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Sandwell and West Birmingham Hospitals 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**	2nd December 2021

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

This paper presents the oversight assessment tool as required following the Ockenden report. It provides the Board with a high level overview on any present or emerging concerns and the safety of the maternity service. This update is new to Board this month and will be included as a monthly update moving forward. The in-depth detailed report is presented to the Quality and Safety committee on a monthly basis, for the scrutiny and challenge of the Executives and Non-Executives represented.

Workforce also remains a key risk; the report provides a quarterly overview of workforce fill rate and the impact of acuity and capacity. Quality improvement initiatives to support both acuity and capacity and therefore reduce risk have seen a positive impact.

- The two main areas of concentration are reducing delays to induction and staff redeployments of over 4 hrs. Delays to induction have seen a 54% reduction in delayed induction over the last 8 weeks. The reduction in redeployment of staff to support acuity and capacity over the past four months has reduced from 75 to 24 occasions.
- Staffing within community midwifery remains a challenge. To support the team and the activity, community midwifery are working within their business continuity plan (current rag rating Amber), this plan centralises care and deploys workforce at all levels, therefore supporting reduced workforce. Caseloads are monitored by the matrons and QI lead. Workforce initiatives in place include; recruitment of international midwives and rotational posts for band 5 and band 6 midwives to community (11wte. rotated out by May).The service is currently scoping a pilot into an alternative community model to support both the Trust and the wider LMNS (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	x	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. **APPROVE** the oversight Frame

b. **DISCUSS** the workforce risks and assurance in place

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: 2nd December 2021

Maternity Services Update

1.0 Introduction

Board level oversight for maternity and neonatal services is fundamental to the quality improvement programme, to ensure transparency and safe delivery of services. The purpose of the report is to inform Trust Board of the present position and highlight to Trust Board any emerging safety concerns or actions that are required. The paper reflects the Board level oversight as required from the initial Ockendon recommendations (2020)

2.0 Oversight Framework

2.1 The Board Oversight Framework Summary Table is new to Board this month and will be updated monthly. The detailed report is discussed at Q&S on a monthly basis. It is a requirement of the Ockendon report for this to be shared at Trust Board and it is contained in Annex 1 of the paper**.** The key exception to outline is the Progress in achievement of CNST10. We currently achieve 8 of the 10 requirements and an action plan is in place to work towards achievement of the full 10 requirements which has been presented at Quality & Safety Committee

3.0 Focus on Key Risk – Maternity Workforce

Workforce remains a key risk. The current positions for both inpatients and community are outlined below.

3.1 Inpatients

Safe staffing for inpatient areas combines fill rates against actual requirements, with red flag events (Red flag events are where there has been an impact on care provision related to midwifery staffing). Twice daily staffing huddles are in place to provide an overview and support for safe staffing.

Table 1, below, shows the distribution of the workforce and fill rate. This table does not consider workload or acuity which is found in BAPM and BR+ tools respectively with incidents of unsafe staffing reported and captured through incident reporting

Fill Rate Against Actual					
			August	**September**	**October**
% fill rate	**Delivery Suite**	**Qualified**	**95%**	**97%**	**98%**
		MSW	**98%**	**98%**	**99%**
	Induction Bay	**Qualified**	**closed**	**100% (when open)**	**97%**
		MSW	**94%**	**96%**	**98%**

	M1	**Qualified**	**94%**	**98%**	**99%**
		MSW	**100%**	**99%**	**100%**
	M2	**Qualified**	**94%**	**96%**	**98%**
		MSW	**96%**	**97%**	**99%**
	Serenity	**Qualified**	**95% (closed for 2 weeks)**	**96%**	**98%**
		MSW	**100%**	**100%**	**100%**
		MSW	**100%**	**100%**	**100%**

3.1.1 The birth-rate plus acuity tool highlighted two main areas of focus against red flags; these were delayed inductions and staff redeployment for over 4 hours. With focused QI developments these areas have seen a significant downward trend:

- Reducing delays to induction have seen a 54% reduction in delayed induction over the last 8 weeks.
- The reduction in redeployment of staff to support acuity and capacity over the past four months has reduced from 75 to 24 occasions.

3.2 Community

Community midwifery are working within their business continuity plan (current rag rating Amber, see annex 2), this plan centralises care and deploys workforce at all levels.

Caseloads are monitored by the matrons and quality lead. Twice weekly assurance meetings are in place within the directorate. Further work is underway to ensure all leaders are included in the community business as usual meetings. The current caseloads are demonstrated below:

The average caseloads as observed below in table 2, do not include the team leaders or those on maternity leave. Maternity leave is covered by both long term and short term bank (short term bank does not case hold). Both the short term bank and team leaders work flexibly to meet the peaks of activity and support the caseloads. The care of our women is also supported by specialist midwives and the phoenix team (vulnerable women's team) where their care requires this additional support. The introduction of an enhanced maternity support worker (MSW) team provides additional support both within the early bird pathway and postnatally. The addition of the newly developed third sector collaborative working with the maternity navigators will provide a halo of support during the maternity ensuring community focused peer support essential to our women, and supporting our ambition to reduce health inequalities.

Table 2

Area	Caseload (average) per wte (actual)	Birthrate Plus baseline (based on whole establishment)
City	**132.4**	**92.83**
Sandwell	**121.79**	**92.83**

3.3 Vacancies and Unavailable figures

Table 3

Area	Vacancy wte		Unavailable (maternity leave etc.)
	Midwife	MSW	
Community	10.60	2.0	10.0
Inpatients	6.0	0.0	9.45

Maternity leave fluctuates across the year, with staff returning on a monthly basis. The plan to support the gap of maternity leave will be to look to retire and returns contracts and part temporary contracts.

3.4 Workforce Improvement Initiatives

3.4.1 International Recruitment

We are currently working with the national drive to recruit international midwives, with agreed funding to recruit 5 wte. Also within this area we are working with the Trusts current recruiters to increase this number, initial feedback is positive.

3.4.2 Rotational posts

All new posts are on a rotational basis, this allows fluidity in staffing, supports personalised care and maintains the skills of the workforce and therefore reduces risks associated with all core staff. This initiative as worked well with currently 8 wte rotated out to community, increasing to 11 wte by May.

3.4.3 Nurses working in maternity

A national working group has been established to support the nurses working in maternity services. Within the Trust the current vacancies within in patient will be filled by nurses to support both the postnatal ward. NNU are also supporting work within transitional care.

3.4.4 Workforce Modelling

Community midwifery historically has been modelled around geographical areas, rather than around the birth and family. We are currently scoping a pilot project with the support of the Chief nurse for the ICS to update this model and to provide seamless continuity with the place of birth team, no matter where the family live. This would support the drive for continuity of carer within the LMNS, if the pilot is approved.

4.0 Summary

Work continues to strengthen service provision and assure transparency in line with national, regional and local drivers. The Maternity Improvement plan/CQC Action plan remains on target

and Board will be updated quarterly moving forward on progress In order to provide the Board with end to end overview of care a deep dive of the neonatal service will be included in next month's report, with a view to combine data thereafter.

5.0 Recommendations

The Trust Board is asked to:

A. Approve the oversight Frame
B. Discuss the workforce risks and assurance in place

Helen Hurst
Director of Midwifery

Annex 1 Ockendon Oversight Framework Summary Table

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.	Quarterly PMRT report provided to Trust board, via Quality and Safety Committee.
Findings of review all cases eligible for referral to HSIB	1 case referred in October. 5 cases active with HSIB	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 case was escalated for moderate harm, this case has been called as a serious incident (SI) and is under investigation, as above	Weekly mulit-disciplinary incident review/learning meeting in place within the service. 20 deep dives took place in October. Themes and lessons learnt shared.
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%. K2 fetal monitoring training compliance at 97% for midwives and 100% for medics	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. Midwifery safe staffing analysis included in Quality and Safety report, average fill rate for inpatient (midwifery and NNU) 98%.	Birth rate plus assessment currently entrain. Monetary award against Ockenden workforce bid £427,623 part year across all disciplines. Current recruitment initiatives include international midwives and rotational B5&6 to support community vacancy.
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. Several compliments have also been received. FFT response rates remain low, work to increase ongoing. A wealth of feedback is being captured by the EDI lead. Actions arise out of feedback to

		support a culture of "you said, we did" evidence of which is in all areas. 15 steps will recommence led by the MVP. Also captured in perfect ward.
Staff feedback from frontline champions and walk-abouts	Walkabout schedule by Executive safety champion	During October's walkabout a live skill drill was underway on labour ward, observed by the Exec safety champion, included post drill discussion. Staff raised the issues they were having in replacing furniture in rest areas(a finding from a previous walkabout) , monies found, but the process blocking this Staff raised how busy the unit was.
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 10 Complete 0	Progress against year 4 to be noted, updated provided to Quality and Safety committee. 8/10 areas certain to complete, focus required on 2 areas to complete, which action plans are in place for. Outcome of action plan (monetary bid) tendered following year 3, 8/10 submission remains outstanding; this will impact the achievement of 10/10 for year 4.
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	

Annex 2 Community Amber status BCP

Service Impact Analysis

Critical Function (essential activity):	Amber level implemented Staffing level 65%- 84 % and recovery not anticipated.	Risk rating Starting point :5x3=15 Then 4x3= 12

Amber	Review all current Home births with a view to cease Home Birth Service depending on % of staffing level.
	Review Community midwife escalation out of hours into the inpatient unit depending on % of staffing level.
	Re-allocation of non- clinical midwifery staff to support clinical activity
	Continuity of Care team to redeployed into the community service
	Review and triage community activity inclusive of face to face home visits and all PN/AN clinics dependent on capacity and in accordance to NICE guidance
	All community team managers to work clinically
	Community clerks mobilised to support Team Leaders
	Review and decrease annual leave/ cancel Study/training leave allocation for the whole service ahead for next eight weeks
	Centralise AN/PN clinics into community hubs
	Cross site cover from the existing community Midwifery team
	Raise clinical and raise on the risk register and to alert Group Directors

Effect on Service if disrupted:

Time	Effect on service if disrupted:	Risk rating
First 24 hours	• Minimal impact on service • Service user dissatisfaction	• 5x3=15
24 – 48 hours	• Minimal impact on service • Service user dissatisfaction	• 4x3=12
Up to 2 weeks	• Increased risk of perinatal and maternal morbidity	• 4x3=12
Up to 4 weeks	• Increased risk of perinatal and maternal morbidity and mortality	• 4x3=12