Paper ref:	TB (03/21) 016

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	**Maternity Services Update**		
Sponsoring Executive	Melanie Roberts, Acting Chief Nurse		
Report Author	Helen Hurst, Director of Midwifery		
Meeting	Trust Board (Public)	**Date**	4th March 2021

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

Safety in maternity and neonatal services has been of national focus since 2015 and this has been strengthened with the publication of the interim report of the Independent Maternity Review (Ockenden Report) which provides clear direction for the improvement of maternity services nationally**,** this report provides an update on a number of important areas as follows:

- Birth data
- Risk and governance
- Workforce
- Local maternity and neonatal system
- Clinical negligence scheme for trusts
- Saving babies lives

Ensure that safety, women's, families and staff voices are the golden threads that entwine our service.

Note, discuss and approve the reporting schedule in Annex 2

2. Alignment to 2020 Vision *[indicate with an **'X'** which Plan this paper supports]*

Safety Plan	√	Public Health Plan	√	People Plan & Education Plan	√
Quality Plan	√	Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

4. Recommendation(s)

The Trust Board is asked to:

a.	Note the content of the report
b.	Discuss the report
c.	Approve as required

5. Impact *[indicate with an **'X'** which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register							
Board Assurance Framework							
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

Maternity Services Update
Report to the Public Trust Board:

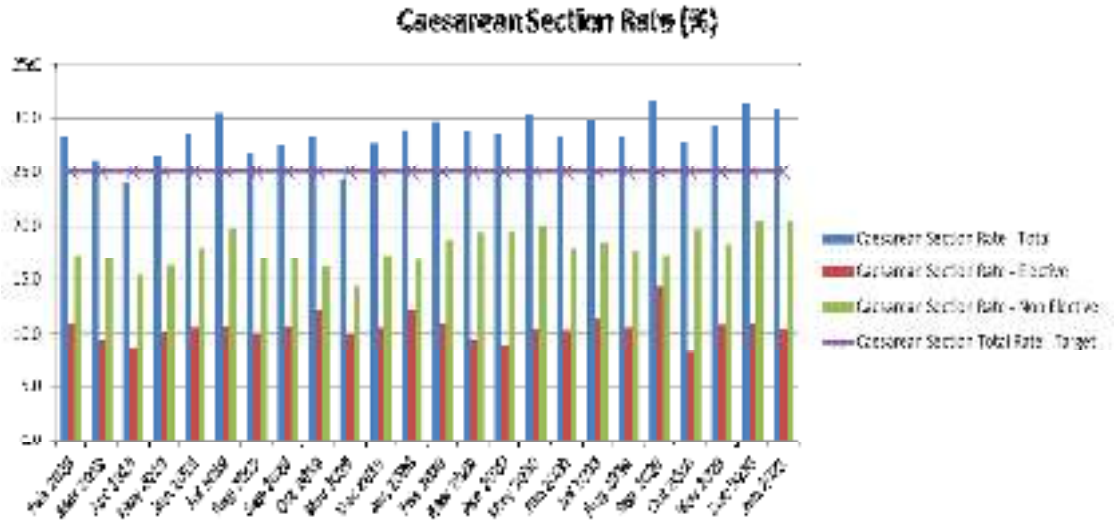
1. Introduction or background

Safety in maternity and neonatal services has been of national focus since 2015 and this has been strengthened with the publication of the interim report of the Independent Maternity Review (Ockenden Report) which provides clear direction for the improvement of maternity services nationally**.**

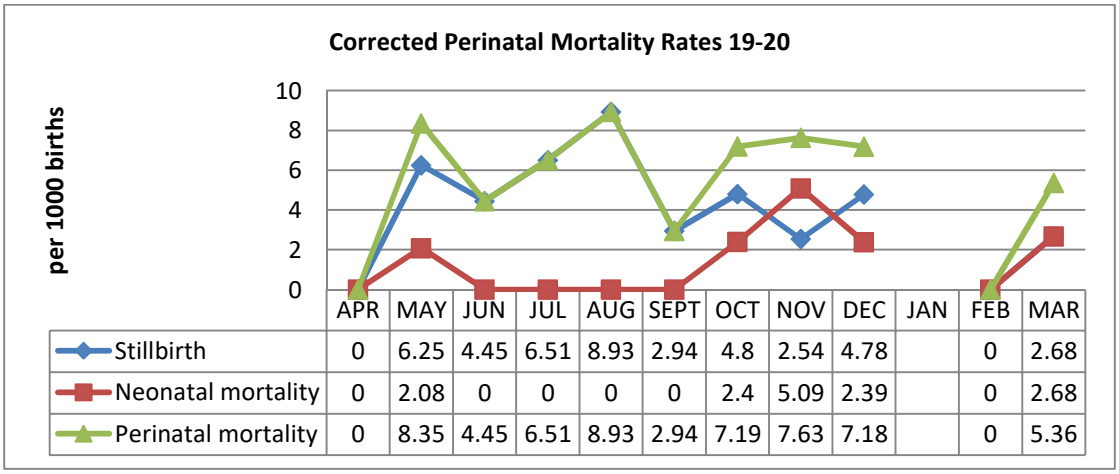
In 2016 the Secretary of State for Health announced a challenging ambition to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth by 2030. To make sure progress was made quickly, there was an interim target that there would be an expectation of a 20% reduction by 2020. The end date subsequently changed to 2025 in order to maximise the positive outcomes that the ambition would support.

In 2016 Better Births was published which set the direction and vision for maternity services and the national maternity transformation programme was created. The implementation of Better Births will ensure that women have safer more personalised care of their choice. It brings together key stakeholders to deliver change. Safety is the "golden thread" which runs throughout the transformation programme. Our organisation forms part of the Black Country Local Maternity and Neonatal System.

2.0 Birth data



(National rate 30%)



	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
Stillbirth	0	6.25	4.45	6.51	8.93	2.94	4.8	2.54	4.78		0	2.68
Neonatal mortality	0	2.08	0	0	0	0	2.4	5.09	2.39		0	2.68
Perinatal mortality	0	8.35	4.45	6.51	8.93	2.94	7.19	7.63	7.18		0	5.36

	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN
Stillbirth	2.7	9.43	11.9	6.44	4.35	4.04	8.75	2.33	10.81	8.65
Neonatal mortality	5.39	2.36	4.76	6.44	0	0	0	2.33	2.7	2.91
Perinatal mortality	8.09	11.79	16.67	12.88	4.35	4.04	8.75	4.66	13.51	11.53

Perinatal mortality (PNM) is defined as the loss of a fetus in-utero after 24 weeks gestation or a neonatal death which occurs up to 28 days of life. As well as these cases, we also submit data on any 22-23+6 wk gestation birth to MBRRACE-UK as mandated, although these cases do not contribute to the national or individual Trust PNM data outcomes. MBRRACE-UK also defines a PNM loss as being >400g birth weight and exclude terminations of pregnancy.

It should be noted that MBRRACE-UK analysis of our population shows very high levels of social deprivation (80% pop live in lowest 2 quintiles) and significantly higher than average births in minority ethnic groups, mainly Black + African and Asian/South Asian groups; these are known risk factors for higher PNM.
All cases from January have had 72 hour reviews where no trends, themes or gaps in care were identified; all cases will now be reviewed via the perinatal mortality review tool (PMRT) by a multidisciplinary group, which includes external experts and parents views and questions.

3.0 Risk and Governance

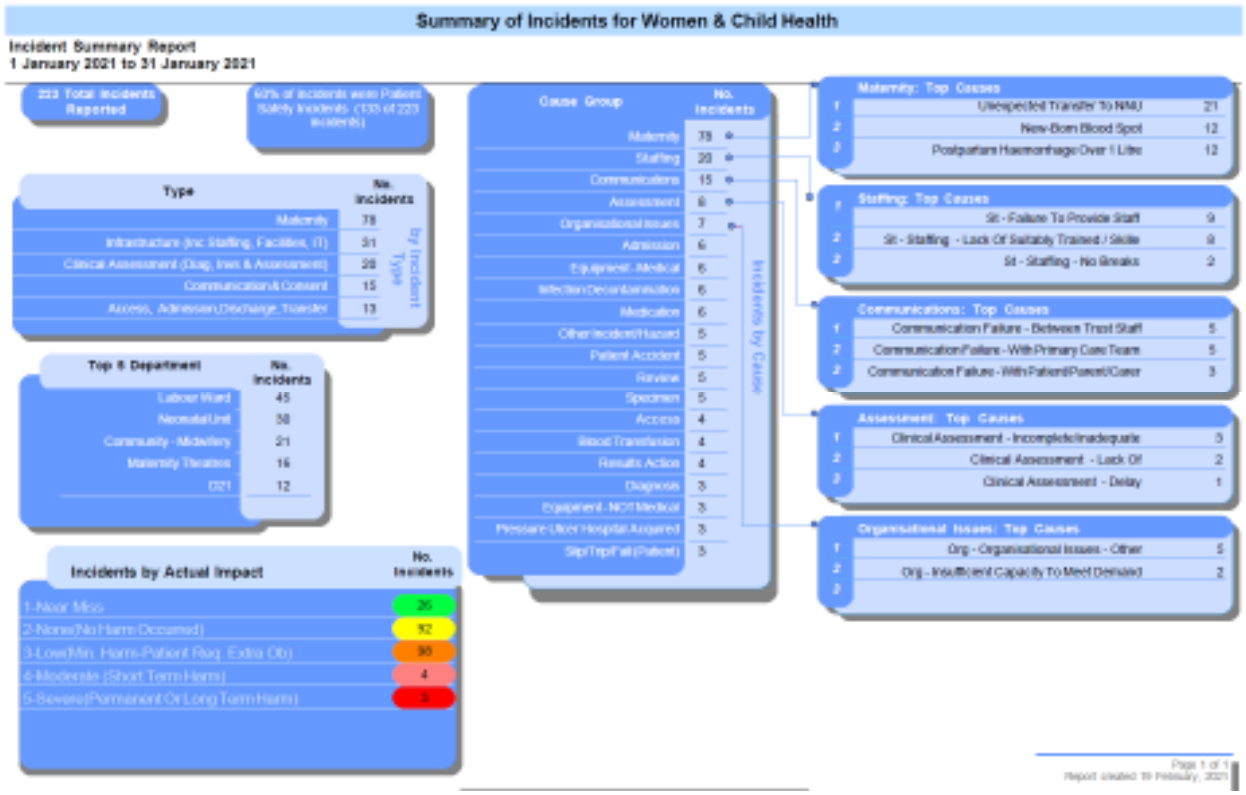
3.1 Serious Incidents/Health Service Investigation Branch (HSIB)

Three cases were referred to HSIB, all cases have had an initial deep dive and no immediate action required.
There were 2 cases of term still birth and 1 neonatal death following transfer for cooling.

3.2 Never Events

There have been no never events

3.3 Incidents and analysis

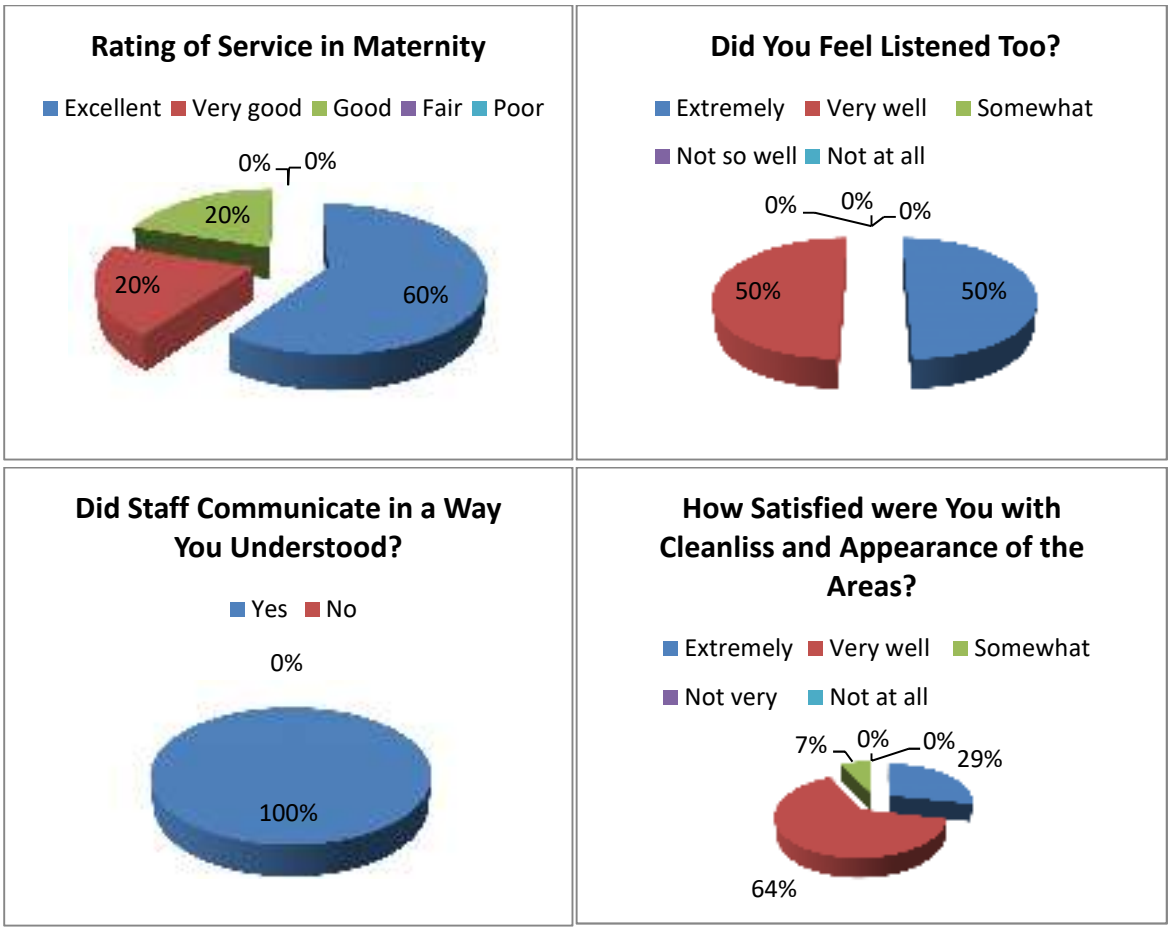


3.4 Lessons Learnt

- Ensure women are kept up to date with plans of care ie results of tests are fed back (COVID) and keeping ladies that are undergoing induction of labour updated on D/S acuity, this has improved since the opening of the induction suite.
- The clinical teams should explain to the woman and their partner the reasons for decision making – some concerns around Cat 2 LSCS being classed as an emergency but some short delays in transferring to theatre – provide information and reassurance, keeping women updated regularly and supporting them and their partners

3.5 Patient Experience

The maternity service, led by the ward managers implemented a local survey to support to ensure the woman's voice is heard and changes can be implemented to support improvement. The survey was introduced in November; the team are working to grow our response rates and continue to develop this further, with engagement both corporately and via the maternity voices partnership. Below is a selection of responses from the January survey.

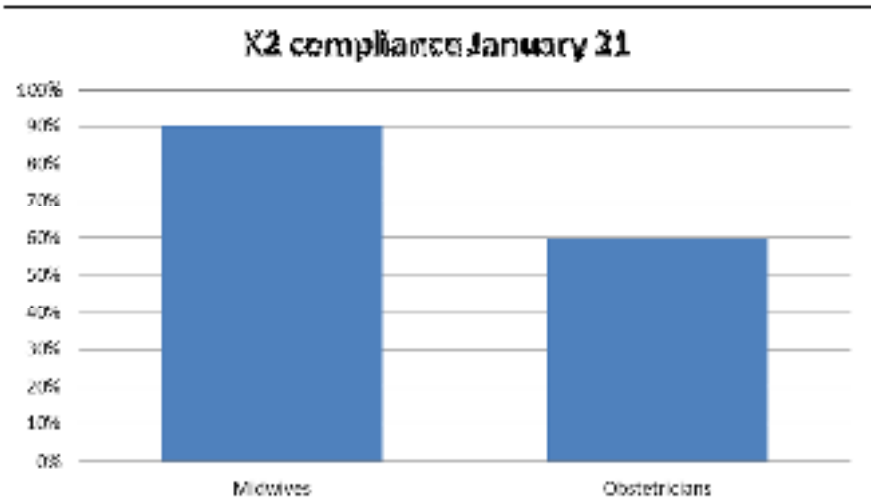


3.6 Mandatory Training

Below are the tables summarising training to date

100 Club

Professional training



K2 is an online Perinatal Training Programme (PTP), with an interactive e-learning tool covering a comprehensive array of topics in Fetal Monitoring and Maternity Crisis Management, including Competency Assessments.

4.0 Workforce

The last Birthrate plus (BR+) review was undertaken in 2019, this showed a deficit of 11wte midwives. Since this review the service has reconfigured the workforce model in community

midwifery, in line with national mode of change to an 80:20 spilt of midwives to band 3 maternity support workers (included in MW numbers in BR+). The Trust has also seen a decline in births in line with a national downward trend, however it should be noted that workforce cannot be based on birth itself, as the population we serve require enhanced antenatal and postnatal care, these two elements forming the larger aspect of maternity care.
The Trust invested in supporting our MSW's to band 3 level and a full competency passport was created in line with HEE guidance to upskill them. This will however alter our BR+ requirements and a review has been requested. The service is currently working through workforce models as we work towards MMUH.

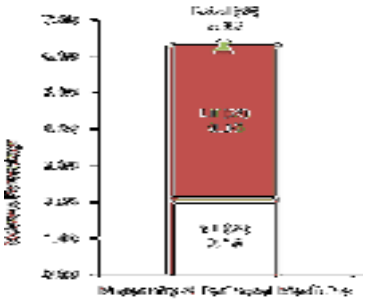
4.1 Safe staffing

The activity within maternity services is dynamic and can change rapidly. It is therefore essential that there is adequate staffing in all areas to provide safe high quality care by staff who have the requisite skills and knowledge. Regular and ongoing monitoring of the activity and staffing is vital to identify trends and causes for concern, which must be supported by a robust policy for escalation in times of high demand or low staffing numbers. Daily staffing meetings are led by the senior team to ensure flexibility and fluidity to meet acuity and capacity.

4.2 Vacancies

Total Directorate Vacancies are 35.66WTE (including NNU), to note the area with the highest vacancy rate is community midwifery an incentive package has been scoped with the support of the chief operating officer, icluding liasing with provider organisations. A revised and enhanced recruitment publicity campiagn has been worked through pending approval of the incentives for immediate launch. This will include job offers to all final year students. There was 1.00 WTE retirement in the Directorate in January.

4.3 Sickness



There were 18 open sickness cases and 2 proceeding to formal process (Dec 2020), the Directorate holds monthly confirm and challenge meetings which includes support ongoing cases and proactively review health and wellbeing.

4.4 Maternity Leave

Mat Leave: 23.00 WTE across the Directorate (including NNU)

4.5 Obstetric Workforce

The service currently holds gaps in both the junior (8) and senior (8) rota's due to incomplete deanery fill, maternity leave, part time workers, reallocation during pandemic, etc. These gaps are filled with NHS locum long term or short term locums to ensure cover and safe staffing out of hours. We currently have locum cover for a consultant shortfall, but consultant cover is maintained at the 98hrs per week required resident on unit cover.

5.0 Local Maternity and Neonatal System Updates

The Trust is working in collaboration with the Black Country Local Maternity and Neonatal System to enact the findings of Better Birth's (2016) and transform services across the STP.

Better Births identifies the following seven key themes for action:

- **Personalised care**- centred on the woman, her baby and her family, based around their needs and their decisions, informed by unbiased information.
- **Continuity of carer** – to ensure safe care based on a relationship of mutual trust and respect in line the woman's decision. Every woman should have a midwife who is part of a small team of 4-8 midwives who delivers at least 70% of her care throughout the pathway
- **Safer care**- with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.
- **Better postnatal and perinatal mental health care** - to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.
- **Multi-professional working** - breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.
- **Working across boundaries** - to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.
- **Reformed payment system** - that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice

5.1 Continuity of Carer (CoC)

The term 'continuity of carer' describes consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period (NHS England 2017). Women who receive midwifery-led continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth and report significantly improved experience of care across a range of measures (Sandall et al 2016). Pre-term birth is a key risk factor for neonatal mortality. Continuity of carer can significantly improve outcomes for women from ethnic minorities and those living in deprived areas (Rayment-Jones et al 2015, Homer et al 2017 in RCM 2018).

There are significant and widening health inequalities in maternity care. When compared to babies of White ethnicity: Black/Black British babies have a 121% increased risk for stillbirth and 50% increased risk for neonatal death and the gap has been widening since 2013; Asian/Asian British babies have a 66% increased risk of neonatal mortality and this risk is rising and an increased risk of stillbirth of around 55%. Babies born to mothers in the most deprived quintile have a 30% increased risk neonatal mortality and the gap between the most deprived and the least deprived quintiles is widening. Draper et al 2018. This difference has been highlighted more during the pandemic and the national direction for supporting improved outcomes for this population has been via continuity of care, with the ambition 75% of this group being on a continuity of care pathway. The revised ambition is for 35% of women to be booked on a pathway by March 2021, this has been particularly hard to achieve due to the pandemic and the effects on workforce and service provision, the service will provide a plan to board and predicted timescales of achievement. The Trust is working in collaboration with the Black Country Local Maternity and Neonatal System to enact the findings of Better Birth's (2016) and transform services across the STP.

The CoC figures for January are as follows:

Total number of women on Cedar's CoC caseload is 219 women of whom 148 women are from BAME populations (67%).

49 of those women were booked by Cedar in January 2021, of whom 37 women were form BAME populations (75%).

6.0 Clinical Negligence Scheme for Trust's (CNST) Update

This update provides the Board with current progress against compliance with the third year of the Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme for Maternity Safety Actions. The scheme offers a financial rebate of up to 10% of the maternity premium for Trusts that are able to demonstrate progress against a list of ten safety actions.
NHSR published an update to the original version of the Incentive scheme on 4th February 2020. The reporting period of the Maternity Incentive Scheme action was deferred and the scheme restarted on 1st October 2020. The submission date planned for May 2021 has moved to July 2021 by NHSR.

The Maternity service has assessed itself against the current incentive scheme and considers that there are 3 areas for focus if the scheme is to be achieved successfully and in full. Some additional amendments have been made to reporting dates with more updates expected from NHSR.

7.0 Saving Babies Lives Update

Saving babies Lives Care Bundle Version 2		
Element	**Compliance**	**Action**
Element 1: Reducing smoking in pregnancy		CO monitoring currently suspended during pandemic due to safety
Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)		
Implementation progress: Element 3: Raising awareness of reduced fetal movement (RFM)		
Element 4: Effective fetal monitoring during labour		Lead obstetrician now in place
Implementation progress: Element 5: Reducing preterm births		Trust preterm guideline updated Feb. 21

This is a care bundle designed to tackle stillbirth and early neonatal death and a significant driver to deliver the ambition to reduce the number of stillbirths, bringing four elements of care together

8.0 Summary

In summary the paper outlines the current positon in maternity services and the work that is being undertaken. As you aware there is an action plan in place for Ockendon and further work is being done across maternity services to capture the views of staff and patients to continue to ensure the service is improving and providing high quality care to mums and babies.

9.0 The Trust Board is asked to:

a) Note the content of the report
b) Discuss the report and highlight any areas for further information
c) Approve as required

Helen Hurst, Director of Midwifery

Annex 1

Glossary

Still birth - is typically defined as fetal death at or after 20 or 28 weeks of pregnancy, depending on the source. It results in a baby born without signs of life.

Neonatal mortality - defined as death within the first 28 days of life

Perinatal mortality - is defined as the loss of a fetus in-utero after 24 weeks gestation or a neonatal death which occurs up to 28 days of life

PMRT – perinatal mortality review tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.
- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

Each baby counts - is the RCOG's national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

Saving babies lives care bundle version 2 – is a care bundle designed to tackle stillbirth and early neonatal death and a significant driver to deliver the ambition to reduce the number of stillbirths, bringing four elements of care together:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

MBRRACE UK - stands for Mothers and Babies Reducing Risk through Audit and Confidential Enquiries. It is a collaboration of researchers, clinicians and Sands.

The aim of MBRRACE-UK is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services

- Surveillance of all maternal deaths
- Confidential enquiries into maternal deaths during and up to one year after the end of the pregnancy
- Confidential enquiries into cases of serious maternal morbidity on a rolling basis
- Surveillance of perinatal deaths including late fetal losses (22-23 weeks gestation), stillbirths and neonatal deaths
- Confidential enquiries into stillbirths, infant deaths and cases of serious infant morbidity on a rolling basis

Maternity and Neonatal Safety Improvement Programme - .The Maternity and Neonatal Safety Improvement Programme (MatNeoSIP), was renamed following the launch of the NHS Patient Safety Strategy in July 2019. It was previously known as the Maternal and Neonatal Health Safety Collaborative.

MatNeoSIP is led by the National Patient Safety team and covers all maternity and neonatal services across England. It continues to be supported by 15 regionally-based Patient Safety Collaboratives.

The programme aims to:

- improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England
- contribute to the national ambition, set out in Better Births of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50% by 2025

Annex 2

Reporting Matrix

Included within the matrix are the board level measures minimum data requirements set out following the Ockenden report.

Monthly	Bi-Monthly	Quarterly	Bi-annually	Annually	In addition
Birth data	CNST	Saving babies lives	Workforce review	Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment	National reports
Risk and governance	Continuity of carer	Staff feedback from frontline champions and walk-abouts		Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours	HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust
Workforce					Coroner Reg 28 made directly to Trust
LMNS updates					