Paper ref:	PublicTB (01/24) 012

PATIENTS PEOPLE POPULATION

AMBITION RESPECT COMPASSION

NHS
Sandwell and West Birmingham
NHS Trust

REPORT TITLE:	Maternity and Neonatal Services Update		
SPONSORING EXECUTIVE:	Melanie Roberts – Chief Nursing Officer		
REPORT AUTHOR:	Helen Hurst – Director of Midwifery		
MEETING:	Public Trust Board	**DATE:**	10th January 2024

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

This report outlines the following:-

- Progress on the Neonatal improvement plan, of the 71 actions contained within the plan, 40 are completed, 30 are in progress and 1 has breached the complete date, as they are awaiting sign off, the agreed pathways, this will complete within the next month.
- Year 5 of the Clinical Negligence Scheme for Trusts has been completed, with all evidence submitted to Quality Committee in December, in preparation for Board sign off. The declaration is for 9 out of 10 safety actions, an action plan is included with the Board declaration for safety action 1, which was not met (detail in the body of the report).
- Annex 2 contains the Ockenden Framework update for October 23.

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		To work seamlessly with our partners to improve lives	

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

Both the Neonatal improvement plan and CNST submission have been to Quality Committee 20th December 2023

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**NOTE** the contents of report.
b.	**RECEIVE** the Neonatal Improvement Plan.
c.	**RECEIVE** and **APPROVE** the CNST year 5 submission.

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 HOSPITALS NHS TRUST

Report to Trust Board: January 2024

Maternity and Neonatal 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. Central to supporting oversight and assurance are external reviews of service provision, the paper includes two for the Boards evidence.

2. Neonatal Improvement Plan Update

2.1 A draft of the final report at the end of the period of support from the external improvement team has been received and is currently being reviewed for factual accuracy.

2.2 The improvement plan previously brought to Board in October, contains 71 actions, assigned to 16 issues and 5 themes. The improvement plan can be found in the reading room. The neonatal team are working well to progress the improvement plan. Table 1 provides a high-level overview of progress.

Table 1

Rag Rating	Number of Actions
Red	1
In Progress	30
Complete	40
Embedded	0

The 1 action outstanding the completion date is:

- Define governance process for high-risk fetal medicine cases.

  There is a clearly defined multidisciplinary meeting held between maternity and neonates, awaiting sign off the updated standard operating procedure to combine the external pathway for referral to a tertiary unit, this is currently going through process.

2.3 The Local Maternity and Neonatal System (LMNS), will be undertaking peer reviews of the four neonatal units across the Black Country, during quarter four of this financial year. This review will provide the Trust with an external review of the progress made since the neonatal review and consequential improvement work and plan.

3. Clinical Negligence Scheme for Trusts Year 5

3.1 NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous

years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund. Declaration by the Trust is required by 1st February 2024.

This report, and the evidence used to inform the assessment, has been submitted to Quality Committee, following acceptance by Women and Child Health Group leadership team.

Chart 1 below provides the overall position of 9 out of 10 compliance.

Chart 1

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	No	8	2
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	6	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	7	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	11	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	4	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	8	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	27	0
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes	12	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes	8	0

Safety action 1 has not met due to:

- Element A: all eligible deaths should be notified to Mothers and Baies: Reducing risk through Audit and Confidential Enquiries (MBRRACE). All deaths have been notified within this time frame, except for 1, where a divergence has been requested due to the complicated nature of the death. NHS resolution have said they will consider this following submission.

- Element C has not met as this requires 95% of reviews being started within 2 months, with the service achieving 90%.

3.2 A dedicated midwifery lead has been employed for perinatal mortality reviews, rather than it sitting as a combined role, is to commence in January, this action should see attainment against this safety action going forward. There has been a significant delay throughout the recruitment process with this post, leading to a commencement date so late in the financial year.

3.3 Safety Action 4, has been met, however with regards to compensatory rest following on calls in line with Royal College of Obstetrics guidance to be sustained for the long term a business case will be required, as part of the action plan, that was required.

4. Summary

4.1 In summary the neonatal team are working hard to make the changes required, these need to be embedded and sustained. Whilst it is disappointing that safety action 1 for CNST has not met, progress has been made from last year and the remedial action to ensure safety action 1 is met for year 6 is in place.

5. Recommendations

5.1 The Public Trust Board is asked to:

a) **NOTE** the contents of report.
b) **RECEIVE** the Neonatal Improvement Plan.
c) **RECEIVE** and **APPROVE** the CNST year 5 submission.

Helen Hurst
Director of Midwifery

11th December 2023

Annex 1 Neonatal Improvement Plan

	Issue	No	Actions	RAG Status
1	The Trust is an outlier in relation to stillbirth and mortality rates.	1.1	Update risk on RR and ensure active monitoring of risk through risk register	
		1.2	Agenda item on Directorate Governance Meeting to monitor all actions and workstreams in relation to stillbirth and mortality rates	
		1.3	There should be thematic reviews focusing on the stillbirths and neonatal deaths with an aim to identify if an actions to reduce avoidable stillbirths and neonatal deaths. These action plans should be shared the Trust and Staff through the Directorate governance structure (see action 1.2) actions should also be shared with the maternity and neonatal networks.	
		1.4	2nd PRMTconsultant to facilitate grading of cases (Obstetrician should not be grading own cases)	
2	The Trust is an outlier in admissions to the neonatal unit	2.1	Review of admission and discharge polices including NCOT/TC (update/create)	
		2.2	Sign off policy through Directorate/Group/Trust Governance (MPEG first)	
		2.3	Implement ways of improving communication regarding policies/ audits for all staff groups	
		2.4	Define process of continuous audit and review	
		2.5	Define process for exception reporting	

		2.6	Define process for governance structure & reporting structure	
3	Caring for babies out of network pathway	3.1	Review maternity pathways to ensure the network pathways are being adhered too.	
		3.2	Define governance process for high risk fetal medicine cases.	
		3.3	All out of pathway admission should be reported through the Unit, Directorate, Trust Governance - needs defining	
4	Review of midwifery NIPE pathway to ensure prompt and effective discharges. (reframe ? Where issues are?)	4.1	Allocate workstream leads	
		4.2	Scope proposal and changes to pathway	
		4.3	Sign off final model through Group Governance	
		4.4	Implement pathways	
5	Compliance against neonatal network policies and guidelines (merge)	5.1	Review of policies and guidelines to make sure local adjustment remain current and in line with best practice.	
		5.2	Audit programme to monitor compliance against polices and guidelines.	
		5.3	Development of neonatal dashboard	
		5.4	Define process for governance and oversight at Unit, Directorate and Trust Level for 5.1,5.2 and 5.3	
6	The Trust is an outlier for length of course for antibiotics within the neonatal unit (babies remained on abx following negative culture)	6.1	Review of current policies and guidelines ensure in line with national recommendations.	
		6.2	Review and audit of use of KPSC tool	

		6.3	Risk lead to review data and standardise practice.	
		6.4	Add to continuous audit (5.2) and dashboard (5.3)	
7	Leadership role and responsibility are not clearly defined within the unit	7.1	Review of roles and responsibilities of all staff band 2 -8b.	
		7.2.1	All staff band 6 above to attend Trust Arc program me (B7)	
		7.2.2	All staff band 6 above to attend Trust compassionate care giver course (B6)	
		7.3	Matron sign off and review rota	
		7.4	Progress recruitment of ward manager post	
		7.5	Ensuring all managers have undergone leadership and management training specifically in relation to conflict and behavioral management	
		7.6	Development of team charter - code conduct	
		7.8	Development of regular senior medical, junior medical, ANNP, and senior nurse forums - clear actions and feedback escalated through the Unit and Directorate Governance Structure	
8	Review of the Nursing Leadership structure for the neonatal services.	8.1	Benchmarking against similar sized/level units. Do they have lead nurse role?	
		8.2	Group Leadership to review benchmarking and confirm structure options and present proposal to executive team.	
9	Review of ANNP Structure	9.1	Review of management and supervision structure - including benchmarking with similar sized level units	
		9.2	Discussion with Trust ACP Lead	
		9.3	Review of rosters and SPA (roles)	
		9.4	Development of Lead ANNP?	
10	Outstanding and unresolved HR cases	10.1	HR tracker to be pulled together to track progress on all cases	

		10.2	Review and completion of outstanding grievances	
		10.3	Review and resolution where indicated in relation to Sickness management	
		10.4	Review of return to work and phased returns within the unit	
11	Review of cot configuration and associated nursing workforce including TC	11.1	Review cots based on recent activity data (validate activity data)	
		11.2	Review TC activity and criteria in line with national standards	
		11.3	Present cot configuration through Directorate, Group Trust Governance	
		11.4	Present cot configuration to Network and Commissioners	
		11.5	Review staffing establishment against proposed cot configuration including TC	
		11.6	Review Band 7, QIS and Supernumary roles	
		11.7	Sign off Staffing establishment within Group and Trust	
		11.8	Implement cot configuration and new models of staffing	
12	Consultant Job Plans	12.1	Review current job plans to ensure parity in allocation of roles and acute work.	
		12.2	Review level 3 requirement to be included in Job Plans costed and funding sourced	
		12.3	Directorate and Group sign off job plans	
13	Review of Tier 1 & 2 Rota's to ensure robust staffing in place	13.1	Review current rosters to expenditure budget	
		13.2	Analysis of gaps over last 2 years	
		13.3	Options for sustainability of rosters/mitigation of gaps - JSD further ANNP's joint posts with Paeds. Inc finance	
		13.4	Sign off of options through Directorate, Group, Trust Governance	
14	Clarity of governance across Unit, Directorate, Group & Trust	14.1	Mapping of Unit Directorate and Group Governance (group structure)	
		14.2	Review of Risk Register and process for reviewing, updating and communication risk up and down, through the governance structure.	

		14.3	Governance flow chart structure to share with all staff groups	
		14.4	Review of all agenda's to make sure key subjects are covered on agendas (neonates)	
		14.5	Review of upward reports information required for meetings (neo matron pack) (dashboard)	
		14.6	Embed new governance structure	
15	Staff Experience	15.1	Review of communication strategy for the Unit & Directorate	
		15.2	Devise engagement strategy for Unit & Directorate	
		15.3	Review of QIHD to include key information i.e. risk, pathways, review progress, feedback from forums.	
16	Patient Experience	16.1	Review visiting policy	
		16.2	Recruitment to family integrated nurse (LMNS money)	
		16.3	OD Intervention to be looked at by RT, SS, SC & SSK.	
		16.4	Patient experience forum.	

Annex 2

Ockenden Framework Update for October (October data) 2023

<table>
<tr><th>Data Measures</th><th>Summary</th><th>Key Points</th></tr>
<tr><td>Findings of review of all perinatal deaths using the real time data monitoring tool</td><td>
<table>
<tr><th></th><th>July</th><th>August</th><th>September</th><th>October</th></tr>
<tr><td>Corrected Stillbirth rate</td><td>9.98</td><td>4.3</td><td>6.91</td><td>6.4 (3)</td></tr>
<tr><td>Neonatal Mortality Rate</td><td>2.0</td><td>2.1</td><td>0</td><td>2.1</td></tr>
<tr><td>Perinatal Mortality Rate</td><td>11.98</td><td>6.4</td><td>6.91</td><td>8.5</td></tr>
</table>
</td><td>Thematic review is being undertaken by the LMNS. 3 cases in October, ranging from 28- 39+6 weeks, contributory factors, Decreased fetal movements and unknown</td></tr>
<tr><td>Findings of review all cases eligible for referral to Maternity and neonatal safety investigation MNSI)</td><td>2 cases have been referred to MNSI for investigation.1 as baby was transferred out for therapeutic cooling and 1 early neonatal death following an instrumental delivery.

1 finalised report was received in October, this case was that of a Still Birth at term, there were no safety recommendations highlighted, there were some areas were learning has been identified and areas of notable practice.

Report on completed cases due to Board in March, with themes and learning.</td><td>MNSI has replaced the Health Services Investigations Branch (HSIB).</td></tr>
<tr><td>The number of incidents logged graded as moderate or above and what action being taken.</td><td>1 serious incident (SI) declared.</td><td>Weekly multi-disciplinary incident review/learning meeting in place within the service.</td></tr>
<tr><td>Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training.</td><td>Training for all staff groups is above the 80%, following revised requirement notified in November, required for CNST and indeed has been met at above 90%.</td><td>Professional training database (core competency framework) monitored by education team. CNST requirement of 80% MDT training has now been updated to 80% in 12 consecutive months.</td></tr>
<tr><td>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.</td><td>
<table>
<tr><th>2023</th><th>Fill rate</th><th></th><th></th><th></th><th></th></tr>
<tr><th>Area</th><th></th><th>July %</th><th>Aug %</th><th>Sept %</th><th>Oct%</th></tr>
<tr><td>Delivery Suite</td><td>Registered</td><td>83</td><td>85</td><td>86</td><td>80</td></tr>
<tr><td></td><td>MSW</td><td>93</td><td>94</td><td>94</td><td>93</td></tr>
<tr><td>M1</td><td>Registered</td><td>92</td><td>94</td><td>94</td><td>93</td></tr>
<tr><td></td><td>MSW</td><td>94</td><td>94</td><td>94</td><td>95</td></tr>
<tr><td>M2</td><td>Registered</td><td>82</td><td>90</td><td>96</td><td>92</td></tr>
<tr><td></td><td>MSW</td><td>94</td><td>96</td><td>95</td><td>94</td></tr>
</table>
</td><td>High midwifery vacancies persist at 15% of the establishment. Retention midwife starts in post in January 2024. 3rd year students will be sent offer letters and supported meetings to commence in January. 10 recruits commencing by January 2024. Daily staffing reviews in place.</td></tr>
</table>

	Serenity	**Registered**	**-**	**-**	**90**	**-**	
		MSW	**97**	**-**	**96**	**-**	
Service User Voice feedback	The maternity and neonatal partnership continue active support with both maternity and neonates. Both maternity and neonates have set up patient experience groups which feed into the core Trust meeting. These are well supported by third sector partners and service users. An action plan is in progress against last years CQC maternity survey and is monitored via this group.						Themes from complaints are communication and attitudes and behaviours, patient stories are being woven into shared learning. Several compliments have also been received. These themes are monitored and actioned via the patient experience group and MNVP. A dedicated patient experience midwife is now in post supporting improvements, including the offer of debrief for all service users.
Staff feedback from frontline champions and walk-abouts	feedback from Executive and Non-Executive safety champion has been positive overall. Walkabouts have been undertaken on both maternity and neonates, workforce concerns remain the main issues raised.						
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	CQC request for information made, around safe staffing, perinatal mortality and triage, full response provided.						
Coroner Reg 28 made directly to Trust	None						None
Progress in achievement of CNST10	Declaration in report.						
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						