Paper ref:	TB (03/21) 012

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**	1st April 2021

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

The Quality Improvement plan in the appendix is for noting and discussion. It provides an overarching plan for improvement across the sphere of the service encapsulating multiple work streams, this plan brings together the journey of improvement the service commenced and continues.

The briefing in the appendix provides clarity on the Trust's position following the article published in the HSJ on 10th March 21 and works entrain as above.

Included within the report are the data escalations and highlights that combine both maternity and neonatal data to provide an overview of care. Vacancies within maternity, especially community midwifery remain an area of high focus; this is also combined with high maternity leave. An incentivised options paper has been escalated to group and support is sort to progress this. A key priority for safety is to ensure that women's, families and staff voices are the golden threads that entwine our service

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 26th March 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

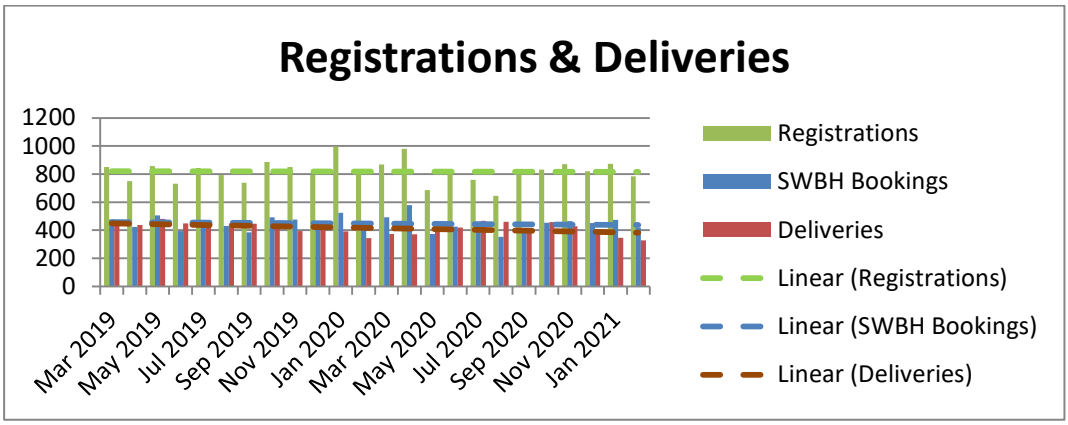
Maternity Services Update
Report to the Public Trust Board: 1st April 2021

1. Introduction or background

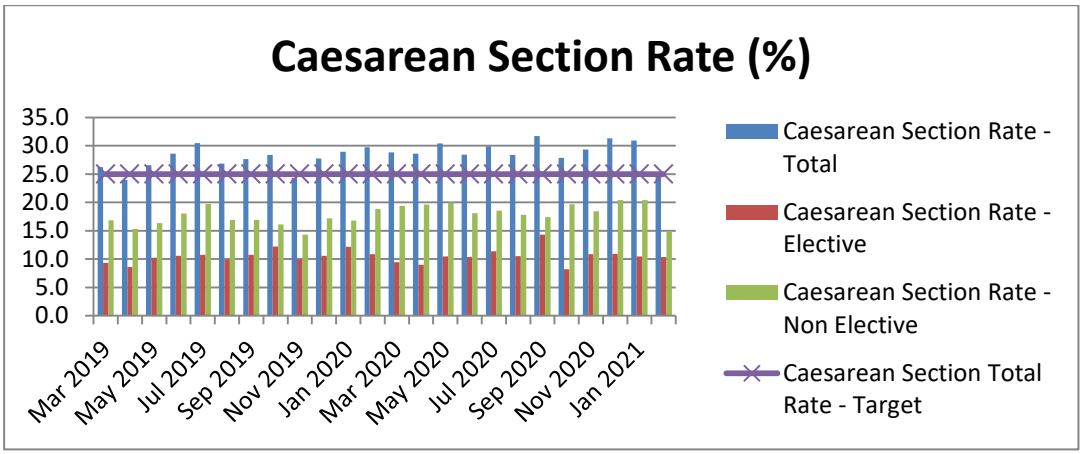
Safety in maternity and neonatal services has been of national focus since 2015 and this has been strengthened with the publication of the interim report of the Independent Maternity Review (Ockenden Report) which provides clear direction for the improvement of maternity services nationally**.**

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

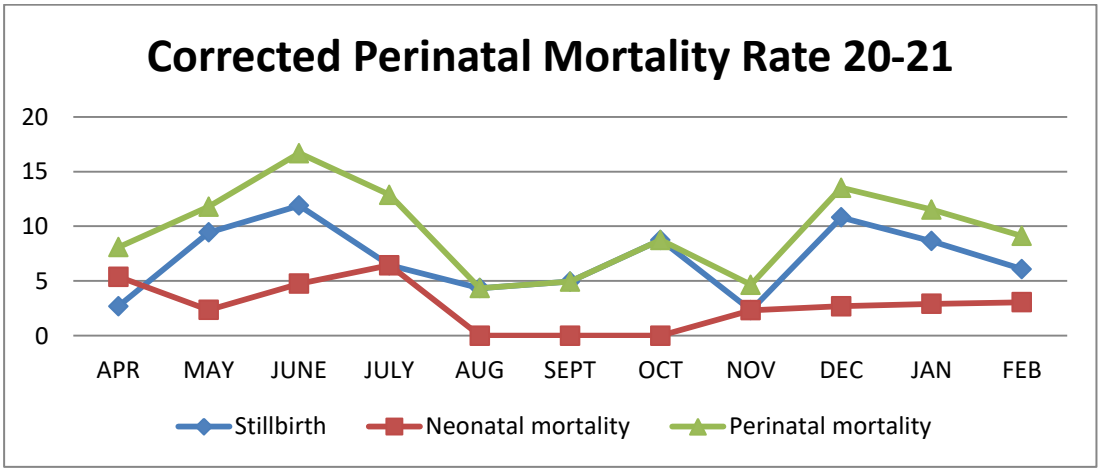


Over the preceding two months we have seen a downward trend in births, whilst bookings on the whole remain stable, this downward trend has been seen over the last few years, this is comparative to a national downward trend. The directorate continue to monitor bookings and had scoped work prior to the 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.



(National rate 30%)

In February the emergency lower segment caesarean section (EMLSCS) rate was 14.9% and the elective caesarean section rate (ELSCS) rate is 10.4% (static from December '20) with a total rate of 25.3% - 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.

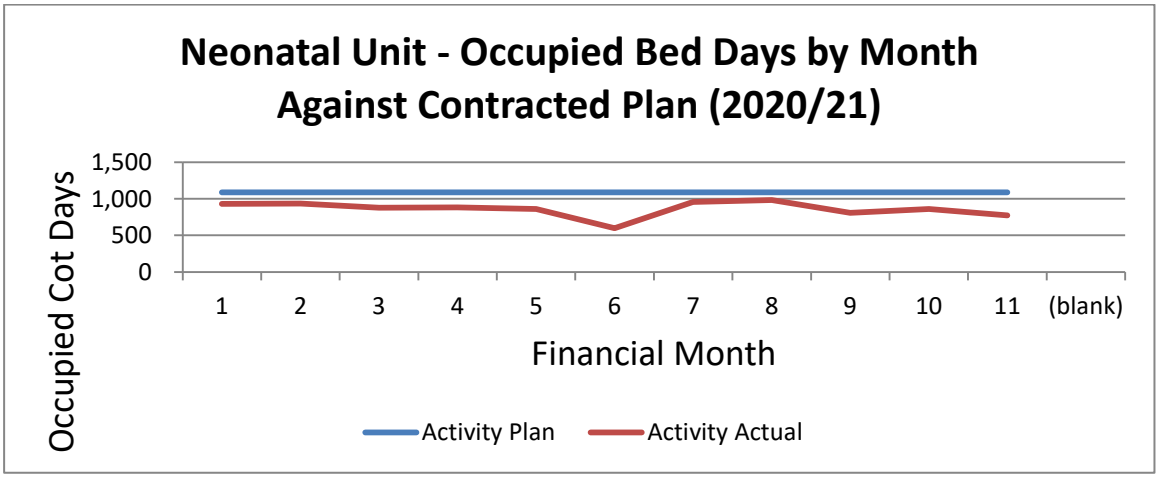


The corrected Still birth rate was 6/1000 births; this pertains to 2 Stillbirths in February.

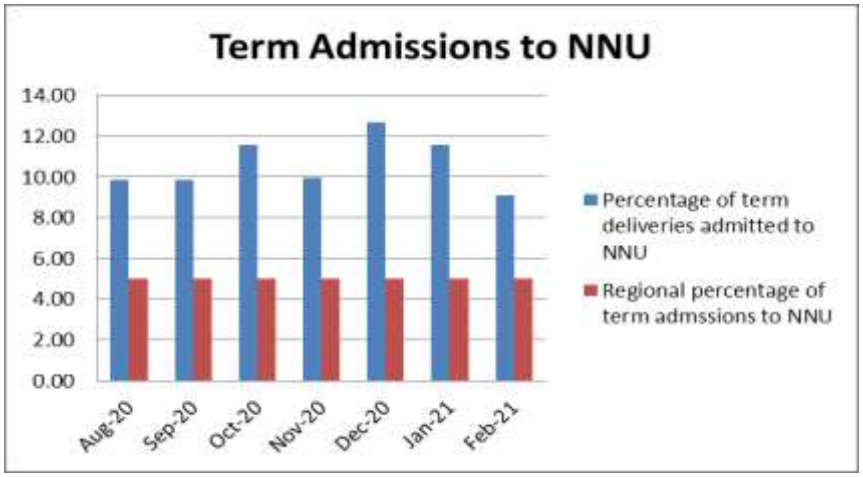
The corrected neonatal death rate was 3/1000; one case in February.

Therefore overall corrected Perinatal mortality rate is 9/1000 – this remains higher than previous months due to the lower number of births in Trust monthly compared to previous years (329 in Feb).

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

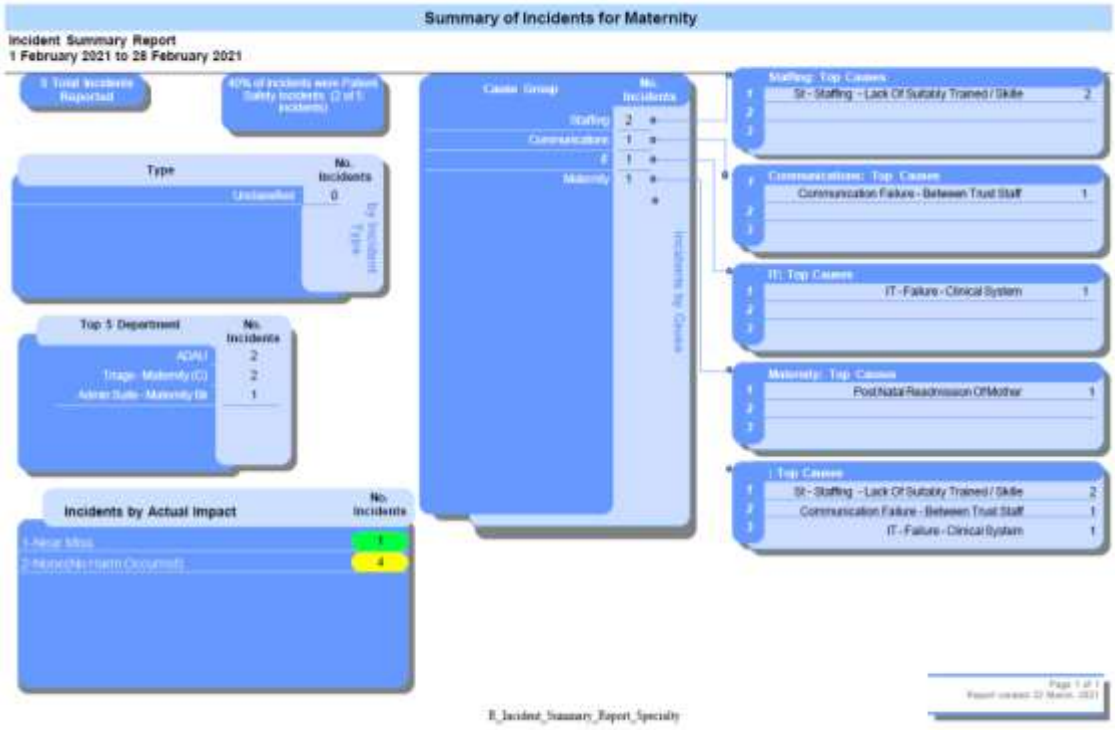
3.1 Serious Incidents/Health Service Investigation Branch (HSIB)

One case referred to HSIB in February- did not meet criteria as the patient was not in labour. Initial 72 hour review completed and discussed at moderate harm meeting, where it was reviewed and did not meet SI criteria- plan to continue with local investigation through directorate governance.

3.2 Never Events

There have been no never events

3.3 Incidents and analysis



3.4 Lessons Learnt

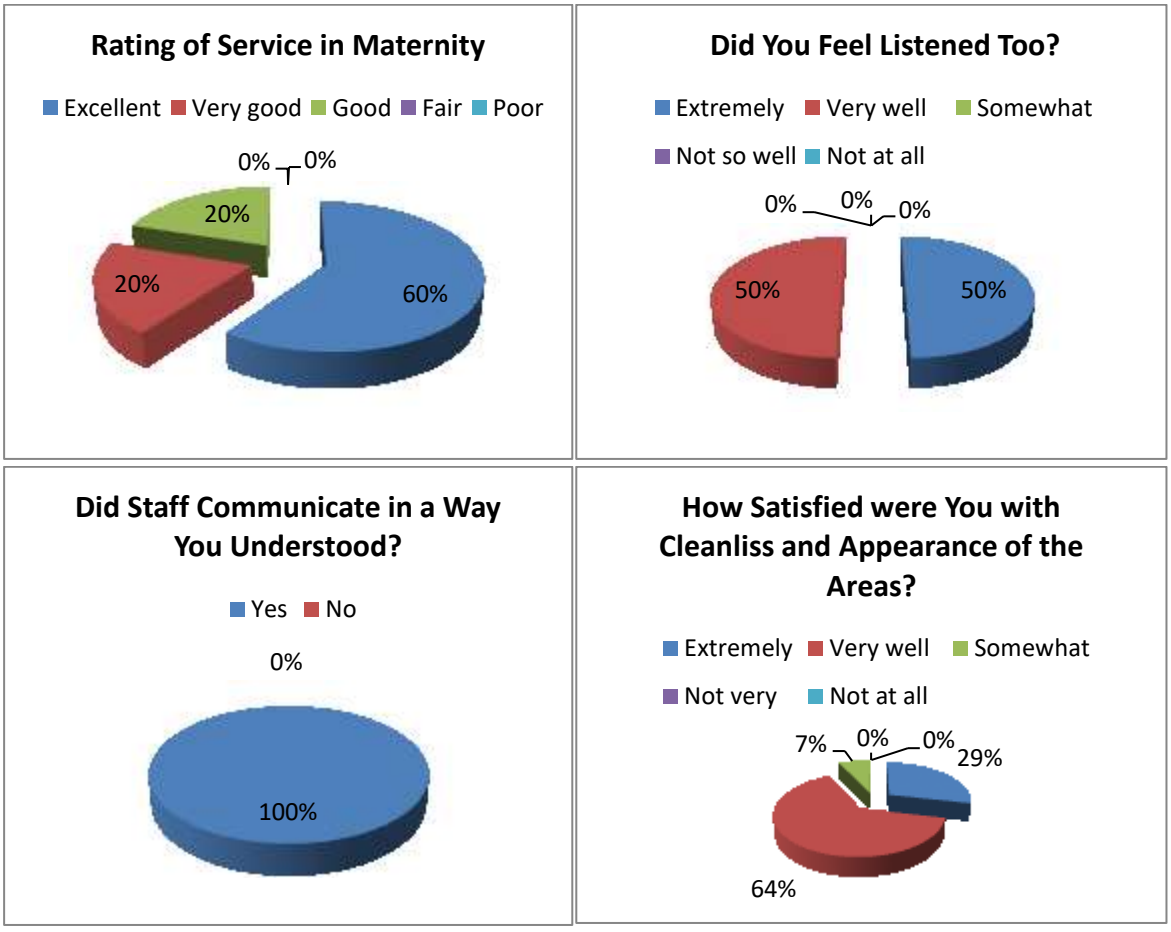
- Scribe documentation; review of recent cases showed inconsistent poor scribe documentation during emergency situations. The education team have used this to run some trolley dashes with the use of examples to highlight the importance to all staff

- MOH; Cases have demonstrated overall improved management with recognition of MOH, activation of protocol and use of ROTEM. However it has been identified that there is a delay in uterotonics in some cases. The education tem have undertaken MDT skill drills on the back of this to reinforce the importance of early administration of medication. Delivery suite has also ensured TXA is now stocked in the delivery suite drug cupboard for early access rather than having to obtain this from obstetric theatre.

- No current pathway for management of persistent maternal tachycardia in pregnancy. A lead consultant to work on a pathway and bring through policies and procedures so that care is uniformed and appropriate further investigations are completed

3.5 Patient Experience

The maternity service, led by the ward managers implemented a local survey to support to ensure the woman's voice is heard and changes can be implemented to support improvement. The survey was introduced in November; the team are working to grow our response rates and continue to develop this further, with engagement both corporately and via the maternity voices partnership. Below is a selection of responses from the February survey, rating is the same as January, work progresses to increase and improve this survey.



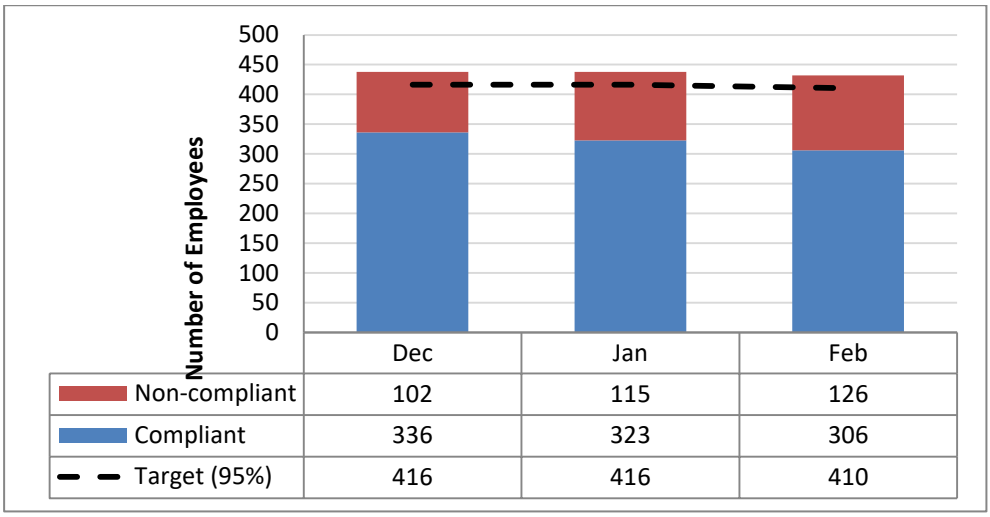
3.6 Complaints

One complaint was received in February with the main themes being communication and clinical treatment, relating to care in 2020. A meeting has been arranged and an investigation of the complaint has been completed.

3.7 Mandatory Training

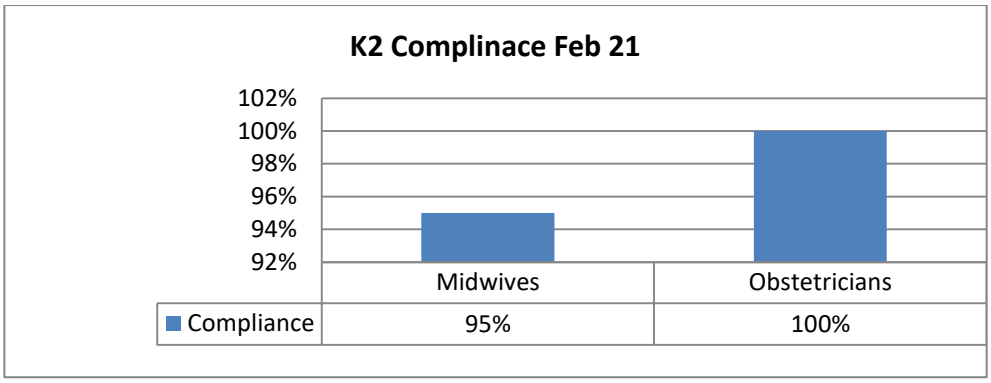
Below are the tables summarising training to date

100 Club



	Dec	Jan	Feb
Non-compliant	102	115	126
Compliant	336	323	306
Target (95%)	416	416	410

Professional Training



	Midwives	Obstetricians
Compliance	95%	100%

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.

4.0 Workforce

The last Birthrate plus (BR+) review was undertaken in 2019, this showed a deficit of 11wte midwives. Since this review the service has reconfigured the workforce model in community midwifery, in line with national mode of change to an 80:20 spilt of midwives to band 3 maternity support workers (included in MW numbers in BR+). The Trust has also seen a decline in births in line with a national downward trend, however it should be noted that workforce cannot be based on birth itself, as the population we serve require enhanced antenatal and postnatal care, these two elements forming the larger aspect of maternity care.

The Trust invested in supporting our MSW's to band 3 level and a full competency passport was created in line with HEE guidance to upskill them. This will however alter our BR+ requirements and a review has been requested. The service is currently working through workforce models as we work towards MMUH. A refreshed review has been commissioned based on the evidence above and due to the particular impact of 45% of exports, whom we provide antenatal and postnatal care for.

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.

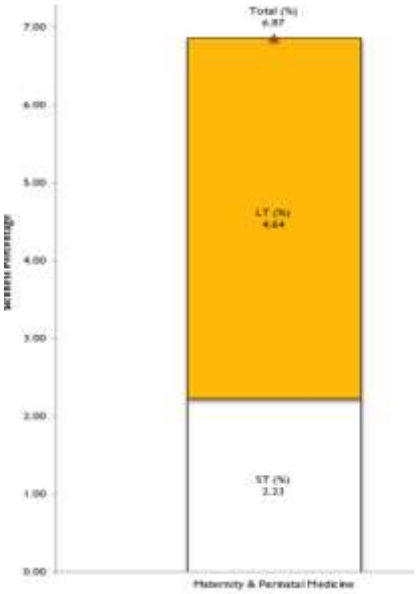
4.2 Vacancies

Row Labels	Sum of Position FTE	Sum of Actual FTE	Sum of FTE Variance
Additional Clinical Services	66.57	69.71	3.14
Administrative and Clerical	38.04	34.49	-3.55
Estates and Ancillary	0.48	0.48	0.00
Medical and Dental	65.19	57.38	-7.82
Nursing and Midwifery Registered	296.65	265.14	-31.51
Grand Total	**466.93**	**427.19**	**-39.74**

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.

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:
27	18	4	5	**4**	**5**

4.4 Maternity Leave

Mat Leave: 23.00 WTE across the Directorate (including NNU)

5.0 Local Maternity and Neonatal System

5.1 Ockenden

Following on from the Ockenden report and submission of the assurance tool, the Director of Midwifery meet with the Regional Chief Midwifery officer to validate the submission. The LMNS

will meet as a Group with the Regional Chief Midwifery officer (7th April), as the next steps prior to submission of evidence to the national portal.

5.2 Equality and Inclusion lead midwife

The service is delighted to have secured funding from the LMNS to support a pilot of a diversity and inclusion lead midwife for 12 months.

Significant inequalities in maternity outcomes persist in the UK, for women from Black, Asian and minority ethnic groups experiencing particular disadvantage. Determinants of health inequalities amongst Black, Asian and minority ethnic women are multifactorial. However, there is evidence that current service provision contributes importantly to adverse outcomes in this group of people.

A number of barriers can be identified that undermine timely access to high quality care for many Black, Asian and minority ethnic groups, with still birth rates twice those of their white counterparts and a 45% higher neonatal death rate. The Equality and Inclusion lead will also assess the training needs of staff so that conversations around race and culture are sensitive and meet the needs of the communities we serve.

The lead will work alongside culturally diverse and vulnerable groups to dispel perceptions and provide assurance that safe, quality care will be provided in maternity services and ensure any barriers that prohibit women and their families accessing such care are removed.

In this position a lead role will also be taken in relation to Equality, Diversity and Inclusion, developing an EDI framework and approach to support the Trust's commitment to foster an inclusive working environment that promotes equality of opportunity and diversity for all staff members, patients and their families.

7.0 Summary

In summary the paper outlines the current positon in maternity services and the work that is being undertaken. The annex outline the improvement plan developed as a continuous cycle for 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 or midwifery

Annex 1

Maternity Briefing March 12th 2021

Introduction

Following the recent article in the HSJ this briefing sets out our improvement plan for Maternity Services at SWBH. The HSJ article raised concerns regarding leadership, culture, governance and staffing and is the result of a letter sent to the HSJ and CQC a month ago. An improvement plan has been in place since the summer for maternity services that aims to address safety, culture and leadership issues. The plan supports a mix of Trust-delivered as well as commissioned external work to review the culture and safety within SWBH Maternity services and the internal governance processes with the main focus being on improving outcomes and continuous learning. It must be recognised that achieving cultural change is a long-term process and effective leadership is fundamental to success so the third part of the plan focuses on leadership development supported by a strong executive and non-executive presence. Some of this work has been delayed due to COVID 19, but is now underway again.

Safety

Safety remains the number one priority for women, babies and families and we have a number of systems in place to monitor and review safety. We have refreshed the monthly maternity safety meetings which are led by our Medical Director who also undertakes safety walkabouts to ensure the staff voice is heard and to support shared learning. We have also recently appointed a non-executive director lead for these meetings. There are staff safety representatives from midwifery, risk and governance, obstetrics and neonates who liaise with all staff to ensure two way communication and learning. We have developed a platform for sharing learning both internally and across the LMNS, which is part of the plan we will continue to build on. A further piece of work is being led by the Associate Director of Learning and Governance who will work with staff to agree the best approach for their learning to make a positive difference to patient care.

Culture

We recognise that culture is a model of reality which tells us how things should be done and how we act, it requires leadership to develop new forms to respond to social changes. In order to understand the current culture within the service a review of staff perception has begun that includes a number of surveys and listening events including those undertaken as part of the national work to improve safety and outcomes, as a benchmark. The next steps will take forward the learning from these listening events and anonymous staff surveys which occurred in November through to January. On March 25th a learning event is being held that will transparently feedback the outcomes of these activities to build the action for change with staff voices at its core. In April, staff will be given the opportunity to speak with an external professional, who will collate the data and complete a report to ensure transparency and non-bias. A further piece of work will also be undertaken by this professional listening to our women and families so we can triangulate the data and work with our key stakeholders to implement sustainable change.

Leadership

To support leaders within maternity develop reflective skills, which allow growth and development, a programme of coaching and mentoring is being provided. Initially 360 degree assessments for senior staff will allow feedback so that individuals can build upon strengths and address any areas for improvement. Recognising the requirement for effective teams will be part of the ongoing work which allows for honest and timely conversations. We have also commissioned with the RCM the insights programme, which is a series of workshops to support leadership which will be offered to all band 7 staff and above.

Transformation

We have commissioned an external organisation to develop a social movement approach to build a kinder culture. This will be delivered via two three hour workshops taking place virtually at the end of June/July 2021. The workshops will be multidisciplinary and include up to 100 staff per workshop. The Trust has also recruited a transformation midwife to lead the critical work within community midwifery, particularly that relating to caseloads, recruitment and resourcing.

Staffing / Recruitment

In 2016 we had 36.11 WTE midwifery vacancies and we now have 27 WTE. In 2019 we had four maternity support worker support roles and these roles were subsequently increased based on an 80/20 split qualified midwives to support workers. We have no vacancies within support workers. In addition we do have 20 midwives on maternity leave. There are staffing safety meetings in place every morning and a template is used to ensure safe staffing against patient acuity and funded establishment. We have also have a Business Continuity Plan for community midwifery which is RAG rated and we are currently amber. This has been greatly affected by staff who have been self-isolating or shielding during COVID.

In conjunction with HR the recruitment drive has been refreshed and an incentive scheme both for hard to fill areas such as community midwifery and midwifery across the service is in place. Also all students have had offers of appointment and a robust preceptorship package is now in place following feedback form staff.

Ockenden Report

In response to the Ockenden report a specific action plan has been developed which is now part of our overall improvement plan. The director of midwifery attends both Quality & Safety Committee and Trust Board and has been reporting monthly since January 2021 presenting our response plan to Ockenden, the refreshed maternity dashboard and a regular maternity update that reflects progress against our plan.

Summary

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. It is currently being reviewed by both the Acting Chief Nurse and Medical Director before being submitted to the April Public Trust Board. There has been a delay in progressing the plan as quickly as the Trust would have liked due to the

wide reaching effects of very high community COVID 19 infection rates in the Black Country, but that is now back on track and moving forwards

Melanie Roberts, Acting Chief Nurse
Helen Hurst, Director of Midwifery
David Carruthers, Medical Director

Annex 2

Maternity Improvement Plan