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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:	8th March 2023

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 on maternity & neonatal services: -

1. The Final report of the screening quality assurance visit undertaken in October 2022 identifies no immediate concerns and highlighted several positive findings, which demonstrates the Trusts focus on quality improvement. 10 high priority findings were identified with themes covering: pathway flow, aligned guidance, process to support robust monitoring and ensuring all screening is of an acceptable standard. Examples of good practice that can be shared were also identified.

2. The service is currently working through issues relating to timely flow of referrals, which impact on screening key performance indicators (KPI) and missed screening within the KPI. This has multiple causations and is currently subject to weekly oversight and assurance with both the Director of Midwifery and Chief Nursing Officer. The actions in place will see resolution of the current excess within 4 weeks.

3. The Care Quality Commission Maternity Survey results for 2022 were released in January 2023, the results showed statistically similar results to 2021, with 1 question showing a statistically significant decrease and 2 an increase.

4. The clinical negligence scheme for Trust submission was approved via Quality and Safety Committee achieving 9 out of 10, full compliance was not achieved for safety action 6 demonstration of achieving all 5 elements of the saving babies lives care bundle.

Annex 2 is the Ockenden framework update for February 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?]*

Maternity and Neonatal data received at Quality and Safety Committee 22nd February 2023.
Safety champion meeting 3rd February 2023.

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 HOSPITALS NHS TRUST

Report to Trust Board: 8th March 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. Screening Quality Assurance Report

2.1 The quality assurance review encompasses both antenatal and new-born screening pathways and was undertaken by NHS England-Midland's Screening Quality Assurance Service (SAQAS) in October 2022.

2.2 The review identified no immediate concerns and highlighted several positive findings, demonstrating the Trusts focus on quality improvement. Examples of good practice that can be shared were also identified.

2.3 Of the 30 recommendations 10 are classified as high priority, the rest being standard recommendations. The identified themes relate to pathway flow, aligned guidance, process to support robust monitoring and ensuring all screening is of an acceptable standard.

An action plan has been developed and amalgamated with the improvement plan already in place with consent of the Chief Nursing Officer (CNO) and SQAS. Governance processes are in place to closely monitor the plan over the next 12 months, within Trust, with SQAS and the Integrated Care System (ICS).

The full report and action plan can be found in the reading room.

3. Screening and Referrals Underperformance

3.1 The service has an average of 174 referrals each week, but with a high DNA rate for bookings and scan (average 18 per week) requires a higher capacity. The current capacity has not met the requirement, leading to outstanding bookings within the pathway. This is affected by multiple factors, such as late notification of pregnancy, late notification of booking not accepted by chosen provider, workforce issues within community midwifery and administration and current processes.

3.2 This has impacted on the optimal screening window for screening being missed in several cases. Screening can still be offered in the form of non-invasive prenatal testing (NIPT) but falls outside of the required compliance. The service has seen a high number of screening safety incidents, with 16 being submitted 12 relating to the antenatal screening pathway

and 4 relating to new-born screening pathway, all incidents have been investigated and closed with Public Health England. The issues are covered in the amalgamated plan previously mentioned.

3.3 A plan is in place to address the issues with referrals and will resolve the issue over the next 4 weeks. Mitigation is in place during this time to ensure daily oversight, feeding into a weekly assurance meeting with the Head of Midwifery and Group Director of Operations, with oversight from the Director of Midwifery (DOM) and weekly report to the CNO and DOM. Repots to date show a positive decrease in outstanding bookings.

4. Care Quality Commission (CQC) Maternity Survey 2022.

4.1 The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services. The NPSP is commissioned by the Care Quality Commission (CQC), the independent regulator of health and adult social care in England. As part of the NPSP, the Maternity Survey started in 2007 and the 2022 Maternity Survey will be the ninth carried out to date. The CQC use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England.

4.2 The survey is split into three sections covering antenatal, intrapartum, and postnatal care, ensuring a whole pathway approach. For those who have care in more than one unit, that information is captured.

4.3 The number of participants invited to take part was 360 and 102 mothers participated (29%).

4.4 The results are benchmarked both against all maternity surveyed and the individual organisations previous year's results.

4.5 The findings were on the whole comparative form the 2021 survey as demonstrated in table 1 below:

Table 1

5. Clinical Negligence Scheme for Trusts

5.1 The clinical negligence scheme for Trust submission was approved via Quality and Safety Committee achieving 9 out of 10, full compliance was not achieved for safety action 6 demonstration of achieving all 5 elements of the Saving Babies Lives Care Bundle (SBLCB), element 3 monitoring of CO levels at 90% over a four-month period was not met.

5.2 The service commenced use of the regional SBLCB compliance toolkit in February, which ensures compliance is monitored on a monthly basis, supported by the Local Maternity and Neonatal System. Following a successful pilot in 5 providers within region this toolkit is set to be rolled out Nationally.

6. 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
21st February 2023

Ockenden Framework Update for September (January 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 0 Neonatal deaths	Monthly data detailed in paper to Quality and Safety Committee. 2 with known fetal anomalies
Findings of review all cases eligible for referral to Health Services Investigation Branch (HSIB)	0 cases referred for investigation.	There are currently 4 active cases.
The number of incidents logged graded as moderate or above and what action being taken.	1 serious incident (SI) declared. Initial deep dive to identify any immediate safety concerns, none were identified.	Weekly multi-disciplinary incident review/learning meeting in place within the service. 7 ongoing SI's which includes the 4 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 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 on amber in their business continuity plan and is supported by daily staffing huddles across maternity to ensure fluidity in staffing. 100% compliance with obstetric labour ward cover. 2 episodes of consultants acting down. Neonatal clinician gap of 0.5 wte within the junior rota	Funding has been granted by PHE to support a best start family provision in community midwifery, this includes both midwifery and midwifery associates. NNU medical workforce is currently being benchmarked across the network.
Service User Voice feedback	Feedback collated from FFT, complaints, PALS, local surveys, and Maternity Voices Partnership (MVP)	CQC Maternity Survey included within the report and reading room.
Staff feedback from frontline champions and walk-abouts	feedback from Executive and Non-Executive safety champion	At the most recent walkabout I was able to see the neonatal units and speak to both medical and nursing staff. They were proud to show me their clinical areas and voiced pride in their service and job satisfaction.

		I was shown around the delivery unit and was able to witness a period of high demand on the team during a particularly busy afternoon. However it was good to see a team that all pulled together in these circumstances, with proactive communication and prioritisation going on with a focus on safety. No specific concerns were raised
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	Submitted 9/10	Included in report and via Quality and Safety Committee.
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	