Paper ref:	PublicTB (11/23) 012

REPORT TITLE:	Maternity and Neonatal Update		
SPONSORING EXECUTIVE:	Melanie Roberts – Chief Nursing Officer		
REPORT AUTHOR:	Helen Hurst – Director of Midwifery Jade Payne – Group Director of Operations Women and Child Health Group (W&CH) Louise Wilde – Head of Midwifery		
MEETING:	Public Trust Board	**DATE:**	8th November 2023

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

This month's report discusses two particular areas as follows:-

- Following the neonatal review, the comprehensive improvement plan has been co-produced to support the required service development. The plan is formulated around five key areas:
  - Clinical Outcomes, Pathways
  - Leadership, Human Resources, and structures
  - Activity and Work force
  - Governance
  - Staff and Patient Experience
- Still births remain higher than we would like them to be (Quality Committee are sighted on this), a thematic review was undertaken by the service in July. The themes around ethnicity are well documented at both local and National level and there is some indication that socio economic factors may play a part in a recent study undertaken in Bradford. In view of the concerns about still birth rate within our own organisation and the rise seen across the Black Country, the Local Maternity and Neonatal System are undertaking a thematic review of all still births within scope over the last six months, this will be completed by the end of January 24. The Terms of Reference for this piece of work is in final draft and will be shared with the Chief Nursing Officers across the system
- Annex 1 contains the Ockenden Framework update for September 23.

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		To work seamlessly with our partners to improve lives	

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

None

4.	Recommendation(s)
The Public Trust Board is asked to:	
a.	**NOTE** the contents of report.
b.	**RECEIVE** the Neonatal Improvement Plan.
c.	**NOTE** the work on stillbirths that will be undertaken by the LMNS.

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			*Make best strategic use of its resources*					
Board Assurance Framework Risk 03			*Deliver the MMUH benefits case*					
Board Assurance Framework Risk 04			*Recruit, retain, train, and develop an engaged and effective workforce*					
Board Assurance Framework Risk 05			*Deliver on its ambitions as an integrated care organisation*					
Corporate Risk Register [Safeguard Risk Nos]								
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 NHS TRUST

Report to the Public Trust Board on 8th November 2023

Maternity and Neonatal Update

1. Introduction

1.1 Board level oversight for maternity and neonatal services is fundamental to quality improvement, to ensure transparency and safe delivery of services.

2. Neonatal Improvement Plan

2.1 An external peer review was commissioned following concerns raised around culture within the neonatal unit. The review was undertaken by clinical neonatal experts and led by a Healthcare Consultant with findings presented at the last Public Board meeting.

2.2 Following the review, and receipt of the findings the Women's & Child Health Group (W&CH) developed an improvement plan and defined the governance structure to ensure delivery of the improvement plan. The plan is owned by the Maternity & Perinatal Directorate with oversight from the W&CH Group. The Healthcare Consultant continues to provide an objective and professional view, providing the Directorate team with additional resource to support delivery.

2.3 Weekly meetings are being held within the Directorate with attendance from key stakeholders to affect the changed required, monitoring via:

2.4 The Improvement plan (see annex 1) is grouped into five areas:

- Clinical Outcomes, Pathways
- Leadership, Human Resources and Structures
- Activity and Workforce
- Governance
- Staff and Patient Experience

2.5 Each area has a series of actions linked to the review findings and work is already in progress within the Neonatal Service and Directorate to ensure the use of one comprehensive plan to drive improvement.

2.6 Each series of actions have an allocated dedicated action owner/owners. Support for the action owner/owners are detailed within the plan.

2.7 Outputs are clear and evidence will be reviewed to ensure actions are met within the agreed target dates and embedded into the Neonatal Service and Maternity & Perinatal Directorate. This will follow a clear line of governance through the Clinical Group and then report through to Quality Committee and a Quarterly update to Board.

2.8 <u>Improvements so far</u>

2.9 The initiation of the review and the subsequent findings focused on culture as the primary concern. Therefore, staff engagement is essential to drive improvement. Meetings have been held with staff to share their thoughts on the review findings and review process; feedback from these meetings supported the development of the improvement plan.

2.10 In conjunction with HR Business partners a communication and engagement strategy is being developed to ensure staff feel part of the improvement journey. Team away days have been planned in October/November. The first planned day is set to have thirty-three members of staff some attending in their own time which shows their commitment to the unit and to improving the culture within the unit.

2.11 Recruitment to key roles to support the delivery of improvements and ensure the workforce is in line with national recommendations is underway.

2.12 The Governance review within the Neonatal Service and Maternity & Perinatal Directorate is underway with planned sign off at November W&CH Group Governance Meeting. The Governance Structure will be open, transparent, and shared with staff to ensure clarity on escalations, particularly in relation to risk and incidents.

2.13 The implementation of 'Right Baby Right Place' document to support the daily huddles to ensure timely and appropriate transfer of babies is now in place, with a review planned to evaluate the benefits and impact of improved communication between the obstetric team and the Neonatal team.

2.14 The Unit's visiting policy is being reviewed following recommendations from the review and revised visiting supporting family integrated care will be implemented from W/C 30/10/2023.

3. Still Births

3.1 Stillbirths remain higher than we would like (data reported and monitored through Quality committee), an internal thematic review was undertaken to review cases in July, by a multidisciplinary panel, separate to the review of the cases utilising the perinatal mortality review tool. There were no new themes identified that would have impacted, other than the well documented area of ethnicity. Lessons learnt were identified, which would not

impact on the outcomes. There are however some discussions and information that identifies that socio-economic factors may well play a part in this. The service is well sighted on women who book late (late bookers), 'did not attend rates' and are working well with local communities to address these issues, as well as the extensive work undertaken by our equality and diversity and inclusion lead (EDI) with local communities, 3rd sector partners and community groups to reduce health inequalities.

3.2 Additionally, a small team are looking at the socio – economic and environmental elements associated with this cohort, supported by public health. There is also the impact on food poverty and the rise of 'sofa surfing' and lack of suitable affordable accommodation for families which could impact on both the antenatal and postnatal period. Our own digital transformation manager and EDI lead are currently working with maternity to support a solution to digital poverty, with equipment and data. Both Integrated Care Systems (ICS), whose population are served by our Trust, being the two ICSs with the highest index of deprivation, with 49.4% and 45.6% of the population being in the most deprived category

3.3 Recent research undertaken by Bradford District and Craven Health Care Partnership, found that the current financial crisis is impacting on the ability of some women to attend antenatal appointments, (Health Services Journal, August 23). The research findings include:

- 'Did not attend' rates increased due to lack of funds for transport to antenatal appointments.
- 'Lack of credit on phones prevented communication between women and maternity services, for example, making (them) unable to rearrange scans or appointments.
- Widespread incidence of 'digital poverty'.
- 'Families with babies on neonatal unit going without food in order to finance transport to and from the unit'.

3.4 Increases in stillbirths can be seen across the Black Country Local Maternity and Neonatal System, as such the system are undertaking an independent thematic review of all still births over the last 6 months. This will be undertaken by a panel, compromising of the Lead for Mortality Reviews across the System (Chief Meidal Officer at Walsall Healthcare Trust), Consultant in Public Health, Lead for Quality Assurance and Risk, Child Death Oversight Panel member and the Lead for Quality and Safety in the Integrated Care Board, with a provisional date for completion by January 2024.

3.5 The findings of the report will be brought through Quality Committee and the Board, the aim of the LMNS following the findings of the report is to establish and short life task and finish group, the actions and progress of this will be reported through internal governance processes to Quality Committee and update to Board.

4. Recommendations

4.1 The Public Trust Board is asked to:

a. **NOTE** the contents of report.
b. **RECEIVE** the Neonatal Improvement Plan.
c. **NOTE** the work on stillbirths that will be undertaken by the LMNS.

Helen Hurst
Director of Midwifery
19th October 2023

Ockenden Framework
August and September 2023

<table>
<tr><th>Data Measures</th><th>Summary</th><th>Key Points</th></tr>
<tr><td>Findings of review of all perinatal deaths using the real time data monitoring tool</td><td>Still Births (SB's)
August : 3 (25-41 weeks gestation)
September: 4 (25- 38 weeks gestation)
Neonatal Deaths (NND's)
August:2
September: 0
<table>
<tr><th></th><th>April</th><th>May</th><th>June</th><th>July</th><th>August</th><th>September</th></tr>
<tr><td>Corrected Stillbirth rate</td><td>4.64</td><td>9.8</td><td>7.2</td><td>9.98</td><td>6.55</td><td>6.91</td></tr>
<tr><td>Neonatal Mortality Rate</td><td>2.32</td><td>2.5</td><td>0</td><td>2</td><td>4.36</td><td>0</td></tr>
<tr><td>Perinatal Mortality Rate</td><td>6.96</td><td>12.3</td><td>7.2</td><td>11.98</td><td>10.98</td><td>6.91</td></tr>
</table></td><td>Monthly data detailed in paper to Quality and Safety Committee.
SB's (27- 35 weeks) Contributory factors:2 decreased fetal movements, 2 known complications of pregnancy, 1 maternal homicide.
NND's: Extreme prematurity 23 weeks</td></tr>
<tr><td>Findings of review all cases eligible for referral to Health Services Investigation Branch (HSIB)</td><td>
<table>
<tr><th>HSIB No</th><th>Safety Recommendations</th></tr>
<tr><td>MI-021834 – IUD (SWBH Trust B)</td><td>- To support staff to access interpreting services to communicate with families when English is not their first language throughout maternity services.
- To ensure all mothers receive written information on reduced fetal movements in a format they can read and understand</td></tr>
</table></td><td>Written information is now supplemented by animated video in specific languages for our local population given the known literacy issues, this has been fed back to HSIB</td></tr>
<tr><td>The number of incidents logged graded as moderate or above and what action being taken.</td><td>0 serious incident (SI) declared.</td><td>Weekly multi-disciplinary incident review/learning meeting in place within the service, to review all moderate and above cases.</td></tr>
<tr><td>Training compliance for all staff groups in</td><td>
<table>
<tr><td>PROMPT Study Day Compliance (%)</td><td>Consultants</td><td>80%→</td></tr>
</table></td><td>Target 90% over the year.
Professional training database (core competency framework)</td></tr>
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<tr>
<td>maternity, related to the core competency framework and wider job essential training.</td>
<td>
<table>
<tr><td></td><td>Trainees</td><td>46% ↓</td></tr>
<tr><td></td><td>Midwives</td><td>94%↑</td></tr>
<tr><td></td><td>MSW/MCA</td><td>46%↑</td></tr>
<tr><td></td><td>Anaesthetic Consultants</td><td>100%↑</td></tr>
<tr><td></td><td>Anaesthetic Trainees</td><td>88%→</td></tr>
<tr><td></td><td>Medical Team</td><td>35%↓</td></tr>
</table>
<table>
<tr><td rowspan="5">Fetal Monitoring Compliance</td><td>Inpatient Midwives</td><td>90%</td></tr>
<tr><td>Community Midwives</td><td>66%</td></tr>
<tr><td>Overall Midwifery Compliance</td><td>78%</td></tr>
<tr><td>Consultants</td><td>58%</td></tr>
<tr><td>Obstetric Trainees</td><td>57%</td></tr>
</table>
</td>
<td>monitored by education team. To note consultant compliance impacted upon by Industrial action, training rescheduled, however could be impacted again.</td>
</tr>
<tr>
<td>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.</td>
<td>Average fill rate within inpatient midwifery is at 90% for the 2 months.
Community Midwifery are Amber in their business continuity plan and is supported by daily staffing huddles across maternity to ensure fluidity in staffing. Position affected by sickness, and new recruits awaited completion of induction.
100% compliance with obstetric labour ward cover. Episodes of consultants acting down.
Neonatal clinician gap of 0.5 wte within the junior rota. There are significant pressures on the neonatal medical rota due to high numbers of long-term sickness, this is covered, however the position is fragile given the impact on staff at work.</td>
<td>Internationally educated midwives have joined the community team and all have now completed OSCE training to gain NMC registration and induction.

Impacted by industrial action.</td>
</tr>
</table>

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<tr><td></td><td colspan="3"></td><td></td></tr>
<tr><td>Service User Voice feedback</td><td colspan="3">Feedback collated from FFT, complaints, PALS, local surveys, and Maternity Voices Partnership (MVP)</td><td>The maternity service has formed a patient experience group, to include the MNVP and other 3rd sector stakeholders to ensure we listen, hear, and learn from our service users. This includes co-production of monthly surveys across maternity.</td></tr>
<tr><td>Staff feedback from frontline champions and walk-abouts</td><td colspan="3">Positive feedback from community midwifery, some concerns raised elsewhere around support, staffing and leadership. Freedom to speak up is active across maternity and neonates.</td><td></td></tr>
<tr><td>HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust</td><td colspan="3">None</td><td>None</td></tr>
<tr><td>Coroner Reg 28 made directly to Trust</td><td colspan="3">None</td><td>None</td></tr>
<tr><td>Progress in achievement of CNST10</td><td colspan="3"><table>
<tr><td>Safety Action 1</td><td>Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?</td><td>On Track</td></tr>
<tr><td>Safety Action 2</td><td>Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?</td><td>On Track</td></tr>
<tr><td>Safety Action 3</td><td>Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?</td><td>In Progress, work in place to ensure MDT review of cases</td></tr>
</table></td><td>Given the time thresholds and alterations to SBLCBV3 scanning requirements, a divergence has been submitted due to the inability to meet the increased requirements, this could impact on SA 6 if the divergence is not accepted as mitigation.</td></tr>
</table>

	Safety Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	On Track		
	Safety Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	On Track		
	Safety Action 6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	In Progress, work in place		
	Safety Action 7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	On Track		
	Safety Action 8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Compliance to improve with Maternity Support Workers and Obstetric Teams		
	Safety Action 9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	On Track		
	Safety Action 10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?	On Track		
Saving Babies Lives Care Bundle V 3 New Tool	Element		Position		Position following the first assessment of the new compliance tool, gaps known and work in place to achieve. Same position across the Black Country, peer group set up to support shared learning across the system
	SBL1 Reducing smoking in pregnancy				
	SBL 2 FGR assessment prevention and surveillance				
	SBL3 Raising awareness of reduced fetal movements				
	SBL4 Effective fetal monitoring				
	SBL5 Reducing preterm birth				
	SBL6 Management of pre exiting diabetes				

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	Results tabled at Trust Board Actions in place to improve, include the introduction of the Improve well App, to support staff having their voices heard to improve services and real time rate my day to ensure support for staff and improve their working experience.
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 – Neonatal Improvement Plan (in the Reading Room)