Paper ref:	TB (06/22) 017

PATIENTS PEOPLE POPULATION

NHS
Sandwell and West Birmingham
NHS Trust

REPORT TITLE:	Maternity Services Update		
SPONSORING EXECUTIVE:	Melanie Roberts - Chief Nurse		
REPORT AUTHOR:	Helen Hurst - Director of Midwifery		
MEETING:	Public Trust Board	**DATE:**	8th June 2022

1.	**Suggested discussion points** *[two or three issues you consider the Trust Board should focus on in discussion]*

The Trust Board is asked to receive this assurance document, as an update to the Board on: -

1. The progress made within the first year of launching the Equality Diversity and Inclusion (EDI) lead role, has been notable. We are listening and hearing our women, families, communities, and colleagues more than ever before, to ensure an environment that is inclusive and not exclusive. Real change has been made with the support from 3rd sector partners to reduce health inequalities, by supporting earlier and easier access to health care, supporting messages to improve outcomes and sustainable change within the service. Our colleagues are exposed to diversity within the workplace, building inclusive habits that will evolve our culture and provide equity for all staff.
2. Workforce remains a focus support the overall quality improvement journey, the current vacancy within the maternity service, including the uplift to the establishment following the Ockenden monies is 37.05wte. The progress with recruitment will see 41wte (21 final year students (accepted) and 20 internationally educated midwives) in post by March 2023 (pending any deviation), which will support future attrition.
3. The monthly update from safety champions in relation to maternity safety meetings

Also included in the appendix 1 is the Ockenden framework update for April 2022

2.	**Alignment to our Vision** *[indicate with an 'X' which Strategic Objective[s] this paper supports]*					
OUR PATIENTS		**OUR PEOPLE**		**OUR POPULATION**		
To be good or outstanding in everything that we do	**X**	To cultivate and sustain happy, productive and engaged staff	**X**	To work seamlessly with our partners to improve lives	**X**	

3.	**Previous consideration** *[at which meeting[s] has this paper/matter been previously discussed?]*

Maternity and Neonatal data received at Quality and Safety Committee 25th April 2022. Safety champion meeting 13th May 2022.

4.	**Recommendation(s)**
The Public Trust Board is asked to:	
a.	**ACCEPT**, **DISCUSS** and **SUPPORT** the EDI update
b.	**ACCEPT** and **DISCUSS** the safety champion update
c.	**DISCUSS** and **APPROVE** the oversight Framework

5.	**Impact** *[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]*	
Board Assurance Framework Risk 01	x	*Deliver safe, high-quality care.*

Board Assurance Framework Risk 02	x	*Make best strategic use of its resources*						
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*						
Board Assurance Framework Risk 04	x	*Recruit, retain, train, and develop an engaged and effective workforce*						
Board Assurance Framework Risk 05		*Deliver on its ambitions as an integrated care organisation*						
Corporate Risk Register [Safeguard Risk Nos]		Workforce risks 4480,3831,3576,4575,4326,2625						
Equality Impact Assessment		Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment		Is this required?	Y		N	x	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to Trust Board: 8th June 2022

Maternity Services Update

1.0 Introduction

1.1 Board level oversight for maternity and neonatal services is fundamental to the quality improvement programme, to ensure transparency and safe delivery of services. A vital driver for the programme is ensuring we hear, respond, and improve from listening to our women, families, communities and workforce to ensure and evoke real, sustainable change.

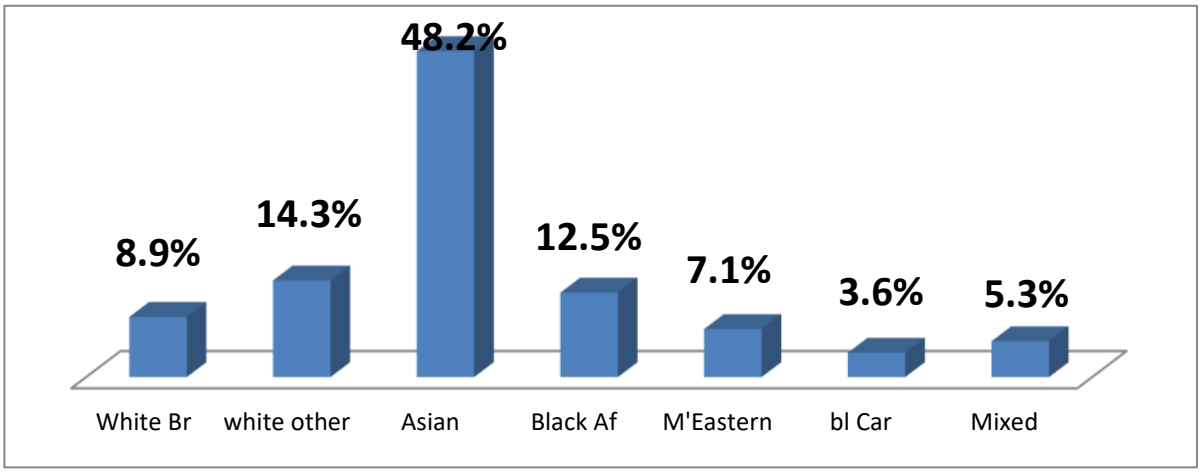
2.0 Equality Diversity and Inclusion Update One Year on

2.2 Equity ensures that all mothers and babies will achieve health outcomes that are as good as the groups with the best health outcomes. For this, maternity and neonatal services need to respond to each person's unique situation and will require increasing support as health inequalities increase. Our colleagues deserve an environment with equal opportunity for progression and training to fulfil individual potential, ensuring we work in an inclusive and not exclusive culture.

2.3 One year on there are positive steps both with the interaction with our local communities and our workforce, supporting cultural change. Listening and more importantly hearing, has supported our journey of continual improvement, so that we now move forward in an inclusive way determined by hearing the feedback and acting upon it. We have engaged with our local communities to ensure we had both the qualitative and quantitative data to enact that change. Fundamental to this has been understanding the perception of pregnancy within different cultures, enabling us to provide the services our women both want and need. Part of this has supported the work to reduce late bookers; we know that historically we have averaged 22% against a national average of 13% and local average of 17% of women who book late (after 12 weeks and 6 days). The development of the online self-referral portal now counts for 35% of the referrals. We secured £17k funding from the West Midlands Safety Innovation and Improvement fund to Pilot with Sandwell's Children's Centre, 7 neutral venues to become Maternity Referral Centres. These centres are now offering a variety of universal family support services supporting the wider determinants of health and improving outcomes.

2.4 The introduction of the accessible antenatal birth classes has seen significant uptake from across the diversity of our communities. The chart below demonstrates that change, previously attendees were predominantly attended by white British women.

2.5 Table 1 below demonstrates the distribution by ethnicity of attendance since introduction for the last 7 months.



2.6 We have partnered with local media, visited schools, attended resource centres, attended community events, local supermarkets and used social media with inclusive videos to ensure wide, inclusive distribution of health and well-being messages. This has significantly improved attendance especially for women with reduced fetal movements.

2.7 We have led on the work within the Black Country and West Birmingham for refugees and people with no recourse for funding. This has made a significant difference for those families, by ensuring care was delivered in the refugee hotels or where they were accommodated, ensuring system wide standard operating procedures, guidelines and leaflets were co-designed and in place to ensure continuity of carer. This has led to our involvement in the National programme.

2.8 The lead role was funded as a pilot by the local maternity and neonatal system (LMNS). Within six months, the success had been recognised and now all providers have been included, ensuring networks across the system. A business case has been written to support the team substantively, we wait to hear, but we are pleased to confirm that the LMNS have agreed to fund the lead post for a further year.

3.0 Midwifery Workforce Update

3.1 Workforce remains a focus of the service, especially within the hard to fill area within community midwifery. To ensure safe staffing, assurance and support, meetings are held three times per week, with the community teams. We have also partnered with third sector organisations to provide additional support and look to consolidate on this relationship with a contractual agreement. The introduction of nurses into postnatal ward areas, has received excellent feedback from women and staff, releasing midwives to deliver specific midwifery care. We continue to scope alternative workforce support and we are currently reviewing the use of pharmacy technicians to work within ward areas and paramedics in triage.

3.2 The current vacancy within the maternity service, including the uplift to the establishment following the Ockenden monies is 37.05wte. The progress made with recruitment will see

48wte:-21 final year students (accepted) and 20 internationally educated midwives in post by March 2023 (pending any deviation). A further 7 midwives and 4 maternity support workers were recruited from the women's and child health recruitment event held on the 7th of May, all of these posts will support future attrition. This provides a positive shift, the significance of which should not be underestimated.

4.0 Safety Champion Update

4.1 The May meeting reviewed progress with the Ockenden report recommendations and staffing risks, particularly in the neonatal unit. Short term plans for locum appointments and longer term internal training plans were discussed. Gaps from training rota at midgrade are to be reviewed at next months meeting, considering the impact on the rota and training opportunities. Safety data and case reviews of the stillbirth and neonatal cases were discussed with any immediate learning highlighted. Plans for a visit to community services are under development. Further progress meetings are in planning for review of progress against the Ockenden recommendations, with a focus currently on full compliance with training requirements.

5.0 Summary

5.1 Our quality improvement journey continues and is strengthened by co-designing services with our women, families, communities, and colleagues. This is only achievable when we listen, hear and act upon what we have heard. Ensuring our workforce has the capacity to deliver safe, high quality, woman, and family personalised care, supports our journey and safety culture. Whilst ensuring job satisfaction, which supports health and well-being, retention and makes us the workplace of choice.

6.0 Recommendations

The Trust Board is asked to:

A. **ACCEPT**, **DISCUSS** and **SUPPORT** the EDI update
B. **ACCEPT** and **DISCUSS** the safety champion update
C. **DISCUSS** and **APPROVE** the oversight Framework

Helen Hurst
Director of Midwifery
18th May 2022

-

Annex 1

Ockenden Framework Update for April 2022

Data Measures	Summary	Key Points
Findings of review of all perinatal deaths using the real time data monitoring tool	All relevant cases have been reported to MBRRACE. Perinatal Mortality Review Tool (PMRT) reviews, meeting CNST requirements. 2 still birth's 1 Neonatal death	Quarterly PMRT report provided to Trust board, via Quality and Safety Committee. Monthly data detailed in paper to Quality and Safety Committee
Findings of review all cases eligible for referral to Health Services Investigation Branch (HSIB)	1 case referred for investigation. 4 cases active within the process. 2 final reports received. Report1 no contributing factors and no safety actions Report2 no contributing actions, 1 safety action.	Cases included in the Quality and Safety Committee report and discussed at monthly Safety Champion meeting. Themes and lessons learnt embedded across the service and incorporated into professional study days.
The number of incidents logged graded as moderate or above and what action being taken.	1 serious incident (SI) declared, HSIB case as above. No SIs were finalised for the Directorate. The Directorate currently has 12 open Sis 2 pending closure following receipt of HSIB report (seven of which are also HSIB investigations, which are automatically recorded as SIs).	Weekly multi-disciplinary incident review/learning meeting in place within the service.
Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training.	Training against core competency framework remains above expected target of 90%.	Professional training database (core competency framework) monitored by education team. CNST requirement of 90% MDT compliance on track

Minimum safe staffing in maternity services, to include obstetric cover on the delivery suite, gaps in rotas and minimum midwifery staffing, planned vs actual prospectively	100% compliance with obstetric labour ward cover. Neonatal clinician gap 1.2 wte on Tier 2 and this is set to increase further at the end of April with maternity leave for one trainee. Midwifery safe staffing analysis included in Quality and Safety report, average fill rate for inpatient (midwifery and NNU) 97%.	Birth rate plus assessment currently entrain. Community midwifery workforce review, included in paper. Member of National Pilot of Recruitment and Retention. Monies approved from national bid for a retention midwife to support newly qualified and new in post midwives.
Service User Voice feedback	Feedback collated from FFT, complaints, PALS, local surveys and Maternity Voices Partnership (MVP)	Themes from complaints are clinical treatment and attitudes and behaviours, patient stories are being woven into shared learning. Several compliments have also been received. No responses received in month as no feedback messages were sent out by envoy, this is under investigation. Maternity is working with Head of Patient Involvement and Insight to ensure patient experience is captured, survey questions in development. MVP group continues to grow and supports development across the service, including guideline reviews. A wealth of feedback is being captured by the EDI lead, captured in Board report. Actions arise out of feedback to support a culture of "you said, we did" evidence of which is in all areas. Also captured in perfect ward.
Staff feedback from frontline champions and walk-abouts	Walkabout feedback Executive and Non-Executive safety champion	Included in report
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Nil received	Nil received
Coroner Reg 28 made directly to Trust	None	None

Progress in achievement of CNST10	CNST Compliance Rag Rating Outstanding 0 In progress 8 Complete 2 Currently on track to achieve 10/10	Notification has been received of new dates and criteria following lifting of the pause. Board declaration must now be submitted on 5th January 2023. The team are now reviewing against new amendments.
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment	Yearly survey	
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical	Yearly survey	