable to currently progress
	Gap identified actions not yet complete
	Gap identified actions fully completed
	No gap identified – no action required

Recommendation	RAG rating	Evidence to support	Action required	By who	By when
1. Enhanced Safety					
A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly		Awaiting publication	Yes – to be developed following publication of model		To be confirmed when model is published
All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB		SIRG minutes QRSM minutes LMNS Board Minutes	-SI summaries need to go to QGC as the Quality representative of the Board -Send SIs to LMNS Board	Governance Lead	Jan 2021 then monthly
2. Listening to Women and their Families					
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity		Already implemented: - MVP meetings -HoM Q&A sessions -Postnatal Survey -Report on birth choices -Membership of Task & Finish Groups -Member of Labour Ward	No further action required		

services		Forum			
In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.		Already implemented: -Mark Yates-NED -Vicky Morris Board Level Safety Champion	No further action required		
3. **Staff Training and working together**					
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.		Already implemented: -Rotas available and sign in sheets/medical rota	No further action required		
The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.		Already implemented: -Practical Obstetric Multi-Professional Training (PROMPT) in place -TNA -Attendance sheets -Training action plan completed to ensure that we meet 90% compliance for PROMPT.	No further actions required		
Confirmation that funding allocated for maternity staff training is ring- fenced and		Partial compliance: 20/21 Proposal for use of 200K of incentive to support	-Money to be fully ring-fenced -Case for need to be	Director of Finance Divisional Management Team	July 2021 (CNST submission) March 2021 (year-end)

any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety		additional costs from: • PROMPT training business case • Continuity of carer roll out costs • Pre-term clinic QIA completed	completed to identify existing plus new expenditure required to meet the CNST standards to provide outstanding care -Any resulting business case to be considered favourably by S&P and TME	Executive Team	March 2021 (year-end)
4. **Managing complex pregnancy**					
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place		Partial compliance as not recently audited: - All complex women have a named Consultant which is recorded on Badgernet. - Criteria for referral in antenatal guideline and risk assessment on Badgernet	- Audit to be completed via Badgernet to demonstrate 100% compliance	Clinical Director	Jan 2020
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres		-NHS E/I working regionally to develop networked approach to management of maternal medicine; including referral to tertiary centres -Engagement in regional discussions and provision of local data on maternal medicine activity	-Continued engagement in clinical meetings to discuss clinical pathways and tiered approach to maternal medicine care in region. -Engage in development of / adopt pathway criteria and guidance *Action marked as green as we are aware of steps required to support this work and continue to engage*	Clinical Director	Next meeting with CDs January 2021; timescale being driven by NHS E/I
5. **Risk Assessment throughout pregnancy**					
A risk assessment must be completed and recorded at		Partial compliance: -Risk assessment	Review current guideline	Matron for Community Midwifery Services	Jan 2020

every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance		traditionally completed at booking and 36 weeks unless a change in pregnancy pathway. -Staff all recently trained to use Badgernet and the requirement to repeat risk assessment at each contact was implemented at this time.	Audit via Badgernet	Digital Midwife	Jan 2020
6 Monitoring Fetal Wellbeing					
Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.		Partial compliance: -Funding for MW Lead provided by LMNS for 12 months and recruitment process underway -We are compliant with all other requirements of SBLV2 - element 4.	-Progress recruitment of midwife lead -Identify funding for obstetric lead for fetal monitoring	Director of Midwifery Clinical Director	December 2020 Jan 2020
7 Informed Consent					
Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster		Partial compliance as website does not include pathways: -Pathway on Badgernet 'Maternity App' Describes visiting schedule by pathway and additional tasks and recommended	Develop website to include information on pathways	Clinical Director / Director of Midwifery / Communications	April 2020

website.		reading. Personalised to each woman.			
8 Workforce					
The report is clear that safe delivery of maternity services is dependent on a Multidisciplinary Team approach. The Maternity Transformation Programme has implemented a range of interventions to deliver increases in healthcare professionals and support workers including: the development of the maternity support worker role, the expansion of midwifery undergraduate numbers, additional maternity placements and active recruitment.		-HEE MSW bid successful – ongoing scoping exercise due to complete in March 2021 -Student Midwife places increased and a number of additional placements arranged e.g Infant Feeding Team, Governance Team etc -Recently recruited 7.2WTE in October – start dates given, further advert currently in progress for additional posts (4WTE) and additional posts (10WTE) funded to support COVID impact. Rolling recruitment in place. -Proactive filling of medical vacancy both short term via bank and locum cover and via succession planning for permanent staff	No further action required		
Alongside this, local maternity leaders should align assessments, safety, and workforce plans to the needs of local communities. We are therefore asking Trust Boards to confirm that they have a plan in place to the Birthrate Plus (BR+) standard by **31 January 2021** confirming timescales for		-Full funding to meet BR+ requirements from 2018 audit -Full BR+ audit completed every 3 years; planned re-audit in spring 2021 -Desktop BR+ audit completed every six months	No further actions required		

implementation.		- In normal circumstances, a monthly workforce report is prepared and submitted to People and Culture and onto Board. - - 6 monthly report to Board -Recent agreement to fund a further 10WTE due to staffing challenges experienced in Q2/3 due to COVID19; this is over and above BR+ recommended establishment			

Matthew Hopkins
Chief Executive Officer
21st December 2020

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 February 2021
Paper number	Enc F3

Maternity Serious Incident Report Quarter 3 (September – December 2020)

For approval:		For discussion:	x	For assurance:	x	To note:	

Accountable Director	Vicky Morris (Chief Nurse/ Maternity Safety Board Champion)		
Presented by	Justine Jeffery (Divisional Director of Midwifery & Gynaecology Nursing)	**Author /s**	Nicola Robinson (Divisional Governance Lead)

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources		Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome
QGC	28th January 2021	

Recommendations	To note the Serious Incidents reported in Maternity in Q3 – October – December 2020 contained within the report and the Ockenden recommendations for the reporting and scrutiny of all serious incidents.

Executive summary	This report provides a summary of all Maternity serious incidents (SIs) reported during Q3 October – December 2020. Monthly reporting will follow in accordance with the recommendations outlined in the recently published Ockenden report. Within this quarter two (2) cases were reported as SI's - 1 neonatal death and 1 maternal death. Duty of candour has been completed in both cases and the investigations are progressing within the expected timeframe. Following the publication of the Ockenden report in December 2020 it is now recommended that: • external clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death (for those cases that do not meet investigation by HSIB). The Division plans to invite the current external specialist who is a member of the Perinatal Mortality Review Tool (PMRT) Board. • All SI's will be shared with the local Maternity and Neonatal System (LMNS) for scrutiny, oversight and transparency. A process to support this is currently under review by the (LMNS).

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 February 2021
Paper number	Enc F3

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	

Assurance Level (x)	0		1		2		3		4		5		6	x	7		N/A	
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*																						

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 February 2021
Paper number	Enc F3

Introduction/Background

This report provides a summary of all Serious Incidents (SIs) reported by the Maternity and Neonatal Directorates during October – December 2020. The Directorate will provide a report through appropriate internal Governance processes to the Trust Board every month outlining all serious incidents, the progress of duty of candour and the report themes (where identified) and any lessons learned.

There were two serious incidents reported between October– December 2020 and are presented in this report.

In December 2020, A national publication "The Ockenden Report" was published and in the recommendations the following requirements were placed for all Trusts to implement:

- Trusts must work collaboratively to ensure local investigations into serious incidents (SIs) have regional and local maternity system (LMS) oversight. All maternity SI reports (and summary of the key issues) must be shared with the Trust Board and at the same time to the local LMNS for scrutiny, oversight and transparency.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

Issues and options

There were 2 cases reported in this quarter:

<u>Case 1</u>

Incident category – Neonatal Death

Woman in her 1st pregnancy booked late at 25 weeks gestation and appropriately booked for consultant led care. Antenatal care – no concerns identified.

At term, the mother called triage, reporting bleeding with spontaneous rupture of membranes.

Immediately seen on arrival and a fetal bradycardia was noted, a category 1 lower segment caesarean section (LSCS) was called and a baby girl was born within 30 minutes. Birthweight 3232grams on the 30th centile, requiring extensive resuscitation – which was unsuccessful and therefore a neonatal death was confirmed.

The Immediate Case Review was discussed at the Divisional Quality and Safety Review Meeting (QSRM) on 09.12.20 further information requested before a decision on how the case should proceed. Presented again at QSRM on 16.12. 20 agreed to escalate as an SI - escalated to corporate team & reported via StEIS on 21.12.20

Terms of reference agreed:

- Investigate all aspects of maternity care in the antepartum, intrapartum and postpartum period, with specific focus on:

- The review at 38 weeks in triage and decision making in the intrapartum period.
- The process around the decision for induction
- The resuscitation and care of the baby up to the point of CPR being stopped.

- Ensure that the perception of events is captured from the family, the Trust and staff directly involved in the care of the mother and the baby

Immediate learning & review of guidance

- If the woman presents at or after 37+0 weeks of gestation, it is important to establish if the bleeding is an Antepartum Haemorrhage (APH) or blood stained 'show'. In the event of a minor or major APH, national guidance recommends induction of labour with the aim of achieving a vaginal birth to avoid adverse consequences potentially associated with a placental abruption. (Royal College of Obstetricians & Gynaecologists Green Top Guideline, No 63, page 12, Nov 2011)

- In cases of recurrent unclassified APH, induction of labour should be considered at or near term even if fetal growth is satisfactory. (WHAT-TP-094, 15/11/19).

Duty of Candour was completed by the Consultant Obstetrician.

Case was immediately referred to:

- Coroners

- HSIB; however this case did not meet the criteria (as the woman not in labour).

Current status

Investigation ongoing completion expected 01.03.20 (60 working days)

Case 2

Incident Category – Maternal Death

A woman in her 3rd pregnancy attended maternity triage at Worcestershire Royal Hospital with a history of left sided lower abdominal pain. After assessment and treatment she was discharged with a plan for follow up in the Maternity Day Assessment Unit (DAU).

She was reviewed the following day at maternity DAU complaining of frontal headache, screening for pre-eclampsia test undertaken and test result suggested that woman was low risk for developing pre-eclampsia. A plan was made for further follow up in 1 week.

She attended as per plan and was complained of worsening symptoms. Admission was recommended to enable further investigations to be completed and she then had regular

reviews, further blood tests and chest x-rays.

During her inpatient stay the woman was reviewed by the consultant and noted to have a mild headache, visual disturbances and epigastric pain.

The woman was found collapsed and unresponsive at her bedside. Cardiopulmonary Resuscitation (CPR) was commenced and a peri-mortem caesarean section was undertaken within the recommended 5-7 minutes. A live baby was born and transferred to the neonatal un for CPAP. Ongoing maternal resuscitation continue however following an extensive period of resuscitation and further surgical intervention resuscitation ceased following agreement with the attending team.

Immediate learning & review of guidance

- VTE assessment was completed; however there has been discussion about whether the most appropriate dose of LMWH was prescribed.
- Duty of Candour completed with partner by Matron and letter provided. Family supported by bereavement specialist midwives.
- Staff supported by Trust Clinical Psychologist, OH advice provided and support from clinical leads, Matrons and wider DMT.
- Referred to HSIB – Investigation ongoing. Investigation within reporting deadlines (6 months HSIB)
- Referred to MBRRACE and Coroner
- Escalated to corporate patient safety team and reported via StEIS.

Initial postmortem – no cause of death identified.

Conclusion

In conclusion there have been two serious incidents reported in quarter three.

Non- compliance with APH and VTE guidance noted. Local guidance has been reviewed and noted to be correctly aligned to national guidance.

One case was referred to HSIB; however the other case was not assessed as meeting the criteria for review by HSIB and is now being investigated under the Trust's SI Framework.

In both cases, the Duty of Candour has been completed with the families

	Incident Category	***Declared SI***	***HSIB referral***	***Duty Of Candour completed***
Case 1	*Neonatal Death*	*Yes*	*Yes - Did not meet criteria*	*Yes*
Case 2	*Maternal Death*	*Yes*	*Yes*	*Yes*

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 February 2021
Paper number	Enc F3

Recommendations
To note the findings of the summary of the incidents within maternity services during Q3 and the timeframes for completion. To also note the recommendations outlined in the recently published Ockenden report.
Appendices

NHS
Worcestershire Acute Hospitals
NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 February 2021
Paper number	Enc F4

Audit and Assurance Committee Assurance Report

For approval:		For discussion:		For assurance:	X	To note:	

Accountable Director	Anita Day Chair, Audit and Assurance Committee		
Presented by	Anita Day Chair, Audit and Assurance Committee	**Author /s**	Martin Wood Deputy Company Secretary

Alignment to the Trust's strategic objectives (x)							
Best services for local people		Best experience of care and outcomes for our patients		Best use of resources	X	Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board is requested to • Note the report for assurance.
Executive summary	This report summarises the business of the Audit and Assurance Committee at its meeting held on 12 January 2021.

Risk			
Which key red risks does this report address?	*N/A*	**What BAF risk does this report address?**	*N/A*

Assurance Level (x)	0		1		2		3		4		5		6		7		N/A	X
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 February 2021
Paper number	Enc F4

Introduction/Background

The Audit and Assurance Committee has been established to critically review the governance and assurance processes upon which the Trust Board places reliance, ensuring that the organisation operates effectively and meets its strategic objectives. Membership is three Non-Executive Directors.

The Committee has met once since the last report, on 12 January 2021.

Issues and options

The key issues discussed were as follows:-

- **External Audit Progress Report:** We were informed that COVID-19 has impacted on the work of external auditors both in the NHS and Local Government and as a consequence their planning and interim audit work will not now start until February 2021 which is later than they originally expected. We were assured that this delay is not expected to be an issue as meetings are to be arranged with the external auditors to discuss the programme and any issues identified will be brought to the Committee's attention. We are seeking clarification as to whether a different approach will be undertaken to the stocktake. We were informed of the challenges facing Trusts nationally in the appointment of external auditors.
- **Head of Internal Audit Opinion and COVID Briefing:** We were informed that COVID-19 has impacted on the ability of internal audit to deliver their audit programme and as a result they have sought to reschedule and flex audits around the Trust's commitments and workloads. We were assured that sufficient work is expected to be undertaken for an unqualified Head of Audit Opinion to be provided.
- **Internal Audit Progress Report:** We noted current progress. The workplan is to be presented to our next meeting giving us an opportunity to review the focus for the work to be undertaken.
- **Internal Audit Reports:** We noted the BAF Review (level A assurance), Health and Safety Review – Follow up (significant level of assurance) and Governance Arrangements Divisions Review (significant level of assurance).
- **Cyber Security:** We noted the Cyber Security Survey – The Impact of COVID-19 on the NHS providing themes for consideration. We have asked the Chief Digital Officer to consider the themes identified to demonstrate how assurance could be gained on our current risk exposure.
- **Counter Fraud Progress Report:** We noted the summary of the Trust's counter fraud activities in 2020/21. We discussed how decisions are taken as to whether to continue with cases and the sharing of information between organisations to raise awareness of fraud activities. We noted the Counter Fraud workplan for 2020/21.
- **Annual Accounts Timetable 2021:** We noted the timetable for the preparation and presentation of the Annual Accounts for 2021 based on current guidance. In the light of this guidance it will be necessary to reschedule the Committee's meeting in May 2021.

Other items considered

- Review of terms of reference
- Tender waivers
- Debt write offs

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 February 2021
Paper number	Enc F4

Conclusion
Recommendations
The Trust Board is requested to • Note the report for assurance.
Appendices - None