COVERSHEET	
Meeting	Board of Directors' meeting in PUBLIC
Paper Title	Maternity Report
Date of meeting	5th November 2020
Date paper was written	24th October 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 Quality Operational Committee

A process for the evidencing of each completed action has been agreed in order to provide robust assurance. This includes review within the care group, peer review with other units in the West Midlands (system agreed with West Midlands Heads of Midwifery Advisory Forum) and also review of selected actions by the expert external assurance panel.

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

- CNST Maternity Incentive Scheme (appendix 1)
- Midwifery staffing report – CNST Safety action 5 (appendix 2)
- PMRT / NHSR Early Notification Scheme – CNST Safety action 1 & 10 (appendix 3)

More reports will be received at Board for other CNST safety actions over the coming months.

The Board are asked to take assurance from this report.

Previously considered by	Reported in September 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	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

	without formally approving it		

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 Quality Operational Committee

Assessment

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

RAG rating (current compliance)	Number of actions					
	Feb 2020	May 2020	July 2020	Aug 2020	Sept	Oct 14th
	4	3	1	1	2	1
	1	4	5	5	4	5
	5	3	4	4	4	4

2) **Midwifery Staffing report**

- Midwife to Birth ratio is positive at 1:26
- Delivery Suite did not achieve the required level of positive acuity -81% in August.
- Red flags continue to be reported with 19 reported in August – this is an increase and is being monitored
- Labour ward co-ordinator not supernumerary on 1 occasion
- All areas except Wrekin MLU achieved at least 90% fill rate for midwifery staffing
- The Birthrate Plus assessment is complete and a draft report received by the Director of Midwifery. This is being reviewed and will provide the information required in order to develop a midwifery workforce plan.

3) **Perinatal Mortality review tool and NHSR Early notification system report**: The Q2 report is included:

- 2 stillbirths;
- 1 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.

CNST Maternity Incentive Scheme- NHS Resolution
– Year 3 progress and action plan as at Oct 14th 2020
appendix 2 – Maternity Report Board of Directors' meeting 05.11.20)
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.

2.2 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 was deferred due to Covid-19 and it recommenced on 1st October with an updated scheme document published. A review of the new scheme and changes contained within is in progress. The new submission deadline is noon **20th May 2021**

3.2 Therefore, this report shows the status as at 14th October, which includes the ongoing impact of Covid-19 in relation to achieving the actions. There is also a brief note, which details whether there have been changes already noted, in the new scheme.

3.3 Following a concern in September when IT identified an issue with the Maternity services dataset the status declined. A manual workaround has been identified which has rectified the issue. The status of the scheme otherwise 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.

3.4 It is important to note that the status may change next month due to the changes in the new scheme. The PMO team are supporting the development of a full project plan, and the DoM is briefing each safety action lead on the changes to their action.

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 *Update & changes in new scheme including new dates*	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 Manual workarounds have been developed to support the submission. *Date changes in new scheme*	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 is in development The deadline has been amended to reflect the status and required time to be able to complete the work satisfactorily. *Update & changes in new scheme including new dates*	Dec 2020	Director of Midwifery

Action	Maternity Safety Action	Previous status	Current Position	Action required to mitigate and resolve issue	Deadline	Lead
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 *Minor changes in new scheme*	March 2021	Clinical Director
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 *Update & changes in new scheme including new dates*	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. *Minor changes in new scheme*	March 2021	Clinical Director

Action	Maternity Safety Action	Previous status	Current Position	Action required to mitigate and resolve issue	Deadline	Lead
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. *Minor changes in new scheme*	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 Covid -19 and the subsequent suspension of training. MDT training has recommenced *Significant changes in new scheme*	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?			Executive and Non-executive Board Level safety champions now in post 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 *Minor changes in new scheme*	December 2020	Board level safety champion

Action	Maternity Safety Action	Previous status	Current Position	Action required to mitigate and resolve issue	Deadline	Lead
10	Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?			This action has been delivered *Minor changes in new scheme*	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 Report
(appendix 2 – Maternity Report for the Board of Directors' meeting on 05.11.20)
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 service provides two models of care:

- 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.
- a continuity of carer model whereby a small team of midwives provide antenatal, intrapartum and postnatal care to a caseload of women.

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.

3. Current situation

3.1 The bi-annual report submitted will comprise evidence to support a, b and c progress or achievement. The report has been submitted bi-monthly with each Public meeting of the Board of Directors. This will now be monthly.

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 is complete and a draft report submitted to the Director of Midwifery 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. All areas with the exception of the Wrekin MLU 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.

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
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
Aug	123	109	121	99	98	74	105	48

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
June	108.2	101.5	101.9	96.7	No Data			
July	84	100	105	92	106	100	97	98
Aug	94	119	98	98	101	99	97	101

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 is being developed following the receipt of the draft Birthrate Report and any required actions will be detailed within.

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 August was 1:26 (contracted).

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. A number of Specialist Midwives form part of the clinical midwifery establishment in line with Birthrate plus recommendations.

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

- *IT*
- *Bereavement – a second post has been appointed to which will enable support to both Neonatal and Gynaecology (Early pregnancy) Services*
- *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 not achieved in August at **81%.** This correlates with an increased number of births, increased acuity of women particularly women who were postnatal requiring more time on DS and increased numbers of inductions in month*

Compliance with completion of the acuity tool for the scheduled times of reporting (3am 7am, 11am 3pm, 7pm and 11pm) is being maintained with a confidence rating of >85% being achieved.

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 no episodes where 1:1 care was not provided.

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 1 occasions in August.

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 19 red flags recorded during this period, which shows an increase. Of these 16 related to delayed induction of labour. 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 Q2 2020/21 report
(appendix 3 – Maternity Report for the Board of Directors' meeting on 05.11.20)
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 2 stillbirths reported in Q2, 1 draft report generated and one under review

Out of the 1 neonatal death reported, the case is under review

Out of the 2 late fetal losses, , 1 draft report generated and one under review

In all cases the families have been informed that a review is taking place. In addition their perspective and any concerns they may have about their care or that of their baby has been sought.

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

3.6 Actions have been developed from each case where required.

It was not possible to tell from the notes whether the parents were offered the opportunity to take their baby home or if they were told when the baby was taken to the mortuary. These aspects of care follow the National Bereavement Care Pathway.
Action completed 30/09/2020 – The Fetal Loss Care Pathway has been updated to include a revised checklist that highlights these care issues to staff. Staff have been informed of these changes.

There was no documentation that a mother was asked about domestic abuse at booking.
An audit of notes is to be completed by the Community Matron and Safeguarding Lead Midwife to ascertain compliance with this standard by 30/11/2020.

There was no documentation that a mother was asked provided with information about monitoring fetal activity.
During COVID 19 restrictions bookings have been completed over the telephone as well as the 16/40 appointment when the information packs have historically been given. Information packs have been given out at the point where the women come in for their initial blood tests but has not been consistently documented to provide the evidence that the woman has the relevant information. Community Midwifery staff will be informed of the need to document when this information is being given to the women by 31/10/2020.

Neonatal Care Issues identified
Discussion and feedback at joint obstetric and neonatal perinatal mortality and morbidity meeting 06/11/2020

4. Recommendations

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