Paper ref:	TB (11/21) 008

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title:	Maternity Services Update		
Sponsoring Executive:	Melanie Roberts - Chief Nurse		
Report Author:	Helen Hurst - Director of Midwifery		
Meeting:	Trust Board	**Date**	4th November 2021

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

- Three national reviews have highlighted the importance of robust governance systems and processes (Kirkup, 2015, Cwm Taf, 2019 & Ockenden 2020) these findings were reiterated in Trust level review and listening events within the maternity service. Actions taken following the internal review and LIA's have developed both the structure and systems and processes within maternity governance, highlights of which are included in the body of the report.

- The CQC inspection (May 2021) identified good governance practice within the maternity service:

  "The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service"

- Key risk remains workforce, vacancies have reduced from 23wte to 18wte, the service are currently scoping alternative models of care internally and how this can be support across the ICS.

2. Alignment to our Vision *[indicate with an 'X' which Strategic Objective 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		To work seamlessly with our partners to improve lives	

3. Previous consideration *[where has this paper been previously discussed?]*

4. Recommendation(s)

The Trust Board is asked to:

a.	Note and discuss content of the report
b.	Approve as required

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register							
Board Assurance Framework							
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: 4th November 2021

Maternity Services Update

1.0 Background

Fundamental to providing safe, effective, high quality maternity care is promoting a solid foundation of governance. Ensuring systems and processes are in embedded and that the culture is one in which reporting is valued and encouraged, with feedback to those who produce reports and shared learning from the investigations, driving open and honest conversations. *Getting safer faster* (CQC 2020) states that "services that were rated as outstanding had clear governance processes in place with effective policies, assurance, risk management and leadership at every level. These approaches were seen to encourage openness and continuous learning, with effective incident reporting and investigations, and learning processes in place. Services that prioritised learning were able to ensure that staff had the correct skills, knowledge and experience to do their job, and that they were supported to maintain and further develop their professional skills and experience"
Strong governance and organisational memory with clear processes to ensure learning from serious adverse events, and to engage with families, is echoed in the three key maternity reviews over recent years, Kirkup (2015), Cwm Taf (2019) and Ockenden (2020). Governance was noted as a theme within the Trust level review and listening events undertaken within the maternity service from November 2020 and has formed part of the improvement plan. The paper below outlines the progress made to strengthen governance within maternity services. As a result of the work undertaken this was identified as an area of good practice during the CQC unannounced inspection in May 2021.

2.0 Structure

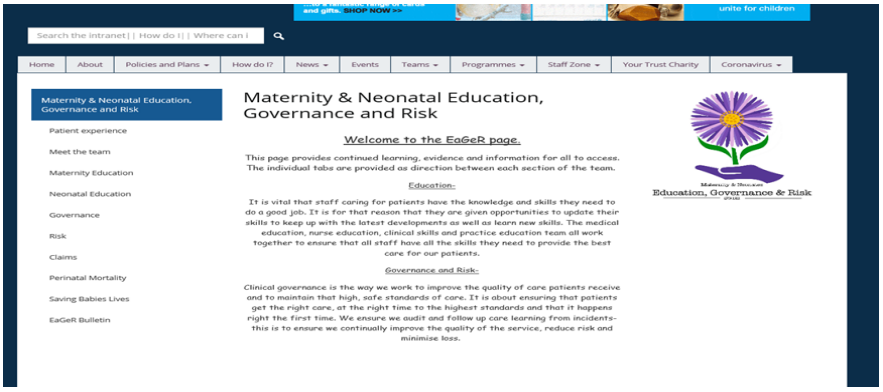
The structure within Maternity governance has been enhanced to support an improved safety culture in line with the expanding requirements, to enable support to improve outcomes, and to reduce health inequalities. The structure is inclusive of a lead midwife, midwifery risk leads, saving babies lives midwife, clinical educators, lead midwife for perinatal mortality and morbidity, fetal monitoring lead midwife. Clinician involvement has also been enhanced building on the lead clinician role for obstetrics, clinical lead for risk (obstetrics and neonates), lead clinician for multi-professional training (obstetrics, anaesthetics, neonates) lead for perinatal morbidity/mortality and lead for fetal monitoring

3.0 Systems and Processes

A number of systems and processes have been refreshed or added to ensure a transparent service that learns and supports development in line with best practice, these include:

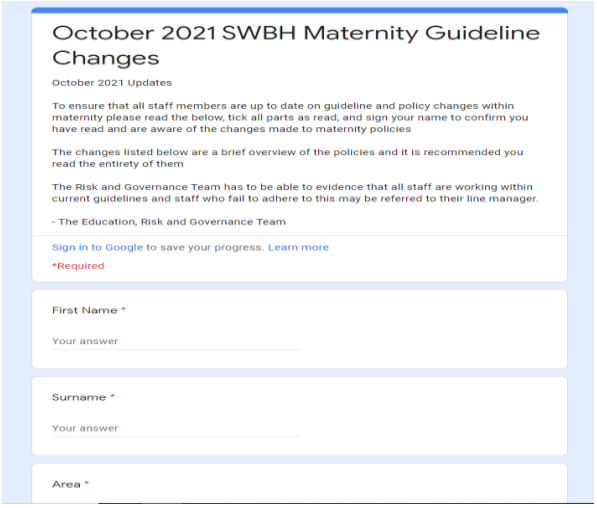
- Perinatal mortality review meeting which includes an external obstetrician, CDOP nurses and the families voice
- Perinatal risk management group and board (PRMG and PRMB)
- Launch of Weekly Incident Review meeting to identify and address issues in care earlier
    - Review cases each week via 72 hour review
    - Summary of incidents in the last 7 days including themes and trends
    - Open forum for staff of all areas to come and participate in discussions
    - Decides on whether the case requires further escalation or management at local a level
    - Opportunity for the leads of the ward areas to bring any risk or incident issues to the group

- Sharepoint to impart information across the service and organisation: Health Service Investigation Board (HSIB) reports (local and national reports), PRMB and PRIMG actions, guideline & Standard operating procedure (SOP) updates, education opportunities and training dates



- HSIB recommendation board on Delivery Suite
  - Summary of recommendations from reports

- Google Drive & Guideline SOP to support robust management of guidelines ensuring they are updated in with review dates and auditable data of dissemination to the workforce
  - Staff are sent a link on Google Drive for the guideline updates for that month
  - Compliance monitored through the guideline SOP to encourage staff to update themselves with new practices
  - This change was published in the HSIB national newsletter and has a lot of interest from other units across England.



* Example of google drive as sent out with specific guideline

- Monthly Risk & Governance posters with updates on risks, incidents, complaints, compliments, training compliance
  - Keep staff updated on new risks
  - Number of incidents in web-holding
  - Compliments for the month and complaints
  - Education training compliance for all areas
  - Top 3 incident themes
  - Learning of the month

- Serious incidents of the month

- Education, Governance and Risk (EGR) quarterly bulletin
  - Relaunched to include updates from education risk and governance
  - Themes of learning
  - Guidelines that have been updated
  - Saving babies lives (SBL) audit results
  - Focus of the month

- Pledge to Patient Safety folder on Delivery Suite
  - Introduced following HSIB recommendation
  - Communicate monthly major learning theme for obstetric and midwifery staff
  - Signatures collected to collect data

- Launch of Just a Minute (JAM)
  - By Obstetric Lead Consultant, Fortnightly
  - Sharing short pockets of learning and gentle reminders with all staff around recent incidents

- Attendance at maternity forums and QIHD to discuss updates and share learning
  - Address learning issues from incidents, HSIB and provide feedback from education, risk and governance
  - Saving Babies Lives (SBL) audits

- Development of guidance co-designed with the professional midwifery advocates and occupational health in order to provide a suite of tailored support for staff following incidents to support their health and well-being

4.0 Training

- Risk and Guidance deliver on Maternity Mandated Day to support knowledge around risk and governance
  - Interactive session to allow staff to understand how 72 hour reviews are conducted, different processes of escalation and why
  - Staff can learn why changes in practice and guidelines occur
  - Learning from incidents

- Return of face-to-face learning PROMPT and re-launch of MMD
  - Post-COVID interactive sessions which are more beneficial for learning

- STORK training programme
  - Staff education training to standardise information given to parents to reduce perinatal mortality rates
- Saving Babies Lives (SBL) study day
  - All elements of SBL shared with staff
  - Current audit figures
  - SBL linked to relevant HSIB cases to express importance of SBL
  - Documentation standards to ensure care bundle is being met
- Electronic Fetal Monitoring (EFM) study day
  - New EFM midwife in post to launch these
  - Improve compliance with completing fresh eyes on cardiotocograph (CTGs)
  - Improve interpretation of CTGs

- Using case examples

- All clinical areas have the SBL handbook
- Monthly GROW charts to highlight good and poor practice to standardise Symphysis Fundal Height (SFH) management in adhering to guidelines
- Trolley dashes and skills drills in the clinical areas
  - Increased during COVID when face-to-face learning was not taking place
  - Share pockets of learning from incidents

6.0 Key Risk

6.1 Workforce

6.1.1 Vacancies within the maternity service remain a key risk to service delivery currently at 18wte, this will reduce further with the new starters and work continues to both retain and recruit staff.

6.1.2 A recruitment open day was held on 9th October whilst this was well publicised whilst appointments were made at this event, it did not yield the expected recruitment.

6.1.3 The service is now scoping alternative workforce models to enhance the service, and will be working with our external partner to recruit international midwives. This will include modelling across the ICS.

7.0 Summary

It is clear that the governance team, systems and processes have been enhanced to ensure solid foundations are in place. Continuing to embed a safety culture is one in which reporting is valued and encouraged, with feedback to those who make reports and shared learning from the investigations, driving open and honest conversations, will ensure every pregnant woman and birthing people have a positive birth experience. Every member of staff working in a maternity service wants to provide safe, high-quality care and support the *Getting safer faster (CQC 2020)* agenda.

8.0 Recommendations

The Trust Board is asked to:

a) Note and discuss the content of the report
b) Approve as required

Helen Hurst
Director of Midwifery
25th October 2021