Paper ref:	TB (11/22) 007

PATIENTS PEOPLE POPULATION

NHS
Sandwell and West Birmingham
NHS Trust

REPORT TITLE:	Maternity Services Update		
SPONSORING EXECUTIVE:	Melanie Roberts - Chief Nursing Officer		
REPORT AUTHOR:	Helen Hurst - Director of Midwifery		
MEETING:	Public Trust Board	**DATE:**	2nd November2022

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 report, as an update to the Board: -

1. The Insights report has been received into the organisation, following the visit on the 14th of September. Building on the initial feedback provided to Board last month, the report in annex 1 provides the detail of areas that now require audit to ensure they are embedded. Requirements found in our own report mirror some of those themes identified in the regional overview (annex 2). To note no Trust within region was fully compliant with having embedded all elements based on audit.
2. On the 11th of October Public Heath England undertook their delayed Quality Assurance visit for screening. This looked at all aspects of the screening programme, antennal screening, ultrasound, new-born screening and hearing screening. There were no immediate safety concerns raised. The full report will come to Board in January.
3. The report into East Kent Maternity Service was released on the 19th October, this report reconfirmed the requirements for Boards to maintain the focus on delivering personalised and safe maternity and neonatal care. As well as the importance of listening, hearing and acting upon the experience of women, babies, families and colleagues and that we respond with respect, compassion and kindness.

Also included in the annex 2 is the Ockenden framework update for September 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 28th September 2022.
Safety champion meeting 2nd October 2022.

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**DISCUSS** the Insights Report
b.	**NOTE** the initial East Kent maternity report overview
c.	**NOTE** the initial feedback from the QA Screening Visit
d.	**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	x	*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		If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y		N		If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to Trust Board: October 2022

Maternity Services Update

1. 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. Central to supporting oversight and assurance are external reviews of service provision, the paper includes two for the Boards evidence.

2. Regional Insight Assurance Visit

2.1 The Insights report has been received into the organisation, following the visit on the 14th of September. Building on the initial feedback provided to Board last month, the report in annex 1 provides the detail of areas that now require audit to ensure they are embedded. Overall attainment was met at 75%, with clear direction to meet the 25%. All elements could be clearly seen and described in practice during the visit, but now requires to be evidence by auditable data.

2.2 Key areas noted were in relation to audit of the twice daily ward rounds and named consultant, these have commenced. The elements of non-compliance for saving babies lives relates to a data pull issue, which meant we were unable to provide the evidence on the day. Work has been ongoing to address this situation, with one outstanding area (carbon monoxide monitoring to fully address). These two areas are found in 4 of the elements and therefore impacts on the attainment.

2.3 Requirements and points of celebration found in our own report mirror some of those themes identified in the regional overview in table 1 and 2. To note no Trust within region was fully compliant with having embedded all elements based on audit.

2.4 Key themes and areas for consideration from regional analysis

- The LMNS role of assurance in the Clinical Quality Surveillance Model is still developing and not fully embedded in all ICS especially in single trust LMNS's
- Many of the trusts are reviewing and recruiting additional staff roles, strengthening leadership teams, and building specialist positions in all areas which will accelerate improvement in time
- The majority of Non-Executive Director (NED) had an excellent understanding of maternity issues risks and concerns in their organisation
- A more positive picture is seen with recruitment and retention of staff
- Innovative Remodelling of workforce examples in place for the service
- Many organisations are achieving external representation for SI and PMRT reviews
- Many Innovative QI projects, new clinical pathways and governance reporting tools have been seen showcasing the brilliant work underway in many of the organisations

- In many of the organisations the NED and Executive lead for maternity services needs to be more visible in the system to staff, women and their families who were unaware of who the individual was and what the role entailed
- More work is required with the LMNS firming up an agreement with either a named buddy organisation or a LMNS review team for external review of serious incidents including Memorandum of Understanding (MOU) agreement documentation
- Many organisations needed to strengthen the processes in place for auditing of Ockenden actions to gain monthly assurance of progress -particularly for consultant twice daily ward rounds, antenatal risk assessment at every visit and SBLCB2 assurance
- Several LMNS and trusts need to advance a new Maternity Voices Partnership (MVP) strategy with comprehensive funding and expansion of users to the team to develop the ability to undertake all the required work
- Multiple units still had issues, due to staffing issues, with obstetric and midwifery staff attending mandatory PROMPT ensuring Multi-Disciplinary Training (MDT) as planned affecting Ockenden compliance
- Many of the Trusts need to update their website to ensure women and their families have information on place of birth and access to important information in any language required, with facilities for auditory and visual impairments
- Electronic Patient Records concerns were raised in multiple trusts with difficulties in viewing care records by staff and women and extracting data for audit and incident investigation with a requirement to work closely to national standards
- It was seen there was a need to strengthen the governance, process and management of guidelines ensuring exception reporting is tabled monthly on divisional governance meetings in several units
- Continued work is required to achieve all the actions to become SBLCB2 full compliance, which should be monitored by the LMNS, and risks CNST maternity incentive scheme achievement in year 4

2.5 Key points of celebration in region.

- A clear Perinatal Clinical Quality Surveillance Model was in place in almost all Trusts
- An open and honest culture was seen in numerous organisations which is echoed from all the representatives spoken to on the day of the visits, with shared understanding of issues at all levels
- The majority of trusts report a positive multidisciplinary working relationship across midwifery and obstetric teams which was evident in many of the visits
- Many Trusts are reviewing and recruiting additional roles, strengthening leadership teams and building specialist positions in all areas which will accelerate improvement in time
- The majority of NED's had an excellent understanding of maternity issues, risks and concerns in their organisations
- A more positive picture is seen with recruitment and retention
- Innovative remodelling of workforce examples in place for the service
- Many organisations are achieving external representation for reviews
- Many innovative quality improvement projects, new clinical pathways and governance reporting tools have been seen showcasing the brilliant work in many of the organisations.

3. Screening Quality Assurance Review

3.1 On the 11th of October a team from PHE undertook a quality assurance visit to assess the screening programmes within maternity. This Quality assurance (QA) visit aims to maintain national standards and promote continuous improvement in antenatal and new-born (ANNB) screening. This is to ensure that all eligible people have access to a consistent, high-quality service wherever they live. QA visits are carried out by the PHE screening quality assurance service (SQAS). Initial feedback from the visit was that there are no immediate safety concerns but several areas for consideration and improvement, it was also noted the amount of ongoing work to improve the service and the notable differences. The feedback however would not separate out what is or has already been completed as per the ongoing action plan. The full report will be submitted as part of the update to January's Board.

4. East Kent Report – Reading the Signals

The report into East Kent Maternity Service was released on the 19th of October, this report reconfirmed the requirements for Boards to maintain the focus on delivering personalised and safe maternity and neonatal care. As well as the importance of listening, hearing, and acting upon the experience of women, babies, families, and colleagues and that we respond with respect, compassion, and kindness. The report outlines four areas for action:

- To get better at identifying poorly performing units
- Giving care with compassion and kindness
- Teamworking with a common purpose
- Responding to challenge with honesty.

A single delivery plan for maternity and neonatal care will be published in 2023 by NHSE, which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and NHS Long-Term Plan and Maternity Transformation Programme deliverables. The work we have undertaken to date in our own maternity improvement plan incorporates these key findings.

5. Summary

5.1 The continuum of improvement at all levels is imperative to improve services, outcomes, and future proofs our services. External reviews and support are essential to ensure the service is progressing and developing to ensure high quality, safe, effective and with co-production as a central role.

6. Recommendations

6.1 The Trust Board is asked to:

a. Discuss the feedback from the Regional Insight Visit
b. Note the initial East Kent maternity report overview
c. Note the initial feedback from the QA Screening Visit

d. Approve the oversight Framework

Helen Hurst
Director of Midwifery

23rd September 2022

Annex 1: Insights Report
Annex 2: Ockenden Framework Update for October

Ockenden Framework Update for October (September's data) 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. 1 still birth's and 0Neonatal 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)	4 ongoing cases 1 case returned complete	Cases included in the Quality and Safety Committee report and discussed at monthly Safety Champion meeting. Key themes from returned relate to documentation, escalation, and situational awareness. Actions have been completed and the service have met with the family to update and support them. 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.	0 serious incident (SI) declared. The Directorate currently has 5 ongoing cases, 4 of which are HSIB cases.	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% for midwives. 75% for doctors this impact due the new rotation, dates in place will be completed by the end of October.	Professional training database (core competency framework) monitored by education team. CNST requirement of 90% MDT training has now been updated to 90% in 12 consecutive months.
Minimum safe staffing in maternity services, to include obstetric cover on the delivery suite, gaps in rotas and minimum	100% compliance with obstetric labour ward cover. Obstetric tier 1 and 2 gaps following new rotation from the	Birth rate plus assessment currently entrain. Community midwifery workforce review, included in paper.

Data Measures	Summary	Key Points
midwifery staffing, planned vs actual prospectively	deanery. Plans in place to mitigate. 2 episodes of consultants acting down. Neonatal clinician gap improvement with September with new rotation to compliance Midwifery safe staffing analysis included in Quality and Safety report, average fill rate for inpatient (midwifery and NNU) 96%. High levels of short tern sickness noted red BCP enacted in community midwifery	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. High numbers of short-term sickness, areas reconfigured to support safe staffing. BCP's initiated to support safe staffing fluctuating between amber and red due to sickness. 9 newly qualified commenced in post, 5 more awaited. 9 internationally educated MW's awaiting landing. System recruitment event 23/11/22
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.
Staff feedback from frontline champions and walk-abouts	feedback from 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	None	None
Coroner Reg 28 made directly to Trust	None	None
Progress in achievement of CNST10	Currently on track to achieve 8/10 with new updated requirements.	Board declaration must now be submitted on 2nd February 2023. New amendments awaited. new amendments have caused concern across the region and have been escalated to NHSR.
Proportion of midwives responding with 'Agree or Strongly Agree' on whether	Yearly survey	

Data Measures	Summary	Key Points
they would recommend their trust as a place to work or receive treatment		
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical	Yearly survey	