APPENDIX THREE

MATERNITY SERVICE IMPROVEMENT WORK (at 29/12/20)

Maternity Transformation Programme (MTP)

- A local Maternity Transformation Plan in place with 5 key work-streams led by multi-professional teams. This was launched at a formal event in August 2019.

  The five work-streams are:

  - Clinical Quality and Choice
  - People and Culture
  - Governance and Risk
  - Education and Partnerships
  - Communications and Engagement

- All work-streams have a lead and executive sponsor. Each team has been established and workstream action plans are in place.
- PMO in place to support the MTP and wrap project management methodology around all work-streams.

Leadership and oversight

- New Care group Medical Director, New Clinical Director for Obstetrics, New Director of Midwifery and Care Group Director – in post from November 2019 onwards and all working collaboratively
- The Director of Midwifery attends the Board of Directors' meeting to speak to maternity issues and papers. Governance and Assurance have been strengthened at operational and Board sub-committee levels, also.
- Maternity Quality Operational Committee in place, chaired by Director of Nursing reviewing operational and quality matters relating to maternity services.

Staffing

- There has been an increase of 29 WTE midwives to the workforce numbers, which brought the service in line with the Birth Rate Plus (BR+) 2017 assessment. A new assessment has been undertaken recently and the draft report has been received. The full report will be made available in January 2021, the results of which will be presented to the Board of Directors, in due course.
- Birthrate plus intrapartum acuity tool is also being used. This is completed by the delivery suite co-ordinator every 4 hours and a monthly report to the Board of Directors as part of the maternity staffing report.
- Twice-daily safety huddles take place with the midwifery managers to review staffing and acuity across the service and appropriate escalation where required.
- Consultant presence on the delivery suite now covers 0830 hrs – 2100 hrs 7 days a week.
- Funding has been approved recently and recruitment commenced for a further 6 consultants to enable residential consultant night cover. There are 18.5 WTE consultants in the service currently, which will increase to 24.5 WTE by summer 2021.
- There is dedicated senior cover in place from 0700 hrs to 1900 hrs during weekdays for maternity triage. Outside of these times, triage always has a tier 2

level doctor available 24/7 (Labour Ward Registrar) and 0830 hrs to 2100 hrs (resident cons) and an escalation policy to call non-resident consultant in if needed is in place already.
- Funding secured to support the implementation of the Maternity Support Worker (MSW) programme in line with Health Education England's recommendations

Training and staff development
- Maternity Safety Support Programme (MSSP) continues to enable national oversight and benchmarking against best practice, and facilitate active learning.
- Two Professional Midwifery Advocates recruited during 2020
- PROMPT (PRactical Obstetric Multi Professional Training) has been changed to include a session on twin births since October 2020
- Weekly and ad-hoc multi-disciplinary team simulations undertaken on delivery suites, including Twin birth simulation exercises.
- Royal College of Midwifery professional development programme agreed but not yet commenced – delayed due to RCM pause on training. Awaiting confirmation of funding allocation from NHSEI ID
- Twice weekly Cardiotocograph (CTG) multi-disciplinary training sessions held
- MIST (Midwifery Identification Stabilisation and Transfer of the newborn) package developed by SaTH and now available nationally on e-learning for health

Governance and Safety
- External reviewers involved in serious incident reviews where appropriate
- Birmingham Symptom- specific Obstetric Triage System (BSOTS) is in place for triage which allows rapid assessment, recognition of deterioration and rapid escalation.
- The previously used centralised triage system of assessing risk at booking has been removed and replaced by a continuous risk assessment process that commences at booking and is repeated throughout the woman's care by the midwives and Obstetricians.
- MDT Safety huddle at commencement of every shift.
- MDT handover twice daily in place includes discussions about high risk women on antenatal and postnatal wards.
- Consultant ward rounds on delivery suite are in place twice daily as a minimum with a signed handover sheet in place. Additional board rounds also held.
- Consultants are non-resident after 9pm. Criteria for involving/calling consultants enhanced and escalation policy reviewed. Posters produced to support policy and communicated to staff. Local policy goes beyond guidance from RCOG.
- Weekly MDT risk meeting held to review all clinical incidents.
- There are a minimum of twice daily safety huddles in all areas
- Transitional care for babies born pre-term or requiring extra clinical support is now in place and there has been a reduction in term admissions to the neonatal unit, in line with the national transformation agenda.
- Since 2018, all high-risk women are seen in triage at the Obstetric unit and not in the remote standalone midwifery led units.
- Fetal Monitoring Lead Midwife and Consultant Obstetrician in place
- Maternity Improvement Plan in place aligned to CQC Core Assessment Framework
- Risk register monthly meeting held, which reviews progress and ensures accountable actions are taken. Risks have been resolved that had been present

for the service for many years, including the cessation of midwives scrubbing for theatre cases.
- CQC Section 31 regulatory notice lifted on 05.10.20.
- Implementation of Perinatal Mortality Review Tool (PMRT) which, from September 2020, includes external representation

Provision of Services
- New Midwifery-Led Unit has been designed, built and opened in April 2020. This is co-located to the obstetric unit, allowing rapid transfer of women to the labour ward should complications arise.
- The National Bereavement Care pathway is being implemented, working in partnership with the Stillbirth and Neonatal Death Society (SANDs). A second bereavement Midwife has been recruited and is due to start in January 2021.
- Partnership working with St Mary's Manchester, Trusts in the South and in London is in place to learn and adopt good practice from those Trusts, specifically in relation to bereavement care
- Continuity of Carer teams launched in September 2020 in line with Better Births. Two teams now in place with 11.6% of women booked on the pathway. Additional teams are planned.
- Pre-term birth prevention clinic established 2020 to support SBL
- Twin clinic commenced November 2020 to meet NICE guideline
- New induction of labour pathway introduced

Patient and Public Involvement
- An independent Expert External Advisory Panel is in place chaired by Bill Kirkup.
- Collaborative working with the Maternity Voices Partnership is in place and representatives are involved in the workstream on communications and engagement.
- Bimonthly meetings with the Maternity Voices Partnership (MVP) are in place.
- Women have helped produce our birth choices leaflet, have been part of recruitment processes for specialist midwives, the naming of birth rooms in the new build MLU, and the continuity of carer team names.
- Research is being undertaken as part of the Maternity Transformation Programme (has recently secured ethical approval) to speak with families that have experienced our service.
- Two "who's shoes" events held involving service users and other key stakeholders