Paper ref:	TB (07/23) 013

PATIENTS PEOPLE POPULATION

AMBITION RESPECT COMPASSION

NHS
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:	Public Trust Board	**DATE:**	12th July 2023

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 report, as an update on maternity & neonatal services: -

- The report contains an overview of completed investigations undertaken by the Health Service Investigation Branch (HSIB) in the last six months. These incidences occurred between April to November 2022. The themes highlighted in the cases are consistent with those seen at both a national and regional level and actions are in place to support improvement. It should be noted that actions from previous reports have seen a significant decrease in the recommendations.
- The screening update provides an overview of the issues relating to scan capacity and the work undertaken by both the Imaging and Women's and Children's Clinical Group to address the issue. Included is the positive action to support the referral process of the developed Patient treatment list, which is currently in testing phase prior to go live.
- An external review of the neonatal service was commissioned following concerns raised around culture in the unit, this has been completed and a draft report received. The full report with associated improvement plan will be presented at Trust Board in September.
- Annex 1 contains the Ockenden framework update for March 2023

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 March 2023. Safety champion meeting 3rd March 2023.

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**NOTE** the detail of the report.
b.	**DISCUSS** the content
c.	**NOTE** and **ACCEPT** the Ockenden Framework Update

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	x	*Deliver on its ambitions as an integrated care organisation*						
Corporate Risk Register [Safeguard Risk Nos]		Workforce risks 4480,3831,3576,4575,4326,2625						
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: 12th July 2023

Maternity & Neonatal Services 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. Six-month update - Health Service Investigation Branch (HSIB) reports received by Maternity and Perinatal Directorate

2.1 The Healthcare Safety Investigation Branch (HSIB) is an independent organisation which was established to conduct maternity safety investigations as per learning from investigations within The Safer Maternity Care report (2016) and has been operating in all NHS Trusts since 2019. The HSIB mission is to improve patient safety through professional safety investigations that do not apportion blame or liability. Maternity safety investigations are underpinned by fundamental systems thinking principles; HSIB work with families, NHS staff and support NHS Trusts to influence systemic changes through published reports outlining key findings and recommendations.

2.2 HSIB will conduct maternity investigations in accordance with the set eligibility: term babies (at least 37 weeks gestation of pregnancy onwards) born following labour who have the following outcomes:

- **Intrapartum Stillbirth** – *Where the baby was thought to be alive at the start of labour and was born with no signs of life.*
- **Early Neonatal Death** – *When the baby died within the first week of life (0-6 days) of any cause.*
- **Potential Severe Brain Injury** – *Potential Severe brain injury diagnosed within the first seven days of life; when a baby was diagnosed with moderate or severe Hypoxic Ischaemic Encephalopathy (HIE), required therapeutic hypothermia treatment to reduce impact of HIE, or had decreased central tone, was comatose and had seizures of any kind.*
- Additional criteria in relation to maternal outcomes:
- **Maternal Deaths** – *Both direct and indirect deaths of women while pregnant or within 42 days of the end of pregnancy. This excludes suicide as cause of death.*

2.3 All HSIB cases are also reported as Serious Incidents (SI's) externally to the Integrated Care Board (ICB) as part of Trust Governance process.

2.4 Between December 2022 – June 2023 the Trust has received four completed HSIB reports, and criteria met was for two intrapartum stillbirths, one early neonatal death and one case of potential severe brain injury. These incidences occurred from April to November 2022. The overview of these cases can be found in Annex 1 table 1. An overview of ongoing

cases, position and learning is provided monthly to both Quality and Safety Committee and Safety Champion meetings.

2.5 Annex 1 Table 2 provides the detail of the Learning and recommendations that have come through reports, you will note these are the same themes seen at both National and Regional level.

- Clinical Assessment
- Fetal Monitoring
- Clinical Oversight
- Escalation

2.6 Chart 1 in Annex 1 shows the significant reduction in recommendations, particularly in relation to fetal monitoring, clinical oversight, and guidance. Table 3 in Annex 1 provides detail per sub-category and includes Trust actions. Two examples of these are:

- **Management of Preterm Rupture of Membranes -** The Trust to ensure that the staff are supported to discuss the risk and benefits of all options for management when the mother present with prelabour rupture of membrane at term, in line with local and national guidance.

  Action - Review of the Preterm, Premature Rupture of Membranes (PPROM) guideline, updated guidance introduces in January 2023.

- **Interpreting services -** The Trust to ensure staff are aware of local translation and interpreting policies and reinforce the importance of utilising interpreters in cases where English is a second language.

  Action - The issue with access to quality, consistent interpretation for the diverse languages used by our population has been challenging. The service has Introduced Wordski on Wheels (WOW) live interpreter devices, this includes British Sign Language, which was successfully used in a complex case. The WOW has been welcomed by both Women, birthing people and their families and our staff.

2.7 Action plans are discussed in the monthly multidisciplinary Perinatal Risk Investigation (PRIMe) meeting and monitored by the Directorate, who provide upward assurance to the Clinical Group and Safety Champion meetings.

2.8 The families receive copies of the HSIB reports and are all offered a tripartite meeting (between the family, HSIB and the Trust) or just between the family and the Trust.

3. Screening Update

3.1 Following the briefing to Quality and Safety Committee, Trust Executive, and verbal update to the last board regarding the issues to ensure timely antenatal screening relating to the capacity to undertake ultrasound scans. A short-term solution was found utilising our Consultant Obstetricians covering the mid- trimester scanning to allow for sonographers to be relieved to accommodate additional capacity for dating scan appointments.

3.2 Concerns were raised with both the Imaging and Women and Child health Clinical Groups to ensure capacity was met and a long-term solution found, which both are working to resolve, short term capacity has been released and at the time of witing the report there are no outstanding scans and prospective capacity available.

3.3 To support the overview of the referral into the maternity service, a patient treatment list (PTL)has been developed utilising existing PTL's and will be introduced to work alongside Badgernet (digital shared care record) to facilitate the management of referrals in a timely manner. This is currently being tested in real time prior to go live at the beginning of July.

3.4 Whilst awaiting the roll out of the PTL system, there has been an introduction of a weekly PTL meeting to support the assurance meeting already in place. There is also now a daily Matron/ Manager touchpoint meeting with the administration team to discuss concerns regarding referrals. The administration team are also presently working to complete a Standard Operation Procedure making the referral processing more robust.

4. External Neonatal Peer Review

4.1 An external peer review was commissioned following concerns raised around culture within the neonatal unit. This review was undertaken by clinical neonatal experts and led by a health care consultant. The draft report has been received for factual accuracy and will be presented to Board in September with the associated Improvement Plan.

4.2 The review team found that where very aware of the issues and a passion to improve was evident. The review team felt that with changes in leadership structure, a review of policies and clearly defined processes for staff to be heard and supported then the change required could be initiated.

4.3 The high-level themes are:

- Listening to families and workforce improved two-way communication.
- Robust governance processes and escalation
- Strong and correct leadership structures
- An improved safety culture built upon mutual respect and a no blame.

5. Recommendations

The Trust Board is asked to:

a. **NOTE** the detail of the report.
b. **DISCUSS** the content.
c. **NOTE** and **ACCEPT** the Ockenden Framework Update

Helen Hurst
Director of Midwifery
20th June 2023

Annex 1

Six-month update - Health Service Investigation (HSIB) Supporting Data

Table 1: Description of completed HSIB reports December 2022 – June 2023

Case Ref:	Referral Criteria	Summary / Outcome
MI-008438	**Intrapartum Stillbirth**	This was the third pregnancy, and the patient was high risk due to previous Caesarean Section (CS) and Gestational Diabetes Mellitus (GDM). Patient presented to Maternity Triage at 37+5 weeks gestation with confirmed Spontaneous Rupture of Membranes (SROM), PV bleeding and in early labour. Sadly, Intrauterine Death (IUD) was confirmed on the Antenatal Ward later the same day and baby was stillborn the following morning.
MI-010020	**Potential Severe Brain Injury**	Second pregnancy, booked for Midwifery Led Care (MLC). The patient had 3 reported episodes of Reduced Fetal Movements (RFM) in the week leading up to her Triage admission at 38+4 weeks with RFM and back pain. Cardiotocograph (CTG) was pathological, and baby was born via Category 1 CS in very poor condition (abnormal neurology and seizures); required transfer to Level 3 Neonatal ICU with clinical diagnosis of Hypoxic Ischaemic Encephalopathy (HIE)
MI-013782	**Intrapartum Stillbirth**	This was a second pregnancy; high risk due to previous CS at 34 weeks for severe pre-eclampsia. She presented to Maternity Triage at 38+2 weeks gestation in early labour and sadly an IUD was confirmed, birth followed the next day
MI-011835	**Intrapartum Stillbirth**	Third pregnancy, booked late at 15+1 weeks; high risk for GDM and Female Genital Mutilation (FGM). At 39+2 weeks gestation, patient attended with DFM suspected labour and IUD was sadly confirmed. The Patient had an Antepartum Haemorrhage (APH) of 200mls and required a Category 1 CS, total blood loss – 4 litres.
MI-014112	**Potential Severe Brain Injury**	This was the patients first pregnancy and was booked under MLC but was seen under Fetal Medicine Unit (FMU) for fetal antenatal diagnosis of mild hydronephrosis. At 39+5 weeks gestation, patient attended Maternity Triage with RFM and SROM for 21 hours, CTG concerns were identified, and baby was born in poor condition following Category 2 CS. Baby was commenced on Therapeutic Hypothermia treatment in view of seizures and was transferred to a Level 3 NICU as per pathway
MI-017150	**Early Neonatal Death**	This was the second pregnancy, attended for Induction of Labour (IOL) at 40 weeks in view of booking late for care at 36+4 weeks gestation. Due to pathological CTG with ongoing IOL, baby was born via Category 1 CS in poor condition and required treatment with Nitric Oxide. Baby was transferred to a Level 3 NICU however was reorientated to comfort care and passed away at 3 days of age.

Table 2 provides and overview of themes at all levels.

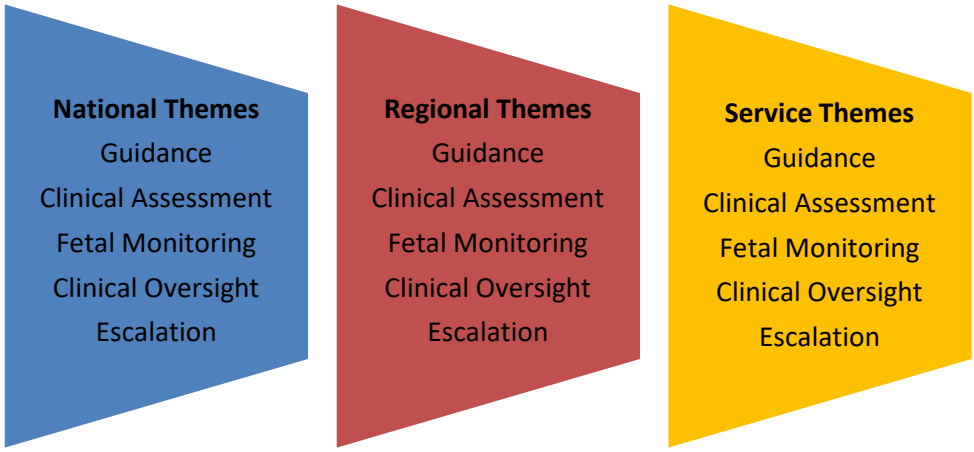

Chart 1 Provides an overview of recommendations from Q4 2019/20 onwards, the significant reduction in recommendations, particularly in relation to fetal monitoring, clinical oversight, and guidance.

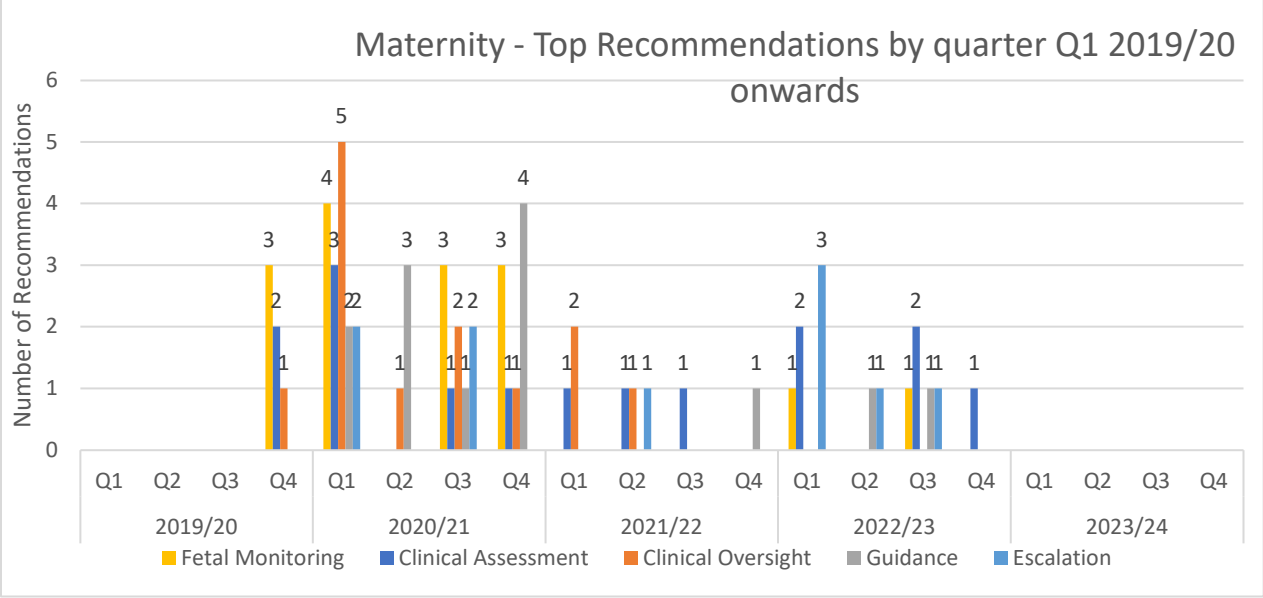

Table 3: Themes- by sub-category / Safety recommendations and Trust Actions

Themes – by sub-category and Safety recommendation	**Our action**	**Progress**
Management of Preterm Rupture of Membranes • The Trust to ensure that the staff are supported to discuss the risk and benefits of all options for management when the mother present with prelabour rupture of membrane at term, in line with local and national guidance.	Review of the Preterm, Premature Rupture of Membranes (PPROM) guideline	Completed Guideline was updated Jan 2023

Risk assessment and communication • The Trust to support the staff in identifying all clinical risk factors present to fully inform decision made regarding to the timing of IOL. • The Trust to ensure that any new clinical findings are risk assessed and incorporated into further management decisions, including priority status for transfer to the delivery suite.	Education about identification and escalation of clinical risk on Midwifery Mandatory Day (MMD)	Completed – included in teaching session
Operational / staffing escalation • The Trust to ensure that the staffing levels are to be maintained to the recommended levels within the unit. If, after escalation staffing cannot be brought to a safe level, diversion and closure of the unit should be made	Escalation policy to be refreshed and split into operational and clinical escalation	Ongoing, currently developing policy
Antenatal Management Plans • The Trust to ensure every woman identified as high risk admitted to the antenatal ward, is reviewed on the consultant ward to ensure ongoing management plans are clinically suitable.	Communication to the Obstetric team to ensure this is being conducted. Email communication was sent out to raise awareness amongst medical team	Completed
Fetal Heartrate concerns • The Trust to provide staff with clear guidelines for how and when to call for assistance if a fetal heat beat is not heard. he Trust to provide staff with clear guidelines for how and when to call for assistance if a fetal heat beat is not heard.	Message in Weekly Maternity Matters Memo to say that there needs to be urgent action if no fetal heart is heard	Completed
	Development of a Pathway of what to do if no fetal heart is heard in all care settings (including Community / clinics and inpatients)	Completed – Flow chart in all clinical areas
Staff Support • The Trust to ensure a compassionate and supportive culture where staff are able to seek assistance without feeling the pressure of being judged.	Communication to all staff through Maternity Memo, Pebbles in Shoes and Professional Midwifery Advocate (PMA) support.	Completed
	Safety Huddles to commence	Completed
Fetal Monitoring • The Trust ensures that staff are supported to undertake a prompt holistic review of a mother who presents with an abnormal CTG and escalate if this is not possible.	Discuss and implement when to escalate such cases to the on-call consultant at home to review via working group	Ongoing
Medicines Management • The Trust ensures staff are supported to administer medications without interruptions or multiple tasks	Internal Communication from neonatal risk lead to all doctors and consultants regarding not interrupting nurses when doing drugs.	Completed

	To disseminate via effective handover, to ensure second checker does check the line is connected before leaving.	
Maternity Telephone Triage processes • The Trust should ensure that there is clear guidance, to support clinical decision-making during telephone triage.	Additional training provided for triage midwives and support staff on handling telephone triage and prioritising attendance advice.	Immediate and ongoing
	Support is given by the senior midwife with triaging phone calls	
	Second calls to be recorded on the same call sheet which is scanned to BadgerNet	
Interpreting services • The Trust to ensure staff are aware of local translation and interpreting policies and reinforce the importance of utilising interpreters in cases where English is a second language.	Ongoing communications via multiple channels cascaded to teams via Matrons	Completed
	Introduction of Wordski on Wheels (WOW) live interpreter devices in intrapartum areas	
Documentation from Oversees • The Trust to ensure official paperwork from overseas organisations are used to inform decision making when mothers arrive in the UK and book late.	Communication to raise awareness amongst medical team	Ongoing
Placental Histology • The Trust to ensure placentas are labelled correctly and sent for pathological examination including histology in line with national guidance (RCPath, 2019)	Feedback to individual regarding correct procedures and reminder regarding labelling and processes following all births where histology is appropriate. Ongoing audit of compliance with processes	Ongoing
Shared Learning • Ensure learning from incidents if communicated to all relevant staff	Presentation of case to MMD	Completed
	Presentation of case in Electronic Fetal Monitoring (eFM) study days	
	Presentation of case in Risk and Governance Learning event / QIHD	

Annex 2
Ockenden Framework Update (April and May 2023 data)
Detail r and Oversight via Quality and Safety Committee

Data Measures	Summary	Key Points
Findings of review of all perinatal deaths using the real time data monitoring tool	Still Births (SB's) April: 3 (25-41 weeks gestation) May: 4 (25- 38 weeks gestation) Neonatal Deaths (NND's) April:2 May: 1	Monthly data detailed in paper to Quality and Safety Committee. SB's (25- 41weeks) Contributory factors: Decreased fetal movements, Abruption, Prolonged preterm ruptured membranes from 19 weeks, and 2known complications of pregnancy. NND's: Extreme prematurity (22+3 weeks, Preterm 26+3 and a Sudden Unexpected Death at home.
Findings of review all cases eligible for referral to Health Services Investigation Branch (HSIB)	In paper	In paper
The number of incidents logged graded as moderate or above and what action being taken.	0 serious incident (SI) declared.	Weekly multi-disciplinary incident review/learning meeting in place within the service, to review all moderate and above cases.
Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training.	Midwifery training currently above 80% for all components. Obstetric Consultant at 100% and 58% Trainees 81% and 58% Consultant Anaesthetist 91% Trainees 87%	Target 90% over the year. Professional training database (core competency framework) monitored by education team. To note consultant compliance impacted upon by junior strike. Training sessions now twice monthly to ensure improved compliance.
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.	Average fill rate within inpatient midwifery is at 95% 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.	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.

	Neonatal clinician gap of 0.5 wte within the junior rota.	
Service User Voice feedback	Feedback collated from FFT, complaints, PALS, local surveys, and Maternity Voices Partnership (MVP)	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.
Staff feedback from frontline champions and walk-abouts	Visits to both maternity & Neonatal services and meetings with staff. Also, first meeting with new maternity Safety NED as an intro and to plan visits etc.	Themes from walkabouts and meetings with staff include Community Staffing within Sandwell, Scanning and plans. Neonatal services focussed on the review and 27-week pathway
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	Year 5 release, plan in place	
Saving Babies Lives Care Bundle	Compliance Tool kit completed awaiting external verification of compliance.	Version 3 released, diabetes added and new additions. Targets removed, stretch targets to be assigned by the Local Maternity and Neonatal system, based on local data, incremental improvement required.
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 Improvewell 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	