The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
9 December 2021

Agenda item	300/21			
Report	CNST Year 4 progress update, November 2021			
Executive Lead	Hayley Flavell, 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	√	1, 2, 4, 7, 8	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√	1595	
	For noting			
	For information	√		
	For consent			
Presented to:	Board of Directors' Meeting in Public			
Dependent upon (if applicable)**:**	Continued implementation of CNST Year 4 actions within deadlines			
Executive summary:	NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care; this launched in August 2021. As in year three, the scheme incentivises ten maternity safety actions (SA's). Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on 30 June 2022. However, there are a number of reports that the Board of Directors must be provided with by certain deadlines throughout the CNST period. Those with a deadline of November 2021 are enclosed within this report.			
Appendices:	Appendix 1: PMRT Qtr 2 Report (Jul - Sep 2021) Appendix 2: ATAIN Action Plan 2021/22 Appendix 3: Qtr 2 Small for Gestational Age and Fetal Growth Restriction Report and Review of Pre-Term Births. Appendix 4: Maternity and Neonatal Safety Champions Locally Agreed Safety Dashboard and updated Pathway Document.			
Lead Executive:	HFlavell			

1.0 Introduction

1.1. NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

1.2. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

1.3. As in year three, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

1.4. SaTH operates a robust assurance mechanism whereby assurance for completion to date of the actions required to demonstrate compliance with the Safety Actions is provided as appropriate to the following groups and committees:

1.4.1. Maternity Clinical Governance

1.4.2. Women and Children's Divisional Committee

1.4.3. Maternity and Neonatal Safety Champions Group

1.4.4. Local Maternity and Neonatal System Board and the Perinatal Quality Surveillance Group

1.4.5. Maternity Transformation Assurance Committee

1.4.6. Quality and Safety Assurance Committee

1.5. Whilst each of these fora communicates directly or indirectly with the Board of Directors, there are certain reports, updates and plans that CNST stipulates must be received (and in some cases, approved) by the Board of Directors directly, rather than a subcommittee.

1.6. These are spread across the reporting year (August 2021 to June 2022) and have specific deadlines attached.

1.7. Items that must be reported to the Board of Directors by November 2021 are attached as appendices to this report.

2.0 Appendices

2.1. **Appendix 1: Perinatal Mortality Review Tool Quarterly Report – Quarter 2**. This relates to Safety Action 1 ("Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?")

2.1.1. One of the evidence requirements for this action is that 'a report has been received by the Trust Board each quarter from 8 August 2021 onwards that includes details of the deaths reviewed and the consequent action plans.'

2.1.2. Accordingly, the Board of Directors are asked to take assurance that the Trust were complaint with PMRT reporting for the period July – September 2021.

2.2. **Appendix 2: ATAIN Action Plan 2021/22**. This relates to Safety Action 3 ("Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?")

2.2.1. One of the evidence requirements for this action is that 'an action plan (to address points b)[1] and e)[2] being agreed with the maternity and neonatal safety champions and Board level champion and signed off by the Board no later than 30 November 2021.

2.2.2. The ATAIN plan for 2021 was reviewed by the Maternity and Neonatal Safety Champions Group and approved by the Board of Directors as part of CNST Year 3.

2.2.3. However, for the avoidance of doubt, the Board of Directors is requested to approve the plan for 2021/22. Additionally, the Board of Directors is requested to note that the relevant quarterly review and audit findings will be reviewed and discussed by the Safety Champions and appropriate assurance will be provided to the Board of Directors at their January 2022 meeting and quarterly thereafter.

2.3. **Appendix 3**: **Qtr 2 Small for Gestational Age and Fetal Growth Restriction Report and Review of Pre-Term Births (for information)**. This relates to Safety Action 6 ("Can you demonstrate compliance with all five elements[3] of the Saving Babies' Lives care bundle version two?")

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[1] Point b): The expectation is that the audits have been in place since year 3 of the scheme and should now be business as usual. If for any reason, audits have been paused, they should be recommenced, using data from quarter 2 of 2021/22 financial year and be completed on a quarterly basis. There should be evidence that audit findings are shared with the neonatal safety champion each quarter.

[2] Point e): The expectation is that the reviews have been in place since year 3 of the scheme and should now be business as usual. If for any reason, reviews have been paused, they should be recommenced using data from quarter 2 of 2021/22 financial year and be completed on a quarterly basis. There should be evidence that review findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting.

[3] The five elements which comprise the Saving Babies' Lives Care Bundle version 3 are:
Element 1: Reducing smoking in pregnancy.
Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction.

2.3.1. CNST requires evidence of “Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019”. Furthermore, the Saving Babies Lives Care Bundle stipulates that certain data pertaining to Elements 2 and 5 must be shared with the Board of Directors (and the Local Maternity and Neonatal System (LMNS)) for information on a quarterly basis.

2.3.2. Regarding Element 2 (Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)): a data review of babies born in SaTH Small for Gestational Age in Quarter 2 2021/2022 and Accumulative graphical data commencing from October 2020 report included within meeting papers. The Board of Directors is requested to note, as per the SBL requirement for Element 2 that “maternity providers will share evidence of these improvements with their Trust Board and the LMS and demonstrate continuous improvement in relation to process and outcome measures”:

2.3.2.1. Babies <10th centile delivered on or after 40+0 weeks and babies <3rd centile delivered on or after 38+0 weeks is lower than the Perinatal Institutes national GAP average. These are standards within element 2. This demonstrates we are maintaining a good standard of detection and management.

2.3.3. Regarding Element 5 (Reducing Preterm birth): Preterm data, Quarter 2 2021. The Board of Directors is requested to note, as per the SBL requirement for Element 5 that “maternity providers will share evidence of these improvements with their Trust Board and LMS and demonstrate continuous improvement in relation to process and outcome measures”:

2.3.3.1. A linear trend line demonstrates a continuing positive decrease in singleton preterm births. We are below [exceeding] the Government target of 6% by 2025

2.4. **Appendix 4: Maternity and Neonatal Safety Champions Locally Agreed Safety Intelligence Dashboard and updated Pathway Document**. This relates to Safety Action 6 (“Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?”)

2.4.1. One of the evidence requirements for this action is that “board level safety champions present a locally agreed dashboard to the Board on a quarterly basis. To include, as a minimum, the measures set out in Appendix 2 of the Perinatal Quality Surveillance Model, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings”.

Element 3: Raising awareness of reduced fetal movement (RFM).
Element 4: Effective fetal monitoring during labour.
Element 5: Reducing preterm birth.

2.4.2. This dashboard has used the ‘Appendix 2’ format, and was first provided to the Board of Directors in September 2021 as required by CNST. This latest version includes data from October.

2.4.3. The Board of Directors is requested to review and discuss this dashboard, and note also the HSIB escalation letter of 20 September 2021 relating to case MI-003817 referenced in the September entry for the line titled ‘HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust’.

2.4.3.1. This should be kept in mind when the Board of Directors are preparing their CNST declaration, as CNST guidance states on page 5 of the ‘Conditions of the Scheme’ document for Year 4 that “the Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners”.[4]

2.4.3.2. Although the action states that this dashboard should be submitted to the Board of Directors on a quarterly basis, the advice from the Trust’s NHSE/I midwifery advisor and the preference of the Board-level Executive and Non-Executive Champions is that the frequency should be monthly: the Board of Directors are requested to note this.

2.4.4. A further requirement of this action is ‘evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action is in place no later than 30 September 2021.’

2.4.4.1. The revised pathway is in use, and is attached as part of this appendix for information only. It was implemented in September in compliance with the stated deadline, and was affixed to the Safety Champions noticeboard in the same month.

2.4.4.2. The pathway has been approved by the Safety Champions Group and maternity and divisional governance committees; it will be formally reviewed (with a request for approval) on behalf of the LMNS at the December Board and Perinatal Quality Surveillance Group meeting.

2.4.4.3. The Board of Directors is requested to take assurance that this part of the Safety Action has been met.

[4] Maternity incentive scheme year 4, ‘Conditions of The Scheme’ published by NHS Resolution in August 2021, available at: https://resolution.nhs.uk/wp-content/uploads/2021/08/MIS-Y4-guidance.pdf

3.0 **Other updates (no appendices required)**

3.1. Safety Action 5: "Can you demonstrate an effective system of midwifery workforce planning to the required standard?"

3.1.1. The Board of Directors are asked to note a midwifery staffing oversight report (titled 'Director of Midwifery Report') that will be provided to them at the December meeting, under a separate cover, which will contain the evidence required to demonstrate the above standard.

3.1.2. These reports must be provided to the Board of Directors every six months, hence a second such report will be provided at the June meeting.

3.2. Safety Action 4: "Can you demonstrate an effective system of clinical workforce planning to the required standard?"

3.2.1. The Board of Directors are asked to note that the deadline initially proposed for the obstetric workforce document, as required in standard a) part 1 of this action, will reach them at their meeting in February 2022, rather than December 2021 as initially aimed for.

3.2.2. The Board are requested to take assurance that this revised deadline still meets the requirements of CNST (the requirement being 'Sign off [by January 2022) at Trust Board level acknowledging engagement with the RCOG document along with an action plan to review any non-attendance to the clinical situations listed in the document).

3.2.3. It has already been agreed that CNST deadlines that are met by Board of Directors in their meeting of the following month is acceptable; for example the February 2022 meeting will review January 2022 data. Time is needed for reports to be adequately review by divisional committees and Board of Directors' Subcommittees.

3.2.4. This additional time is needed because in order to 'monitor their [The Trust's] compliance of consultant attendance for the clinical situations listed in this document[5] when a consultant is required to attend in person', a specific audit is required (the same review currently being conducted to provide assurance on Ockenden Report Local Action for Learning 4.61[6]), and these findings will not be available until the Christmas Break.

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[5]The document to which this action refers is the RCOG workforce document titled 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology', published by the Royal College of Obstetricians and Gynaecologists, available at: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

[6] Local Action for Learning 4.61: "Consultant obstetricians must be directly involved and lead in the management of all complex pregnancies and labour", published in 'Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust' by the Donna Ockenden Independent Maternity Review Team, published 10 December 2020 and available at: https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

3.2.5. As required by the Safety Action, a further audit and report of the standard will be conducted within six months and the findings submitted to the Board of Directors in time for the CNST deadline of 30 June 2022.

3.3. Safety Action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

3.3.1. One of the evidence requirements for this action is that 'a local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4 in August 2021.'

3.3.1.1. The Board of Directors are asked to take assurance from the fact that this plan has been drafted by the Clinical Education Midwife and Consultant Lead for Clinical Education

3.3.1.2. Regarding the multi-professional training, the Board of Directors is asked to take assurance from the following:

3.3.1.2.1. As of September 2021, the Trust was meeting or exceeding the 90% threshold for PRactical Obstetric Multi-Professional Training for all in-scope groups except for 'Other Doctors' (i.e. non-Obstetric Consultants), and that a proactive training plan is in place to reach targets where they are not yet, and maintain targets already reached.

3.3.1.2.2. The new Learning Management System (LMS) project has taken over from the plan for Maternity Training to be included within the Staff compliance report. The expectation is that following data entry the LMS will be launched to end users in Maternity in November 2021. This will make monitoring of completion levels more efficient.

3.4. Safety Action 10 ("Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?")

3.4.1. The Board of Directors are asked to take assurance that ongoing compliance with this action is monitored in a monthly meeting between the Trust's Assistant Director of Nursing Quality Governance and the Divisional Quality Governance Lead.

3.4.2. The relevant timeframe this Safety Action is reporting to HSIB from Wednesday 1 April 2021 to 31 March 2022.

3.4.3. This means that by May 2022 the Division will be in a position to advise the Board of Directors as to whether they can declare compliance with this Safety Action, ahead of the CNST deadline of 30 June 2022 (monitoring will continue unabated).

3.5. **Future reports for Board of Directors relating to CNST Year 4**. Recurring monthly reports, such as the Safety Champions' locally agreed dashboard and CNST overall progress update are not included here. The Board of Directors is requested to receive and, where indicated, take action on the following:

3.5.1. December 2022:

3.5.1.1. Quarterly audit and review for ATAIN (Safety Acton 3) (information)

3.5.1.2. Director of Midwifery Report (information / assurance)

3.5.2. January 2022

3.5.2.1. Quarter 3 PMRT report (information)

3.5.2.2. Quarter 3 SBL update (Elements 2 and 5) (information)

3.5.2.3. Trust Claims Scorecard as pertains to Maternity and Neonatal Services, alongside incident and complaint data (review and discuss).

3.5.3. February 2022

3.5.3.1. Obstetric workforce document and associated audit funding (information; approval of plans to meet standards if any found not to have been met)

3.5.4. April 2022

3.5.4.1. Quarter 4 PMRT report (information)

3.5.4.2. Quarterly audit and review for ATAIN (Safety Acton 3) (information)

3.5.4.3. Quarter 4 SBL update (Elements 2 and 5) (information)

3.5.4.4. Assurance that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria on the national Maternity Services Dashboard for data submissions relating to activity in January 2022 (for information; to guide declaration),

3.5.4.5. A paper detailing evidence of service user feedback and MVP co-production and overall position statement of compliance with Safety Action 7

3.5.5. May 2022.

3.5.5.1. Assurance of Safety Action 10 fulfilment, including compliance with duty of candour, July 2021 to March 2022, to inform CNST declaration.

3.5.5.2. Preliminary information regarding PrOMPT and NLS completion rates, with final report in June to guide declaration.

3.5.5.3. Anaesthetic, neonatal (medical) and neonatal (nursing) workforce papers (for information; to guide declaration)

3.5.6. June 2022.

3.5.6.1. A second midwifery staffing oversight report to cover the first half of the 2022 calendar year, in accordance with Safety Action 5.

3.5.6.2. Refreshed audit findings regarding obstetric workforce compliance with RCG standards.

3.5.6.3. Final PMRT report, to include audit of all standards required under Safety Action 1 (to guide declaration; information)

3.5.6.4. Final SBL update (Elements 2 and 5) (information) and confirmation as to whether the Trust is compliant with all elements of the Care Bundle (to guide declaration; information)

3.5.6.5. Receive final CNST report with accurate compliance position statement of all Safety Actions from Women and Children's Division.

3.5.6.6. The Board must give their permission to the CEO to sign the Board declaration form (as informed by the above report) prior to submission to NHS Resolution

4.0 **Conclusion**

4.1. The Board of Directors is requested to conduct the actions requested in sections 2 and 3 of this report

4.2. The Board of Directors is requested to note the governance and reporting actions remaining between this point and CNST deadline (30 June 2022) that must be carried out between now and that time in order to achieve full compliance with the requirements of CNST.

4.3. The Board of Directors are requested to take assurance that at this point we are on track in terms of compliance with requirements of the scheme to date.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors, 9 December 2021

Agenda item	Appendix 1 to /20 (CNST Year 4 progress update, November 2021)			
Report	Perinatal Mortality Review Tool Quarterly Report – Quarter 2			
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	√	BAF1, BAF4	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√		
	For noting	√		
	For information	√		
	For consent			
Presented to:	First presented at this meeting (Neo-Maternity Governance), 20/10/2021			
Dependent upon (if applicable)**:**	Nil			
Executive summary:	Data for the months of July, August and September 2021 (Quarter 2) shows: • 1 stillbirth to be reviewed using PMRT; • 3 neonatal deaths (1 <22/40 in July therefore not counted in MBRRACE data and 2 ENND in September born at SaTH and died at other Trusts, therefore no PMRT reviews assigned to SaTH • 0 late fetal loss (22-23+6 weeks gestation); The CNST Incentive Scheme Year 3 reporting targets for Safety Action 1 covered July and up to 7th August 2021. Year 4 reporting targets changed from 8th August. A further change is noted that from 1st September 2021 all perinatal deaths eligible to be notified to MBRRACE UK must be done within 2 working days. This report will reflect both years reporting targets **(Y3)** and **(Y4)**.			

1.0 Introduction

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

This report has been prepared and presented for Neo-Maternity Governance assurance that compliance is being met with safety actions set within the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme in order to continue to support the delivery of safer maternity care. This report covers the time period when the Year 4 targets were introduced and therefore there are different parameters within this quarterly report to consider.

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Safety actions updated as per January 2021 and September 2021 revised safety actions.

1.2 (Y3) All perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11th January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.

(Y4) All perinatal deaths eligible to be notified to MBRRACE-UK from 1st September 2021 onwards must be notified to MBRRACE-UK within two working days and the surveillance information where required must be completed within one month of the death.

100% compliance achieved: all deaths have been notified within the time frames for both years set by MBRRACE as documented in the table below.

Quarter 1 21/22	Fetal loss	Date of death	Date reported to MBRRACE
Quarter 1	Neonatal death	11/04/2021	12/04/2021
Quarter 1	Stillbirth	16/04/2021	18/04/2021
Quarter 1	Neonatal death	17/04/2021	18/04/2021
Quarter 1	Stillbirth	28/04/2021	29/04/2021
Quarter 1	Stillbirth	06/05/2021	06/05/2021
Quarter 1	Stillbirth	22/05/2021	24/05/2021
Quarter 1	Stillbirth	20/05/2021	20/05/2021
Quarter 1	Neonatal death	05/06/2021	06/06/2021

Quarter 2 21/22	Fetal loss	Date of death	Date reported to MBRRACE
Quarter 2 **(Y3)**	Neonatal death	01/07/2021	02/07/2021 (not eligible for review, no further action required as <22/40)
Quarter 2 **(Y4 onwards)**	Stillbirth	03/09/2021	03/09/2021
Quarter 2	Neonatal death	14/09/2021	Responsibility for reporting lies with the Trust where the baby died (reported 14/09/2021)
Quarter 2	Neonatal death	23/09/2021	Responsibility for reporting lies with the Trust where the baby died (reported 23/09/2021)

1.3 (Y3) 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 to 15 March 2021 will have been started before 15 July.

(Y4) A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8th August 2021 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.

Quarter 1 21/22 (Year 3 targets)	Fetal loss	Date of death	PMRT panel date	Status
Quarter 1	Neonatal death	11/04/2021	17/06/2021	Draft report (Coroners PM report awaited)
Quarter 1	Stillbirth	16/04/2021	17/05/2021	Report published
Quarter 1	Neonatal death	17/04/2021	17/05/2021	Draft report (Coroners PM report awaited)
Quarter 1	Stillbirth	28/04/2021	17/05/2021	Report published
Quarter 1	Stillbirth	06/05/2021	17/06/2021	Report published
Quarter 1	Stillbirth	22/05/2021	22/07/2021	Draft report (awaiting PM)

Quarter 1	Stillbirth	20/05/2021	22/07/2021	Draft report (awaiting PM)
Quarter 1	Neonatal death	05/06/2021	19/08/2021	Draft report (Coroners PM report awaited)

Quarter 1 21/22	**Fetal loss**	**Date of death**	**PMRT panel date**	**Status**
Quarter 2 **(Y3)**	Neonatal death	01/07/2021	No further action required due to gestation <22/40	No further action required due to gestation <22/40
Quarter 2 **(Y4 onwards)**	Stillbirth	03/09/2021	23/09/2021	Draft report stage-awaiting placental histology and HSIB report
Quarter 2	Neonatal death	14/09/2021	Awaiting joint review with neighbouring Trust	Under review
Quarter 2	Neonatal death	19/09/2021	Awaiting joint review with neighbouring Trust	Under review

1.4 (Y3) 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 20th December 2019 to Monday 15th March 2021 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 before 15th July 2021.

(Y4) 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 8th August 2021 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 and the report published within six months of each death.

Deaths under review up to the CNST Incentive scheme target date of 15th March 2021 have had draft reports generated or final reports published by July 2021. The stillbirth reported in Q2 has been reviewed and a draft report generated within one month of the death. 100% compliance is therefore reported.

1.5 (Y3) For 95% of all deaths of babies who were born and died in your Trust from Friday 20th December 2019, the parents will have been 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. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions.

(Y4) For at least 95% of all deaths of babies who died in your Trust from 8th August 2021, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or 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 either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.

Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.

All families have had face to face meetings with the Bereavement Midwives who discuss the review of care at this initial point. The families are advised that a letter will be sent to them explaining the review, and asking for their feedback. This letter is generated from the PMRT template source and personalised to each individual case. A spreadsheet has been generated to collate the contact with families and provides easy access to audit this standard. Telephone contact continues with the families in accordance to their individual needs. In Q2 4 families have had further written contact to apologise for delays in results, post mortem final reports have been taking in excess of

20 weeks in Q1 and Q2. Since then 2 families have received their results in face to face feedback meetings, and 2 are still waiting.

1.6 (Y3) Quarterly reports will have been submitted to the Trust Board from Thursday 1st October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.

(Y4) Quarterly reports will have been submitted to the Trust Board from 8th August 2021 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

Quarter 1 report was presented at Maternity governance 19th July 2021 and to Maternity Safety Champions 3rd August 2021.

2.0 Risks and actions

2.1 An action tracker was included in this report as originally submitted to Mat-Neo Clinical Govenance.

3.0 Conclusion

3.1 This report concludes and provides evidence that the National Perinatal Mortality Review Tool is being used to review perinatal deaths to the required standard.

Author name and title
Janet Latham Specialist Midwife Bereavement
Elizabeth Pearson Specialist Midwife Bereavement

Date 07/10/2021

ATAIN Action Plan 2021/22

The 2021/22 ATAIN Action Plan continues the work instituted in the Action Plan from 2018/2019.

Author: Sarah Kirk, Advanced Neonatal Nurse Practitioner

Version: 2.0

Updated: 22 November 2021

Issue	Specific Action Required	Responsible Team	Target date	Evidence of Success
To increase and maintain ATAIN awareness within the Women and Childrens Care Group	Continue with ATAIN working group meetings every 2 months	ATAIN group	Ongoing	ATAIN minutes
	Obtain term admission themes. Take selected cases to ATAIN group for review	Neonatal ATAIN member	March 2021 then quarterly	Themes and cases included within ATAIN meeting minutes
	Share data via the neonatal dashboard	Neonatal team	Ongoing - monthly	Information on neonatal dashboard
	Continue to deliver ATAIN basic awareness lecture to new medical/midwifery/nursing staff at induction	Neonatal ATAIN member	Ongoing	Evidence of individual attendance
	Midwives and neonatal nurses to complete ATAIN e-learning modules	Individual learning	Ongoing	Certificates to Midwife Education Lead
	Monthly run rate charts to visualise term admissions to NNU	Neonatal ATAIN member	Monthly	Charts available around the maternity huddle board and neonatal information board
	Feedback on term admission rates and themes to neonatal and maternity governance meetings	Neonatal ATAIN member	Ongoing	Information within the governance minutes

To decrease the number of term babies admitted to NNU with respiratory issues	Monitor those having elective LSCS between 37-39 weeks gestation to ensure that consideration has been given to the need for antenatal steroids	Maternity team	Ongoing	Documentation of consideration of need for antenatal steroids within elective LSCS pathway booklet (Badgernet system – when in use)
	Elective LSCS pre-clerking clinic to include information on infant feeding, antenatal steroids and skin to skin. Produce an appropriate leaflet	Maternity team	June 2021	Review of notes to ensure correct documentation. Leaflet produced
	Ongoing use of the BAPM NEWTT observation tool within the Maternity unit	Maternity team	Ongoing monthly	Routine use of the BAPM NEWTT tool for neonatal observations
	To introduce a robust system of identifying term admissions with respiratory symptoms. To decide what constitutes an admission	Neonatal team Neonatal consultants	June 2021	Clarification of admission criteria rather than ward attender
	Review of term babies admitted with respiratory symptoms who require no additional respiratory support	Neonatal team	Ongoing monthly	Reduction in number of respiratory admissions
	Feedback mechanism in place to share learning from these reviews	Neonatal team	Ongoing monthly	Monthly multi-disciplinary meetings

To decrease the number of babies developing hypothermia (<36.5^{oc}) following delivery	To utilise the BAPM normothermia toolkit	Neonatal team	Ongoing	A reduction in the number of hypothermic babies on Delivery Suite and Postnatal ward
	Avoid hypothermia after birth through appropriate thermal care which includes skin to skin. Utilise the 'Prevention of hypothermia in infants on delivery suite' flowchart	Maternity team	Ongoing	A reduction in the number of hypothermic babies on Delivery Suite and Postnatal ward
	Increase maternity and neonatal staff awareness regarding the dangers of hypothermia for newborn babies	Maternity and neonatal team	Ongoing	Inclusion of awareness within teaching sessions
	Provision of heated cots/incubators on Delivery Suite and Postnatal ward. Education of maternity staff in the correct use of this equipment	Maternity and neonatal team	Ongoing	A reduction in the number of hypothermic babies on Delivery Suite and Postnatal ward

To reduce number of admissions to the neonatal unit due to hypoglycaemia	Follow Neonatal hypoglycaemia guideline, which is based on the BAPM neonatal hypoglycaemia framework for practice	Maternity team	Ongoing	Reduction in number of babies admitted to NNU with severe or persistent hypoglycaemia
	Promote skin to skin between mother and baby as soon as possible after delivery to increase the chances of successful breastfeeding	Infant feeding co-ordinator	Ongoing	Increasing numbers of those breastfeeding at discharge
	Review of neonatal hypoglycaemia cases identified, requiring admission to NNU. Share any learning with multi-disciplinary team	Neonatal team	Ongoing	Reduction in number of babies admitted to NNU who can otherwise be managed with promotion of effective feeding

To improve the early detection and management of babies with suspected jaundice	To review the use of transcutaneous bilirubinometers(TcB) within the community and inpatient settings to ensure the early identification of neonatal jaundice	Maternity team	Ongoing	Review babies readmitted from home requiring phototherapy – detect any themes
	Use of 'Bilicocoon' phototherapy units to enable early treatment and reduce the need for mother-baby separation. Potential for treatment in alternative areas	Maternity team	Ongoing	Use of 'Bilicocoon' phototherapy nests. Development of alternative treatment pathway

To ensure that all babies at risk of neonatal sepsis are assessed and treated in the most appropriate place	Follow the 'Neonatal Infection' guideline which is based on the NICE Neonatal Infection guideline.	Neonatal team	Ongoing	Review number of babies admitted to the NNU with early onset sepsis not initially treated with IV antibiotics
	Neonatal assessment and delivery of IV antibiotics where appropriate within one hour of decision to treat on Delivery Suite (preventing separation of mother and baby)	Neonatal team	Ongoing	Reduction in number of Datixes for failure to administer IV antibiotics within 1 hour of the decision to treat

Appendix 3 to Board of Directors Meeting – December 2021

The Shrewsbury and Telford Hospital NHS Trust

Saving Babies Lives Element 2

Review of Small for Gestational Age births at SaTH in Quarter 2 2021/2022

and

Accumulative graphical data commencing from October 2020

Lindsey Reid
Lead Midwife for Saving Babies' Lives

Reported October 2021

Introduction

Version two of the Saving Babies' Lives Care Bundle (SBLCBv2 (ref 1)), has been produced to build on the achievements of version one. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice.

Element 2

Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR). The previous version of this element (SBLCBv1) has made a measurable difference to antenatal detection of small for gestational age (SGA) babies across England. It is however possible that by seeking to capture all babies at risk, interventions may have increased in women who are only marginally at increased risk of FGR related stillbirth. The updated element seeks to address this possible increase by focussing more attention on pregnancies at highest risk of FGR, including assessing women at booking to determine if a prescription of aspirin is appropriate. The importance publication of detection rates and review of missed cases remain significant features of this element.

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Definition

Small for Gestational Age (SGA) – birth centile under (<) the10th to above (>) the 3rd

Fetal Growth Restriction (FGR) – birth centile under (<) the 3rd

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Aims and standards

Aim

To monitor compliance with standards contained within SBLCBv2.

Standards

Monitoring of babies born >39+6 and < 10th centile to provide an indication of detection rates and management of SGA babies (SBLCBv2 Element 2).

Percentage of babies < 3rd centile born > 37+6 weeks. This is a measure of the effective detection and management of FGR (SBLCBv2 Element 2, Outcome indicator).

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Methodology

A retrospective quarterly data review of babies born below the 10th centile using hospital notes and Medway (maternity information system)

Time period– 1/07/21 – 30/09/21 (Quarter 2)

Cases analysed– 1184 babies (live born and stillborn)

Method of analysis – Microsoft Excel

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Results

The next slide shows SaTH's internally reviewed data.

The Perinatal Institute's (PI) quarter 2 national GAP user average data is included for a comparative measure.

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Quarter 2 2021/2022		SaTH reviewed data	Perinatal Institute National GAP user average Data Comparison
Total births (excluded 2 births, twins, intrauterine transfer in prior to delivery at 34+1 weeks, 1 x Powys patient with all antenatal care in Powys)	N	1181	-
SGA rate <10th – 0 centile	N %	164 13.8	13.3
SGA detection rate (<10th – 0 centile)	N %	67 40.6	41.8
Babies <10th centile delivered on or after 40+0 weeks	N %	40 24.4	28.5
SGA rate (<3rd centile)	N %	60 5.1	4.5
SGA detection rate < 3rd centile	N %	39 65.0	41.8
Babies <3rd centile delivered on or after 38+0 weeks	N %	27 45.0	51.8

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Conclusion

All Babies born <10th centile **13.8%**, is comparative to PI national average of 13.3%.

Antenatal detection (suspected by ultrasound assessment) rate of all babies <10th centile **40.6%** is slightly under PI national average of 41.8%

Babies <10th and >3rd centile, delivered on or after 40+0 weeks **24.4%** which is better than the PI national average of 28.5%. This indicates better detection and management than the average national rate.

Babies born <3rd centile **5.1%** which is slightly higher this quarter than the PI national average of 4.5%.

Antenatal detection (suspected by ultrasound assessment) rate of all babies <3rd centile **65.0%** better than the PI national average of 41.8%

Babies <3rd centile delivered on or after 38+0 weeks **45.0%** PI national average of 51.8%.

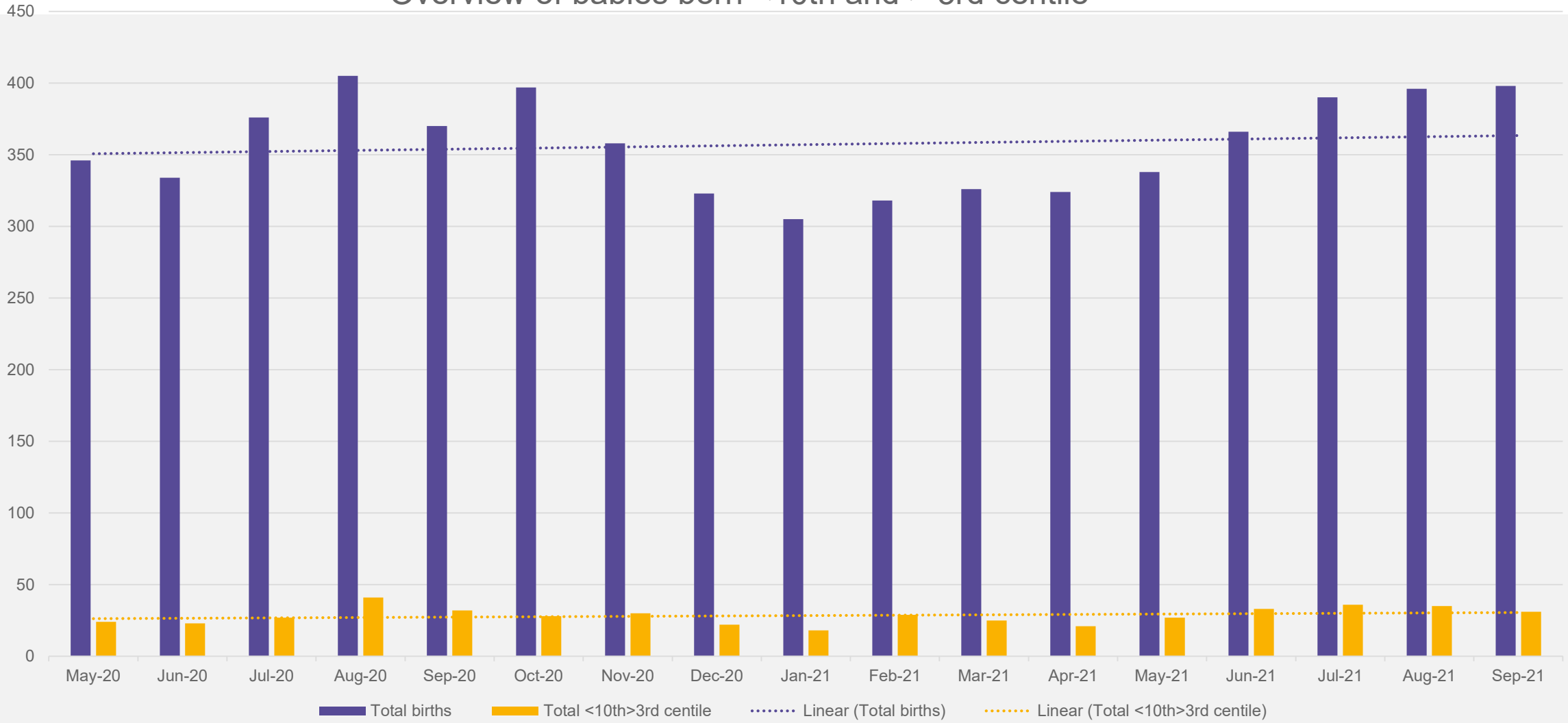
Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

The following slides show accumulative monthly data of:

- Babies born <10th >3rd centile
- Expand <10th >3rd centile data
- Babies born < 3rd centile
- Expand <3rd centile data

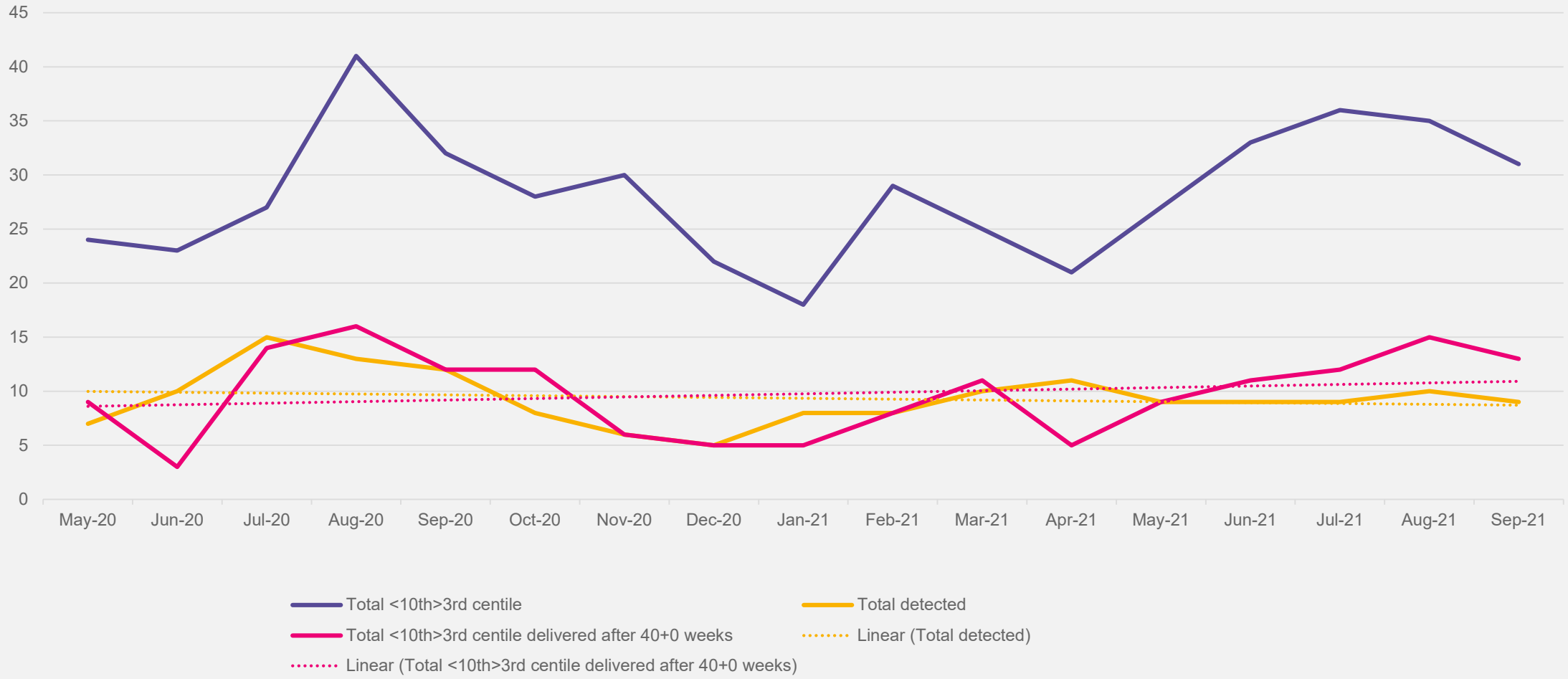
Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Overview of babies born <10th and > 3rd centile



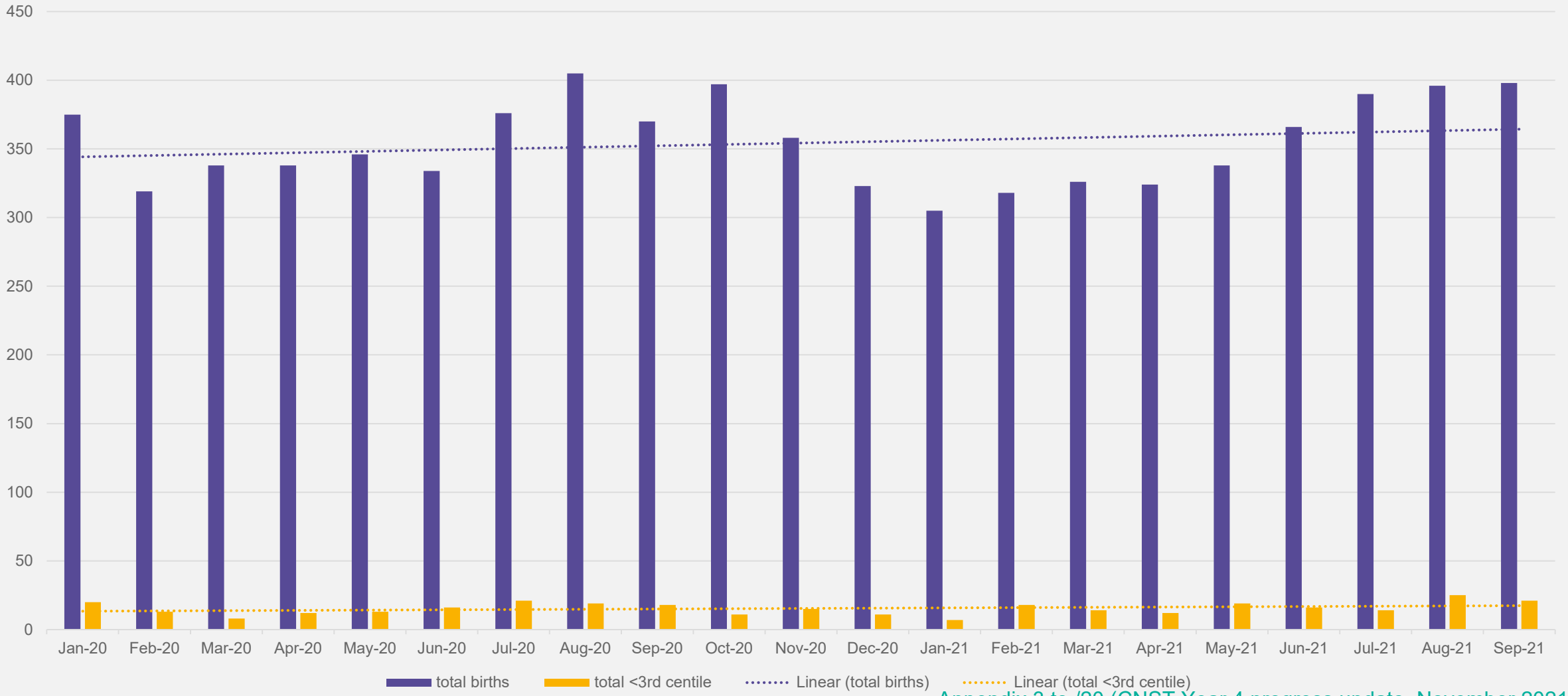
Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Expanded <10th to >3rd centile



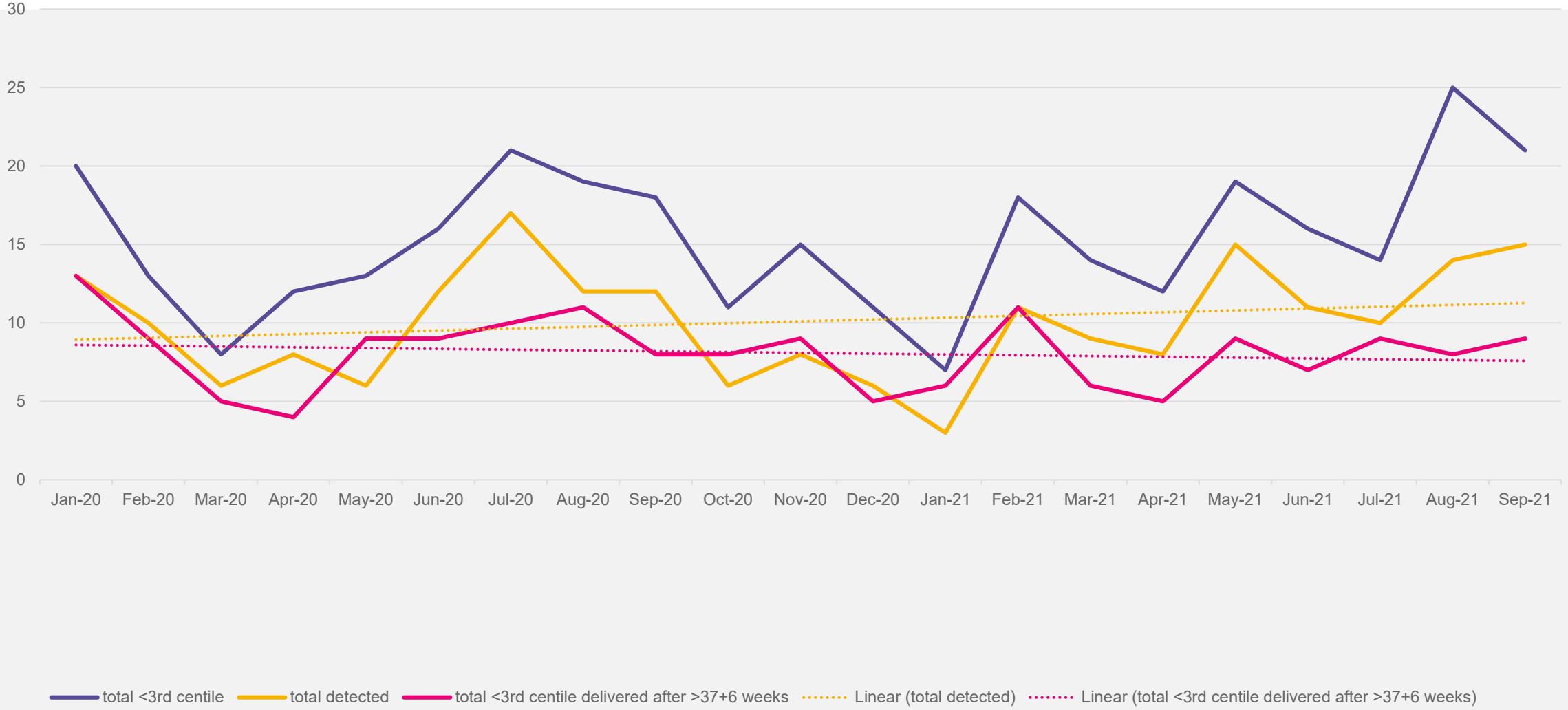
Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Overview of babies born < 3rd centile



Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Expanded <3rd centile birth data



Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Reference

1. NHS England (2019) Saving Babies' Lives A care bundle for reducing perinatal mortality version 2 https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

Quarter 2 2021/2022 Review of Preterm Births

Lindsey Reid
Lead Midwife for Saving babies' Lives
Data collated 4/10/21

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Background

Version two of the Saving Babies' Lives Care Bundle (SBLCBv2)((ref 1)), has been produced to build on the achievements of version one. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice

Element five - Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented was introduced in version 2.

This element of the care bundle was developed in response to The Department of Health's 'Safer Maternity Care' report which extended the 'Maternity Safety Ambition' to include reducing preterm births from 8% to 6%.

This element focuses on three intervention areas to improve outcomes, which are **prediction** and **prevention** of preterm birth and better **preparation** when preterm birth is unavoidable.

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Aim

To review compliance of the following standards and outcome indicator included in element 5

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Standards

Standards

Saving Babies' Lives Care Bundle version 2 – Element 5 (ref1)

- Percentage of singleton live births (less than 34+0 weeks) receiving a full course (2 injections, 12 to 24 hours apart) of antenatal corticosteroids, within seven days of birth

- Percentage of singleton live births (less than 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Antenatal Steroids

Explanation

A complete course of steroids reduce death by 30% in infants less than 34 weeks, including those less than 25 weeks where mortality effect is greater

Steroids also reduce Respiratory Distress Syndrome (RDS), Intraventricular Haemorrhage (IVH) and Necrotizing Enterocolitis (NEC) including in extreme preterm gestations

Optimum timing is within 7 days of birth with course completed 24 hours before birth (only 22% of women who give birth under 34 weeks receive steroids in this timeframe)

Benefits of steroids do not exceed 7 days

Mortality benefit remains for steroids given 6-12hours before birth

Repeat courses reduce respiratory morbidity but do not reduce mortality and may impact fetal growth

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Standards

Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth (ref 1)

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Magnesium Sulphate

Explanation

Given within 24 hours before birth at 30 weeks and under reduces the risk of cerebral palsy and death without risk to mother or fetus

Similar effects across a range of gestations including extreme preterm infants

Optimum level is at least 4 hours after loading dose

Benefit remains if given under 4 hours where birth is imminent

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Standards

Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). (ref1)

ODN – Operational Delivery Networks

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Optimum Place of birth

The Shrewsbury and Telford Hospital NHS Trust

Explanation

Singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation and any gestation with an estimated fetal weight of less than 800g should be born in a maternity service on the same site as a neonatal intensive care unit (NICU). (Ref 2)

- Reduced risk of death of extreme preterm infants if birth occurs in a high volume, neonatal intensive care setting
- Reduction in mortality is around 50%
- Reduction in major morbidities of extreme preterm infants if born in a tertiary centre
- Being born in a non-NICU setting and then transferred to a NICU is associated with increased risks of mortality, IVH and severe brain injury in extreme preterm infants

For information- NICU are a level 3 unit. SaTH has a neonatal unit and is level 2.

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Standards

- Outcome indicator (ref 1)

The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a percentage of all singleton births occurring at SaTH:

a. In the late second trimester (from 16+0 to 23+6 weeks).

b. Preterm (from 24+0 to 36+6 weeks).

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Methodology

A retrospective review of preterm births under 36+6 weeks using hospital notes and Medway (maternity information system)

Time period – 1/7/21 – 30/9/21

Cases analysed –1184 total births (1146 singleton births)

Method of analysis – Microsoft Excel

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Results

The Shrewsbury and Telford Hospital NHS Trust

1. Percentage of singleton live births (24 – 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth

Cases in review period n=12

Table 1

Percentage of singleton live births (24 - 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth (n=12)			
Number of cases in review	12		
Number of cases standard not applicable	0	Total number cases assessed for standard	12
Criteria	Received full dose within 7 days	Did not receive full dose or over 7 days	Total %
• Percentage of singleton live births (24 - 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth	6	6	50%

2 cases received a single dose – 25+5, in 1st stage of labour on admission and 32+4 weeks, both delivered before 2nd dose. No missed opportunities.

3 cases received a full dose but delivered after 7 days (see next slide)

1 case did not receive any antenatal steroids – awaiting notes to review case

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

2. Percentage of singleton live births (24 – 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids

Cases in review period n=12

Table 2

Percentage of singleton live births (24 -34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids (n=12)			
Number of cases in review	12		
Number of cases standard not applicable	3	Total number cases assessed for standard	9
Criteria	after 7 days	by 7 days	Total % after 7days
Percentage of singleton live births (24 - 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids	3	6	33%

Case 1 – full course at 23 weeks at time of rescue cervical suture. Further single dose at 28+2 weeks following premature preterm rupture of members (PPROM)

Case 2 – PPROM at 29 weeks, steroids given as per guideline, delivered at 33+4 weeks

Case 3 – PPROM at 31 weeks, steroids given as per guideline, delivered at 33+3 weeks

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

3. Percentage of singleton live births (24 -30+0 weeks) receiving magnesium sulphate (MgSO4) within 24 hours prior to birth

Cases in review period n=3

Table 3

Percentage of singleton live births (24 - 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth (n= 3)			
Number of cases in review	3		
Number of cases standard not applicable	0	Total number cases assessed for standard	3
Criteria	Received MgSO4	Did not receive MgSO4	Total %
• Percentage of singleton live births (24 - 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth	3	0	100%

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

4. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).

Cases in review period n=1184

Table 4

Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). (n=1184)			
Number of cases in review	1184		
Number of cases standard not applicable	1 (Stillbirth)	Total number cases assessed for standard	1183
Criteria	Yes	No	Total %
Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).	1181	2	99.8%

Case 1– 25+5 presented in 1st stage of labour, no opportunity to transfer to a level 3 unit before birth. Transferred after delivery but sadly died at 4 days old (Perinatal Mortality Review Tool (PMRT) not available at time of report writing)

Case 2 – 23+5 Antepartum haemorrhage prior to delivery, no opportunity to transfer to a level 3 unit before birth. Transferred after delivery but sadly died at 4 days old (PMRT – no issues found with antenatal or intrapartum care at SaTH)

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

5. The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a percentage of all singleton births:

a. In the late second trimester (from 16+0 to 23+6 weeks)

Cases in review period n=1184

Table 5

The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a. In the late second trimester (from 16+0 to 23+6 weeks)			
Number of cases in review	1184		
Number of cases standard not applicable	38 (38 x Multiples)	Total number cases assessed for standard	1146
Criteria	16+0 to 23+6 weeks	> 24 weeks	Total %
The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a. In the late second trimester (from 16+0 to 23+6 weeks)	2	1144	0.2%

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

5. The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a percentage of all singleton births:

b. Preterm (from 24+0 to 36+6 weeks).

Cases in review period n=1184

Table 5

The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: b. Preterm (from 24+0 to 36+6 weeks).			
Number of cases in review	1184		
Number of cases standard not applicable	40 (38 Multiples and 2 x 16-23+6 week births)	Total number cases assessed for standard	1144
Criteria	24+0 to 36+6 weeks	> 37 weeks	Total %
The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: b. Preterm (24+0 to 36+6 weeks)	51	1093	4.4%

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Conclusion of Quarter 1 2021/2022

The Shrewsbury and Telford Hospital NHS Trust

Percentage of singleton live births (24 -34 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth **50%** (table 1)

Percentage of singleton live births (24 - 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids **33%** (table 2)

Percentage of singleton live births (24 - 30+0 weeks) receiving magnesium sulphate (MgSO4) within 24 hours prior to birth **100%** (table 3)

Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance) **99.8%** (table 4)

5. The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a percentage of all singleton births:

a. In the late second trimester (from 16+0 to 23+6 weeks) **0.2%** (table 5)

b. Preterm (from 24+0 to 36+6 weeks) **4.4%** (table 6)

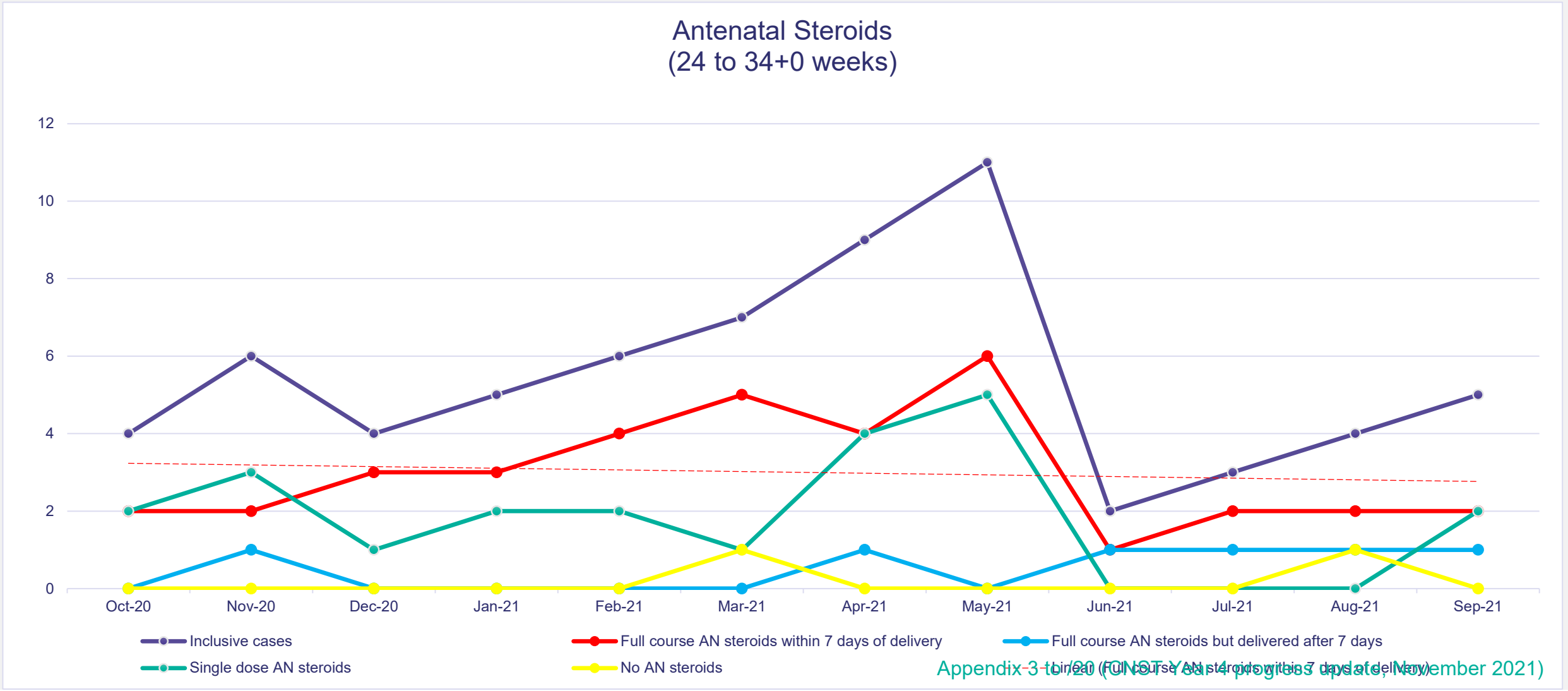
Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

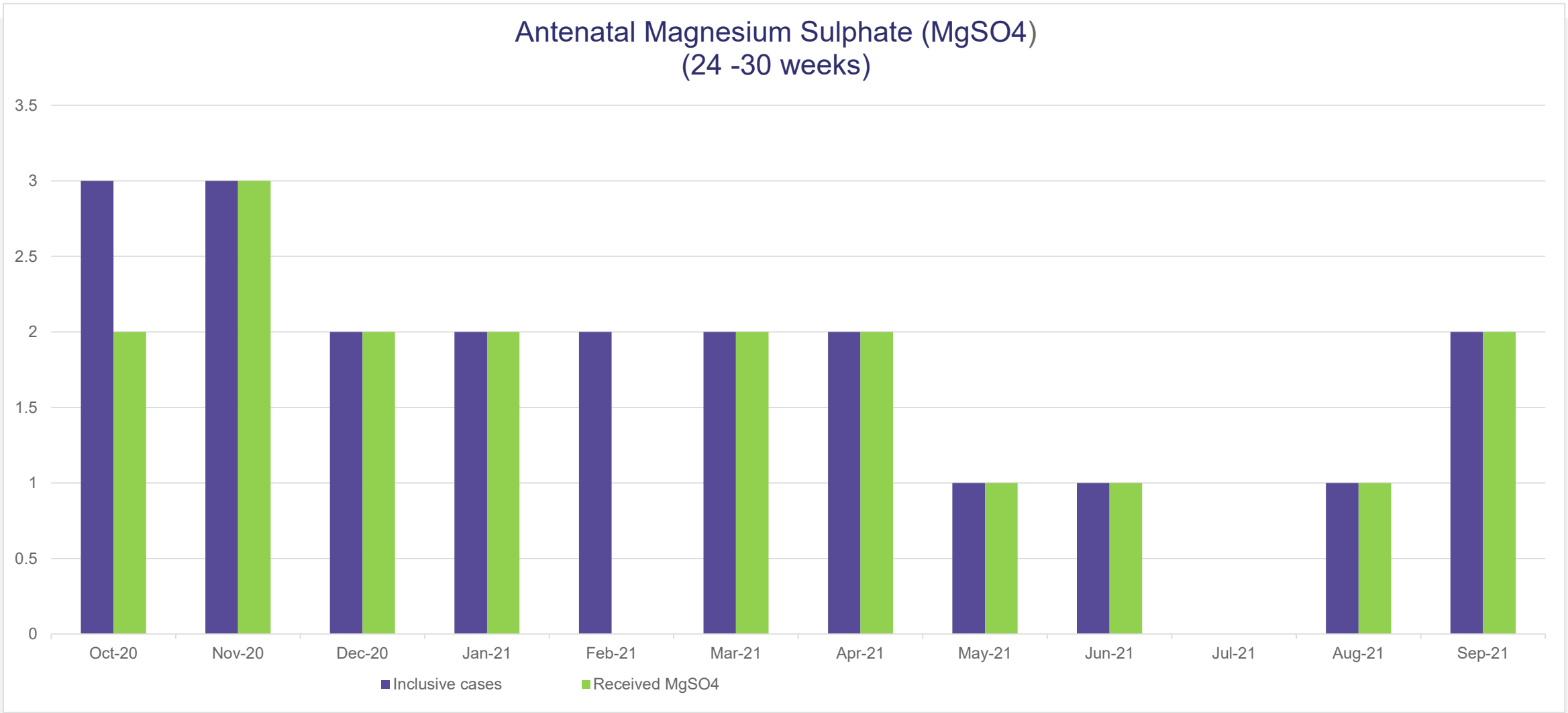
Accumulative Data

The Shrewsbury and Telford Hospital NHS Trust

The following set of slides shows the accumulative Standards data commencing from October 2020

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

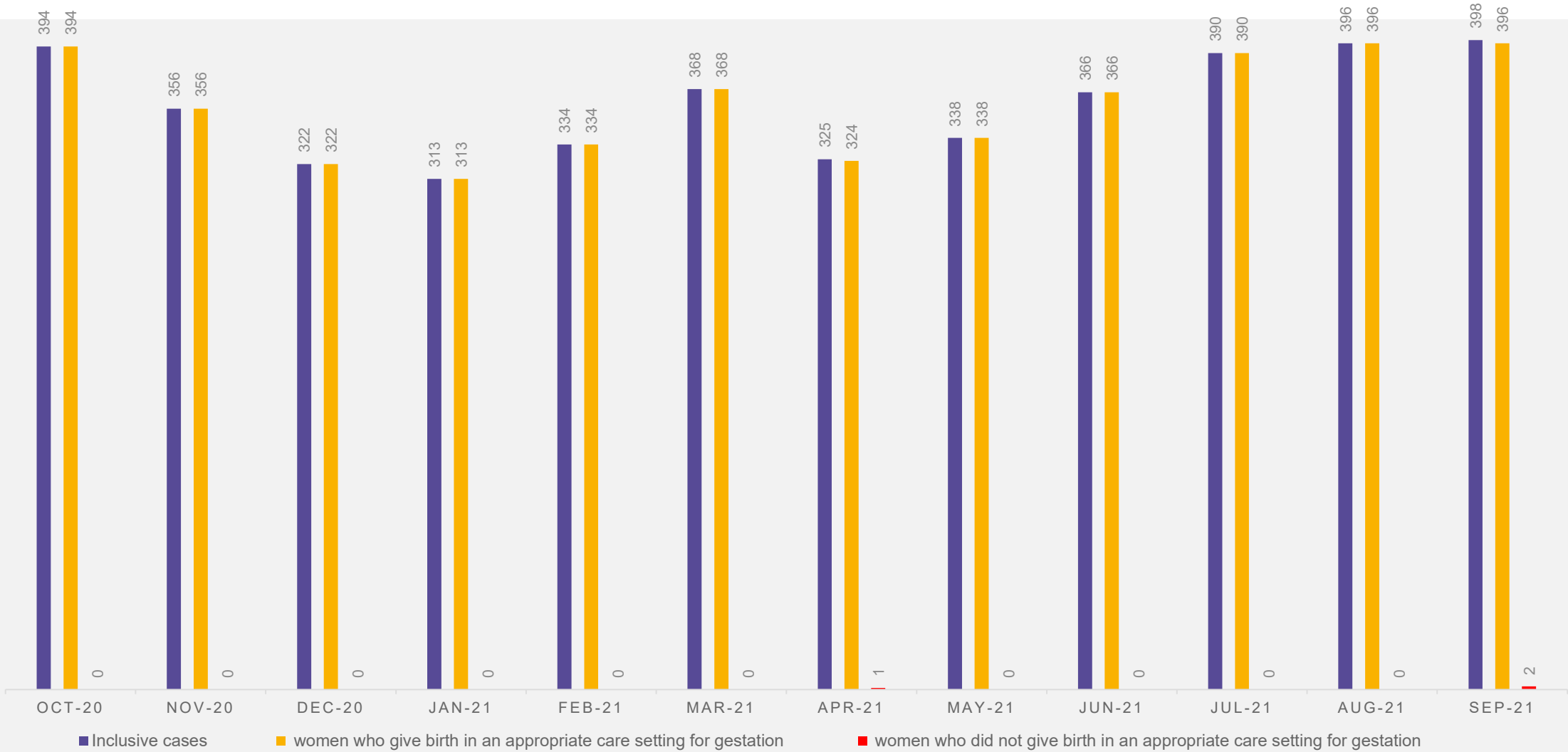

Antenatal Steroids
(24 to 34+0 weeks)
12
10
8
6
4
2
0
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Inclusive cases
Full course AN steroids within 7 days of delivery
Full course AN steroids but delivered after 7 days
Single dose AN steroids
No AN steroids
Linear (Full course AN steroids within 7 days of delivery)



Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

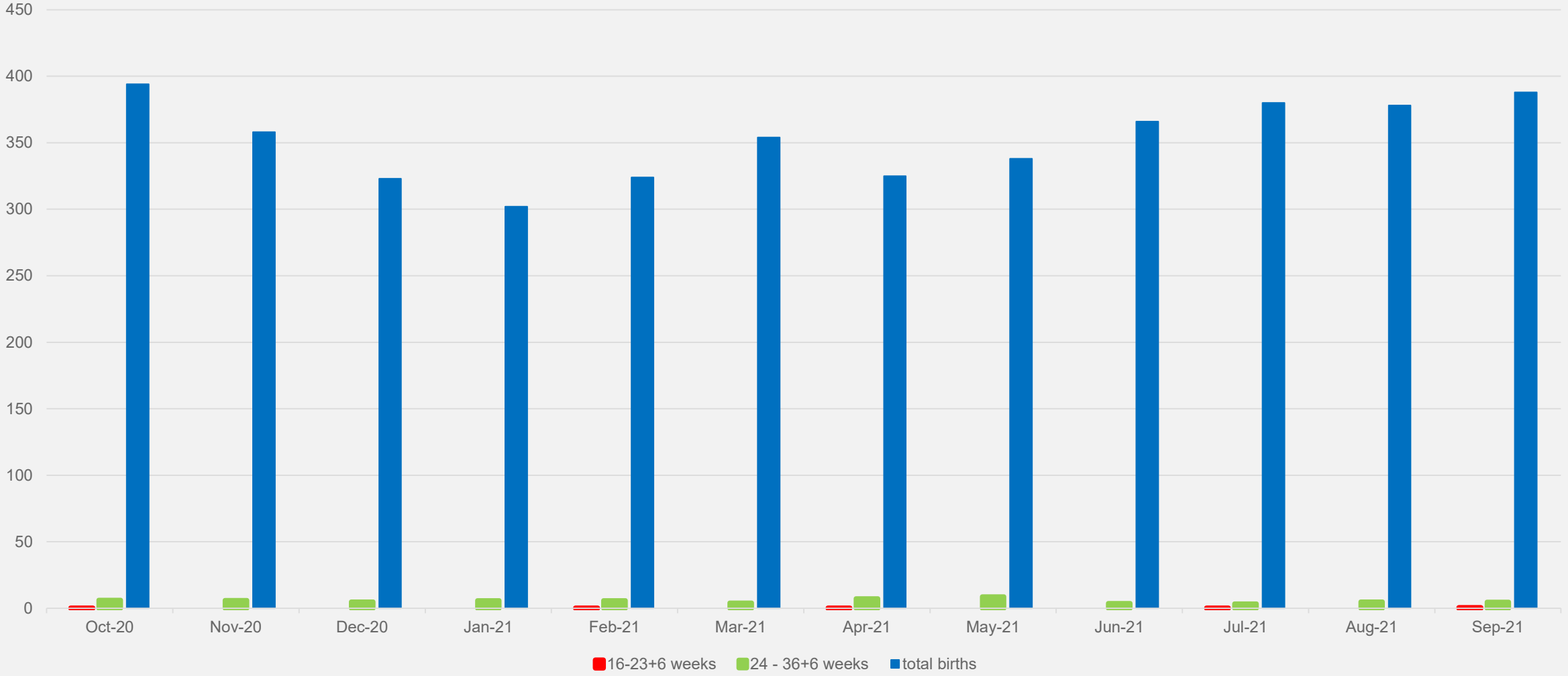
WOMEN WHO GAVE BIRTH IN AN APPROPRIATE CARE SETTING (SINGLETON AND MULTIPLE LIVEBIRTH)

The Shrewsbury and Telford Hospital NHS Trust



Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Monthly percentages of singleton preterm births against total monthly singleton births commencing October 2020

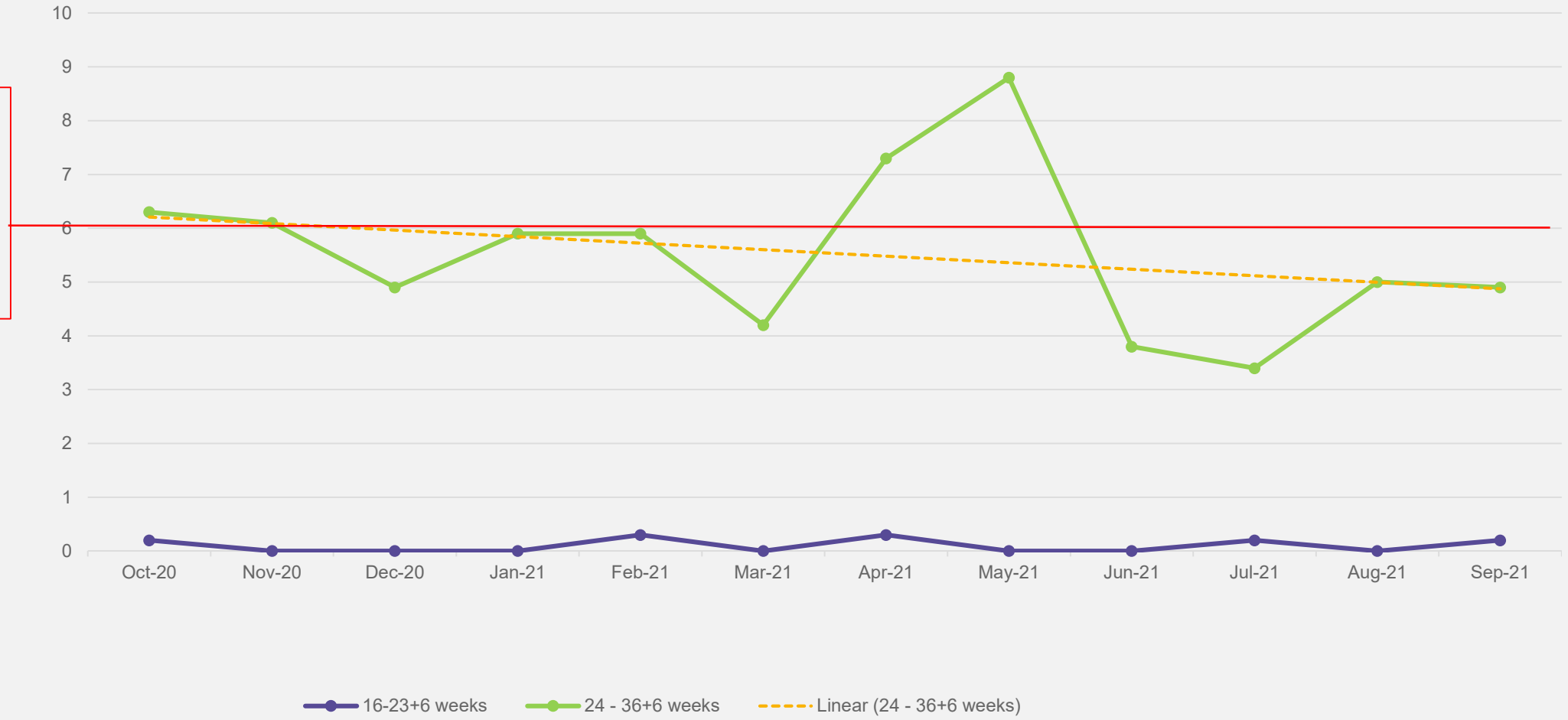


Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Incidence of singleton preterm births at SaTH
Q3 2020/2021 – Q2 2021

The Shrewsbury and Telford Hospital NHS Trust

Government target of 6% by 2025



Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Intrauterine transfer (IUT) cases update

The Shrewsbury and Telford Hospital NHS Trust

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Below is an update on cases that were IUT's out of SaTH to NICU's in quarter 2

Case 1 25+1 transferred for threatened preterm labour (had a cervical suture at 16+ weeks). Remains pregnant at time of report writing (36+/40)

Case 2 23+2 Twin pregnancy transferred for threatened preterm labour. Delivered alive within several days of transferred. Both twins now transferred to SaTH for ongoing care

Case 3 23+6 transferred due to premature preterm rupture of members and antenatal haemorrhage. Delivered alive. Now transferred to SaTH for ongoing care

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Reference

1. NHS England (2019) Saving Babies' Lives A care bundle for reducing perinatal mortality version 2 https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf
2. Antenatal Optimisation Toolkit | British Association of Perinatal Medicine (bapm.org)

Appendix 3 to /20 (CNST Year 4 progress update, November 2021)

Appendix 4 to /20 (CNST Year 4 progress update, November 2021)

Shrewsbury And Telford Hospital NHS Trust

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good

Maternity Safety Support Programme	Yes

Key:

No safety concerns OR no CNST compliance concerns	safety concern OR risk of not being compliant with CNST	New safety concern OR CNST requirement missed

	2021											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data monitoring tool						Qtr 1 report submitted (April, May, June 2021). 6x SB to be reviewed using PMRT, 6x NND to be reviewed, 0x late fetal losses. 100% compliance with Safety Action 1.				Qtr 2 report submitted (Jul, Aug, Sep 2021). • 1 stillbirth to be reviewed using PMRT; • 3 neonatal deaths (1 <22/40 in July therefore not counted in MBRRACE data and 2 ENND in September born at SaTH and died at other Trusts, therefore no PMRT reviews assigned to SaTH Fully compliant with Safety Action 1.		
Findings of review all cases eligible for referral to HSIB.							5 SI's (incl HSIB) relating to maternity / obstetrics reported for the month.	2 SI's (incl HSIB) relating to maternity / obstetrics reported for the month.	2 serious incidents have been reported 1 case has been reported to and accepted for investigation by HSIB 1 new risk added to the Risk Register 1 stillbirth reported to MBRRACE within the designated reporting timescales	1 case was discussed with HSIB (stillbirth) but was rejected by them after their triage of the case. On triage of the case the baby's condition at birth indicated that sadly she had passed away some time before and HSIB rejected the case on the basis that this was not an intrapartum death.		
Report on: •The number of incidents logged graded as moderate or above and what actions are being taken •Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training •Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite , gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.								1. 11 maternity incidents were reported as moderate harm and 1 neonatal incident (See Appx 3.) 2. No concerns to report for training compliance in the month of August. 3. The Birthrate Plus report compiled in May 2021 indicates a variance of -4.25 whole time equivalent midwives in SaTH's current funded establishment vs the recommendations from the tool. Recruitment is underway. There are no obstetric rota issues to report. A more detailed safe staffing report will be developed for the next distribution of this safety dashboard.		262 incidents reported in October of which 20 were logged as moderate harm, 2 as severe and 1 as death. **Note:** Incidents are reviewed and grading can be amended following a review. Incidents are expected to be reviewed within 30 days, and indeed those reported as moderate harm and above will be reviewed at the weekly Neonatal Obstetric Incident Review (NOIR) meeting and at the Trust Rapid Review also weekly. Therefore whilst 23 have been initially logged as moderate harm and above this amount is likely to be lower following the reviews of care		

Service User Voice feedback		MVP / SaTH co-led comms and engagement meeting with service users and community healthcare partners. No specific safety concerns raised. Ockenden IEA 7 (informed consent) discussed, and service users recommended update to current information videos / leaflets. This is being acted upon within MTP Workstream 5.	MVP / SaTH co-led comms and engagement meeting with service users and community healthcare partners. No specific safety concerns raised.	MVP / SaTH co-led comms and engagement meeting with service users and community healthcare partners. No specific safety concerns raised.	MVP / SaTH co-led comms and engagement meeting with service users and community healthcare partners. No specific safety concerns raised.	First workshop to launch the MVP/SaTH co-produced 'User Experience System' - Theme: Partner Support. See Appx/ No specific safety concerns raised. No specific safety concerns raised, but the conversations led to improved service user experience in terms of second birth partners and partners able to attend antenatal appointments.	MVP / SaTH co-led comms and engagement meeting with service users and community healthcare partners. No specific safety concerns raised.	No formal comms and engagement meeting due to holiday period. End of 'sprint' 1 (time bound delivery period for the UX system) report shows 12 / 17 user-specified actions delivered on time. This focuses on partner support, which can be a safety issue. All parties felt this had been a positive and productive start the new system.	Co-produced work delivered: 'Ask Me' posters to encourage service users to be confident and comfortable in asking questions of staff. Ongoing co-production on induction of labour videos.	Launched next UX Theme: Bereavement Care. Service user experience cards received and will feed into Sands review in November.		
Staff feedback from frontline champions and walk-abouts			The MNSCG conducted a walkabout of the antenatal ward. The looked into a concern raised that, at times, midwives can be reallocated for escalation to the labour or postnatal wards. A study of the acuity tool proved that at no point was there an unsafe level of staffing (3 midwives must be on shift from a safety perspective) (see Appx 6.)	No safety alerts from this month's walkabout. AAA report provided via MTAC. (Appx 7)	The MNSCG discussed challenges to the continued rollout of the Continuity of Carer model with the national lead. The group conducted a walkabout of Wrekin MLU where they were notified about the buzzer to consultant-led AN ward not working: this was escalated and is being dealt with. (See Appx 8).	June MNSCG focussed on closing actions from previous walkaround. Group bolstered with addition of Interim co-medical director and interim HoM. No alerts identified this month. (See Appx 9).	July MNSCG meeting comprised a walkaround at RSH MLU and PRH Postnatal Ward. The NED Safety Champion also conducted an out-of-hours walkaround. Safety concerns raised included staff vulnerability on home visits. Accordingly, this was mitigated by provision of and training in the use of lone worker devices. For full details see minutes (See Appx 10).	August MNSCG focussed on closing actions from previous walkaround. Note AAA by executive safety champion, which had alerts relating to acuity modelling impacts requiring heavier use of doctors. Mitigated in safety huddles and normal escalation procedures. (See Appx 11.)	Discussed and esclated issues relating to space in maternity outpatients (Covid precautions), an appropriate waiting area for Glucose Tolerance Tests, mask fit testing rates, lack of quick access to drug charts and correct functionality of Badgernet regards to recording what centile the fetus is. All have been escalated and are being managed.	1. We have above average smoking at time of delivery and will not meet the national target of 6% by March 2022 however we have seen substantial progress on this since 2017 2. Support for a Family approach to stopping smoking is only available in Telford part of county 3. We continue to have single tier 2 doctor for paediatrics and neonatal care.	There is a concern with the level of support provided to the Neonatal unit given the Tier 2 cover is provided across both Paediatrics and the NNU. The Trust Acting Medical Director will review mitigation with the local teams and deal with as appropriate.	
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust									The BoD are advised of an HSIB escalation letter relating to case MI-003817.			
Coroner Reg 28 made directly to Trust	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		
Progress in achievement of CNST 10					Identified that SaTH unlikely to achieve full compliance for Year 3.	CNST submission: not fully compliant, but no safety concerns. Plan submitted to NHS-R on how SaTH will achieve this standard for Year 4.	CNST relevant data checked and validated with help from Patient Safety Team (Year 3 close-out)	CNST Year 4 published. The division is working towards a monthly-check of SA 10 compliance, and is currently being supported in this by the Trust's Head of Patient Safety and a newly-appointed risk and governance midwife.	The divisional governance team has now been fully recruited to.	Compliant, year to date.		

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	TBC - data not yet available

Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	89.06% (source: GMC National Trainees Survey 2021, Appx 13)