Paper ref:	TB (10/22) 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:**	5th October 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 report, as an update: -

1. The regional insights visit took place on the 14th of September to assess progress against the 7 immediate and essential actions (IEA's) from the first Ockenden report. The visit was overall positive, with both clear points of celebration and for consideration. The fully implemented actions, now require audit to ensure they are embedded.
2. The Maternity Voices Partnership (MVP) undertook a 15 steps audit, this uses an observational approach to understand what service user's experience when they access the local maternity care. The observation found both positive points and points for consideration, some of which related to the estate. An action plan has been developed and is being monitored via directorate and group governance. Next steps will be to formulate 15 steps to support our move to the Midland Metropolitan University Hospital.
3. We welcomed both a new executive and non-executive safety champion, who attended their first safety champion meeting. Plans are now in development to inform and progress their support, especially with our service users. Current focus is on progress against the clinical negligence scheme for trust (CNST) submission and the screening action plan.

Also included in the annex 3 is the Ockenden framework update for August 2022

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 28th September 2022.
Safety champion meeting 2nd September 2022.

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**DISCUSS** the Insights visit feedback
b.	**DISCUSS** the 15 steps feedback
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	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 HOSPITALS NHS TRUST

Report to Trust Board: October 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. Central to supporting oversight and assurance are external reviews of service provision, the paper includes two for the Boards evidence.

2. Regional Insight Assurance Visit

2.1 An Insight visit was completed on the 14th of September 2022 by the Regional Midwifery team. The purpose of the visit was to provide assurance against the 7 immediate and essential actions (IEA) from the initial Ockenden report (table 1). The visit used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were implemented and subsequently embedded in practice. Conversations were held with members of the senior leadership team and many front line staff ranging in job roles.

Table 1: The 7 IEA's

IEA 1 Enhanced Safety
IEA 2 Listening to Women and Families
IEA 3 Staff Training and Woking Together
IEA 4 Managing Complex Pregnancy
IEA 5 Risk Assessment Throughout Pregnancy
IEA 6 Monitor Fetal Well-Being
IEA 7 Informed Consent
Workforce Planning and Guidelines

2.2 The visiting team reported an overwhelming positive feel to the service and good innovation in place.

Points of Celebration:

- Investment in leadership roles clearly demonstrated
- Good grasp across the whole organisation of maternity services.
- Good evidence that we are reactive to staff concerns, voiced in numerous areas, including during the walk around, staff are happy to be here and eager to continue to work here - Evident across the disciplines, including those in training; student midwives, trainees and Consultants who chose to comeback after being trainees. It felt like a family, and they were well supported.

- Good demonstration of staff involved in the journey, including the communication tools used.
- Partnership working with service uses and co-production very evident, this also included with medical leadership (quite unusual)
- Great work within governance and education to ensure a timely and reactive shared learning and a no blame culture.
- Hub working at Aston Pride clearly had the service users voice and co-production and was seen as a great innovation
- Matrons active interest in staff wellbeing and staff reported how well appreciated this was. Also, the support from the Trust for health and wellbeing with the supported activities.
- Noteworthy posters clearly identifying the Quality Improvement work undertaken.

Points for consideration:

- Evidence of implementation but audit now required to ensure embedded (theme across several organisations)
- Consultant ward round sheet evident for the morning but not pm, but evident from speaking to staff that these are done.
- Safety champions posters good, but add email addresses for ease of contact
- Evident that staff know and work with the service level safety champions, but due to change in roles, that relationship now needs to be built at Non-Executive and Executive Safety Champion level.

2.3 The team are now required to complete audits against all fully implemented elements to ensure they are fully embedded and signed off accordingly.

2.4 Regional and National themes will now be identified, areas of good practice will be shared, and support based on the on identified themes.

3. Maternity Voices Partnership (MVP) 15 Steps Audit

3.1 The maternity 15 steps tool kit is part of the suite of tool kits developed to explore different health care settings through the eyes of those that use them and their relatives or carers. 15 Steps for maternity brings together those users with the maternity voices partnership (MVP) and uses an observational approach to understanding what service users experience when they access the local maternity care.

3.2 The observation took place on 26th June, the overall feedback was very positive with some points for consideration. An action plan has been developed for each area to address points for consideration and has been progressed and will be monitored through directorate and group governance.

3.3 **Positives from the day**

- Loved the Care Quality Commission (CQC) posters displayed in various languages
- Ward managers were very knowledgeable and friendly
- Process of collecting feedback seemed good
- Staff seemed polite and helpful

- Equipment readily available for mums to use
- The environment was clean and somewhat colourful
- Lots of great information available
- Welcoming
- Comfortable seating and refreshments available for service users
- A service user said that in their experience they were made to feel 'special' on this ward by staff
- Lots of infant feeding information available
- Clearly displayed roles on badges

3.4 **Points for consideration**

- Some felt the décor was depressing, the area felt dark and think there should be brighter and more baby themed decoration
- Digital boards as teaching aids
- Language assistants, not always an interpreter
- Feedback boards could be more transparent, maybe a QR code or link that allows the service user to see more information on this online
- Coffee shop to re-open
- Maps with 'you are here' and where to go. This would be useful in all areas
- TV to maybe include subtitles in other languages as well as English, and maybe use sound, if possible, for visually impaired
- General comments made about the estate and layout; they are aware we are to move to Midland Metropolitan University Hospital (MMUH)

3.5 Next steps with the MVP 15 steps will be to start to develop the tool to support preparation for the move to MMUH to ensure co-production.

4. Safety Champion Update

4.1 We welcomed Mark Anderson and Lesley Writtle as new executive and non-executive safety champions, to their first safety champion meeting. Plans are now in development to inform and progress their support, especially with our service users. Current focus is on progress against the clinical negligence scheme for trust (CNST) submission and the screening action plan.

4.2 The CNST date for submission has again been moved to 2nd February 2023 following amendments, release of these is awaited.

5. Summary

5.1 The continuum of improvement at all levels is imperative to improve services, outcomes, and future proofs our services. External reviews and support are essential to ensure the service is progressing and developing to ensure high quality, safe, effective and with co-production as a central role.

6. Recommendations

6.1 The Trust Board is asked to:

a. **DISCUSS** the feedback from the Regional Insight Visit
b. **DISCUSS** the Feedback from the 15 steps audit
c. **ACCEPT** the safety champion update
d. **APPROVE** the oversight Framework

Helen Hurst
Director of Midwifery
23rd September 2022

Annex 1

Ockenden Framework Update for September (August's data) 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. 3 still birth's and 0Neonatal death	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)	0 cases referred for investigation. 0 completed cases returned. 4 active cases.	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.	0 serious incident (SI) declared. The Directorate currently has 3 ongoing cases.	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% for midwives. 60% for doctors this impact due the new rotation, dates in place will be completed by the end of October.	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. Obstetric tier 1 and 2 gaps following new rotation from the deanery. Plans in place to mitigate. 2 episodes of consultants acting down. Neonatal clinician gap 1.2 wte on Tier 2. Expected improvement	Birth rate plus assessment currently entrain. Community midwifery workforce review, included in paper. Member of National Pilot of Recruitment and Retention. Monies approved from national bid for a retention midwife to support newly qualified and new in post midwives.

	from September with new rotation. Midwifery safe staffing analysis included in Quality and Safety report, average fill rate for inpatient (midwifery and NNU) 96%.	High numbers of short-term sickness, areas reconfigured to support safe staffing.
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, patient stories are being woven into shared learning. Several compliments have also been received. 15 steps feedback included in the body of the report.
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	Currently on track to achieve 10/10	Board declaration must now be submitted on 2nd February 2023. New amendments awaited. The team are now reviewing against new amendments.
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	