Paper ref:	TB (02/22) 012

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:	Trust Board (Public)	**Date**	2nd February 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 present 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 four areas:

1. Recruitment and retention initiatives to support the maternity workforce in light of shortages that match those seen nationally. Highlighted in the report is the work ongoing to support developmental opportunities for all staff, updates on staff pipelines and staff escalators for entry to midwifery, alternative workforce models including nursing in maternity services, 3rd sector support and work to ensure our community establishments meet the needs of the service. An overview of the regional daily sitrep tool to support safe staffing is included.
2. Cultural Transformation; the initial improvement plan is now complete; the paper highlights next steps, the requirement to evaluate progress at regular intervals, assess if it is embedded within the service and a forward look at phase 2. It is integral to implement and sustain the continuum of cultural change as a long-term process, which requires time to embed.
3. Update from safety champions in relation to maternity safety meetings and walkabouts
4. Lessons learnt following an overview of changes with the management of fluid balance and work to support early booking within the service to support improved care to reduce the risk of stillbirths. Also included in the appendix is the Ockendon framework update for December 2021

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

4. Recommendation(s)

The Trust Board is asked to:

a.	**APPROVE** the Ockendon oversight Framework
b.	**DISCUSS** the workforce risks and assurance in place
c.	**NOTE** the lessons learned work and culture within the service

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

Trust Risk Register	X	3831,4407,4489,2625					
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 NHS TRUST

Report to Trust Board: 2nd February 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. The oversight framework is included in annex 1 for Trust Board to approve.

2. Workforce Programmes

2.1 The service have worked through multiple initiatives to both support retention and recruitment, taking into account the national shortage and therefore the requirement to support alternative models of care and routes into neonates and midwifery**.**

2.1.1 Retention

2.1.1.1 To ensure equality in developmental opportunities for all staff, the Directorate has developed a plan to support retention, key within this plan are:

- Share actions taken in community midwifery following flexible working survey and implement across the directorate
- Introduce yearly career MOT workshops to support personalised plans for all staff, ensuring both developmental and succession planning is woven into the fabric of business as usual within the directorate and is a transparent process for all.
- Launch the dissemination of information strategy to ensure standardisation for all staff groups
- Neonates currently have an over recruitment at band 5 line to support the development of their own Qualified in Service (QIS) Nurses as there is a national shortage. This pipeline currently has 9 nurses training, 2 to qualify in May 2022, providing good succession planning and resolution against the 7.89 vacancy

2.1.2 Recruitment

2.1.2.1 The directorate has established incentivised recruitment within the hard to fill workforce groups within the directorate; this though still has not reaped the success that was envisaged. Given the national shortage of both Midwives and Qualified in Speciality (QIS) neonatal nurses it is clear that alternative models such as below continue to be implemented;

- Introduction of nurses within the maternity setting has proven a positive experience for all; a full competency framework has been developed to support the safe introduction of this model. This will be developed further with the support of the chief nurse's office, in the wake of the positive reaction during the unprecedented negative workforce affect the Omicron surge had on maternity, during the festive period, with the deployment of gynaecology nurses to support safe staffing levels. This would also support a pipeline to midwifery training should those nurses wish to do so.
- There are four nurses about to undertake the midwifery MSC short course, supported with Health Education England funding.

- Apprenticeship midwifery training has commenced, providing an alternative route into the profession.
- Work continues to build the relationship with 3rd sector organisations, such as the maternity navigators who work with community midwifery to support the pregnancy journey work is now required to grow further their ability to support and that of the Bethel doula's
- The community midwifery workforce review tool has now been built. The review is to commence with input from the staff with a completion target of 28th February. This is a huge undertaking, but one that should provide a true reflection on the workforce requirement based of the number of women cared for and not just births. This is different from any other review.
- 22 offer letters have gone out to final year midwifery students.

3. Culture Improvement programme

3.1 Work on the improvement plan is now complete with all 147 actions enacted. It is imperative that this phase is now evaluated to ascertain if the actions are embedded, prior to commencement of phase two. Phase two will be led by the staff to ensure transparency, engagement and ownership integral to implement and sustain the continuum of cultural change as a long term process. Once this work is completed it will be shared at both Quality & Safety Committee and Trust Board

3.2 The new communication strategy, (dissemination of information) launched in January, following work with staff, to support an improved sharing culture.

3.3 Human factors are now built into all aspects of training and safety culture training to build on the workshops is now online.

3.4 The number of professional midwifery advocates continues to grow to support restorative practice, service and staff development.

3.5 The chief nurse will also undertake dedicated meetings and shifts within maternity services over the next 3 months, some of them jointly led with the Chief Executive.

4. Safety Champion Update

4.1 The monthly safety champion meeting, attended by the Medical Director and one of our Non-Executive Directors, reviewed issues around late bookers and the processes in place in the community to reduce incidence of late presentation in pregnancy. The planned fluid audit in January was discussed in response to monitoring of the changes put in place after the maternal death at the end of 2020 and the high sickness rate amongst maternity and neonatal staff as a consequence of COVID was reviewed and the mitigations in place for reducing risk on the units. All incidents in the preceding month were reviewed, with low number of stillbirths and neonatal deaths reported for December after the spike of stillbirths in October.

4.2 A walkabout happened on 13/01/22 with the Director of Midwifery, visiting M1 and M2, talking to ward managers and staff. The challenge of a need for a split in ward beds for covid positive patients was well managed, given the high number of incidental positive PCR tests in mothers. There was still a difficulty in balancing midwifery staff between red and amber pts and a discussion was had about breaks and how to better structure those during the day – short and frequent as opposed to one long break. The most positive aspect was around the impact that gynaecology and neonatal nurses had had covering additional shifts on the wards, particularly overnight in providing additional care with the provision of iv antibiotics and undertaking neonatal/baby checks. This had improved learning for midwifery staff, support for care of these Transitional Care babies, and released time for midwifery duties. At a busy time this additional

skill mix on the ward was well received and something to consider going forward for midwifery support. Infection prevention control processes were working well on ward in general, with partners getting required lateral flow tests done in most (but not all) instances.

5. Lessons Learnt

5.1 How incidents are reviewed with maternity

5.1.1 All incidents are reviewed within 72 hours and taken to a weekly meeting for review. Those that need escalating are taken to either PRIMe (Perinatal Risk Management meeting) or PMRB (Perinatal Mortality Review Board) and if deemed to be potential Serious Incidents, they are presented to the Trust's Moderate Harm Meeting. Maternal deaths, stillbirths and cases of hypoxic ischemic encephalopathy are referred to external organisations (Health Services Investigation Branch -HSIB and Mothers and Babies: Reducing Risk through Audits and Confidential Enquries across the UK- MBBRACE-UK) who conduct separate, independent investigations.

5.1.2 Within maternity there is a dedicated Education, Governance and Risk (EaGeR) team. This partnership means that it is possible to implement early targeted learning which results from identification of risk the review of incidents.

5.2 Learning from a maternal death

5.2.1 Following a maternal death in December 2020, there was an immediate review by the EaGeR team and the case was referred to HSIB. The immediate review identified that while the mother died of natural cases (she had severe acute fatty liver of pregnancy, AFLP – a rare disorder which carries a high mortality rate), there were areas of suboptimal care, in particular around fluid administration and fluid balance. (It is important to note that the Coroner confirmed that that this did not contribute to the outcome and confirmed that the mother had died of natural cases and that the Trust was not to blame for her death).

5.2.2 Once the issue of fluid management was identified immediate training actions were put in place including 'trolley dashes' (a trolley dash is an approach in which the education team take resources to each of the clinical areas so that they can take the teaching direct to the 'shop floor'). Training was to:

- Ensure all staff understand the importance of fluid balance charts and know how to access and use these
- Ensure that fluid balance is communicated with the obstetric team during ward rounds
- Ensure that all fluid is prescribed and signed for via electronic prescription charts
- Ensure that all include the woman's fluid balance history
- All staff were familiar with the NICE (National Institute for Clinical Excellence) algorithm for fluid therapy in pregnancy

5.2.3 Other activities included:

- Skills drills to include recognition of the deteriorating woman
- A 'Pledge to Patient Safety' folder was also started on the Labour Ward to highlight safety topics for discussion at each handover (staff have to sign when they have read the contents)
- Development of an Education, Governance and Risk intranet page

5.2.4 Action plans for this case and others are regularly reviewed to ensure completion. Fluid balance work continues and fluid balance is reviewed for all incidents and there is currently an audit in the unit of fluid balance.

5.3 **Learning from stillbirths**

5.3.1 Similar learning has emerged from review of a cluster of stillbirths seen in October 2021 (there were 5 cases and on average there are 2-3 per month). An immediate three stage review of these cases was conducted to try and understand whether there were gaps in care. The three stages were:- 1) Deep dive of cases to identify themes, 2) A review of proposed actions and 3) Meeting with Community Team leaders to identify operational challenges and potential solutions.

5.3.2 Immediate actions were as follows:

1. Community Effective handover to include information about importance of testing urine at every visit and risk assessment at every visit.
2. Booking operating procedures developed and circulated
3. Review of exclusion criteria for telephone booking (especially for women who speak rare languages)
4. All women to be allocated to 'families' within the community to allow oversight of their care
5. Recruitment drive to increase the number of midwives within Triage Department
6. Continued recruitment drive to increase the number of community midwives
7. Continued use of bank midwives to ensure that women are booked in a timely manner

5.3.3 Continued work includes:

1. 'Back to Basics' course to be taken out to the community to ensure competencies
2. Review of the antenatal care guideline
3. Improving women's access to information
4. Highlighting the 'self-referral' pathway to improve early presentation of women into maternity service.

5.4 The occurrence of late bookers within the particular catchment we serve is long standing; the service has been working on a two pronged approach to ensure earlier booking.

5.4.1 Firstly, we needed to understand why this occurred. Listening events are now held within our local communities, supported by the Place Based Partnership and groups within communities, faith groups and publicity via local media to try to understand the drivers behind late booking. The partnerships with 3rd sector organisations have also provided vital information. The wealth of information has supported much wider than booking alone, and will help assist the continuum of service development.

5.4.2 Secondly, we have developed partnerships to ensure access to our services is easier. Our self-referral pathway has seen increasing numbers and now approximately 30% of bookings are received this way. In the analysis of the data we have seen some duplicate bookings, from women who had initially booked via their GP. We are also partnering with pharmacies to scope how women can be sign posted/booked as soon as they have a positive pregnancy test, this could include maternity staff within pharmacy settings.

5.5 In February the team is holding a lessons learned event within the maternity unit to summarise the maternity incidents from 2021 to highlight gaps in care, the action plans in place to address this and a of review cases that were managed well. The team aims to promote a positive attitude towards incident reviews and demonstrate that through learning from incidents and implementing targeted learning we can work together to ensure that our women and babies receive safe and timely care.

6. Summary

6.1 Work continues to strengthen service provision and assure transparency in line with national, regional and local drivers. Understanding our local communities is key to reducing health inequalities and improving outcomes.

7. Recommendations

7.1 The Trust Board is asked to:

A. **Approve** the Ockenden oversight framework (Annex 1)

B. **Discuss** the workforce risks and assurance in place

C. **Note** the work to on lessons learned and culture within the service.

Annex 1 - Ockendon Oversight Framework Summary Table

Helen Hurst
Director of Midwifery

25th January 2022

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 Health Services Investigation Branch (HSIB)	2 cases 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, both for cooling and accepted by HSIB.	Weekly mulit-disciplinary incident review/learning meeting in place within the service. 10 deep dives took place in November. 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 96% 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) 97%.	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. Community midwifery workforce review underway. 22 offer letters to final year students.
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	Included in report

	champion	
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	