The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
11 March 2021

Agenda item	056/21			
Report	NHS Resolutions CNST Maternity Incentive Scheme			
Executive Lead	Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners		Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF1204	
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting			
	For information			
	For consent			
Presented to:	NA			
Dependent upon (if applicable)**:**	NA			

Executive summary:	This overall Maternity Report provides an update on a number of important areas as follows: **Maternity:** • CNST Maternity Incentive Scheme (appendix 1) • Midwifery staffing report (appendix 2) • PMRT / NHSR Early Notification Scheme (appendix 3) **Risks and actions** CNST – 10 safety actions – 2 areas for focus Safety action 8 – Training due to ongoing impact of covid Safety action 9 Safety champion due to changes with team and evidencing early actions required. Continue to monitor the progress against the action plan, flag any risks Staffing Report - Quarter 3 report Birthrate plus assessment complete Fill rate – all areas achieved >90% except Wrekin MLU Red flags – 33 reported – reviewed with no adverse outcome 1:1 care in labour – achieved Supernumerary status of co-ordinator – achieved Specialist / managerial roles – 8-9% of midwifery establishment The escalation policy is implemented when staffing shortfalls are identified as required Covid-19 continues to have an impact on staffing levels throughout the service To continue monitoring the Midwifery & medical staffing and to report on the Birthrate + outcome once the report is completed PMRT, HSIB, NHSR EN Scheme - Quarter 3 report 2 stillbirth reported 1 neonatal death reported but not supported for PMRT review 1 Late fetal losses reported but not supported for PMRT review 3 qualifying incidents noted and referred to HSIB and NHSR EN scheme. All reporting criteria met Continue to monitor the neonatal outcomes reported on the Perinatal Mortality Review tool and NHSR Early notification system report. **4.0 Conclusion** 4.1 The Board are asked to take assurance from the report

Appendices	Appendix 1 - CNST Maternity Incentive Scheme, Appendix 2 - Midwifery staffing report Appendix 3 - PMRT / NHSR Early Notification Scheme

Appendix 1

CNST Maternity Incentive Scheme- NHS Resolution

Year 3 progress and action plan

1.0 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. 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 In addition, this paper details the submission requirements and includes the Board declaration document.

2.0 Background

2.1 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.

2.2 NHSR published an update to the original version of the Incentive scheme on 4th February 2020. Since then the scheme has been updated and relaunched following the pause due to Covid-19 with a revised submission deadline of July 2021. The action plan has been amended to reflect changes which includes Covid-19 reponse.

2.3 There are 10 safety actions to be achieved with a total of 128 standards which need to be evidenced in order to be fully compliant.

2.4 It is anticipated that a number of the actions will be subjected to external validation as they involve electronic submission to national databases such as PMRT, MBRRACE, NHS Resolution and the Maternity Services Dataset.

2.5 The Maternity service is in the process of confirming compliance with the differing elements of the scheme in readiness for Board approval and submission.

3.0 Current Situation

3.1 This report shows the status as reported to MQOC in February 2021, 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.

3.2 Some actions have now been completed and can be evidenced.

3.3 A process for the approval of completed actions and confirmation of the evidence to support is being developed.

3.4 The Trust will undertake a peer review with Sherwood Forest Hospitals NHS Foundation Trust to provide additional oversight and assurance.

4.0 Scheme status

Action	Maternity Safety Action	Current Position	Update	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?	On track	10 standards This is currently on track and will be monitored monthly	None required	May 2021	Bereavement Midwife
2	Are you submitting data to the Maternity Services Data Set to the required standard?	On track	3 standards with sub-criteria On track to achieve.	Badgernet Maternity EPR is being implemented. This will enable full compliance with MSDS and ISN	May 2021	Data analyst
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?		8 standards: In progress and evidence being reviewed	This action continues to progress.	May 2021	Inpatient Matron
4	Can you demonstrate an effective system of medical workforce planning to the required standard?		12 standards	Further recruitment is in process. Currently included on Risk Register	May 2021	Clinical Director
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		8 standards There is a risk to this action due to the increase in reporting period from 3 to 6 consecutive months	The service is currently complying with this action and the standards within. Draft Birthrate plus® report has been received and a final report is expected in early February. Ongoing monitoring is required to maintain 1:1 care in labour and the supernumerary status of the co-ordinator. There is a detailed Escalation Policy in place to support periods of high acuity / short staffing.	June 2021	Deputy HOM
6	Can you demonstrate compliance with all five elements		32 standards On track to compete	Audit in place to ascertain the current rates of compliance with each element.	June 2021	SBL Lead midwife / Fetal

Action	Maternity Safety Action	Current Position	Update	Action required to mitigate and resolve issue	Deadline	Lead
	of the Saving Babies' Lives care bundle?			Standalone report required by Trust Board		monitoring Lead MW/ Obstetrician
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?		5 standards: Complete	The service is compliant with the recommendations. Evidence has been approved at Maternity governance committee	Sept 2020	Deputy HOM
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?		19 standards There is a risk to this action due to the requirement for 90% of each staff group to attend MDT training. This is a challenge within the anaesthetic team due to issues with backfill Risk also due to suspension of training during pandemic	MDT training has recommenced (August). PROMPT training delivered online Changed requirements since relaunch	June 2021	PD Midwife
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?		27standards There is a risk to the achievement of 35% continuity of carer bookings by March as staffing levels fluctuate due to Covid-19 – need 7 teams to achieve compliance. Confirmation from NHSR that Trusts must have a plan for the roll out of teams but will not be penalised if 35% not achieved.	Two Continuity teams have been successfully rolled out – 11% women booked onto CofC pathway in November Further roll out paused whilst staffing levels are reassessed with increased absence rates during the heightened phase of the pandemic	May 2021	Board level safety champion – exec and non-exec

Action	Maternity Safety Action	Current Position	Update	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?		4 standards On track to deliver and SOP in development regarding process of reporting to NHSR and HSIB.	None required	June 2021	Bereavement Midwife

5.0 Recommendations

5.1 The Executive Directors are asked to discuss the recommendations in this report and approve the report.

Appendix 2

Midwifery Staffing Report – Quarter 3 report

1.0 Introduction

1.1 The maternity service currently operates a hub and spoke model of care.

1.2 The Obstetric unit is situated at PRH, containing the following units:- Antenatal, Triage, Day Assessment, Delivery Suite, Postnatal, Outpatients and scan. There are also Consultant outpatients based at the Mytton Oak House RSH.

1.3 The Midwife Led Unit at PRH is situated alongside the Consultant Obstetric Unit and was opened for antenatal and postnatal clinics on 9th April and intrapartum care on 27th April.

1.4 The Freestanding Midwifery led unit at RSH continues to be closed to births whilst essential building work takes place. The antenatal, postnatal community visits and outpatient activity including scans operate from this site.

1.5 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.

1.6 The service also provides community midwifery care via teams of community midwives linked to each of the MLUs and two further community outposts at Whitchurch and Market Drayton.

1.7 The current model of care is both a traditional model (team working to provide antenatal and postnatal care with core midwives providing inpatient care) and a Continuity of Carer model (better births)

1.8 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.

2.0 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.

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 systematic, evidence-based process to calculate midwifery staffing establishment is complete.

- 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
- All women in active labour receive one-to-one midwifery care
- Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board.

3.0 Current situation

3.1 The report submitted will comprise evidence to support a, b and c progress or achievement. This report is a review of Quarter 3 data.

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

- Services which do not have the recommended number of midwives as detailed in a Birthrate+ assessment have an increased risk of a high number of midwifery staffing red flags and times when the DS coordinator cannot be supernumerary.
- A full Birthrate+ assessment was completed by the service in April 2017 and Trust is currently working to these levels.
- Agreement was reached in April 2019 to recruit to the recommended level of midwives as detailed in the report.
- At its meeting in public on 7th January 2021, the Board of Directors was advised that a letter, dated 14th December 2020, had been sent to all NHS Providers of maternity care requiring them to confirm the implementation of the seven immediate and essential actions arising from the first Ockenden Report (2020).
- In addition, trusts were requested to:
  "…Alongside this, local maternity leaders should align assessments, safety, and workforce plans to the needs of local communities. We are therefore asking Trust Boards to confirm that they have a plan in place to the Birthrate Plus (BR+) standard by 31 January 2020 confirming timescales for implementation."
- A further BirthRate+ audit was undertaken in 2020 and the draft report has been received by the Trust. The Trust awaits the final report which is expected in February 2021
- A full workforce review is in progress

3.3 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 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 when the template number is achieved.
- In Quarter 3 all areas except the MLU achieved >90% fill rates for both midwifery and support 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
October	125	107	125	98	90	71	94	45
November	117.3	116.6	105.6	99.3	92.9	95.8	80.6	60
December	118	110	98	94	90	87	77	47

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
October	92	118	100	99	90	99	92	99
November	95.7	96.74	111.1	91.94	98.4	94	96.9	96.9
December	96	97	103	97	95	95	95	97

3.4 An action plan to address the findings from the full audit or table-top exercise of Birth Rate+ or equivalent undertaken, where deficits in staffing levels have been identified.

- The draft report suggests extra funding is required for the midwifery establishment and this needs some time to work through and triangulate alongside quality and risk information, and following an affordability assessment.
- Once this has been completed, a proposal and phased implementation plan needs to be developed that will then need to go through the Trust's internal governance and assurance processes before being ready for the Board of Directors to approve.
- It is clear that some additional investment will be required if the Trust is to meet all required national standards and objectives. However, it is essential that this is undertaken correctly and with the due diligence having taken place first.
- Therefore, in terms of taking this forward, the following timetable is proposed for the Board to approve:

Action	**Due Date**	**Accountable Officer**
Divisional approval	~~23/02/2021~~ 02/03/21 (Date changed due top postponement of Divisional Committee)	Director of Midwifery
Maternity Quality Operational Committee Approval	09/03/2021	Executive Director of Nursing
Investment & Innovation committee	03/2021	Director of Finance
Workforce proposal, including BirthRate + assessment and plan presented to the Board of Directors	08/04/2021	Executive Director of Nursing

3.5 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
- Use of bank staff supports any deficits identified

3.6 The midwife: birth ratio (Regular reviews and have plans to flexibly adjust midwife to woman ratio if needed due to Covid-19)

- 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 Midwife to Birth ratio ranged from 1:20 to 1:25 1:22 (establishment) which represents a positive status in terms of midwives in post for the number of births being performed. Further work is ongoing in order to accurately calculate the worked midwife to birth ratio. This reflects a reduction in births in month.

3.7 The percentage of specialist midwives employed and mitigation to cover any inconsistencies. Birth Rate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. The specialist roles are currently under review as part of the workforce plan to ensure the service has the correct specialist posts for the demographic served and in line with current national initiatives

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

IT Digital lead
Bereavement
Infant feeding
Risk / governance
Education
CPE/F
Improving women’s health (Mental Health & Substance misuse)
Safeguarding
Antenatal and Newborn Screening
Guidelines
Professional Midwifery Advocate
Public Health Midwife
Diabetes Specialist Midwife
Saving Babies Lives Lead Midwife
Fetal Monitoring Lead Midwife

- Further specialist roles are being developed to support the ongoing work of the transformation programme and wider national agenda including the Ockenden report such as an Audit Lead Midwife. The risk is currently partially mitigated with the distribution and prioritisation of audit work and a dedicated audit lead will enable the full cycle of audit to be completed.

3.8 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).
- 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 Q3 at 82.5%
- 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 Q3 there were 0 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 supernumerary on all occasions in Q3.
- 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).
- SaTH has adopted the red flags detailed in the NICE report. There were 33 reported in Q3 with the majority of these relating to delayed induction of labour. No adverse outcomes were reported as a result of the red flags and the escalation policy was implemented when required to maintain safe staffing.
- The West Midlands Heads of Midwifery Advisory Group is reviewing the current red flags as part of a wider West Midlands work stream in order that all units are reporting on a minimum agreed dataset of red flags in order to offer consistency and ease of benchmarking.

3.9 Did Covid-19 cause impact on staffing levels? Was the staffing level affected by the changes to the organisation to deal with Covid-19? How has the organisation

prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves?

- The pandemic continues to impact on midwifery staffing levels due to illness and self-isolation of contacts.
- Guidance has been received from RCOG and RMC to support the safe provision of maternity services during the pandemic, including details of services to change and reduce in order to maintain safe care with reduced staffing numbers.
- Safety huddles take place twice per day Monday to Friday to assess workload and also enable a look forward to the week ahead. This is complemented by twice daily meetings on DS when the workload of all areas is considered. There is a manager on call 24 hours per day for the care group and times of peak demand the busiest periods are supported on site by a band 8 midwife 7 days per week.
- A weekly staffing return is submitted to NHSEI
- The Home birth service and MLU births were suspended in March 2020 and reinstated in April 2020.
- All ultrasound scans were centralised to the 2 main hospital sites to enable the full scan service to continue during the pandemic.
- Face to face appointments were replaced by telephone appointments where it was considered safe to do so.
- A Business Continuity Plan was developed in March 2020 and updated in January 2021 clearly detailing actions to take should midwifery staffing shortages impact upon the ability to provide all maternity services based on a prioritisation of care. This is used in conjunction with the Escalation policy.

Appendix 3

Perinatal Mortality Review Tool (PMRT) Quarter 3 report

1.0 Introduction

1.1 Obstetric incidents can be catastrophic and life-changing, with related claims representing the schemes 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.

1.2 This report details cases reported in November 2021. A quarter 3 report will be available at the next Board of Directors in March 2021, which will include details of actions noted, and progress.

2.0 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.

2.2 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 and report 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?
- Reporting of all outstanding qualifying cases to NHSR EN scheme for 2019/20
- Reporting of all qualifying cases to HSIB for 2020/21

3.0 PMRT

3.1 Stillbirths – there were 2 stillbirths reported which fulfilled the PMRT criteria and all assessment criteria were met for CNST.
3.2 Neonatal deaths – there was 1 neonatal death reported but this was not supported for review using the defined criteria.
3.3 Late fetal losses – there was 1 late fetal loss reported but this was not supported for review using the defined criteria
3.4 The reviews have been completed for both
3.5 Both reviews had MDT attendance with one conducted with an external reviewer in attendance.
3.6 Both cases were graded B – issues were identified but were not considered to have made a difference to the outcome
3.7 The actions identified are included in the table below

Perinatal Case ID	Issue Text	Outcome Contribution	Contributory Factor	Issue comment	Action plan text	Implementation text	Person responsible	Target completion date
71546/1	There is no evidence in the notes that this mother was asked about domestic abuse at booking	Not relevant to the outcome, but action is needed	Patient Factors - Social Factors	There was one other opportunity to ask the question about domestic abuse and this was missed.	Audit proposal has been discussed and agreed to review questions asked at booking and review compliance with guidance.	Audit proposal to be submitted at Audit group meeting in December	Quality Improvement Midwife	31/12/2020
71546/1	This mother had poor/no English and family members were used as interpreters on occasions during her antenatal care	Not relevant to the outcome, but action is needed	Task Factors - Guidelines, Policies and Procedures - Not adhered to / not followed	Interpreters were offered and the family declined their use. As per national guidance interpreters should be used rather than using family members.	Review of guidance for the use of interpreters.	Maternity SOP in place. Guidelines Midwife has reviewed maternity SOP and as there is a new Trust guideline will replace the SOP with the Trust guidance. Promote the use of designated translator services in the weekly brief, and discourage use of family members.	Quality Improvement Midwife	31/12/2020

4.0 NHS Resolution Early Notification Scheme

4.1 There were 3 qualifying incidents and all cases were reported to NHSR

5.0 HSIB Referrals

5.1 There were 3 qualifying incidents (as above) and all were referred to HSIB