Paper ref:	TB (05/22) 017

REPORT TITLE:	Maternity Services Update		
SPONSORING EXECUTIVE:	Melanie Roberts - Chief Nursing Officer		
REPORT AUTHOR:	Helen Hurst - Director of Midwifery		
MEETING:	Public Trust Board	DATE:	10th May 2023

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

In March this year, the three year delivery plan was launched providing a clear direction of travel to ensure, safer, more personalised, and more equitable care for all women, babies, and families. It outlines responsibilities for Trusts, Integrated Care Boards and Systems (ICB's/ICS's) including Local Maternity and Neonatal Systems (LMNS) and Operational Delivery Networks (ODN's), and NHS England (NHSE). This report outlines the key themes and included in appendix 1 are the actions within the delivery plan for the next three years, with benchmarking included.

On the 18th of April the Local maternity and neonatal system (LMNS), in conjunction with the Integrated Care Board (ICB) undertook a peer review of the maternity service. The initial feedback was overwhelmingly positive, recognising the progression made, with some minor points for consideration.

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?]*

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: 10th May 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. Three Year Delivery Plan

2.1 The plan launched in March, brings together themes identified through listening and engaging with families, workforce, maternity and neonatal reviews and other organisations. The plan describes the building blocks required to ensure the needs of women, babies and families are at the heart of services. It summarises responsibilities for each part of the NHS including Trusts, Integrated Care Boards and Systems (ICB's/ICS's) including Local Maternity and Neonatal Systems (LMNS) and Operational Delivery Networks (ODN's), and NHS England (NHSE). The full plan and associated letter are included in the reading room.

2.2 The plan outlines 4 key themes to ensure safer, more personalised, and more equitable care:

1 **Listening to women and families with compassion which promotes safer care.**
• All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.
• During 2023/24, Integrated care systems (ICSs) will publish equity and equality plans and take action to reduce inequalities in experience and outcomes.
• From 2023/24, Integrated care boards (ICBs) will be funded to involve service users. National policy will be co-produced, keeping service users at the heart of our work.

2. **Supporting our workforce to develop their skills and capacity to provide high-quality care**.
• Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.
• During 2023/24, trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.
• From 2023, NHS England, ICBs, and trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability.

3. **Developing and sustaining a culture of safety to benefit everyone.**
• Throughout 2023, effectively implement the NHS-wide patient safety incident response framework (PSIRF) approach to support learning and a compassionate response to families following any incidents.
• By 2024, NHS England will offer a development programme to all maternity and

neonatal leadership teams to promote positive culture and leadership.
• NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

4. **Meeting and improving standards and structures that underpin our national ambition.**
• Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new maternity early warning score (MEWS) and New-born early warning trigger (NEWTT-2) tools by 2025.
• In 2023, NHS England's new taskforce will report on how to better detect and act sooner on safety issues, arising from relevant data, in local services.
• By 2024, NHS England will publish digital maternity standards; services will progress work to enable women to access their records and interact with their digital plans.

2.3 The plan does not provide a detailed roadmap to deliver the remaining 15 essential immediate actions from the final Ockenden report or the themes identified in reading the signals from the Kirkup East Kent report. The ICB through the LMNS will progress a safe introduction of a plan to incorporate deliverables against these actions, where they can be supported at Trust and ICB level.

2.4 Appendix 1 contains a breakdown of the actions within the three-year delivery plan, aligned against actions for providers, ICB's and NHSE. The service has undertaken an initial benchmarking. The gaps identified fall into work in progress, such as perinatal pelvic health services, introduction of service user voices in meetings and complaints processes, maternal network provision, medical workforce guidance etc., all actions denoted amber are in progress and will complete. The areas that have not commenced are any new guidance that have just been released or are awaited, such as the new version of the saving babies lives care bundle. There are no concerns that the actions from the delivery plan cannot be met.

Rating	Number
In place	46
In progress	15
To commence	3

2.5 The LMNS and ICB plans are developed in line with the perinatal quality surveillance model and transformation accountability to progress against the actions aligned to them, rag rating is also included within the spreadsheet in appendix 1.

3. Maternity Peer Review – Initial Feedback

3.1 The LMNS and members of the ICB undertook a peer review of the maternity service on 18th April.

3.2 Initial feedback given post review on the day was overwhelmingly positive, with some minor areas for consideration:

- Improved Leadership – all staff feedback they were well supported and well led.
- Strong triumvirate team with clarity of working.
- Strong culture around safeguarding and noted the investment and value added of the two band 6 posts – staff felt supported and knew how to escalate.

- Robust governance – good culture of reporting, feedback and lessons learnt, confidence from staff then when issues are raised, they are addressed.
- Clear line of sight from floor to board and board to floor
- Strong medical workforce and sense of multi-professional teamwork and shared goals.
- Outstanding work being undertaken with equity and equality, especially noteworthy the equality and diversity lead.
- Staff were passionate and loved their job, with safety culture embedded.
- Areas around the estate noted, but infection prevention practice good.
- 1 patient commented on her experience being poorer due to the environment, not care. The patient was undergoing induction of labour.
- Community well sited on the issues, with mitigation and work on going.

3.3 Once the report has been shared following factual accuracy an improvement plan will be developed and presented to Board.

4. 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
12th April 2023

Ockenden Framework Update (March 2023 data)

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. 5 still birth's and 4 Neonatal deaths	Monthly data detailed in paper to Quality and Safety Committee. SB's 27-34 weeks gestation NND's 21, 22 and 38 weeks gestation
Findings of review all cases eligible for referral to Health Services Investigation Branch (HSIB)	1 case referred for investigation.	There are currently 5 active cases.
The number of incidents logged graded as moderate or above and what action being taken.	1 serious incident (SI) declared, as above. Initial deep dive to identify any immediate safety concerns, none were identified.	Weekly multi-disciplinary incident review/learning meeting in place within the service. 8 ongoing SI's which includes the 5 HSIB cases.
Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training.	Training against core competency framework (professional training) remains above expected target of 90%.	Professional training database (core competency framework) monitored by education team.
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.	Fill rate within inpatient midwifery is at 95%. Community Midwifery are red 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. 2 episodes of consultants acting down. Neonatal clinician gap of 0.5 wte within the junior rota. Impacted by industrial action.	Internationally educated midwives have joined the community team and are being supported to complete required OSCE training to gain NMC registration and induction. NNU medical workforce is currently being benchmarked across the network. This will also form part of the NNU external review to be undertaken in May 2023.
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	feedback from Executive and Non-Executive safety champion	None
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	Awaiting year 5	
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	