Paper ref:	TB (05/22) 014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title:	Maternity Services Update		
Sponsoring Executive:	Melanie Roberts - Chief Nurse		
Report Author:	Helen Hurst - Director of Midwifery		
Meeting:	Public Trust Board	**Date**	4th May 2022

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

The Trust Board is asked to receive this assurance document, as an update to the Board on: -

1. The bespoke community midwifery review has been completed collectively with the community teams. The review has triangulated against accepted caseloads, care hours per woman and literature reviews. The literature review has demonstrated this type of workforce review focusing on community midwifery for the entire episodes of care and not just based on births has not been undertaken previously. The review demonstrates a shortfall in community midwifery establishment of 11% midwifery posts.

2. The monthly update from safety champions in relation to maternity safety meetings, with particular reference to how we move forward to capture caesarean section (CS) data utilising Robson criteria and move away from the emphasis being on percentages of CS's performed and gaps within the middle grade workforce in neonates.

Also included in the appendix 1 is the Ockenden framework update for March 2022

2.	**Alignment to our Vision** *[indicate with an **'X'** which Strategic Objective 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		

3.	**Previous consideration** *[where has this paper been previously discussed?]*
Maternity and Neonatal data received at Quality and Safety Committee 23rd March 2022	

4.	**Recommendation(s)**
The Trust Board is asked to:	
a.	**Accept**, discuss and support the community midwifery workforce review
b.	**Accept** and discuss the safety champion update
c.	**Discuss** and approve the oversight Framework

5.	**Impact** *[indicate with an **'X'** which governance initiatives this matter relates to and where shown elaborate]*						
Trust Risk Register	x	Workforce risks 4480,3831,3576,4575,4326,2625					
Board Assurance Framework							
Equality Impact Assessment	Is this required?		Y			If 'Y' date completed	TBC
Quality Impact Assessment	Is this required?		Y			If 'Y' date completed	TBC

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to Trust Board: 4th May 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. A fundamental driver for the programme is ensuring we hear, respond and improve from listening to our women, families, communities and workforce to ensure and evoke real, sustainable change.

2. Community Midwifery Workforce Review

2.1 Community midwifery workforce has been a challenged service both presently and historically. There is currently no workforce tool that captures the entirety of care delivered in the community setting, especially allowing for high levels of women who have their antenatal and post-natal care with one Trust but choose to birth at another (exports). Workforce tools that are currently used within a maternity setting purely base the community midwifery requirement on births. To ensure we therefore have our workforce at a level to meet the needs of our communities, a bespoke review tool was developed. The project team utilised engagement and scoping across staff, our women and accessing current data sources

2.2 The project has involved community midwives, community team managers, matron, digital midwife; equality and diversity inclusion lead (EDI), clinical lead midwife-transformation and finance. The methodology incorporated both qualitative and quantitative models, utilising survey, task and finish groups, forums, open door sessions and women's voices heard through our EDI lead. A current caseload acuity baseline was undertaken by means of triangulating sources including the electronic record keeping system, individual caseload survey and our digital midwife.

2.3 The wealth of data has been analysed and validated with the support of finance and has been shared with the staff. The analysis shows a deficit of 11%, with the current establishment at 64.08 whole time equivalent (WTE) against a requirement of 71.94 WTE (excluding the MSW 80/20 split) with a gap of 7.86 WTE midwives. The redistribution of budget leaves an unfinanced gap of 2.22 WTE. This can be achieved by incorporating current vacant posts from a previously established continuity of carer budget into the community establishment. Continuity of carer should not have a separate budget but be aligned within an organisational change of a whole service, when the building blocks required to safely move forward with this are in place, which includes a fully established workforce. The plan to achieve continuity of carer will be presented at the next quality and safety committee.

3. Safety Champion Update

3.1 The maternity safety champions meeting this month naturally focused on the report by Donna Ockenden and the support that had provided to staff after its publication. A walk about was undertaken ad drop in session provided for those who wished to discuss aspects of its content, with a planned ½ day session to review the report in more details with staff groups. There was also a focus on support to mothers and families with additional support to be provided via our bereavement midwives where needed for those families who had previously experienced loss. As reflected elsewhere in the Board papers the actions from the report are being reviewed and assessed for actions that are needed. The executive safety champions have also written to all maternity staff thanking them for their work, dedication and contribution to the programme of work that is seeing steady improvement around our speak up and safety culture as well as in our quality standards.

3.2 More specific areas that were reviewed related to the changes within the LMNS dashboard, soon to be reflected in our own, of inclusion of more specific criteria for outcomes from delivery (Robson criteria) in place of caesarean section data. This will allow additional reflection and actions from birth data. The ongoing challenge with neonatal staff recruitment was reviewed and the efforts being made to look at options for the work force at consultant and mid-grade level, prioritising out of hours work at the moment. As standard, a review of incident reporting and the processes in place to review these and identify actions as well as feedback from the departmental safety champions was taken. Staffing levels and some training issues were identified and are under review.

4. Summary

4.1 Work continues to strengthen service provision and assure transparency in line with national, regional and local drivers. Ensuring our workforce meets the requirements of our complex population and is aligned to provision of all care and not just designated by place of birth is fundamental to ensuring safe, high quality, woman and family personalised care. Whilst ensuring job satisfaction, which supports health and well-being, retention and makes us the work place of choice.

5. Recommendations

5.1 **The Trust Board is asked to:**

a) **ACCEPT**, discuss and support the community midwifery workforce review
b) **ACCEPT** and discuss the safety champion update
c) **DISCUSS** and approve the oversight Framework

Helen Hurst
Director of Midwifery
22nd April 2022

Annex 1

Ockenden Framework Update for March 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. February data 1 still birth 0 Neonatal 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. 6 cases active within the process.	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.	No serious incidents (SI) were declared. No SIs were finalised for the Directorate in March. The Directorate currently has 11 open SIs (six of which are also HSIB investigations, which are automatically recorded as SIs).	Weekly mulit-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	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.

	inpatient (midwifery and NNU) 98%.	
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. Low response rate is due to the envoy system not sending out text messages. Maternity is working with Head of Patient Involvement and Insight to ensure patient experience is captured. MVP group continues to grow and supports development across the service, including guideline reviews. A wealth of feedback is being captured by the EDI lead. Actions arise out of feedback to support a culture of "you said, we did" evidence of which is in all areas. Also captured in perfect ward.
Staff feedback from frontline champions and walk-abouts	Walkabout feedback 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	Nil received	Nil received
Coroner Reg 28 made directly to Trust	None	None
Progress in achievement of CNST10	CNST Compliance Rag Rating Outstanding 0 In progress 8 Complete 2 Currently on track to achieve 10/10	Current 3 month pause in place in view of the Omicron surge, scheduled to restart in April and submission date set for October, refreshed guidance waited. No further update received.
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	