Paper ref:	TB (05/21) 011

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	**Maternity Services Update**		
Sponsoring Executive	Melanie Roberts, Acting Chief Nurse		
Report Author	Helen Hurst, Director of Midwifery		
Meeting	Trust Board (Public)	**Date**	6th May 2021

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

Community Midwifery remains a challenging environment, a robust improvement plan has been developed in collaboration with the teams, and with increased oversight and support we are seeing improved assurance. 16 key areas have been identified to support the transformational agenda for Community Midwifery.

Ockenden: NHS England and Improvement is investing an additional £95.9m in 2021/22 to support the system to address all 7 IEAs consistently and to bring sustained improvements within maternity services, the Trusts proposal requests investment of £700k in 21/22, with a recurrent cost of £1,270k. This covers the three main areas: Midwifery workforce, Obstetric workforce and multidisciplinary training.

Quality Improvement plan work progresses against the plan, including improvements in community midwifery, improved platforms for shared learning, a learning in action event was held on 25th March with over 60 attendees to co-design change and the external culture review has commenced.

Data maternity and neonatal data provides an overview of care and productivity.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	√	Public Health Plan	√	People Plan & Education Plan	√
Quality Plan	√	Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

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

Maternity and Neonatal data, escalations and highlights at Quality and Safety Committee 30thApril 2021

4. Recommendation(s)

The Trust Board is asked to:

a.	Note the content of the report
b.	Discuss the report
c.	Approve as required

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

Trust Risk Register	X	Risk 4407,4356 (draft)workforce risks						
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

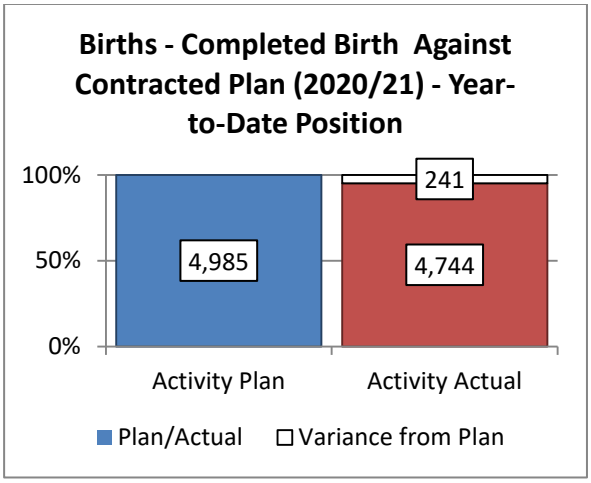
Maternity Services Update
Report to the Public Trust Board: 6th May 2021

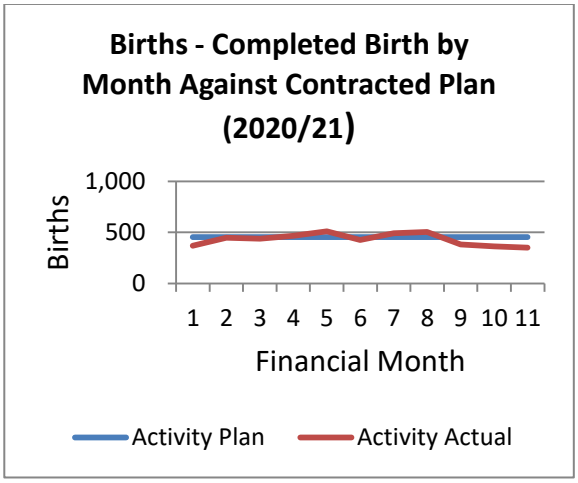
1.0 Introduction or background

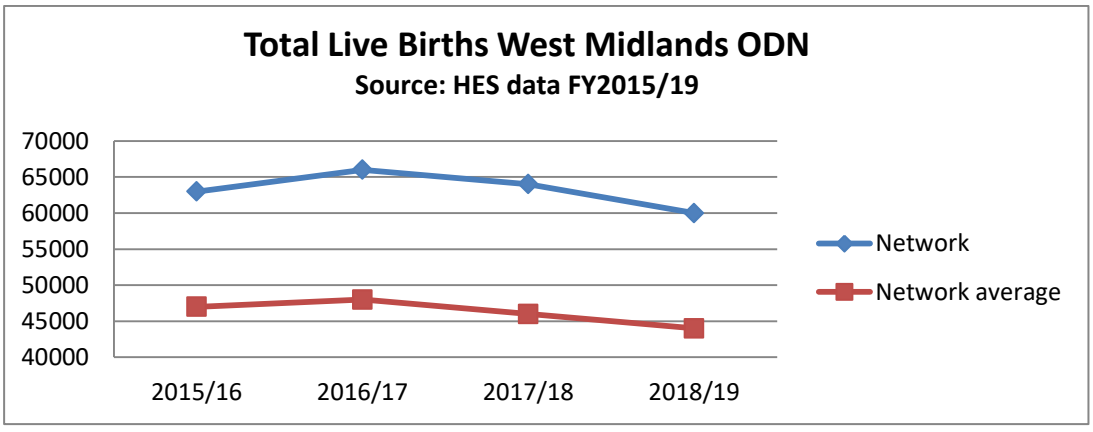
Safety in maternity and neonatal services has been of national focus since 2015 and this has been strengthened with the publication of the interim report of the Independent Maternity Review (Ockenden Report) which provides clear direction for the improvement of maternity services nationally**.**

The National impetus for change within maternity services to improve outcomes, improve experience and ensure that the woman and baby are at the centre of care, has brought together key stakeholders to deliver change. Safety is the "golden thread" which runs throughout the transformation programme and the Trust's vision.

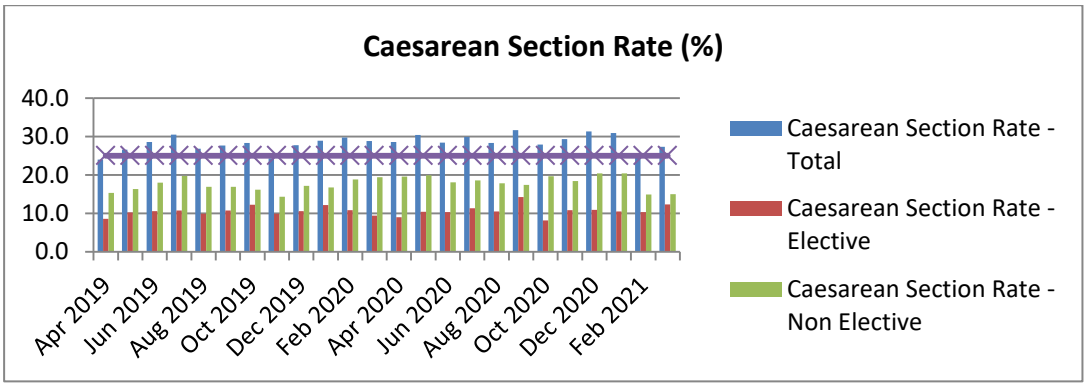
2.0 Birth data







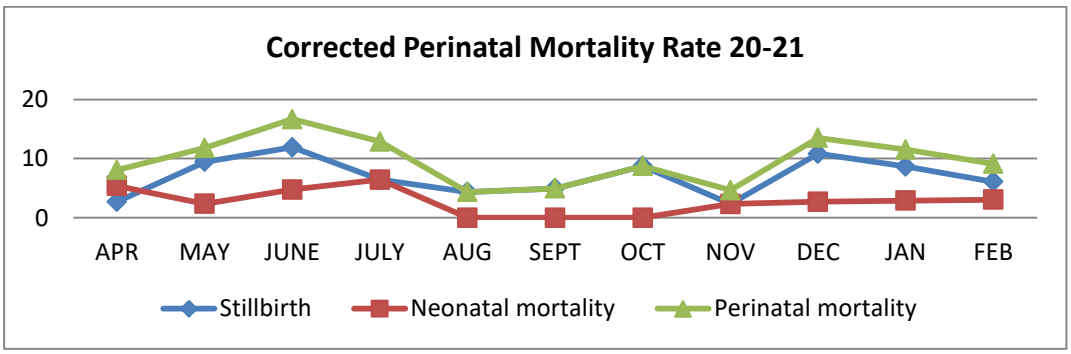
Over the preceding 5 months we have seen a downward trend in births, whilst bookings on the whole remain stable, this downward trend has been seen over the last few years. March saw some improvement in delivery numbers (407) being the first month in 2021 more than 400 dels/month however this remains well below the predicted / budgeted 450 dels/month in the business plan. The directorate continue to monitor bookings and had scoped work prior to the pandemic to work with our local stakeholders to ensure all women have the choice in place of birth but that we are the first choice for our local population. This work will form part of the restoration of services and working towards moving to MMUH. This downward trend is evident in data on births across the West Midlands, as noted in the graph above over the preceding 3 years, we await the figures for this financial year.



(National rate 30%)

In March the emergency caesarean section (EMLSCS) rate was 15.0% and the elective caesarean section rate (ELSCS) rate is 12.3% with a total rate of 27.3% - below Directorate average total rate year to date is 29.7% against a national average of 30%.

All EM CS's are reviewed within the multi-disciplinary team handover each morning (previous 24hr cases) to ensure correct and timely care pathways and decision-making. Trends or clinical issues from these reviews are escalated to R&G team and/or Labour Ward lead for further assessment. All cases for February have been reviewed and appropriate care noted.



The corrected Still birth rate was 9.8/1000 births; this pertains to 4 Stillbirths in March:

- 3 Term SBs - 1 x Type 1 diabetes booked for planned CS at 37+ wks – IUD found when attended for op
    - 2 x no known risk factors during the pregnancy
- 1 x 36 week SB – attended in labour

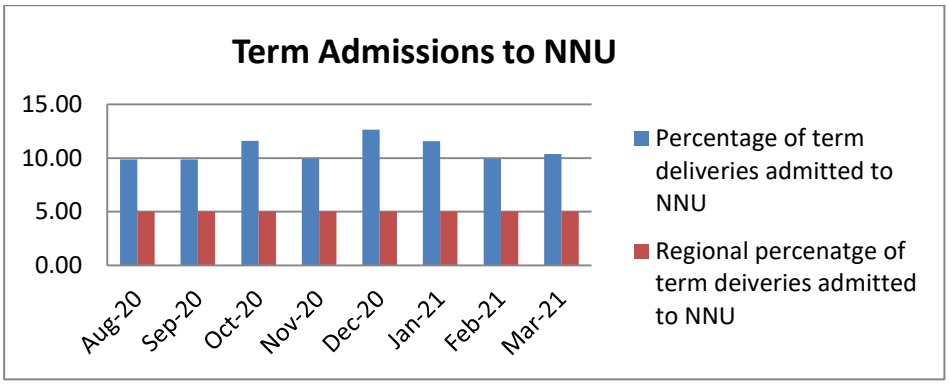
The corrected neonatal death (NND) rate was 0/1000; no cases in February:

- 2 cases (both born alive at 20 weeks gestation) are recorded as NND but discounted from the corrected data due to pre-viability

Therefore, overall corrected Perinatal mortality rate is 9.8/1000 – this remains higher than previous months primarily due to the lower number of births in Trust monthly compared to previous years (407 in Mar).

On conducting 72-hour reviews, no themes or trends have been identified or gaps in care. These will be presented for in-depth review and analysis by the multidisciplinary board, which includes external obstetric membership from RWT and CDOP nurse from Sandwell CCG. The board includes the parent's voice with their reflections and questions brought to the board by the bereavement midwives. The perinatal mortality review tool is used for all cases.

Cots days are below plan, this can be seen two-fold, one as a positive non-requirement of specialist support for our new-borns, but also is impacted upon by the reduction in births'.



The National ATAIN scheme requires all Trusts to have admission rates of term infants below 6% by March 2019. The service has been working through a steering group to reduce term admissions and have achieved a reduction the criteria for hypoglycaemia and hypothermia, which has been significant. The highest proportions of babies are admitted for respiratory distress, with the top 3 indicators being prolonged rupture of membranes (PROM), infection and meconium. The ATAIN group have brought about change to action these with the introduction of new guidelines on the management of PROM, the opening of the induction bay to support improved acuity and capacity and therefore flow on delivery suite. All term admissions are reviewed by via a multidisciplinary panel and outputs are monitored by the directorate and shared at QIHD.

3.0 Risk and Governance

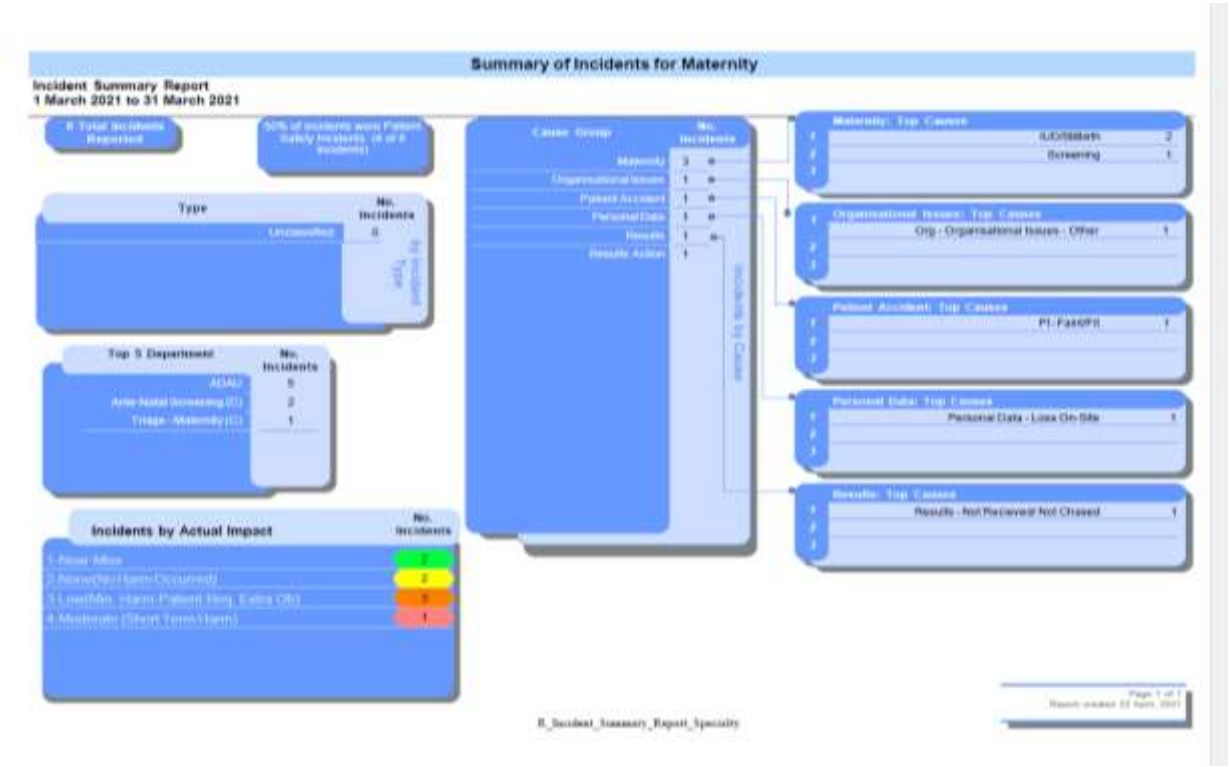
3.1 Serious Incidents/Health Service Investigation Branch (HSIB)

There have been no SI's declared and no referrals to HSIB

3.2 Never Events

There have been no never events

3.3 Incidents and analysis



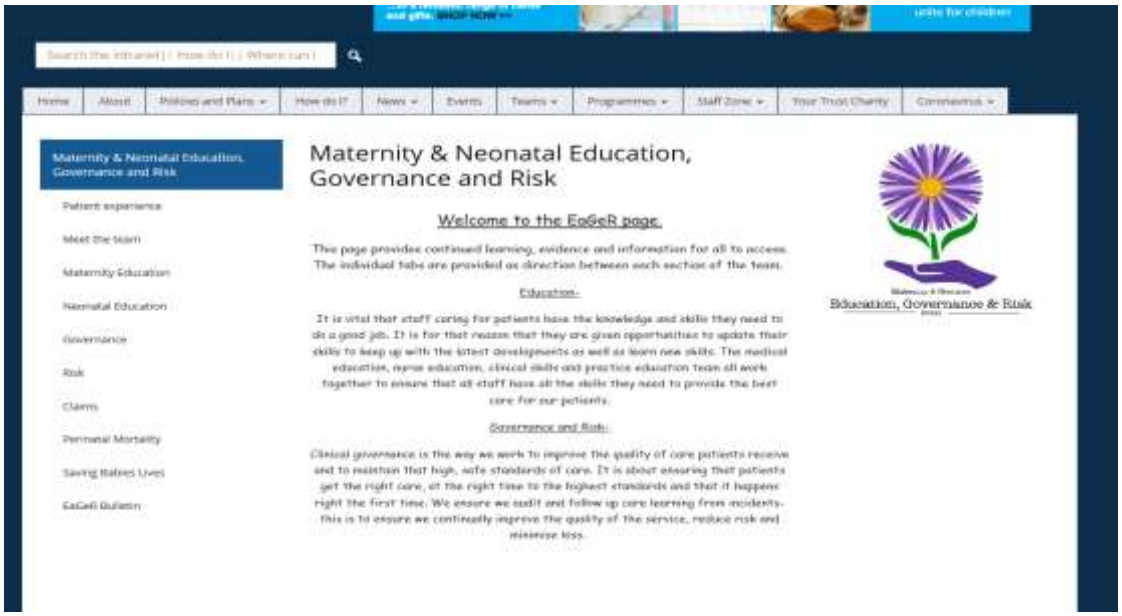
3.4 Lessons Learnt

- Following a HSIB recommendation relating to fluid balance and the robust and accurate recording. The focus board has driven twice daily safety huddles for two weeks and captured a huge amount of inpatient staff (from consultants down to MSW's) this was very well received and from reviews since this started it has defiantly been evident that fluid balance is being recorded appropriately in Badgernet

- Further focus on Aspirin and the documentation to support compliance once the aspirin risk assessment has been completed. Posters have been produced for the clinical areas to capture the midwives from a visual perspective. This was also a focus during the well-attended inaugural Saving Babies Lives study day; dates have now been set for the next 12.

- Further learning is in relation to scribe documentation, this was a focus of the education team. New neonatal scribe sheets have now been created and are available in the clinical areas to act as a prompt and make things easier during resuscitation.

- The Education, Governance and Risk team share point is now live on the trust intranet. Please visit this page under 'Teams' on the Trust Intranet homepage



The share page will be a central point of information for the EGR Team. Here you will find up to date information on;

- Maternity and Neonatal education; including MMD, PROMPT, information on other training opportunities, simulation training and skill drills
- Policy, guideline and SOP updates
- WeLearn from Excellence update
- Risk updates; monthly incident update, lessons learnt from incidents
- HSIB case reviews
- Perinatal Mortality Update
- Saving Babies Lives update; Monthly audits, findings, recommendations and education

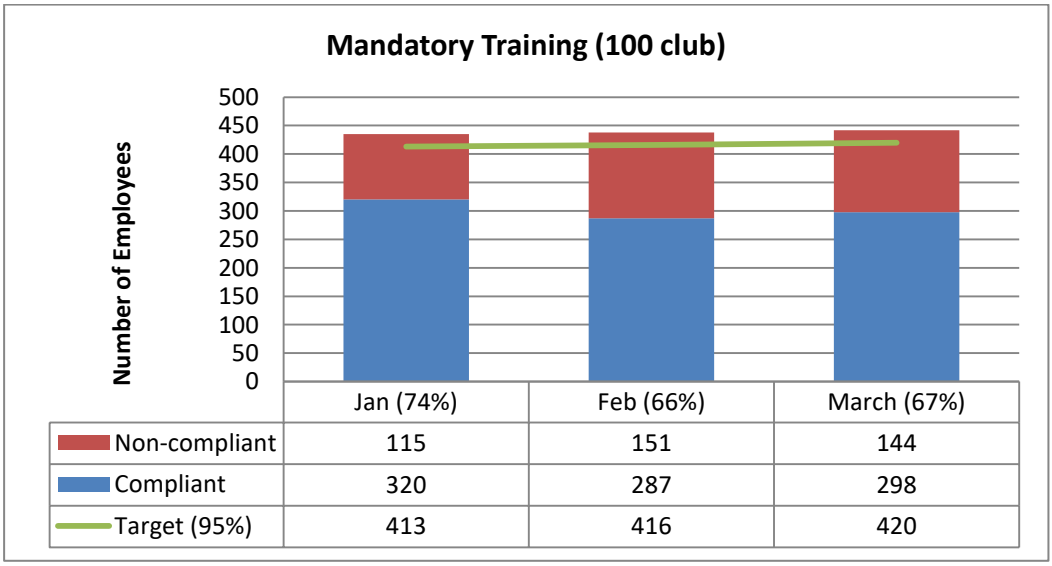
3.5 Complaints

Six complaints have been received in March, covering a timeframe ranging from August 202 to date. This includes areas from both inpatients and outpatients, including a joint complaint with another provider. The themes relate to clinical care and communication. Each complaint is investigated in order to provide the information required to ensure the complainant is supported in their request in order to support their restoration, face to face meetings are offered and lessons learnt are actioned and shared across the teams.

3.6 Mandatory Training

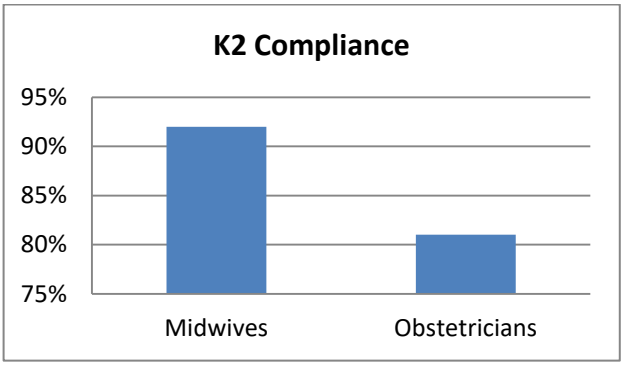
Below are the tables summarising training to date

100 Club



	Jan (74%)	Feb (66%)	March (67%)
Non-compliant	115	151	144
Compliant	320	287	298
Target (95%)	413	416	420

Professional Training



K2 is an online Perinatal Training Programme (PTP), with an interactive e-learning tool covering a comprehensive array of topics in Fetal Monitoring and Maternity Crisis Management, including Competency Assessments. The decline from the preceding month from the 100% for Obstetricians is due to movement within the month, the 4 are working through the programme

4.0 Workforce

4.1 Safe staffing

The activity within maternity services is dynamic and can change rapidly. It is therefore essential that there is adequate staffing in all areas to provide safe high-quality care by staff who have the requisite skills and knowledge. Regular and ongoing monitoring of the activity and staffing is vital to identify trends and causes for concern, which must be supported by a robust policy for escalation in times of high demand or low staffing numbers. Daily staffing meetings are led by the senior team to ensure flexibility and fluidity to meet acuity and capacity.

4.2 Vacancies

Total Directorate Vacancies are 36.89 WTE (including NNU).

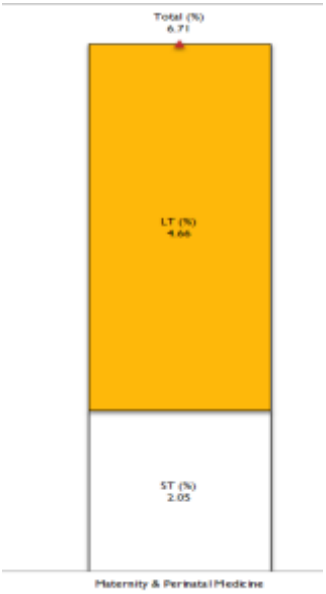
466.73	**429.84**	**-36.89**	**Variance:**	**7.90%**
Position FTE	**Actual FTE**	**FTE Variance**	**Occ code**	**Staff Group**

Total Directorate Vacancies include the full spectrum of workforce, of the 7.82 FTE medical and dental vacanicies, 7.26 FTE sit within obstetrics and gynaecology. These gaps are filled with NHS locum long term or short term to ensure cover and safe staffing out of hours. We currently have locum cover for a consultant shortfall, but consultant cover is maintained at the 98hrs per week required resident on unit cover.

Within the nursing and midwifery registered 12.63 FTE is against a neonatal nursing line, with 18.88 FTE against midwifery, with 10.85 FTE within community midwifery, an incentivised options paper has been escalated to group and support is sort to progress this. We have offered to 21 3rd year students, with 17 acceptances currently, however we should note the probability of further attrition against those accepted. Our consultant midwife is currently scoping options for working in partnership with indepentdent midwives, which has seen success in other areas partcularly in Rotheram.

NNU: Final year students (4 WTE) offered and accepted posts.There are 4 band 5s undertaking QIS with the aim that by Jan 22 they will have completed their QIS consolidation and will be ready to progress to band 6 line and fill vacancy in that line. We have also accepted appointees following the Trusts successful international recruitment who come with a wealth of experience.

4.3 Sickness



Total sickness status for Directorate:

WCH (Maternity and Perinatal) Open Absences:	Long Term Absence	Pipeline:	Short Term Absence:	Returned to Work	Planned RTW:
19	12	2	5	3	0

4.4 Maternity Leave

Mat Leave: 20.20 WTE across the Directorate (including NNU), which is a decrease from the preceeding month, as we see returners.

4.5 Community Midwifery

Across the years Community Midwifery has seen many changes, coupled with the complex and diverse population we serve, this has impacted on both retention and recruitment to this area of the workforce. Reviewing the data for this area highlighted historic vacancies that are 'hard to fill'. Work was undertaken in 2019 led by the community midwifery team to redesign the model in line with Better Birth's with the creation of 'families'. In conjunction some of the historic vacancies were used to create an 80:20 split between midwives and maternity support workers (band 3), as seen in other areas with hard to fill vacancies (Portsmouth, Oxford, Stoke on Trent) thereby releasing midwifery time. Over the past 12-24 months there has been

significant leadership changes in the Community Midwifery team, this impacted the ability to deliver a service to National and local standards.

In January 2021 two new matrons have been employed to support the service with a Transformational Midwife on an interim basis. This post is to concentrate purely on Community Midwifery Team and specifically transforming the service to create a safe infrastructure. Since the commencement of this post there are 16 key areas which have been identified to support the transformational agenda for Community Midwifery.

Milestones of the Transformational agenda have been put in place to ensure the staff are on board and part of this journey. This includes increased oversight with twice weekly meetings and weekly submission of data to the Directorate Triumvirate, the Group, and Director of Midwifery with provision of assurance to the Chief Nurse.

Phase 1 (May-July) - Will see the team introduce a new way of working through a digital platform to mitigate risks and to ensure safe practice. Also the introduction of duty midwife role to ensure all women receive care in a timely manner.
From engaging the team and working with them it has been greatly received and they are reporting that "*finally some-one is listening*" and "*Much needed change*".

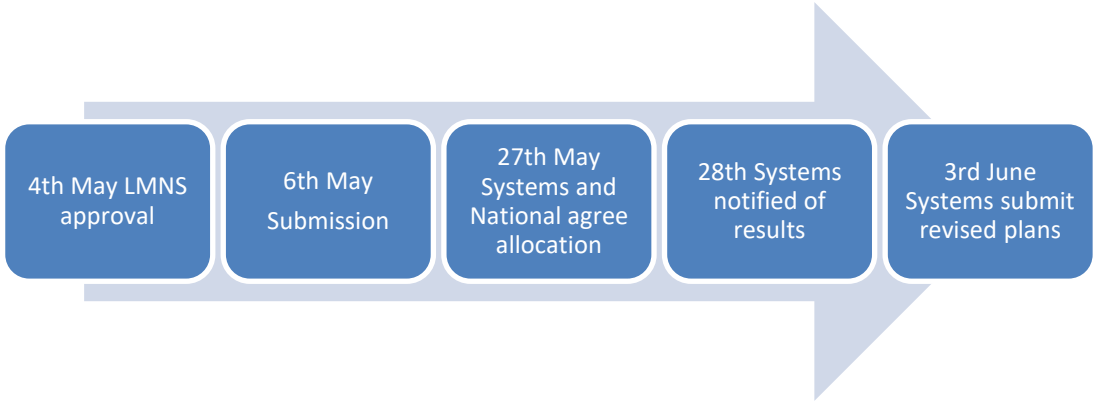
6.0 National and Local Maternity and Neonatal System updates
6.1 Ockenden Update

Following the publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust on 10 December 2020, each Trust was required to provide assurance against the 7 immediate and essential actions (IEAs) identified. It was evident that the IEAs would require investment to enable their application in order to reduce variation in experience and outcomes for women and their families across England. NHS England and Improvement is investing an additional £95.9m in 2021/22 to support the system to address all 7 IEAs consistently and to bring sustained improvements within maternity services. The Trusts will work in partnership with the Local Maternity and Neonatal System (LMNS) to ensure the continuum of transformation. The letter from the Chief Nursing Officer for England on the 8th of April stated that as a minimum systems can plan on the basis that the additional funding supplied this year will be put into CCG baselines for a fair shares distribution in the longer term to ensure that all systems can continue to meet their obstetric workforce requirements, the Birth Rate plus (BR+) recommendations for midwifery workforce, and training and development requirements.

Three key areas have been identified to form the basis of the required investment to enable implementation of the full recommendations of the report:

Midwifery Workforce – The expectation is that every maternity service will meet their BR+ recommendations by the end of 2021/22, using both national funding and by investing in their workforce locally.
Obstetric Workforce – The Ockenden report outlines two key areas requiring increased obstetric input; increased obstetric leadership to promote and develop monitoring of fetal wellbeing and twice daily consultant led ward rounds.
MDT training – The Ockenden report highlights the need for training to be undertaken as a MDT and that training is undertaken in line with/as set out in the core competency framework.

The total cost of the Trusts proposed bid based on the above is £700k in 21/22, with a recurrent cost of £1,270k.



6.2 Reintroduction of Partners

COVID-19 is highly infectious and its effects have been devastating. The infection can be passed very easily from person to person and the use of public spaces (especially internal) and episodes of close contact increases that risk. As part of this the organisation took the decision in line with Government guidance to pause the reintroduction of visitors and decided due to the rise in COVID-19 cases this was also warranted in response to the local or national transmission risk, or if a recent increase in the number of visitors was unsafe. We must not underestimate the impact on the expectant parents and the concerns that have been raised nationally, leading to a mandate of reintroduction from the 12th April. As progress is made on lifting and revising the high level of initial restrictions applied across the UK by Government and within Healthcare, it is vital that services apply a safe and appropriate revision of their restrictions and process. We are pleased that we have fully reintroduced partners for both appointments and visiting across the organisation and within the football stadiums that have partnered us during the pandemic to provide alternative venues for our women.

7.0 Maternity Improvement Plan

Since last summer there has been an improvement plan in place for maternity services. This has been reviewed more recently to ensure that it includes all aspects of what has been captured from staff at all levels, women and families. The overarching plan is formulated of 5 individual action plans, including actions in response to Ockenden.

On the 25th March the service held learning in action event to share the findings of the local staff surveys, the schedule of work to support an improved safety culture and to co-design strategies to design a blue print for real change. The event was attended by over 60 members of staff, including the support of the Chief Nurse.

Momentum continues as we welcomed Debbie Graham into the organisation, who is conducting an independent review on the culture within the service as part of the improvement plan. This includes individual confidential conversations across the spectrum of the workforce, including the Chief Executive and Chief Nurse. This will provide a current baseline to triangulate against a previous report from 2016 and the results of SCOR surveys undertaken as part of the National Safety Collaborative in 2017/18.

8.0 Summary

In summary the paper outlines the current positon in maternity services and the work that is being undertaken as a continuous cycle of monitoring and support to ensure the service is improving and providing high quality care to our women, babies and families, whilst ensuring all voices are heard.

9.0 The Trust Board is asked to:

a) Note the content of the report
b) Discuss the report and highlight any areas for further information
c) Approve as required

Helen Hurst
Director of Midwifery
May 2021