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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:**	6th July 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 report provides an overview of completed investigations by the Healthcare Safety Investigation Branch (HSIB) or as a Trust level serious investigation in the last six months. There are 6 cases included in the report, which incorporates lessons learnt and notable practice for each case. The learning from these cases supports the continuum for improved quality and safety within the service.
2. Midwifery Continuity of Carer (MCoC) remains the default model of care that all maternity services should enact by March 2024, if all the building blocks are in place, this includes workforce at establishment in line with the Birth-rate plus workforce tool (BR+). As a system the Local Maternity and Neonatal System (LMNS) has proposed a five year plan to achieve this goal, which will include a change of service provision across the system, moving from a model built on geography, to one that provides care based on the choice of place of birth.
3. The monthly update from safety champions in relation to maternity safety meetings is included

Also included in the annex 3 is the Ockenden framework update for May 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 29th June 2022. Safety champion meeting 10th June 2022.

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**ACCEPT** and discuss the overview of cases
b.	**DISCUSS** and support the system approach to delivering MCoC
c.	**ACCEPT** and discuss the safety champion update
d.	**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	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 NHS TRUST

Report to Trust Board: 6th July 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. 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. Six-month update on Serious Incidents reports received by Maternity and Perinatal Directorate

2.1 The Health Services Investigation Branch (HSIB) is an independent organisation that investigate at factors that have harmed or may harm National Health Service (NHS) patients. The criteria for inclusion for maternity specific cases are:

2.1.1 Term babies (at least 37 weeks completed gestation) who have the following outcomes: intrapartum stillbirth, early neonatal death and potential severe brain injury. They also investigate any maternal death while pregnant or within 42 days of the pregnancy ending (indirect or direct cause). All HSIB cases are automatically reported as serious incidents (SIs) to the Care Commissioning Group (CCG).

2.2 Over the past six months (December 21 – June 22) we have received six completed HSIB reports. Of these there was one neonatal death (at two days of age), two intrauterine deaths (IUDs) and three cases where babies were actively cooled (to reduce the impact of hypoxic ischaemic encephalopathy (HIE). These reports relate to incidents that occurred in May – November 21.The overview of these cases can be found in Annex 1.

2.3 The reports include safety recommendations to support Trusts to reduce the risk of similar incidents reoccurring. One of the completed reports had no recommendations identified. The table of safety recommendations from the 6 cases can be found in Annex 2. These have been captured within themes, including management of neonatal hypoglycaemia, induction of labour, aspects of the saving babies lives care bundle, placental histology, fetal monitoring and escalation. These themes are also noted across England.

2.4 There have been no additional completed Trust level serious incidences in the past six months.

2.5 Action plans are discussed in the monthly multidisciplinary Perinatal Risk Investigation (PRIMe) meeting and monitored by the Directorate, who provide assurance at Group and Safety Champion meetings.

2.6 The families receive copies of the HSIB reports and are all offered a tripartite meeting (between the family, HSIB and the Trust) or just between the family and the Trust. Of the

above six reports, two families have declined a meeting with the Trust as they have reported that they are happy with report and have no questions.

3. Midwifery Continuity of Carer System Proposal

3.1 Better Birth's (2016), the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives. Following a pause of roll out due to the pandemic, the revised date of March 2024 for Midwifery continuity of carer to be the default model of care for maternity services if all the building blocks are in place, this includes workforce at establishment in line with the Birthrate plus workforce tool (BR+).

3.2 Within the Local Maternity and Neonatal System (LMNS) MCoC has been difficult to progress due to a number of factors. Two main factors for this are the deficit within the workforce and the high number of exports and imports (not all 3 elements of maternity care by the same provider). In order to support safe delivery of the request the LMNS has proposed a five year implementation plan, to NHSE/I which will include a change of service provision across the system, moving from a model built on geography, to one that provides care based on the choice of place of birth, a decision on the proposal is awaited from them.

3.3 To support recruitment and retention of our workforce and to ensure equitable developmental opportunities, whilst supporting fluctuations in service demand across the system, we will work towards the introduction of a Black Country and West Birmingham (BCWB) Midwife and maternity support worker.

3.4 The plans for 2022-23 include development and commencement of an engagement and communication strategy for both our communities and our workforce. To build resilience within our workforce strategy, to ensure strengthened support for our high-risk women, working collaborative with organisations and communities to co-produce the offer including co-operative delivery of a portfolio of care with 3rd sector organisations, to ensure continuity of support throughout the pregnancy.

3.5 The initial phased role out of 20 teams across all four providers will be based on highest indices of deprivation and BAME population based on NHSE/I data of number of births in the lower decile (based on 2020 birth data in the most deprived 10% of neighbourhoods nationally). This supports the reduction in health inequalities and improved outcomes for these high risk communities.

4. Safety Champion Update

4.1 Progress against the requirements of the Ockenden review were updated, with collation of all the evidence being done in June, but good progress expected with no areas of particular concern. Though some areas are still awaiting confirmation from the national team, a focus on training continues, with a focus on CTG training and face to face case based training becoming more embedded within study days. Safety data was reviewed with discussion of potential learning and actions from cases escalated the previous month. Though 2 cases where support from ICU was needed, these were short term with no harm. There have been no COVID cases admitted. The capacity pressures across the systems were reviewed and we

continue to progress towards completion of the work needed for governance sign off of for the data sharing agreement for Badgernet access between organisations when the mother's care is transferred. Staffing pressure continue particularly within community midwifery and on the neonatal unit, where all options are being explored to recruit and plan for longer term staff development.

5. Summary

5.1 The continuum of improvement at all levels is imperative to improve services, outcomes and future proofs our services. Learning from investigation is a key component to improve our services, crucial to this is transparency and working collaboratively with families, to ensure, we listen, hear, act and support. Ensuring that provider transform service united within a system will ensure the scope of improved outcomes and workforce satisfaction is broader and evokes wider knowledge and support.

6. Recommendations

6.1 **The Trust Board is asked to:**

a) **ACCEPT** and discuss the overview of cases
b) **DISCUSS** and support the system approach to delivering MCoC
c) **ACCEPT** and discuss the safety champion update
d) **DISCUSS** and approve the oversight Framework

Helen Hurst
Director of Midwifery
21st June 2022

Annex 1 - Overview of Completed Cases
Annex 2 - The safety recommendations from these cases are as follows and our actions in response
Annex 3 - Ockenden Framework Update for May 2022

Annex 1

Overview of Completed Cases

Neonatal death: A 27-year-old woman, pregnant with her second baby, was booked for maternity care at 8 weeks gestation. She had one admission to triage at 32+1 weeks and then two days later with decreased fetal movements. She was discharged home with no concerns and had induction of labour booked for 41+6, which the hospital changed to 42 weeks due to activity. On the day of the scheduled induction, the woman experienced reduced fetal movements. She was asked to attend the unit and following review the decision was made for a category 1 caesarean section. Baby was born in poor condition, requiring resuscitation. Baby was cooled and transferred to a regional intensive care unit. Baby sadly died two days later.

IUD: A 27-year-old woman in her first pregnancy self-referred to maternity triage a 31+4 weeks' gestation reporting an absence of fetal movements for one week. The woman was a migrant and non-English speaking. She was booked and had an ultrasound which indicated normal fetal growth. She was booked for an induction of labour at 40+6 weeks. Following admission, the woman reported that she did not want to proceed with the induction. A growth scan at 41+1 indicated a tail off in baby's growth and oligohydramnios. Induction of labour was offered and accepted. Induction commenced at 41+2 and the woman started contracting within 5 hours. The baby's heartrate could not be heard on auscultation and a bedside scan sadly confirmed fetal demise.

IUD: A 25-year-old woman in her first pregnancy was booked at 8+1 weeks' gestation. She attended triage at 25+2 with abdominal pain and was discharged home. She had a growth scan at 40+2 weeks where baby's weight was above the 50th centile. At 41 weeks' she attended the midwifery led unit in early labour. On arrival, the midwives were unable to locate the baby's heartbeat. A bedside scan confirmed fetal demise.

Baby received cooling treatment: A 24-year-old woman in her first pregnancy was booked for maternity care at 11+4 weeks' gestation. Antenatal care included growth scans. At 40+2 the woman was admitted in the latent phase of labour. Whilst on the CTG there were concerns with the baby's heartrate, so a category 1 caesarean section was called. Baby was born in poor condition, requiring resuscitation. Baby was cooled and transferred to a regional neonatal intensive care unit.

Baby received cooling treatment: A 22-year-old woman, with raised BMI, was booked at 9+4 for her second pregnancy. At booking it was noted that her previous baby was born small for gestational age (SGA). Serial growth ultrasound scans (USS) were planned. She presented at 40+4 to triage with irregular contractions. She was transferred to labour ward for an ARM, due to concerns with the CTG. There was a prolonged deceleration and the woman was encouraged to push. Baby was born via SVD and required resuscitation and was admitted to the neonatal unit where cooling commenced. Baby was then transferred to the regional unit.

Baby received cooling treatment: A 28-year-old woman was booked at 10+3 in her first pregnancy. Her pregnancy progressed without complications until 40+1 where the woman presented with a prolonged period of decreased fetal movements. On scan baby was noted to be large for gestational age. At 41+2 the woman presented in latent phase of labour. Her labour was augmented and baby was born via forceps. Baby was initially thought to be clinically well, but then deteriorated and required resuscitation. Baby was admitted to the neonatal until where cooling commenced. Baby was then transferred to the regional unit.

Annex 2

The safety recommendations from these cases are as follows and our actions in response

Themes	Safety recommendation	Our action	Progress
Management of neonatal hypoglycaemia	The Trust to ensure that neonatal hypoglycaemia is monitored and treated according to national guidance in all babies receiving intensive care.	Medical team to review all results on blood gas reports including blood sugar	
		Awareness about importance highlighted to neonatal and labour ward staff in neonatal safety handover, via email communication/effective handover and in neonatal mortality meeting	
		Posters to be displayed in the neonatal and labour ward as reminder to review all bloods, glucose and bili.	
		BAPM framework & network guidelines on management of hypoglycaemia highlighted to neonatal and midwifery team via email communication and Perinatal MDT meeting Neonatal and Midwifery study days	
Induction of labour	The Trust to ensure that clear guidance is introduced as to the expected timeframe between a CTG to check for fetal wellbeing and the administration of prostaglandin.	IOL guideline has been updated	
	The Trust to ensue all relevant risk factors and the mother's wishes are considered when planning the timing of IOL	Ongoing awareness around the need for risk assessment at each encounter and for care plans to be made together with the women.	
Saving Babies Lives Care Bundle	The Trust to review local guidance to ensure it is consistent with national guidance (Saving Babies Lives v2) for the management of RFM.	Ongoing. Saving Babies Lives (SBL) Midwife ensures that Trust is complaint with all elements of the SBL care bundle	
Placental histology	The Trust to ensure placentas are sent for pathological examination including histology in line with national guidance	Ongoing awareness. Now embedded into practice.	
Fetal monitoring	Fetal monitoring: The Trust to ensure antenatal CTG interpretation is used	Ongoing. Antenatal CTG interpretation is an agenda item on the fetal monitoring study day, which	

	when a mother is not in labour.	is mandatory for all midwives and obstetricians	
	Compliance with fetal monitoring training	Ongoing. Work to ensure that all maternity staff are compliant with K2 training	
Escalation	The Trust to ensure that when an obstetric opinion is requested that there is a holistic assessment of fetal wellbeing to support situation awareness.	Ongoing. Includes awareness of new risk factors, such as significant meconium-stained-liquor	
	The Trust to ensure that staff are supported to urgently escalate to the multi-disciplinary team when there are concerns	Ongoing. Includes escalation of significant meconium-stained-liquor	

Key	
Red	Outstanding
Blue	Ongoing
Green	Complete

Annex 3

Ockenden Framework Update for May 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 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)	0 cases referred for investigation. 4 cases active.	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.	0 serious incident (SI) declared. The Directorate currently has 12 open (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	Themes from complaints are clinical treatment and attitudes and behaviours, patient stories are being

	Maternity Voices Partnership (MVP)	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	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	HSIB cause for concern raised	The service deep dive had already been identified the issue and escalated to Execs, with an associated action plan. HSIB were also informed upon referral of the case. The action plan has been shared with HSIB as requested.
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	