The Shrewsbury and Telford Hospital NHS Trust

Cover page	
Meeting	Trust Board
Paper Title	CNST Maternity Incentive Scheme- NHS Resolution – Year 3 progress and action plan
Date of meeting	28th May 2020
Date paper was written	19th May 2020
Responsible Director	Maggie Bayley, Interim Chief Nurse
Author	Nicola Wenlock, Director of Midwifery

Executive Summary

This paper provides an update to the Board in relation the compliance with the third year of the Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme for Maternity Safety Actions since the previous update in February. The scheme offers a financial rebate of up to 10% of the maternity premium for Trusts that are able to demonstrate progress against a list of ten safety actions.

The assessment and progress report against the safety actions are outlined as well as intervention required to achieve compliance. It should be note that since the emergence of the covid-19 pandemic there has been a pause in reporting nationally for the scheme NHS Resolution (NHSR) 26/03/20

The reporting period of the Maternity Incentive Scheme action has been deferred and will run from 31st August 2020 to 31st March 2021.

Therefore, this report shows the current status which includes the ongoing impact of Covid-19 in relation to achieving the actions and compares to the status as reported in February 2020. Further information has been requested from NHSR with regards to an update on the timescales of the scheme.

It should be noted that two actions have declined (3 & 9) and one has improved (6) when compared to the position as at February 2020.

Safety action 3 has declined following an initial audit which has demonstrated that the criteria for Transitional care needs to be standardised and that the staffing model needs to be reviewed.

Safety action 9 has declined as there has been a change in Board Level Safety Champion and the Covid Pandemic has led to the bi-monthly meetings with the maternity and neonatal safety champions not being held and the monthly staff feedback meetings have not been held. The maternity transformation work has been paused and therefore the work towards continuity of carer has been paused and monthly feedback to Trust Board has not occurred since March. As we enter the restoration and recovery phase of the pandemic the meetings are being re-established.

RAG rating (current compliance)	Number of actions	
	Feb 2020	May 2020
	4	3
	1	4
	5	3

Mitigation is outlined in the table to address the areas that have deteriorated with estimated timeframes for rectification.

A further two papers are attached to support assurance in relation to delivery of the scheme which have been reviewed at the care group level and Maternity oversight committee

- Q4 Staffing paper – Appendix 1
- PMRT – Appendix 2

Previously considered by	Action plan has been shared and discussed at Maternity Governance meeting (21/05/20) and Maternity Oversight Committee (21/05/20). The Q4 staffing report & PMRT reports were discussed at Care Group Board (but full reports not shared at that time)

The Board (Committee) is asked to:			
☐ Approve	☑ Receive	☐ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☑ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☑ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☐ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	*1204*

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	*Funding has been received to support elements of year 3*

Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme for Maternity Safety Actions

1. Introduction

1.1 This paper provides an update to the Board in relation the compliance with the third year of the Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme for Maternity Safety Actions since the previous update in February. The scheme offers a financial rebate of up to 10% of the maternity premium for Trusts that are able to demonstrate progress against a list of ten safety actions.

1.2 The assessment and progress report against the safety actions are outlined as well as intervention required to achieve compliance. It should be note that since the emergence of the covid-19 pandemic there has been a pause in reporting nationally for the scheme NHS Resolution (NHSR) 26/03/20

2. Background

2.1 NHSR published an update to the original version of the Incentive scheme on 4th February 2020. There were some changes to the document and the action plan has been amended to reflect those changes.

2.2 The maternity service has assessed itself against the current incentive scheme and considers that there are 4 areas for focus if the scheme is to be achieved successfully and in full. All other safety actions are at present considered to on target for compliance.

2.3 NHSR has published the Maternity Incentive Scheme for the third year running. This scheme for 2020/21 builds on previous years to evidence both sustainability and on-going quality improvements. The safety actions described if implemented a reconsidered to be a contributory factor to achieving the national ambition of reducing stillbirths, neonatal deaths, perinatal morbidity and maternal deaths by 50 % by 2025.

3. Current Position

3.1 The reporting period of the Maternity Incentive Scheme action will be deferred and will run from 31st August to 3ist March 2021.

3.2 Therefore, this report shows the current status which includes the ongoing impact of Covid-19 in relation to achieving the actions and compares to the status as reported in February 2020. Further information has been requested from NHSR with regards to an update on the timescales of the scheme.

3.3 It should be noted that two actions shown in the table below have declined (3 & 9) and one has improved (6) when compared to the position as at February 2020. **Safety action 3** has declined following an initial audit which has demonstrated that the criteria for Transitional care needs to be standardised and that the staffing model needs to be reviewed. **Safety action 9** has declined as there has been a change in Board Level safety champion and the covid pandemic has led to the bimonthly meetings with the maternity and neonatal safety champions not being held and the monthly staff feedback meetings have not been held. The maternity transformation work has been paused and therefore the work towards continuity of carer has been paused and monthly feedback to Trust Board has not occurred since March.

4. Recommendations

Trust Board members are asked to **receive** the current position statement and **note** that a report will continue to be presented to the Public Trust Board bi-monthly and where requested to the Private trust Board for assurance.

Action No	Maternity Safety Action	Status as reported to the Board on 20th February	Current Position	Action required to mitigate and resolve issue	Deadline	Lead
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?			This is currently on track and will be monitored monthly	March 2021	Director of Midwifery
2	Are you submitting data to the Maternity Services Data Set to the required standard?			Badgernet Maternity has been purchased and implementation is being planned for August	March 2021	Director of Digital Transformation/ Director of Midwifery/ Clinical Director
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?			Risk to compliance as first audit has identified an issue with the criteria being used. Monthly audits to commence once the criteria and guideline has been reviewed. Also, the current staffing model needs to be reviewed in order to be a fully bespoke model. This will be part of the current Birthrate Assessment audit.	July 2020 Aug 2020	Director of Midwifery
4	Can you demonstrate an effective system of medical workforce planning to the required standard?			This is currently on track and will be monitored monthly NNU staffing complies with BAPM standard	March 2021	Clinical Director Director of Midwifery

Action No	Maternity Safety Action	Status as reported to the Board on 20th February	Current Position	Action required to mitigate and resolve issue	Deadline	Lead
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?			Risk to compliance and Birthrate plus assessment current in progress. There are still times when the coordinator is not supernumerary and further work is required to understand the reasons for this including 1:1 with coordinators and DoM, reviewing and updating escalation policy & training on the acuity tool for coordinators.	Sept 2020	Director of Midwifery
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle?			Risk to compliance due to Medway antenatal roll out, development of new pathways of care and evidencing implementation of the care bundle. However, the risks are reduced with regards to providing data and also in evidencing as the updated guidance advises the target range for successful implementation. Confirmation of the action plan monies from NHSR has been received - this will enable to recruitment of a midwife for audit and oversight of the care bundle	March 2021	Clinical Director

Action No	Maternity Safety Action	Status as reported to the Board on 20th February	Current Position	Action required to mitigate and resolve issue	Deadline	Lead
				as well as a fetal monitoring lead (in post from May 2020) – both posts for 12 months.		
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?			This is a CCG led area of work as part of the LMS whose activity is currently suspended due to Covid. Plans will be developed in line with national guidance	Sept 2020	Director of Midwifery
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?			Risk to compliance due to additional requirements for training and the need to ensure all staff groups have been trained. The suspension of training in response to the pandemic has also impacted upon this overall. The service has held a faculty meeting to discuss measures which can be implemented to ensure that training continues in some format.	March 2021	Director of Midwifery / Clinical Director
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?			There is a risk to this action due to changeover of Board Level safety champion plus the impact of the current pandemic upon the meetings. The maternity safety champions are also changing to incorporate the	July 2020	Chief Nurse/ Director of Midwifery

Action No	Maternity Safety Action	Status as reported to the Board on 20th February	Current Position	Action required to mitigate and resolve issue	Deadline	Lead
				midwifery safety champion role into that of the Professional Midwifery Advocate.		
10	Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?			This action has been delivered – it must be recognised that the time frame may change. This is an ongoing report	March 2021	Director of Midwifery

Cover page	
Meeting	Trust Board
Paper Title	Appendix 1: Midwifery Staffing report Q4 2019/20
Date of meeting	28th May 2020
Date paper was written	26th April 2020 Updated 05/05/20
Responsible Director	Maggie Bayley, Interim Chief Nurse
Author	Nicola Wenlock, Director of Midwifery

Executive Summary

This paper is an appendix to the CNST paper regarding Safety Action 5

NICE published the report Safe midwifery staffing for maternity settings in 2015, updated in 2019. This guideline aims to improve maternity care by giving advice on monitoring staffing levels and actions to take if there are not enough midwives to meet the needs of women and babies in the service. The guidance was produced in response to previous reports such as the Francis report (2013).

The Maternity Incentive Scheme operated by NHS resolution asks whether the service can demonstrate an effective system of midwifery workforce planning to the required standard. This report provides the monthly data which relates to those elements of the standard including:

- Midwife to Birth ratio
- Red flags
- The provision of 1:1 care in labour and a supernumerary coordinator on each DS shift
- Details of the specialist midwives employed

The main findings of this report are:

- Delivery Suite (DS) is not achieving the required level of positive acuity
- Red flags continue to be reported and the majority relate to delays with Induction of labour
- There continue to be time when the labour ward coordinator is not supernumerary
- The Birthrate Plus assessment has now commenced and will provide more accurate data as to the required staffing levels for the current configuration of maternity services

Previously considered by	Care Group Governance 21/05/20 and MOC 11/05/20. Reported to Care Group Board 19/05/20

The Board (Committee) is asked to:			
☐ Approve	☑ Receive	☐ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☑ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☐ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☑ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☐ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	Number 1204

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	

Main Paper

Situation

The maternity service currently operates a hub and spoke model of care. The Obstetric unit is situated at PRH, with a midwifery led unit situated within the main hospital. A new build MLU alongside the OU was opened for antenatal and postnatal clinics on 9th April.

The Freestanding Midwifery led unit at RSH is currently closed to births whilst essential building work takes place but both antenatal and postnatal clinics operate from there.

In addition there are 3 freestanding midwifery led units; Oswestry, Bridgnorth and Ludlow. Births are currently suspended in all of these units pending a public consultation as to the future of midwifery led services in these units. All of the units provide antenatal and postnatal care.

The service also provides community midwifery care via teams of community midwives linked to each of the MLUs. There are consultant led antenatal clinics, a triage unit and a day assessment unit.

The current model of care is a traditional model of team working to provide antenatal and postnatal care with core midwives providing inpatient care on DS and the wards and outpatient care in triage, DAU and ANC.

The activity within maternity services is dynamic and can change rapidly. It is therefore essential that there is adequate staffing in all areas to provide safe high quality care by staff who have the requisite skills and knowledge. Regular and ongoing monitoring of the activity and staffing is vital to identify trends and causes for concern, which must be supported by a robust policy for escalation in times of high demand or low staffing numbers.

Background

NICE published the report Safe midwifery staffing for maternity settings in 2015, updated in 2019. This guideline aims to improve maternity care by giving advice on monitoring staffing levels and actions to take if there are not enough midwives to meet the needs of women and babies in the service. The guidance was produced in response to previous reports such as the Francis report (2013). A gap analysis was completed against this and this is currently being reviewed by the Director of Midwifery

Safety action number 5 of the Maternity Incentive Scheme asks:

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The required standard for this is detailed below:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is complete.
b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
c) All women in active labour receive one-to-one midwifery care
d) Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board.

The minimal evidential requirements for this standard are:

The bi-annual report submitted will comprise evidence to support a, b and c progress or achievement. It should include:

• A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.
• Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing.
• An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified.
• Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.
• The midwife: birth ratio.
• The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.
• Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.
The year 2 standard also included information regarding red flags which have been omitted from year 3 but due to the importance of noting and acting upon these they have been reported in this paper.

Assessment

Birthrate Plus assessment

A full Birthrate plus assessment was completed by the service in April 2017. Services which do not have the recommended number of midwives as detailed in a Birthrate plus assessment have an increased risk of a high number of midwifery staffing red flags and times when the DS coordinator cannot be supernumerary. Agreement was reached in April 2019 to recruit to the recommended level of midwives as detailed in the report. A repeat Birthrate plus assessment commenced 27th April 2020 using retrospective data analysis.

Action: Complete Birthrate plus assessment and develop workforce plan – in progress with anticipated draft report by July 2020

Midwife to Birth ratio

The monthly midwife to birth ratio is currently calculated using the number of Whole time equivalent midwives employed and the total number of births in month. This is the contracted or established Midwife to birth ratio. A more accurate midwife to birth ratio is given when using the actual worked ratio which is in use across the West Midlands network for the calculation of monthly midwife to birth ratio. This takes into account those midwives who are not available for work due to sickness or maternity leave whilst adding in the WTE bank shifts completed in each month. This "worked" calculation will show greater fluctuations in the ratio but provides a realistic measure of the number of available midwives measured against actual births each month. This was a recommendation of the RCOG report 2017. The reporting of the contracted ratio is a useful measure to assess the recruitment and retention of midwives to the service although will show small fluctuations due to this as well as changes in birth numbers each month.

Action: Provide worked midwife to birth ratio each month alongside contracted ratio from April dashboard onwards – this will be implemented and be presented for monitoring on the new maternity dashboard currently in development.

Planned versus actual staffing levels

Each month the planned versus actual staffing levels are submitted to the national database using the information provided from the Allocate rostering system, as part of the unify report for all inpatient areas.

The template for the inpatient areas in maternity was corrected in February. This has resulted in the January data not being accurate retrospectively in terms of percentage fill rates.
The antenatal ward had some staffing shortages in March and staff were moved to compensate.
DS staffing did not meet template and this is reflected in the acuity tool. Recruitment is ongoing to fill midwifery and support worker vacancies in maternity. This is mitigated by the use of bank staff and the implementation of the escalation policy if required which will result in staff being moved to areas of higher activity.

Table 1 March planned versus actual fill rates – Day shifts

	Day					
	RN/RM			HCA/NA		
Ward 21 - Postnatal Maternity	1911	1715	89.74%	1488	1383	92.94%
Ward 22 - Antenatal Maternity	1128	940	83.33%	371	301	81.13%
Ward 24 - Labour Ward	3924	3408	86.85%	1284	980	76.32%
Wrekin Midwife Led Unit	804	726	90.30%	766	484	63.19%

Table 2 – March planned versus actual fill rates – Nights shifts

	Night					
	RN/RM			HCA/NA		
Ward 21 - Postnatal Maternity	1500	1415	94.33%	1128	1073	95.12%
Ward 22 - Antenatal Maternity	744	716	96.24%	384	341	88.80%
Ward 24 - Labour Ward	3435	2886	84.02%	1198	1015	84.72%
Wrekin Midwife Led Unit	744	423	56.85%	744	298	40.05%

Table 3 - Fill rates for Delivery Suite and Wrekin midwifery Led unit - % - monthly comparison

	Fill Rates DS RM		Fill rates DS WSA		Fill Rates Wrekin RM		Fill rates Wrekin WSA	
	Day	Night	Day	Night	Day	Night	Day	Night
Jan	120.9	113.1	94.9	96.8	104.6	88.4	106.5	92.2
Feb	108.5	99.5	83.0	93.2	85.9	91.6	89	51.1
Mar	86.85	76.32	84.02	84.72	NA	NA	NA	NA

Table 4 - Fill rates for antenatal ward and postnatal ward - % - monthly comparison

	Fill Rates AN ward RM		Fill rates AN ward WSA		Fill Rates PN ward RM		Fill rates PN ward WSA	
	Day	Night	Day	Night	Day	Night	Day	Night
Jan	104.7	149.	92.1	178.	140.	112.0	113.9	98.1
Feb	77.4	100.3	92.1	91.5	99	98.6	95.7	96.6

Mar	83.33	81.13	96.24	88.80	89.74	91.94	94.33	95.12

Action: Monitoring and reporting of fill rates each month and escalation if fill rates not being achieved to minimum level of 90% or if above 110% for three consecutive months using acuity tool to inform data analysis and activity
Action: Workforce plan once Birthrate assessment completed – BR+ commenced 27/04/20

Intrapartum Acuity

The maternity service implemented the use of the Birthrate intrapartum acuity tool in 2017. This was initially using an excel based programme. From September 2018 the service introduced the web based App. The data is inputted into the system every 4 hours by the Delivery Suite coordinator and measures the acuity and the number of midwives on shift to determine an acuity score. Birthrate defines acuity as "the volume of need for midwifery care at any one time based upon the number of women in labour and their degree of dependency"

A positive acuity scores means that the midwifery staffing is adequate for the level of acuity of the women being cared for on DS at that time. A negative acuity score means that there may not be an adequate number of midwives to provide safe care to all women on the DS at the time. In addition the tool collects data such as red flags which are defined as a "***warning sign that something may be wrong with midwifery staffing***" (NICE 2015). SaTH has adopted the red flags detailed in the NICE report plus added some local indicators (Appendix 1) and an example of the data collection tool for one day and also the staffing versus workload chart which is produced as a result of the data collection can be reviewed in appendix 2 & 3 respectively.

The Royal College of Midwives in discussion with Heads of Midwifery has suggested that a target of 85% staffing meeting acuity should be set but that this can be reviewed and set locally depending upon the type of maternity service. In addition there should be a compliance with data recording of at least 85% in order to have confidence in the results.

In Q4 the service did not achieve 85% positive acuity. The majority of negative acuity is amber with up to 2 midwives short with a much smaller percentage of occasions being red which equates to 2 or more midwives short. There are no adverse incidents reported as a result of this

Compliance with the data recording has improved overall for the scheduled times of reporting (3am 7am, 11am 3pm, 7pm and 11pm).However, data is also recorded ad hoc which together with the scheduled recordings has been used to provide the information below. In addition the actions taken by the coordinator when there is negative acuity is not always recorded meaning that they may take action to redeploy staff during times of high acuity but it is not possible to always evidence this is happening. This information is sometimes recorded on the escalation sheet and the team leaders should be advised to use the acuity tool to record this.

Action: Meeting planned with Coordinators to review use of acuity tool – delayed due to Covid-19 – planned for June 2020
Action: Birthrate team to visit to review use of tool - completed
Action: Review of staffing to ensure correct numbers of midwives are available to work in delivery suite matched to acuity levels – under review as part of Birthrate assessment
Action: Review of the escalation policy to ensure that it adequately supports the movement of staff around the unit during periods of high acuity – delayed due to covid-19 workload but to be completed by June 2020

Red flags

In total there were 72 red flags recorded during in Q4. The majority of these (43) related to delays in the induction of labour process. All delays are reported via the Datix system and care reviewed to assess impact. There are no adverse incidents reported as a result of this

Action: Review of the Induction of labour pathway especially the process for prioritisation at times of high activity – delayed due to covid-19 but recovery phase and actions now being developed – review to be undertaken once in recovery phase but to be commenced June 2020

1:1 Care in established labour

1:1 care is defined as "care provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same midwife for the whole of labour" (NICE 2015). During Q4 there was 1 occasion when 1:1 care was recorded as not being provided following review of the records

Action: All cases where 1:1 care in labour has not been provided will be reviewed to assess impact and outcome. This will be triangulated with the acuity and implementation of the escalation policy – ongoing monthly monitoring of cases but to be commenced June 2020

Supernumerary status of the coordinator

Supernumerary status of the coordinator is defined as the coordinator not having a caseload. The acuity tool has time built in for the coordinator to be supernumerary when it is recorded. The data identified that the coordinator was not supernumerary on 11 occasions during Q4 . The risk when this happens is that there is a loss of the oversight of delivery suite which increases the longer that the coordinator is not supernumerary. In addition the senior leader is not freely available for support and advice during these times. There have been no adverse incidents reported as a result of this.

Action : Review of the Escalation policy to ensure that it supports the supernumerary status of the coordinator and clearly defines the actions to take to mitigate in times of high activity / acuity – delayed due to covid-19 workload but to be completed by End June 2020

Specialist Midwives

The service has a wide range of specialist midwifery posts as detailed below:

- IT
- Bereavement
- Infant feeding
- Risk / governance
- Education
- Safeguarding
- Antenatal and Newborn Screening
- Guidelines
- Professional Midwifery Advocate

Table 3 – Acuity, red flag data and midwife to birth ratio

Month	Red flags	1:1 care not met (number)	Supernumerary not met (number)	Midwife to birth ratio (contracted)	Acuity % Positive	Red %	Amber %	Acuity Recorded
Jan	14	1	0	1:23.4	77	3	20	158

Month	Red flags	1:1 care not met (number)	Supernumerary not met (number)	Midwife to birth ratio (contracted)	Acuity % Positive	Red %	Amber %	Acuity Recorded
Feb	23	0	4	1:20.9	83	1.3	15.7	152
Mar	36	0	7	1:21.5	78	5	17	183

Recommendation

The Board is requested to:

- Note the findings of this report and take assurance form the actions taken to address staffing issues.
- Note this report will now be included monthly at both Maternity Governance and Care Group Board with a quarterly submission to Trust Board until such a time that the Board agree a bi-annual submisison.
- Note the metrics will be included on the new maternity dashboard which will also provide additional monthly overview at the Maternity Oversight Committee and through to the Quality and Safety Assurance Committee.

Appendix 1

Midiwfery staffing red flags

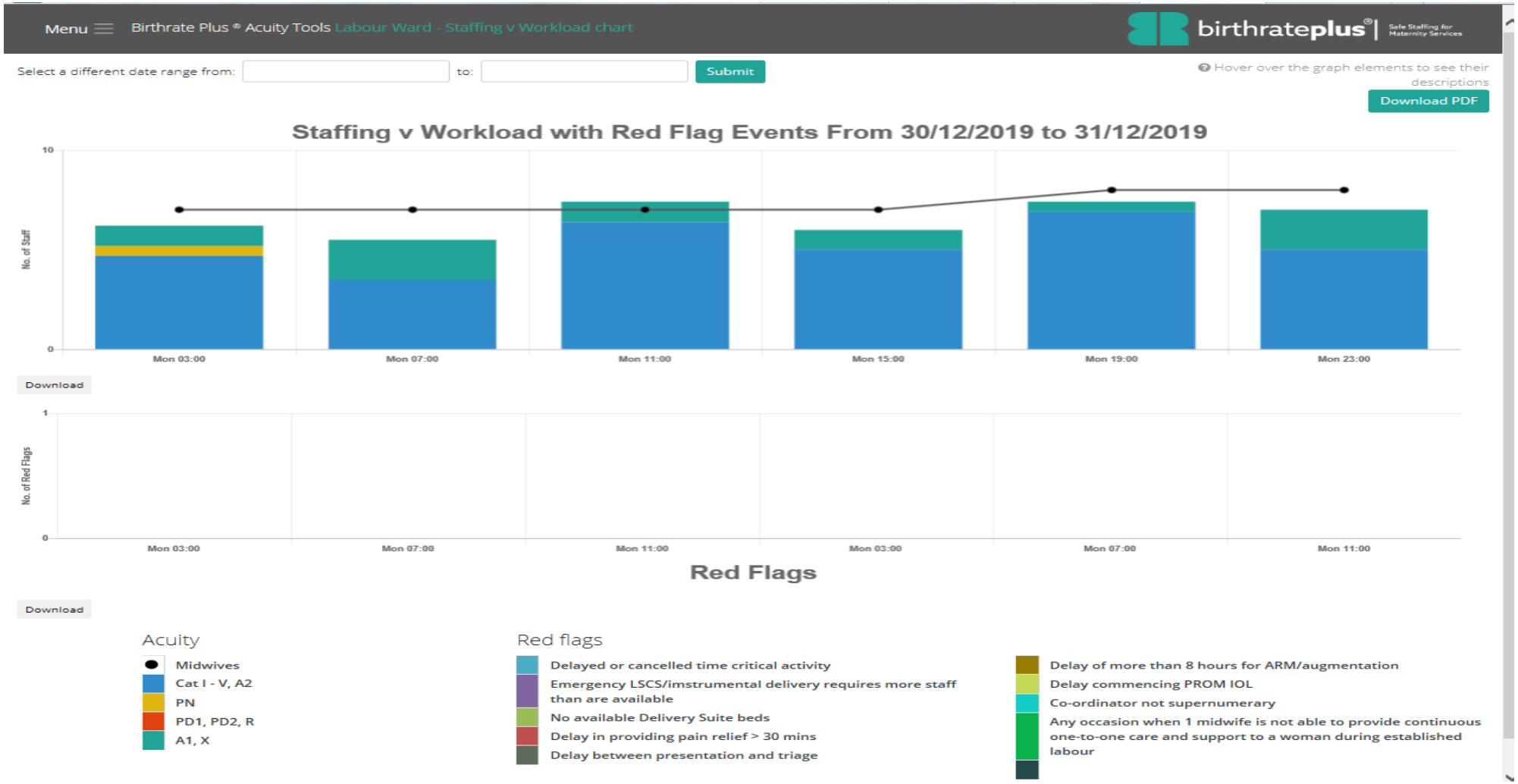
Appendix 2

Mon 30/12/2019

Time	Cat I	Cat II	Cat III	Cat IV	Cat V	Cat A2	PN Readmission	Cat PD1	Cat PD2	Cat PN	Cat A1	Cat X	MWs & Coordinator	Total no. of women in acuity	Acuity	
03:00		1	2	1						2	2		7	8	0.80	Info
07:00		1	1	1							4		7	7	1.50	Info
11:00			3		2						2		7	7	-0.40	Info
15:00			3		1						2		7	6	1.00	Info
19:00		1	3	1		1					1		8	7	0.60	Info
23:00			2	2							3	2	8	9	1.00	Info

T... 31/12/2019

Appendix 3


Menu
Birthrate Plus ® Acuity Tools Labour Ward - Staffing v Workload chart
birthrateplus
Safe Staffing for Maternity Services
Select a different date range from:
to:
Submit
Hover over the graph elements to see their descriptions
Download PDF
Staffing v Workload with Red Flag Events From 30/12/2019 to 31/12/2019
No. of Staff
10
0
Mon 03:00
Mon 07:00
Mon 11:00
Mon 15:00
Mon 19:00
Mon 23:00
Download
No. of Red Flags
1
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Mon 03:00
Mon 07:00
Mon 11:00
Mon 03:00
Mon 07:00
Mon 11:00
Red Flags
Download
Acuity
Midwives
Cat I - V, A2
PN
PD1, PD2, R
A1, X
Red flags
Delayed or cancelled time critical activity
Emergency LSCS/imstrumental delivery requires more staff than are available
No available Delivery Suite beds
Delay in providing pain relief > 30 mins
Delay between presentation and triage
Delay of more than 8 hours for ARM/augmentation
Delay commencing PROM IOL
Co-ordinator not supernumerary
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour

Cover page	
Meeting	Trust Board
Paper Title	Appendix 2: NHS Resolution's Early Notification Scheme/ Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme incorporating Perinatal Mortality Review Tool (PMRT)
Date of meeting	28.05.20
Date paper was written	06.04.2020
Responsible Director	Maggie Bayley, Interim Chief Nurse
Author	Nicola Wenlock Director of Midwifery Elizabeth Pearson Quality Improvement Midwife

Executive Summary -Situation

Appendix 2 CNST paper

This report has been prepared and presented for assurance that compliance is being met with 2 of the 10 safety actions set within the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme in order to continue to support the delivery of safer maternity care. The report considers both:

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Safety action 10: Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?

The cases that fit the criteria for review using PMRT from Quarter 4 (January, February and March 2020) and including cases from December 20th 2019 (the start of year 3 for CNST) are:

- 2 stillbirths;
- 4 Neonatal deaths – these babies were born at SaTH but 3 died at neighbouring Trusts, those Trusts have responsibility for the PMRT and we will assist them with a joint review of care;
- 1 late fetal loss (22-23+6 weeks gestation)
- 3 qualifying 2019/20 cases have been referred to the NHS Early Resolutions Scheme.

Previously considered by	Maternity Governance meeting. Maternity oversight Committee.

The Board is asked to:

☐ Approve	☐ Receive	☑ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☑ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☐ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☐ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	Completion of the reviews is linked to the Maternity Incentivisation programme.

Situation

Obstetric incidents can be catastrophic and life-changing, with related claims representing the scheme's biggest area of spend. Of the clinical negligence claims notified in 2018/19, obstetrics claims represented 10 percent (1,068) of clinical claims by number, but accounted for 50 per cent of the total value of new claims, £2,465.5 million of the total £4,931.8 million. Now in its third year, the maternity incentive scheme supports the delivery of safer maternity care through an incentive element to trusts contributions to the CNST. This report will focus on 2 of the 10 safety actions agreed with the national maternity safety champions in partnership with the Collaborative Advisory Group (CAG).

Safety Action 1: Are you using the perinatal mortality review tool to review perinatal deaths to the required standard?

- A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 will have been started within four months of each death. This includes deaths after home births where care was provided by your trust staff and the baby died.

- At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your trust, including home births, from Friday 20 December 2019 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool, within four months of each death.

- For 95% of all deaths of babies who were born and died in your trust from Friday 20 December 2019, the parents were told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your trust staff and the baby died.

- Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the trust maternity safety champion.

- **Safety action 10:** Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?

Assessment

- A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from 20 December 2019 have been started within 4 months of each death.

Stillbirths	Number of cases	Number of PMRT started	% Compliance
2019/2020 Quarter 4 and including data from 20.12.2019	2 SB 1LFL	2 0	100% Review to be started by July 2020 to be compliant
Neonatal Deaths	Number of cases	Number of PMRT started	% Compliance
2019/2020 Quarter 4 and including data from 20.12.2019	1 *3 NND have been registered with neighbouring Trusts	Case not yet reviewed on PMRT	100% compliant provided case review commenced by May 2020
Overall compliance to date 100%			

- At least 50% of all deaths who were born and died at your Trust (including home births that died) from 20th December 2019 will have been reviewed by a multidisciplinary team with each review completed to the point that a draft report has been generated, within four months of each death.

Stillbirths	Number of cases	Draft report generated	% Compliance
2019/2020 Quarter 4 and including data from 20.12.2019	2 SB 1LFL	2 0	100% Report by July 2020 to be compliant
Neonatal deaths	Number of cases	Draft report generated	% Compliance
2019/2020 Quarter 4 and including data from 20.12.2019	1	Case not yet reviewed	100% provided case reviewed and draft report generated by May 2020
Overall compliance to date 100%			

- In 95% of all deaths of babies who were born and died in your trust the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.

Stillbirths	Number of cases	Parents review and questions answered	% Compliance
2019/2020 Quarter 4 to date and including data from 20.12.2019	2 SB 1 LFL	Both families informed. Family not yet informed at the time of this report	100%
Neonatal deaths	Number of cases	Parents review and questions answered	% Compliance
2019/2020 Quarter 4 to date and including data from 20.12.2019	1	Family informed	100%
Overall compliance 100%			

- Quarterly reports will be submitted to the trust Board that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the trust maternity safety champion.

Quarter 4 report prepared for Maternity Governance and then to be presented at Trust Board.

- Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?

Acute maternity trusts are required to notify NHS Resolution within 30 days of all babies born at term (≥37 completed weeks of gestation), following labour, that have had a potentially severe brain injury diagnosed in the first seven days of life, based on the following criteria:

- Have been diagnosed with grade III hypoxic ischaemic encephalopathy (HIE); OR
- Were actively therapeutically cooled; OR
- Had decreased central tone AND were comatose AND had seizures of any kind.

NHS Early Resolution's Early Notification Cases	Number of cases	Reason for referral	% Compliance
2019/2020	2	Required therapeutic cooling following delivery.	100%
2019/2020	1	Neonatal collapse on day 2 of life, admitted from home, comatose and seizures noted.	100%
Overall compliance 100%			

Actions

Actions are listed from PMRT cases reviewed below using the SMART mnemonic acronym incorporating the 5 characteristics: specific; measurable; attainable; relevant and time based.

Action from review of Q4 stillbirth 1:

During this mothers labour maternal observations, commensurate with her level with her level of risk and national guidelines were not carried out, the partogram was only partially completed.	
S	Full completion of the partogram is expected for a woman in labour, from the onset of established labour or from the administration of the first dose of misoprostol for women with fetal losses.
M	All fetal loss cases are reviewed using PMRT therefore all cases will be measured consistently that this is being completed.
A	Midwives should keep clear and accurate records which are relevant to their practice
R	The partogram is a crucial document to provide documentation of the woman's progress during labour.
T	Wording in guidelines to be updated within one month. Mandatory training session for bereavement care starts from April 2020 which will highlight this issue.

The mother's pain was not managed appropriately during labour, when the intrauterine death was diagnosed she discussed her birth plan and requested an epidural. She also requested an epidural again when she was 4cms after the 2nd dose of misoprostol but was encouraged to try other methods of analgesia. It is her one "grumble" with her care documented in her feedback that she wishes she had been more forceful and demanding of what she wanted..	
S	If a mother has expressed a wish for a specific method of analgesia, we should attempt to meet her wishes.
M	All fetal loss cases are reviewed using PMRT therefore all cases will be measured consistently to ensure analgesia needs are being met. CQC monitoring also requests assurance weekly that women requesting an epidural have their request met within 30 minutes.
A	Attainable as this is fundamental to prioritising people within the Midwives code of conduct
R	Relevant as this is fundamental to prioritising people within the Midwives code of conduct
T	One month for this to be disseminated in the 3 Minute Brief to all Obstetric and Maternity staff.

Actions from review of Q4 stillbirth 2:

This mother's progress in labour was monitored on a partogram but the partogram was only partially completed up to the final hour in the second stage of labour (one entry of maternal pulse and uterine activity not documented)	
S	Full completion of the partogram is expected for a woman in labour, from the onset of established labour or from the administration of the first dose of misoprostol for women with fetal losses.
M	All fetal loss cases are reviewed using PMRT therefore all cases will be measured consistently that this is being completed.
A	Midwives should keep clear and accurate records which are relevant to their practice
R	The partogram is a crucial document to provide documentation of the woman's progress during labour.

T	Wording in guidelines to be updated within one month. Mandatory training session for bereavement care starts from April 2020 which will highlight this issue.

There was no description of the baby's appearance and as the parents declined to have a post-mortem how the baby looked, skin integrity and any abnormalities detected would have been beneficial in feeding back to the parents.	
S	An examination proforma facilitating documentation about the baby's appearance is being developed and will be embedded into practice.
M	All fetal loss cases are reviewed using PMRT therefore all cases will be measured consistently that this is being completed.
A	Midwives should keep clear and accurate records which are relevant to their practice
R	Documentation of the baby's appearance is crucial to being able to provide any information to the parents especially in the absence of a post-mortem.
T	Changes to the guideline will be made within one month.

Other ACTIONS
A business plan is being submitted to provide funding to support Neonatal and Obstetric Consultants to attend monthly meetings within their job plan and also for administration support with the running of the meetings. This will facilitate addressing a backlog of cases and maintain the required review of cases that require reports to be published.

Microsoft teams have been initiated to facilitate reviews by a larger team working remotely during the COVID18 pandemic.

Recommendations

Trust Board are asked to:

- Note the content of the report and actions being taken to ensure learning to enhance patient safety