Paper ref:	PublicTB (05/24) XXX

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	8th May 2024

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

This months Trust Board report discusses 4 main points as outlined below:-

- The National Maternity Survey looked at experiences of women and birthing people who had a live birth in early 2023.The survey results remained statistically similar to other organisations within England and we have seen a statistically significant increase in 4 questions in comparison to our 2022 survey.
- The release of the perinatal mortality data for 2022 shows a reduction across all 3 categories (still birth, neonatal deaths and extended perinatal mortality).
- The Trust has been notified of the achievement of the Maternity Incentive Scheme for Trust (MIS) year 5 which is to be celebrated.
- The terms of reference have been set for the maternity review, which will look at the progress following the culture review undertaken in 2020 and support the continued commitment and journey of improvement.
- Annex 1 contains the Ockenden Framework update for approval for February and March 2024.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]

OUR PATIENTS	**-** To be good or outstanding in everything that we do	**X**
OUR PEOPLE	**-** To cultivate and sustain happy, productive and engaged staff	
OUR POPULATION	**-** To work seamlessly with our partners to improve lives	

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

Quality Committee April 2024

4. Recommendation(s)

The Public Trust Board is asked to:

a) **RECEIVE** and **NOTE** the maternity survey findings and actions

b) **RECEIVE** and **NOTE** the Perinatal Mortality Update

c) **NOTE** the achievement of MIS Year 5

d) **NOTE** 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		*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]		
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to Public Trust Board: 8th May 2024

Maternity and Neonatal Services Update

1. Introduction

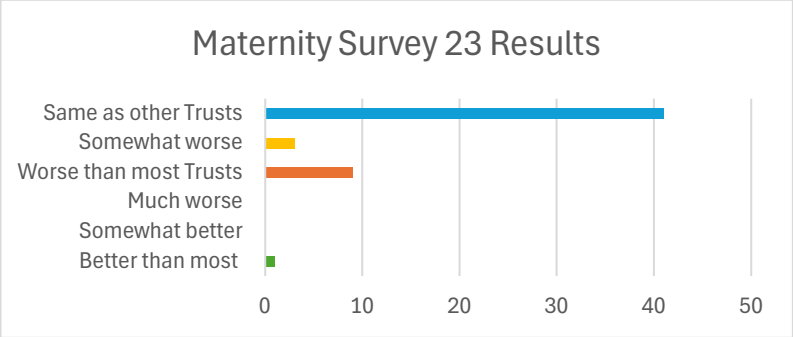
1.1 This paper supports Board level oversight for maternity and neonatal services which is fundamental to quality improvement, transparency and safe delivery of services.

2. Maternity Survey 2023

2.1 The National Maternity Survey looked at experiences of women and birthing people who had a live birth in early 2023. In 2023, no Trusts scored much better than expected, 8 Trusts were better than expected, 5 Trusts worse than expected (including 2 in the Midlands Region), no Trusts much worse than expected.

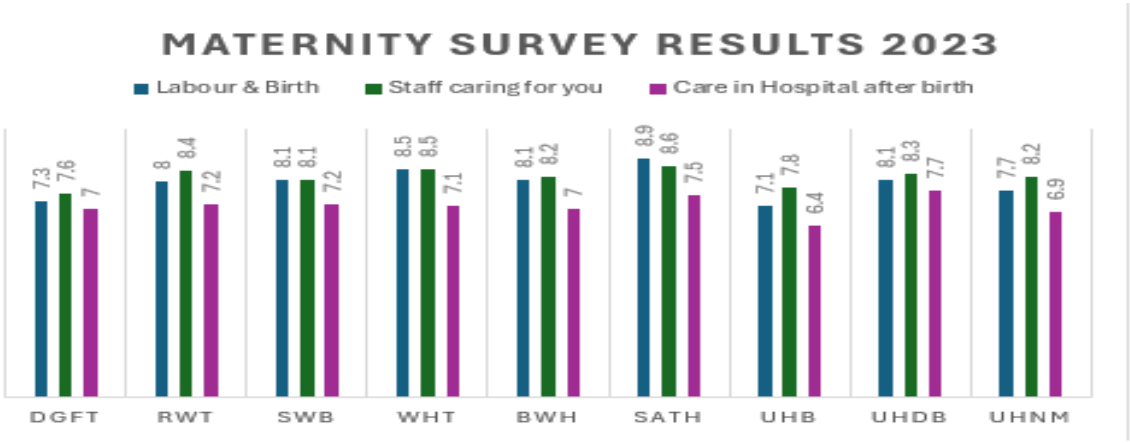
2.2 SWBH survey results remained statistically similar to other organisations within England and a statistically significant increase in 4 questions in comparison to our 2022 survey. Chart 1 provides the breakdown by finding category. The full report can be found in the Reading Room.

Chart 1



2.3 Chart 2 provides a comparison of results across the Black Country Local Maternity and Neonatal System (LMNS) and buddy LMNS's.

Chart 2



2.4 The service is working with key stakeholders to co-produce an improvement plan against the surveys results, reporting through the maternity and neonatal experience group to the patient experience group.

3. Perinatal Mortality

3.1 The data on perinatal mortality for the calendar year of 2022 was released on the 14th March by Mothers and Babies Reducing Risk through Audit and Confidential Enquiry (MBRRACE-UK) 2022**.** This data covers, stabilised and adjusted rates (excluding those with known congenital anomaly) for Still Births (over 24 weeks of gestation), neonatal deaths and extend perinatal mortality (combined result). The chart below shows an improvement across all 3 categories above from 2021. We were one of only 2 Trusts in the Midlands Region to see this reduction. A slide deck can be found in the reading room, providing full regional data.

3.2 The Independent Thematic Review commissioned by the Black Country LMNS, in view of the rising still birth rate in 2023, has completed the analysis phase, with the report now being drafted. High level themes emerging are:

- High incidence within the Global Community, especially language barriers.
- Holistic consistent risk assessment, not being routine.
- Lack of senior oversight.
- Cross border issues
- Smoking and carbon monoxide monitoring
- Ensuring surveillance in the complex pregnancy if tailored to the specific needs, when ultrasound scanning is required and not just following the NICE guidance, which is seen as the minimal surveillance required.

3.3 The report, themes and next steps will report to the Board in July.

3.4 Included in the Reading Room is the quarterly report on perinatal mortality for quarter 3 2023, this has shown a higher perinatal mortality rate, however 82% of the cases showed no factors that could have altered the outcome.

4. Maternity Incentive Scheme Year 5 (MIS) (Clinical Negligence Scheme for Trusts – CNST)

4.1 The Trust have now received confirmation of full compliance with the 10 safety actions for year 5, providing full recovery of the contribution made to the MIS fund, as well as a share of any unallocated funds. Previously the Board were informed of the submission of achieving 9 out of the 10 safety actions, due to mitigation submitted for safety action 1.

5. Maternity Review

5.1 Organisational culture has been identified as a key factor in recent investigations and reports on maternity safety including Freedom to speak up and feedback from students. There is a growing body of evidence clearly linking culture with safety. Given the ongoing scrutiny and spotlight maternity services are under, the increased pressure of vacancies in the workforce, staff survey results and soft intelligence, the Chief Nursing and Medical Officers (CNO, CMO) have commissioned a review to look at the progress made and support areas for continued progress. The terms of reference for the review which will complete in three months are:

- What progress has there been in developing the culture in maternity?
- Have there been improvements in staff's ability to speak up, be developed and have equal opportunities?
- What changes are needed in leadership style?
- How is safety embedded in the department?
- What service improvements are in progress or required to further improve, safety, quality, and communication, as part of the three-year delivery plan?
- Do the current structures across maternity support a culture of quality, safety, staff engagement and ability to speak up?

5.2 This will be supported and monitored via the Women and Child Health Group, with monthly progress meetings with the CNO and CMO, with reporting structure as below.

6. Recommendations

The Public Trust Board is asked to:

a) **RECEIVE** and **NOTE** the maternity survey findings and actions
b) **RECEIVE** and **NOTE** the Perinatal Mortality Update
c) **NOTE** the achievement of MIS Year 5
d) **NOTE** the Ockenden Framework Update

Helen Hurst
Director of Midwifery -12th April 2024

Annex 1: Ockenden Framework Update for May (February and March 24 data) 202

Annex 1

Ockenden Framework Update for May (February and March 24 data) 2024

<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>Month</th><th>Still Births (SB)</th><th>Neonatal Deaths (NND)</th><th>Perinatal Mortality (combined)</th></tr>
<tr><td>February</td><td>2</td><td>1</td><td>3</td></tr>
<tr><td>March</td><td>3</td><td>0</td><td>3</td></tr>
</table>
</td><td>The SB occurred between 28 and 34 weeks, with 1 exception post term, this case had modifiable factors noted, with actions in place as the overarching MNSI action plan to address.
The 1 NND occurred at 24 weeks and was under heightened surveillance.</td></tr>
<tr><td>Findings of review all cases eligible for referral to Maternity and neonatal safety investigation MNSI)</td><td>
<table>
<tr><th colspan="2">Current ongoing MNSI / Serious Incident Investigations</th><th>Case details</th></tr>
<tr><td>Open MNSI Referrals (also reported as corporate SIs)</td><td>9</td><td>1 NND
4 HIE / Cooling
2 Intrapartum Stillbirth</td></tr>
<tr><td>Open Corporate SI Cases</td><td>3</td><td>1 x IUD
1 x NND
1 x Extravasation Injury (Awaiting investigator allocation)</td></tr>
<tr><td>Concise Reviews Commissioned</td><td>0</td><td></td></tr>
<tr><th colspan="2">Completed Reports</th><th>Case Details</th></tr>
<tr><td>MNSI</td><td>1</td><td>1 x NND MI-032462</td></tr>
<tr><td>Corporate SI Cases</td><td>0</td><td></td></tr>
</table>
</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>4 cases reported to MNSI in February
0 reported in March</td><td>Comprising of 2 cases of HIE / therapeutic cooling, 1 Intrapartum Stillbirth and 1 Maternal Death of a woman in the community not previously known to any maternity services, but with in our geographical location.</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>Current compliance is over 80% for Midwives Consultants (impacted upon by industrial action) and trainees (new to Trust, plan in place) range. from 50% to 74%
Anaesthetic Consultants and trainees 91 and 78 %
Trajectory in place to reach 90% with associated actions.</td><td>Professional training database (core competency framework) monitored by education team and reported through Group governance to QC.</td></tr>
</table>

<table>
<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>Midwifery vacancy is 28 wte
Obstetric workforce
<table>
<tr><td>Consultant</td><td>1 vacancy (locum in place)</td></tr>
<tr><td>Middle Grade</td><td>3 Vacancies</td></tr>
</table>
NNU Nursing vacancy mainly within QIS at 13 wte
Neonatal Clinicians
<table>
<tr><td>Tier 1</td><td>0 vacancies</td></tr>
<tr><td>Tier 2</td><td>0 vacancies</td></tr>
<tr><td>Tier3</td><td>10 in post (includes 2 locums)</td></tr>
</table>
</td>
<td>all 3rd year students offered jobs and LMNS wide recruitment event in May to offer remaining vacancies to students within the Black Country, trajectory shows a filled position.
Current obstetric review against college requirements for time in lieu post on calls, a business case will be required as current establishment will not meet the requirement.
NNU nursing plan in place, also at above event, this is a national picture, however we are growing QIS in house, NNU have seen a number of retirees in QIS, who returned to bank but do not want a part time contract, this covers 6 wte vacancies.</td>
</tr>
<tr><td>Service User Voice feedback</td><td>Maternity Survey results for 203 included in the report.</td><td></td></tr>
<tr><td>Staff feedback from frontline champions and walk-abouts</td><td>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.</td><td>LIA events have been held across the services. They will be working together on developing a vision and strategy aligned to the Trusts.</td></tr>
<tr><td>MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust</td><td>On the 1st March, the trust received a letter of concern from Maternity and Newborn Serious Investigations (MNSI) following their identification of a number of emerging themes from 4 cases investigated by their teams from August 2023-March 2024. An action plan has been developed and the governance is in place to monitor this.</td><td>These themes had been identified, reported in the Quality Committee, with actions already in place and monitoring already in place.</td></tr>
<tr><td>Coroner Reg 28 made directly to Trust</td><td>None</td><td>None</td></tr>
<tr><td>Progress in achievement of CNST10</td><td>MIS year 5 in report. MIS year 6 launched with return date set as 3rd March 2025.
Trusts must achieve all ten maternity safety actions.
• The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the director of midwifery/head of midwifery and clinical director for maternity services.</td><td>The team are working through MIS year 6, with governance in place to ensure oversight and provide update via the Group.

LMNS process for governance of progress in place.</td></tr>
</table>

<table>
<tr><td></td><td>• The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
• In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICS) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.</td><td></td></tr>
<tr><td>Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment</td><td>Reported via staff survey report.</td><td></td></tr>
<tr><td>Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical</td><td>GMC National Training Survey - Obs & Gynae specialty
<table><tr><th>Indicator</th><th>Mean score</th><th>Outcome</th></tr><tr><td>Adequate Experience</td><td>67.76</td><td>Within IQR</td></tr><tr><td>Clinical Supervision</td><td>90.66</td><td>Within IQR</td></tr><tr><td>Clinical Supervision out of hours</td><td>86.46</td><td>Within IQR</td></tr><tr><td>Educational Governance</td><td>62.72</td><td>Within IQR</td></tr><tr><td>Educational Supervision</td><td>82.24</td><td>Within IQR</td></tr><tr><td>Facilities</td><td>56.77</td><td>Within IQR</td></tr><tr><td>Feedback</td><td>59.87</td><td>Within IQR</td></tr><tr><td>Handover</td><td>71.27</td><td>Within IQR</td></tr><tr><td>Induction</td><td>86.84</td><td>Within IQR</td></tr><tr><td>Local Teaching</td><td>52.40</td><td>Within IQR</td></tr><tr><td>Overall Satisfaction</td><td>67.11</td><td>Within IQR</td></tr><tr><td>Regional Teaching</td><td>73.44</td><td>Within IQR</td></tr><tr><td>Reporting Systems</td><td>68.42</td><td>Within IQR</td></tr><tr><td>Rota Design</td><td>38.82</td><td>Within IQR</td></tr><tr><td>Study Leave</td><td>63.16</td><td>Within IQR</td></tr><tr><td>Supportive Environment</td><td>65.79</td><td>Within IQR</td></tr><tr><td>Teamwork</td><td>73.69</td><td>Within IQR</td></tr><tr><td>Work Load</td><td>32.46</td><td>Within IQR</td></tr></table></td><td></td></tr>
</table>