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PATIENTS PEOPLE POPULATION

NHS
Sandwell and West Birmingham
NHS Trust

REPORT TITLE:	Maternity Update to Board		
SPONSORING EXECUTIVE:	Melanie Roberts - Chief Nurse		
REPORT AUTHOR:	Helen Hurst Director of Midwifery		
MEETING:	Public Trust Board	DATE:	7th September 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 on: -

1. The service self-assessment against the 15 immediate and essential actions (IEA's) in the final Ockenden report (March 2022). Of these the service has either completed or is near completed with 57% of the actions and has significant work to do for 20%, some of these are out of scope for individual Trusts to achieve and require national action. Bimonthly reviews against progress are in place.
2. The service has seen an increased number of screening incidents (SIAF's) relating to NHS fetal anomaly screening programme (FASP), with 13 occurring. This has been escalated through to the Quality and Safety Committee. An action plan has been formulated to support resolution of the issues and submitted to Public Health England for monitoring.
3. The monthly update from the safety champions meeting in relation to maternity safety meetings and walkabouts, including our thanks to Professor Kate Thomas as she steps down from her Non-Executive Director Safety Champion role. Appendix 1 is the Ockenden Board oversight framework for approval.

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 September 2022. Safety champion meeting 5th August 2022.

4. Recommendation(s)

Trust Board is asked to:

a.	**ACCEPT** the update against the 15 IEAs from the final Ockenden Report
b.	**ACCEPT** the update on screening concerns
c.	**ACCEPT** the Safety Champion Update
d.	**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		*Deliver on its ambitions as an integrated care organisation*					
Corporate Risk Register [Safeguard Risk Nos]		Workforce risks 4480,3831,3576,4575,4326,2625 Screening risk 5062					
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 Public Trust Board – 7th September 2022

Maternity Update to Board

1. Introduction

1.1 Oversight for maternity and neonatal services is fundamental to the quality improvement programme, to ensure transparency and safe delivery of services. Ensuring compliance or progress towards compliance with key performance indicators and drivers for quality improvement are vital to service improvement.

2. Ockenden Update

2.1 In March 2022 the final Ockenden report was published, which contains a further 15 IEAs. Within the 15 IEAs there are 88 sub-actions. In April the multi-disciplinary team at SWBH undertook a self-assessment against these actions. Review schedules are in place to assure progress, bi-monthly. Compliance following the last review is summarised in table 3 below:

Table 3

Immediate essential action	Number of sub- actions	Complete	Near complete	Some progress in this area	Significant work to do	National action
1 Work Force Planning & Sustainability	11	3	3	1	2	2
2 Safe Staffing	10	6	0	2	2	0
3 Escalation & Accountability	5	3	1	0	1	0
4 Clinical Governance Leadership	7	3	1	1	2	0
5 Clinical Governance Incidents	7	2	2	2	1	0
6 Learning from Maternal Deaths	3	2	0	0	0	1
7 MDT training	7	3	0	1	3	0
8 Complex AN Care	5	3	0	1	1	0
9 Preterm Birth	4	2	1	0	1	0
10 Labour and Birth	6	2	0	2	2	0
11 Obstetric Anaesthesia	4	0	2	2	0	0
12 Postnatal care	4	3	1	0	0	0
13 Bereavement Care	4	2	0	2	0	0
14 Neonatal Care	8	2	0	3	3	0
15 Supporting Families	3	3	0	0	0	0
Total	**88**	**39**	**11**	**17**	**18**	**3**
% of total		**44**	**13**	**19**	**20**	**3**

2.2 National update regarding the action to stop new qualified midwives working in community (included in IEA 1), supports the continuation of this rotation with well-constructed systems of support and competency in place.

2.3 Some of the areas of focus to progress the actions with significant work to do are:

- Human factors training, standalone not amalgamated in training
- Succession planning to develop potential leaders
- Development of clinical opinion policy to aid escalation concerns
- Mechanisms to support emotional and psychological needs of staff, both at individual and team level
- Continued co-production with Maternity Voices Partnership and other service-user organisations

3. Screening Concerns

3.1 The service has seen an increased number of screening incidents (SIAF's) relating to NHS fetal anomaly screening programme (FASP), with 13 occurring. This has been escalated through to the Quality and Safety Committee.

3.1.1 This relates to not achieving the dating scan within the appropriate time frames which are 12/14 weeks for dating scans and 10 weeks for screening bloods bearing in mind we have up to 70 referrals a day and have a high percentage of late bookers. Following a deep dive the root cause for this is multifactorial, but the main issue is how we deal with the referrals so a new process is being implemented

3.1.2 These incidents have been amalgamated into 1 Serious Investigation in line with Managing Safety Incidents in NHS Screening Programmes (2021) in conjunction with Public Health England (PHE)

3.1.3 An action plan has been produced to address the issues identified, with weekly oversight led at Group level and governance processes through to Quality and Safety Committee and monitored by PHE.

3.1.4 Immediate actions have been taken which includes digital support for both administration purposes and failsafe, as well as altering the booking processes from a central system to one owned by each community family (7 in total).

4. Safety Champion Update

The monthly safety champion review meeting received an update on progress against the actions required from the Ockenden report and shown above. There were no particular areas of concern and a summary infographic for ease of reference of the actions was reviewed. Safety data was reviewed including a summary of the immediate reviews related to stillbirth cases, where no immediate concerns were identified. The action plan from the screening incidents was reviewed (delay in early screening for fetal abnormalities) and reasons behind the delays discussed. Changes to address the administration process have been put in place to improve booking of new referrals and their initial review. An improved position in staffing within community services was reported from UK and international midwifes. Thanks were given to Professor Thomas as non-exec safety lead as she stepped down from her role having completed her term as non-exec director, to be replaced by Leslie Writtle who has supported maternity in this role before.

5. Summary

Significant work continues within the service to ensure the quality and safety of provision meet the key drivers from National reports. Transparency, escalation, and action when failings against required standards happen are vital to ensure oversight and progress.

6. Recommendations

6.1 The Trust Board is asked to:

a) **ACCEPT** the update against the 15 IEAs from the final Ockenden Report.
b) **ACCEPT** the update on screening concerns
c) **ACCEPT** the Safety Champion Update
d) **APPROVE** the oversight framework

Helen Hurst
Director of Midwifery
16th August 2022

Appendix 1

Ockenden Framework Update July 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. 4 still birth's and 0 Neonatal death corrected for gestational age	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)	1 case was referred for investigation that of an intra uterine death at term. 3 cases active.	Cases included in the Quality and Safety Committee (Q&S) 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 serious incidents (SI) declared. The HSIB case above and the screening SI mentioned in the main body of the report.	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%.	Draft of Birth-rate Plus report received, currently going through validation. 8 further Internationally Educated Midwives arrive at the beginning of September. 4 keep in touch sessions have now been conducted with the newly qualified midwives, of which there remain 19 that have accepted posts, they start between the end of September and February. X2 new neonatologist's posts filled. Qualified in speciality nursing on the neonatal unit continues to carry vacancies, 2 have just qualified, 4 in training.
Service User Voice feedback	Feedback collated from FFT, complaints, PALS, local surveys, and Maternity Voices	Themes from complaints are clinical treatment and attitudes and behaviours, patient stories are being woven into shared learning. Several

	Partnership (MVP)	compliments have also been received 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 15 steps review was supported by the MVP, the findings of which will be reported via Q&S next month.
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	None	None
Coroner Reg 28 made directly to Trust	None	None
Progress in achievement of CNST10	CNST Compliance Rag Rating Significant risk of not completing: 1 Moderate risk of not completing: 2 Will Complete: 7	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. 1 action is at significant risk, relating to transitional care. 1 moderate risk has been escalated to the National team due to a data issue.
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	