Paper ref:	TB (03/22) 012

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:	Trust Board (Public)	**Date**	2nd March 2022

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

The purpose of the report is to inform Trust Board of the current position in Maternity and Neonatal services and highlight to Trust Board any emerging safety concerns, cultural issues or actions that are required.

This month's report focuses on three areas:

1. Final confirmation of the data supplied as part of the benchmarking of all maternity services by NHS England and Improvement following the release of the Ockenden report into maternity services in Shrewsbury and Telford (Dec. 2020), has been received. The Trust has achieved a score of 90% compliance and next steps are highlighted in the report.

2. A summary of the Lessons Learnt Quality Improvement event held on 10th February. This event demonstrates the learning from serious incidents, complaints etc. and the actions that have been taken. This learning event also ensured wider learning with attendance from the Local Maternity and Neonatal System (LMNS), Clinical Commissioning Group (CCG) and Regional Chief Midwifery Office.

3. An update from the safety champions in relation to maternity safety meetings and walkabouts

Also included in the appendix is the Ockendon framework update for January 2022 for approval

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?]*

Maternity and Neonatal data received at Quality and Safety Committee 23rd February 2022

4.	**Recommendation(s)**
The Trust Board is asked to:	
a.	**ACCEPT** the Ockenden benchmarking rating and acknowledge next steps
b.	**DISCUSS** the shared learning event feedback and the benefits of positive exposure for the service
c.	**APPROVE** the oversight Framework

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	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to Trust Board: 2nd March 2022

Maternity Services Update

1. Introduction

1.1 Maternity and Neonatal services continue to be held to account with the release of further publications. Key to driving improvements is Board level oversight for maternity and neonatal services, which are fundamental to quality improvement, and ensure transparency and safe service provision.

2. Ockenden Benchmarking Update

2.1 Final confirmation of the data supplied as part of the benchmarking of all maternity services by NHS England and Improvement (NHSE/I) following the release of the Ockenden report into maternity services in Shrewsbury and Telford (Dec. 2020), has been received. The Trust has achieved an initial score of 92% compliance against the 7 immediate essential actions and the workforce action, as seen below in table 1.

Table 1

Immediate Essential Action	SANDWELL AND WEST BIRMINGHAM HOSPITALS COMPLIANCE
IEA1 Total	100%
IEA2 Total	94%
IEA3 Total	83%
IEA4 Total	93%
IEA5 Total	100%
IEA6 Total	89%
IEA7 Total	86%
WF Total	90%
Total	92%

2.2 Areas that required improvement to achieve were based around introduction of roles, collaboration with the maternity voices partnership and assurance of financial specifications. These requirements are all being actioned or completed.

2.3 In preparation for the release of further reports regarding maternity services this year, (Ockenden 2 and Kirkup, East Kent) services have been requested to complete an assurance assessment tool. This includes the submission against Ockenden and an update on the position against the original Kirkup report into Morecombe bay (2015). The progress against this will be brought to Board next month in alignment with the request from NHSE/I. To ensure local system oversight this will also be shared with the LMNS and Integrated Care System.

3. Lessons Learnt Quality Improvement event

The Quality Improvement Half Day (QIHD) on 10 February 2022 was dedicated to a review of the maternity incidents that took place in 2021. The event was opened by Mel Roberts, Chief Nursing Officer, who highlighted the amount of work that has been achieved within maternity in their work to learn from incidents, in order to identity good practice and areas of development. Delegates from within the service were joined by those from across the Black Country, Clinical Commissioning Group and representation of the Regional Chief Midwifery office. The team feel proud to work at SWB as they feel that there is an excellent multidisciplinary team approach and positive approach to continually striving for improvement.

3.1 Health Services Investigation Branch

3.1.1 The Health Services Investigation Branch (HSIB) achieved national coverage for maternity investigations in April 2019. The criteria for reporting to HSIB includes: term intrapartum stillbirths, early neonatal death, babies with potential severe brain injury and maternal deaths. All HSIB cases are automatically classified as SIs. In 2021, there were 12 cases reported to HSIB. The categories of investigations carried out at the Trust are in line with those carried out nationally, with babies who are cooled as the majority of cases, then intrapartum stillbirths. Recommendations within HSIB reports are themed. Of the top five recommendations, the Trust has the same four as those nationally, namely: fetal monitoring, clinical assessment (continual re-evaluation of a mother's care pathway), clinical oversight (effective team work and good communication), and guidance (practicing in accordance to guidelines). The fifth recommendation for the Trust is risk assessment, whereas for nationally it is escalation. Risk assessment at each contact was also identified in Ockenden and is something that Trust must ensure that we are undertaking in order to have early identification of any risks and then implement appropriate measures to reduce the risk. This is an ongoing piece of work that the governance team are leading on with the service teams.

3.2 Feedback from Services Users and national bodies

3.2.1 Maternity services at the Trust were rated by the Care Quality Commission (CQC) as 'Good' in July 2021. Their report stated that 'the service managed safety incidents well. Staff recognised and reported near misses. Managers investigated incidents and shared lessons with the whole team and wider services.' Feedback was obtained from the Maternity Voices Partnership where a new Mum wrote 'I can't stop talking about my incredible experience.' Feedback from trainees stated that they felt well supported in the unit.

3.3 Lessons learned from major obstetric haemorrhage (MoH)

3.3.1 In 2021 there were 62 cases of postpartum haemorrhage of over 2 litres. Of these, 32 were caesarean sections and 24 were normal vaginal births. Two cases were presented, one where a case was managed well and one where there were missed opportunities to reduce the potential impact of the incident. A summary of the lessons learned included:

antenatal management of haemoglobin, calling for help early, early administration of uterotonics, accurate measurement of blood loss, clear documentation of events

3.4 Lessons learned from effective CTG (electronic fetal monitoring) management

3.4.1 Two cases were presented, one where a case was managed well and one where there were missed opportunities for early intervention. Notable practice included provision of antenatal care in line with local and national guidelines, clear fluid management and good multidisciplinary working. Areas for development included: fresh eyes in labour, delay in recognition of a CTG with abnormalities, importance of recording cord gases and sending placentas for histology.

3.5 Lessons learned from mortality and morbidity

3.5.1 There were no maternal deaths in 2021. Lessons from cases of eclampsia, bladder injury and ITU admissions (mainly due to Covid-19), demonstrated early escalation, appropriate management with senior input and how lessons are shared through multidisciplinary team meetings, newsletters and 1:1s. In terms of perinatal morbidities, which include shoulder dystocia and term admissions to neonatal unit, themes identified included: failure to look at the whole clinical picture, wrong categorisation of CTG, failure to provide intra uterine resuscitation and lack of documentation.

3.6 Action plans from investigations

3.6.1 Actions all have a named person and a time scale. Actions are monitored by the Risk Team. Examples were provided of action plans from investigation including the development of a maternal tachycardia pathway for the community. There is continual emphasis on fluid balance management with trolley dashes and audits. The Risk Team have created a 'Pledge to Patient Safety' folder with safety themes, which is stored on Labour Ward. This initiative helps to make the staff aware of lessons learned.

3.7 Civility saves lives

3.7.1 Human factors have been highlighted as contributory factors of clinical incidents. The 2014 MBBRACE report highlighted human factors. Morecombe Bay report described the repeated instances of failure to communicate important clinical information about patients and highlighted that working relationships between staff groups were extremely poor. The 2015 Each Baby Counts report focussed on human factors. The report highlighted 'individual' (situational awareness, stress and fatigue) and 'team' (intra and inter-professional communications and team relationships) factors. It was reported that the common theme in the well managed incidents was good multidisciplinary working. To demonstrate the importance of communication, the TEDX talk by Dr Chris Turner (ED Consultant, UHCW) was shown. This demonstrates the importance of respect, professional courtesy and valuing each other. Civility between team members creates a sense of safety and is the key ingredient of great teams.

4. Safety Champion Update

4.1 Our regular monthly meeting took place with Professor Thomas as the new maternity NED safety champion, providing additional challenge to the maternity team based on her clinical expertise as a GP as well as extensive leadership experience. Actions from previous month were reviewed and we were pleased to hear of the progress with the fluid audit and recruitment in neonates and maternity. Dashboard data on births, caesarean section rate and time to category one section were reviewed and the improvement in the later point noted. Stillbirth (1) and neonatal mortality (0) were low (perinatal mortality 2.3/1000 births) while bookings and births remain high. Progress with the safety champion teams in ward areas was provided with a full report due on future plans and delivery of this component. Time has not permitted a champion walkabout yet this month.

5. Summary

5.1 Ensuring transparency and oversight of maternity services is a key element from the Ockenden report and essential for improving outcomes and reducing health inequalities. Work continues to support the continuum of service and workforce improvements.

6. Recommendations

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

a. **ACCEPT** the Ockenden benchmarking rating and acknowledge next steps
b. **DISCUSS** the shared learning event feedback and the benefits of positive exposure for the service
c. **APPROVE** the oversight Framework

Annex 1: Ockendon Oversight Framework

Helen Hurst
Director of Midwifery

February 2022

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 Health Services Investigation Branch (HSIB)	1 case referred for investigation. 5 cases active within the process.	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.	2 cases were escalated for moderate harm. 1 for NNU and 1 for maternity	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. 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. Task & finish groups commenced in Community midwifery workforce review. Member of National Pilot of Recruitment and Retention.
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. Also captured in perfect ward.
Staff feedback from frontline champions and walk-abouts	Walkabout schedule by Executive safety champion	Included in report
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 8 Complete 2	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. **Current 3 month pause in place in view of the Omicron surge.**
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	