COVERSHEET	
Meeting	Board of Directors' meeting in PUBLIC
Paper Title	Maternity Update
Date of meeting	8th October 2020
Date paper was written	28th September 2020
Responsible Director	Hayley Flavell, Director of Nursing
Author	Nicola Wenlock, Director of Midwifery
Presenter	Nicola Wenlock, Director of Midwifery

Executive Summary

The maternity unit at SaTH has been under external scrutiny for a number of years and is currently subject to an independent review as ordered by the Secretary of State for Health in response to a number of serious incidents concerning avoidable deaths and serious harm of both mothers and babies.

A recent CQC inspection (November 2019, published 2020) noted that the service was rated as Requires Improvement overall with ratings of good for the domains of effective, responsive and caring and requires improvement for well led and safe.

The Maternity Transformation Programme (MTP) has been developed to provide focus and direction for the service over the next 3-5 years. It is underpinned by a detailed Maternity Improvement plan (MIP) which brings together the recommendations from local and national reports and reviews. This plan is monitored at Maternity Assurance Committee

This report provides an update on the maternity service with particular reference to the:

- MTP (appendix 1
- CNST Maternity Incentive Scheme (appendix 2)
- Midwifery staffing report (appendix 3)
- PMRT / NHSR Early Notification Scheme (appendix 4)

The Board are asked to **discuss, note** and **take assurance** from this report.

Previously considered by	Reported in August to Maternity Governance: actions taken by area leads as required Maternity Quality Operational Committee: issues for escalation to MAC identified Maternity Assurance Committee – Triple A report shared along with full papers for review.

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	None

Main Paper

Situation

The NHS-E has continued to set out a number of ambitions (as part of their Business Plan) within the maternity and neonatal settings to reduce deaths in babies and young children, specifically neonatal mortality and still births. Safety in maternity and neonatal services has been of national focus since 2015.

Background

In 2016 the Secretary of State for Health announced a challenging ambition to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth by 2030. To make sure progress was made quickly, there was an interim target that there would be an expectation of a 20% reduction by 2020. The end date subsequently changed to 2025 in order to maximise the positive outcomes that the ambition would support.

Shortly after the announcement the National Maternity Review, Better Births was published which set the direction and vision for maternity services and the national maternity transformation programme was created. The implementation of Better Births will ensure that women have safer more personalised care with choice regarding their care. It brings together key stakeholders to deliver change. Safety is the “golden thread” which runs throughout the transformation programme.

The Maternity Transformation Programme (MTP) has been developed to provide focus and direction for the service over the next 3-5 years. It is underpinned by a detailed Maternity Improvement plan

(MIP) which brings together the recommendations from local and national reports and reviews. This plan is monitored at Maternity Assurance Committee

Assessment

1) **Maternity Transformation programme: 5 work streams each with an executive sponsor and work steam lead**

- Clinical Quality and Choice
- People and culture
- Governance and Risk
- Education and partnerships
- Communication and engagement

2) **CNST Maternity Incentive scheme**: 10 safety actions

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

3) **Midwifery Staffing report**

- Midwife to Birth ratio is positive at 1:25
- Delivery Suite is continuing to achieve the required level of positive acuity.
- Red flags continue to be reported with 13 reported in July – this is an increase and is being monitored
- Labour ward co-ordinator not supernumerary on 2 occasions
- All areas except AN ward achieved at least 90% fill rate for midwifery staffing (June data included as not available at time of reporting to Board in July)
- The Birthrate Plus assessment is in progress and once reported, will provide accurate data to determine the required staffing levels for the current configuration of maternity services. Initial feedback will be provided to service leads on 30th September.

4) **Perinatal Mortality review tool and NHSR Early notification system report**: The total cases that fit the criteria for review using PMRT in July 2020:

- 0 stillbirths;
- 0 Neonatal Deaths
- 2 late fetal loss (22-23+6 weeks gestation)
- 0 cases that required referral to the NHS Early Resolutions Scheme. 100% compliance with the scheme requirement noted.

Recommendation

The Board are asked to **note** and **take assurance** from this report.

Appendix 1

Transformation Programme Update

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Core Aims

We want to achieve:

High quality services

We want to deliver high quality safe and effective clinical services

Learning culture

We want to build a compassionate learning culture

Build trust

We want to rebuild the confidence and trust of the community

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Where are we now

- Agreed Transformation Programme structure with workstream leads and Executive Sponsors
- Kick off workshop in August with key internal and external stakeholders
- Recruited to Project Management Team – start mid October
- Workstream leads developing workstream plans – identified key high impact actions
- Team Coaching/Development programme in place for delivery team
- Commissioned Qualitative study with Birmingham City University

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Programme Structure

Maternity Transformation Committee: Patients and Partners

THE HOW

WS1	WS2	WS3	WS4	WS5
Clinical quality and choice	People & Culture	Governance and Risk	Education and Partnerships	Comms & Engagement

Patients, our people and Partners

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Workstream Leadership

Workstream	Programme Leadership: Louise Donovan/Martyn Underwood
WS1 Clinical quality and choice	• **Exec Sponsor:** Chief Nurse (DON) • **Workstream Lead:** Mai-See Hon (Clinical Director Obstetrics)
WS2 People & Culture	• **Exec Sponsor:** Rhia Boyode (DOW) • **Workstream Lead:** Janine McDonnell (Care Group Director)
WS3 Governance and Risk	• **Exec Sponsor:** Director of Governance • **Workstream Lead:** Nicola Wenlock (Director of Midwifery)
WS4 Education and Partnerships	• **Exec Sponsor**: Medical Director • **Workstream Lead:** Will Parry Smith (Consultant Obstetrician)
WS5 Communication & Engagement	• **Exec Sponsor:** Director of Governance • **Workstream Lead:** Kirsty Walker (Head of Communications)

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What are we trying to achieve?

There are five key workstreams to achieve success on the programme

WS1	WS2	WS3	WS4	WS5
Clinical quality and choice	People & Culture	Governance and Risk	Education and Partnerships	Comms & Engagement
High quality safe and effective services	Compassionate culture with a happy and valued workforce	Underpinned by a 1st class clinical governance process	Education Programme that transforms us in to best trained maternity workforce in UK	Developing a strategy that is clear we are passionate about delivering the highest standard of care for mothers and babies

WS 5 is required across all workstreams

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Measuring success

High quality services

Measure	Aspiration
Mortality rates: Still birth Neonatal death	Top quartile(GiRFT) No red dots MBRACE
HIE	Top quartile
Cooling babies	Top quartile
Term Neonatal admission	Top quartile
Tear rates	Top quartile
CQC Good across the board	September 2021

Learning culture

Measure	Aspiration
Speak up comfort levels	To be agreed
Leadership perception	
Recruitment and retention rates	
Sickness rates	
Complaints	
Risk	
Training	

Build trust

Measure	Aspiration
Maternity Voices Partnership metrics	To be agreed
Friends and Family Test	

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Workstream Plans – High Impact Actions

Workstream	High Impact Actions/priority areas of focus
WS1 Clinical quality and choice	Overarching action: Explore Pilot a Clinical Informatics service specific to maternity 1) Revised AN Pathway Risk assessment, Continuity of care & Personalised care plans, One stop and specialist clinics (SBL) 2) Birth place choice, enhanced recovery, reduce incidence of Postpartum Haemorrhage, dedicated HDU room (EMC) 3) Perinatal mental health, bereavement pathway, recovery support
WS2 People & Culture	1) Undertaking work with 'Think on' on culture 2) Undertake Listening in to Action 3) Develop behavioural standards framework
WS3 Governance and Risk	1) Identify what best practice clinical governance framework looks like - consider partnership with high performing organisation 2) Project Plan – getting to an outstanding clinical governance framework
WS4 Education and Partnerships	1) Conducting gap analysis of current training programme against 'mind the gap' 2) Designing in partnership with baby lifeline a first class education and training programme 3) Exploring opportunities for partnership working with another unit to include staff rotation etc
WS5 Communication & Engagement	1) Develop and delivery of a first class Communication and Engagement strategy with our patients and community 2) Support, advise and assist the delivery of a quality workforce engagement strategy

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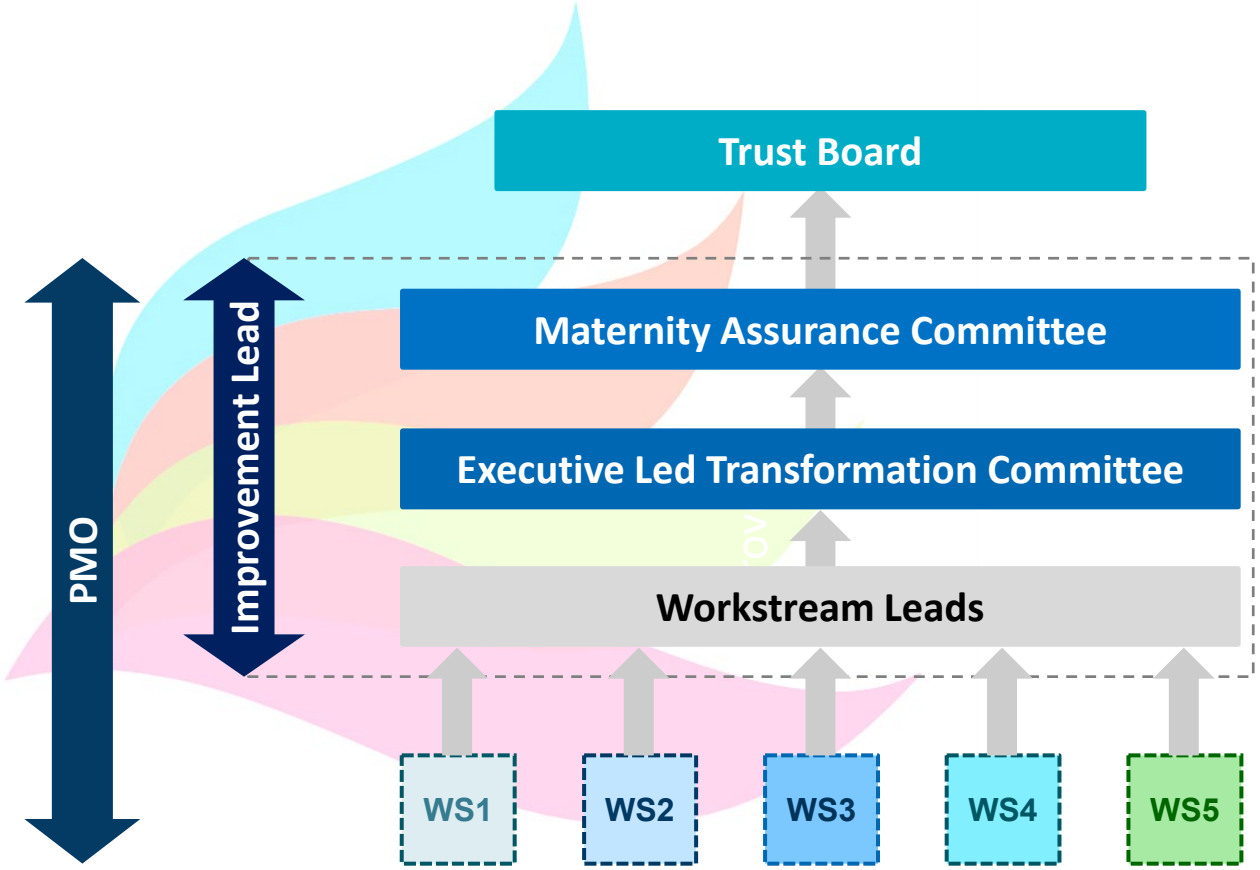
Programme Governance

Roles and Responsibilities will be clearly defined on this programme:



- **Executive Lead** is accountable for delivery of each workstream.
- The programme will be overseen by a **Maternity Transformation Board**, consisting of the workstream leads, PMO, Clinical Leads and chaired by the Chief Nurse.
- **PMO** will provide assurance of delivery through reporting, tracking of milestones and the assembling of evidence that the change is embedded.
- The **Trust Board** will receive assurance via Maternity Assurance Subcommittee.
- External assurance and challenge will be provided by the **External Advisory Group.**
- **Improvement Lead** sits outside of care group to provide independent assurance and will attend executive and sub-board committee

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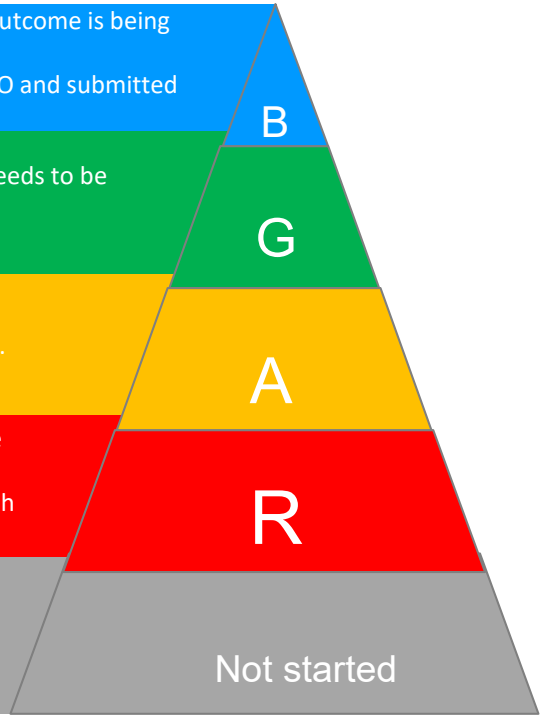
Assurance Process – BRAG Ratings

RAG+B Ratings will allow us to communicate project health at any point in time:

Action embedded with evidence	• Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. • 'Green to Blue' document must have been completed, agreed by workstream PMO and submitted to *** committee with supporting evidence before the action can be turned blue.
Action complete	• All necessary steps have been taken to make the improvement. The action now needs to be embedded.
Action in progress & on track	• Completion of the action is in progress, and on track to meet the completion date.
Action off track	• The completion date has passed with all aspects of the action not being able to be successfully completed. • Off track items are escalated through to Programme Director and Committees with clear reasons for status, mitigation and potential resolutions.
Not Started	• The action has not yet started, but is still on track to be completed within the required time frame.



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CNST Maternity Incentive Scheme- NHS Resolution – Year 3 progress and action plan as at August 2020
appendix 2 – Maternity Update Trust Board 08.10.20)
Executive Lead – Hayley Flavell
Author – Nicola Wenlock

1. Introduction

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

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.

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 situation

3.1 The reporting period of the Maternity Incentive Scheme action has been deferred and the scheme restarts on 1st October 2020

3.2 Therefore, this report shows the current status which includes the ongoing impact of Covid-19 in relation to achieving the actions. Some additional amendments have been made to reporting dates with more updates expected from NHSR.

3.3 Overall status of the scheme remains unchanged overall with one action red which relates to midwifery staffing, specifically the supernumerary status of the coordinator and 1:1 care in labour. There was 1 occasion in July when this did not happen which is a reduction with no adverse outcome and no care was missed.

Action	Maternity Safety Action	Previous status	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	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?			The KPO team are supporting the service with a quality improvement project and process flow sessions. The guidance is being reviewed. A workforce plan to include TC staffing will be developed when BR+ is reported. The deadline has been amended to reflect the status and required time to be able to complete the work satisfactorily.	Dec 2020	Director of Midwifery
4	Can you demonstrate an effective system of medical			This is currently on track and will be monitored monthly	March 2021	Clinical Director

Action	Maternity Safety Action	Previous status	Current Position	Action required to mitigate and resolve issue	Deadline	Lead
	workforce planning to the required standard?			NNU staffing complies with BAPM standard		
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, plus one occasion whereby 1:1 care was not achieved in Labour (no care compromised and all care given appropriately) and hence we have not been able to demonstrate consecutive 3 month period. The escalation policy has been updated and ratified	Mar 2021	Director of Midwifery
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle?			Band 7 Midwife lead post successfully recruited to. New EPR system procured which will enhance the ease of data collection.	March 2021	Clinical Director
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?			The service is compliant with the recommendations.	Sept 2020	Director of Midwifery
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-			Risk to compliance due to additional requirements for training and the need to ensure all staff groups have	March 2021	Director of Midwifery / Clinical Director

Action	Maternity Safety Action	Previous status	Current Position	Action required to mitigate and resolve issue	Deadline	Lead
	house' multi-professional maternity emergencies training session within the last training year?			been trained. The suspension of training in response to the pandemic has also impacted upon this overall. MDT training will recommence in August. There remains a risk to achievement due to the number of staff requiring training. A priority schedule is being developed.		
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?			Meetings are being arranged bi-monthly with the safety champions and monthly walkabout and feedback sessions for staff with the BLSC The safety feedback dashboard needs to be developed Continuity of carer is not on target to achieve 51% by Mar 2020 as the programme was paused. The deadline has changed to reflect changes to the BLSC structure	December 2020	Board level safety champion/ Director of Midwifery
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

4. Recommendations

4.1 The board members are asked to **receive** and **note** the report.

Midwifery Staffing report – August 2020 (July)
(appendix 3 – Maternity Update Trust Board 08.10.20)
Executive Lead – Hayley Flavell
Author – Nicola Wenlock

1. Introduction

1.1. 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 and intrapartum care on 27th April.

1.2. 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

1.3. 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.

1.4. 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.

1.5. 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.

1.6. 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.

2. Background

2.1. 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).

2.2. Safety action number 5 of the Maternity Incentive Scheme asks

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

2.3 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.

2.4 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.

3. Current situation

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

3.2 A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.

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.
Initial feedback to service leads is planned on 30th September 2020 with a full workforce plan being completed by December 2020

3.4 Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing.

Each month the planned versus actual staffing levels are submitted to the national database using the information provided from the Allocate rostering system. The template for the areas was corrected in February. The Covid-19 pandemic had an impact on midwifery and WSA staffing and the MLU and home birth service was suspended for approximately one month to support the delivery of care in all other areas. The service continues to monitor and report the impact of covid-19 on midwifery staffing nationally. The template on DS has been

increased but not changed in the system hence the reason for the apparent over establishment of midwives. However, this increase is supported by the positive acuity data and reduction in red flags compared to Q4. All areas with the exception of the AN ward achieved at least 90% expected fill rate for midwifery staff. The escalation policy is implemented should any area require more midwifery staffing based on patient numbers and acuity/complexity.
A full workforce plan is expected in December following the completion of the Birthrate plus audit.

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
Apr	125.17	113.95	97.45	87.13	76.39	55.14	52.92	26.67
May	120	122.7	88.9	96.4	98.8	97.3	53.9	0
June	118.3	116.4	99.2	99.4	94.6	99.6	64.9	45
July	130	119	103	101	93	90	79	42

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
Apr	98.8	100.14	82.5	85.56	111.83	97.29	93.96	97.78
May	103.3	98.5	80.9	80.9	102.1	98.7	92	94.6
June	108.2	101.5	101.9	96.7	No Data			

July	84	100	105	92	106	100	97	98

3.5 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.

A workforce plan will be developed following the receipt of the final Birthrate Report

3.6 Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.

There is an escalation policy for staff to use in the event of staffing short falls

3.7 The midwife: 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. The M:B ratio in July was 1:25 (establishment). The worked ratios have been calculated and these are being validated.

3.8 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.

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

- *IT*
- *Bereavement – a second post is in the process of being recruited to*
- *Infant feeding*
- *Risk / governance*
- *Education*
- *Safeguarding*
- *Antenatal and Newborn Screening*
- *Guidelines*
- *Professional Midwifery Advocate*
- *Public Health Midwife*
- *Diabetes Specialist Midwife*

3.9 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 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.

*The acuity target was achieved in July at **85.6%***

Compliance with completion of the acuity tool has also improved for the scheduled times of reporting (3am 7am, 11am 3pm, 7pm and 11pm) with a confidence rating of >85% being achieved. As a result the data is more reliable. The report now only includes the scheduled data inputs and no longer includes the unscheduled data input. A review of the unscheduled data inputs is in progress as this will provide valuable information about the department outside of the scheduled input times and will offer information regarding the initiation of the escalation policy. Further improvement is anticipated following meetings with the DS Co-ordinators. These meetings have now commenced. The Escalation policy has been reviewed and updated and will be ratified in August following review in the July guideline meeting.
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 this month there was 1 episode where

1:1 care was not provided as the midwife was also allocated to care for a second lady (who was not in labour) No care was missed for either woman

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 2 occasions in July. These are being reviewed in order to ascertain the circumstances that led to this and what actions were taken at the time

3.10 Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising (Please note: it is for the trust to define what red flags they monitor. Examples of red flag incidents are provided in the technical guidance).

There were 13 red flags recorded during this period, which shows a slight increase. Of these 8 related to delayed induction of labour and two related to the shift co-ordinator not being supernumerary. There were no adverse events because of this.

4. Recommendations

4.1 The board members are asked to receive and note the report.

Perinatal Mortality review tool and NHS Resolution Early Notification Scheme (appendix 4 – Maternity Update Trust Board 08.10.20)
Executive Lead – Hayley Flavell
Author – Nicola Wenlock

1. Introduction

1.1. 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.

2. Background

2.1 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).

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

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

3. Current situation

3.1 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.

3.2 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.

3.3 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.

3.4 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.

Out of the 5 stillbirths reported to date, all families have been contacted, 2 reports have been published and 3 are in the report writing stage.

Out of the 4 neonatal deaths reported all families have been contacted, 2 reports have been published and 2 are awaiting the report to be completed.

Out of the 3 late fetal losses, all families have been contacted, 1 is under review, 2 are pending reviews 13.08.2020

Bi-monthly reports received at Trust Board

Full compliance with all standards achieved.

3.5 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.

No babies have fulfilled the criteria for referral under the NHSR ENS scheme

4. Recommendations

4.1 The board members are asked to **receive** and **note** the report.