Paper ref:	TB Public (09/23) 015

PATIENTS PEOPLE POPULATION

Sandwell and West Birmingham NHS Trust

REPORT TITLE:	Maternity Report – Maternity Peer Review Briefing		
SPONSORING EXECUTIVE:	Melanie Roberts - Chief Nursing Officer		
REPORT AUTHOR:	Helen Hurst – Director of Midwifery		
MEETING:	Public Trust Board	**DATE:**	13th September 2023

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

1. The Integrated Care Board (ICB) undertook a peer review of the maternity service, in line with their quality assurance framework and the perinatal quality surveillance model (NHSE 21). The review team consisted of representatives from the ICB, Local Maternity and Neonatal System (LMNS) and providers and was conducted in April 2023.
2. The overall findings of the review team were that of a good maternity service with systems and process in place to support safe, quality care responsive to the needs of the local population and workforce, a summary of findings and recommendations can be found within the report.
3. The Ockenden assurance framework can be found in Annex 1.

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?]*

None

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**NOTE** the findings of the maternity review
b.	**ACKNOWLEDGE** the recommendations
c.	**NOTE** the Ockenden assurance 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		*Make best strategic use of its resources*
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04		*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]							
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 the Public Trust Board on 13th September 2023

Maternity Report – Maternity Peer Review Briefing

1. Introduction Key

1.1 Maternity services have been in the spotlight for several years, with detailed high-profile reviews highlighting serious failings commencing with the Kirkup report, Morecombe Bay in 2015 to the recent report Kirkup, East Kent -Reading the signals, 2022. In total there have been 4 major reports and one currently entrain, the Ockenden review into maternity services at Nottingham University Hospitals.

1.2 In 2021 the Perinatal Quality Surveillance Model was introduced to provide oversight from provider through to the national maternity and neonatal team in NHSE. As the Integrated Care Boards became the accountable bodies in July 2022, the role of the Local Maternity and Neonatal Systems shifted from that of pure transformation to one also of assurance for safe, high quality service provision. To support this role the Black Country Local Maternity and Neonatal System have developed a Quality Assurance Framework (Hurst,2022).

1.3 Safe, high-quality maternity care is not an aspirational or unrealistic goal, it should be the fundamental care delivered to all women, babies, and families. The framework will promote the pace of change required to support maternity services, along with their Trust Boards and the ICB. To support this, a peer review programme was developed utilising the NHSE self-assessment toolkit and the THIS Institutes seven features of safety in maternity units (Liberati et al, 2020) to provide the key lines of enquiry (KLOE's). The review team consisted of representatives from the Integrated care Board (ICB), Local Maternity and Neonatal System (LMNS) and providers and was conducted in April 2023.

2. Peer Review Key Findings

2.1 Safeguarding practice is well embedded, and staff demonstrated good knowledge. There was positive feedback on the improved support and structure since two band 6 midwives had been appointed to provide support and guidance. Think family is well embedded and could be articulated by the staff spoken to. Several specialist midwives make up the Pheonix Team, to support areas of vulnerability. Good information sharing demonstrated, across multiple care agencies. Safeguarding training included ICON (Infant crying is normal; Comforting methods can help; It's Ok to walk away; Never, ever shake the baby)

2.2 Governance – Robust governance processes in place, including a learning culture around incidents, multidisciplinary reviews and meetings conducted, with good attendance. There is a clear route for escalation through the Trust. Staff knowledgeable about risk (incident reporting), Health Service Investigation Branch (HSIB) cases and risks. There is a good structure for shared learning with the clinical education team sitting within the umbrella of governance. Good preceptorship and internationally educated midwives programmes in place, this includes four months supernumerary time on commencement in post. The preceptorship programme had been extended to two years to ensure a supported rotation to both community and the midwifery led unit, following the concerns raised in the Ockenden report.

2.3 Infection Prevention and Control (IPC)– Overall good IPC practices found, the estate is an issue due to its age. Within the recommendations there are a few pertaining to IPC and estate.

2.4 Workforce and Competency – Good systems in place to track mandatory training, this includes a clear support route for staff not attaining compliance. It should be noted training has been impacted upon at times due to work force vacancies. Professional training involves the full multidisciplinary team (MDT), and a trajectory is in place to achieve 90% compliance against the core framework as per the clinical negligence scheme for trusts (CNST) requirements. The team discussed the challenges and benefit of moving to the Midland Metropolitan University Hospital, which they feel will assist with training and shared learning with the addition of an insitu simulation suite. Staff could articulate vacancies and how this was mitigated. The service has a manager and matron of the day to support the operational flow, which staff report as a positive step. The leadership team were highly praised throughout the visit by several staff. Visible, approachable, passionate, and supportive were some of the opinions held by staff. No issues were identified with the obstetric medical rota following discussions with staff.

2.5 There is an overwhelming feeling that there is positive support for progression and development of staff.

2.6 A two-year Band 5 preceptorship pathway incorporating rotational placements for diverse exposure/experience leading to progression to Band 6 are well embedded which has been motivating and encouraging.

2.7 Appreciation was noted of the open-door approach by managers which staff feel facilitates confidence in raising and reporting issues, incidents and concerns.

2.8 Staff discussed the value of regular feedback and learn approach by management and clinical educators, and expressed appreciation of positive recognition e.g., “shout outs”.

2.9 All staff had a Team structural awareness, and of wider challenges impacting on the service.

2.10 Development of the maternity Support Worker`s role with additional competencies had had a positive transition. Staff recognise the added responsibility of enhanced competence can sometimes be a challenge but proud of the progress within the role.

2.11 The peer review team noted areas that staff spoke about with the challenges for personal safety out of hours, staff did know how to raise alarm, redeployment of staff, acknowledged as being unavoidable but is stressful and working beyond the end of the shift.

2.12 All areas and grades of staff spoken with expressed pride in the service they deliver, and how they deliver it, with strong Team approach evident.

2.13 Leadership and Culture - Throughout the visit, the staff that the ICB Peer Review Team spoke with were highly complementary of the leadership team, with staff recognising the leadership shown from the Ward Managers to the Matrons and up to the Head of Midwifery and Director of Midwifery posts. There was a culture of openness, transparency, and honesty and this was triangulated with direct staff feedback, staff can speak up and escalate concerns. The triumvirate model was clearly visible, the CD is extremely engaged and passionate about the service. There is an Equality and Diversity lead, who is identifying and correcting inequalities for both the local communities and workforce, staff report this has had a positive impact. The review team identified one area that concerned them and that was that the Director of Midwifery does not directly line manage any of the team. Posters describing safety champion responsibilities and who they are. PMA notices with email contacts and how to get in touch.

2.14 Patient Experience and Compassionate Care – The service responsive to complaints raised, one example of this was in relation to a theme that had been noted through complaints regarding long stays due to complications following birth and the introduction of the manager of the day visiting all patients, to identify any issues and support early resolution. Maton walkabouts in place to listen to patients and staff.

2.15 Clinical - The ICB Peer Review Teams observations related to the Clinical KLOEs from visits to the clinical areas:

- Complex discharges – no concerns raised in relation to discharging within Black Country or Birmingham. They have supportive teams within the hospital such as the Outreach, EDI Midwife and Homelessness team who support maternity services with complex discharges.
- No issues identified with non-English speaking patients as they utilise language line and have just introduced 10 translator computers on wheels which can be used by the patient. Not implemented yet.
- Cross border patients – no issues identified due to using single shared records i.e., Badgernet. Predominantly patients are from the Women's Hospital in which they have a good working relationship with, along with Black Country maternity units.
- Triage area functioned well, given the lack of space.
- Abduction drills in place and well executed.
- Midwife new to ward area described incident reporting process and advised she had reported when working on delivery suite and received feedback. Also talked about effective handover and the weekly memo that includes learning from incidents and investigations.
- Good escalation process in place.

3. Summary of Recommendations

3.1 Infection prevention control issues, location for storage on one area due to space and ensuring regular emptying of bins.

3.2 Issues were noted with the estate, (it was also noted the impending hospital move) regarding the flooring and signage in antenatal clinic, antenatal day assessment unit dirty utility plaster coming off walls, issues had been reported appropriately.

3.3 Consideration for an alternative method of allocating shifts to reduce staff relocation where possible and improve communication and /or explanation when this is required.

3.4 Ensure appropriate break room facilities in all areas.

3.5 Consideration to be given for sharing of the senior team's job roles and responsibilities with all staff to prevent any confusion.

4. Recommendations

4.1 The Public Trust Board is asked to:

a. **NOTE** the findings of the maternity review.
b. **ACKNOWLEDGE** the recommendations.
c. **NOTE** the Ockenden assurance framework update.

Helen Hurst
Director of Midwifery
1st September 2023

Annex 1
Ockenden Framework Update (June and July 2023 data)
Detail reported 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) June: 5 July: 5 Neonatal Deaths (NND's) June: 0 July: 1	Monthly data detailed in paper to Quality and Safety Committee. SB's (25- 40weeks) Contributory factors: Decreased fetal movements, Abruption, abdominal pain. NND's: Extreme prematurity Preterm 27 weeks spontaneous at home. LMNS requested to undertake thematic review of perinatal mortality in view of sustained raised numbers.
Findings of review all cases eligible for referral to Health Services Investigation Branch (HSIB)	No new cases returned. 1 case referred pending HSIB triage process.	
The number of incidents logged graded as moderate or above and what action being taken.	3 serious incidents (SI) declared.	1 MRSA 1 birth injury 1 cooling case less than 37 weeks
Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training.	Midwifery training currently above 93% for PROMPT and 87% fetal monitoring. Obstetric Consultant at 80% PROMPT and 64% fetal monitoring. Trainees 67% PROMPT and 94% fetal monitoring Consultant Anaesthetist 91% Trainees 88% PROMPT	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 90% 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, maternity leave, and annual leave. 100% compliance with obstetric labour ward cover. Episodes of consultants acting down.	Job offers made to 26 newly qualified staff 12 accepted at time of writing report. 3 new recruits for roles in community specifically.

	Neonatal clinician gap of 0.5 wte within the junior rota.	Impacted by industrial action.
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. Neonatal parent forum currently being established.
Staff feedback from frontline champions and walk-abouts	Clinical incidents discussed, maternity and neonatal dashboard presented, discussed the neonatal review, screening update provided, medical, neonatal nursing and workforce discussed. Positive student feedback noted for the NNU.	Monthly meetings in place including frontline safety champions for all areas to feedback concerns and highlight good practice. Chaired by the Chief Medical Officer (Executive Safety Champion), attended by Chief Nursing Officer and Non-Executive Safety Champion.
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. Launched in July 44 active users, 6 ideas submitted 55% positive score for rate your day, managers working with staff to support well being based up on their feedback.

Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical	Yearly survey	