Board of Directors' Meeting
10 February 2022

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	017/22			
Report	NHS Resolution CNST Maternity Incentive Scheme Year 4 progress update as at January 2022			
Executive Lead	Director of Nursing, Mrs Hayley Flavell			
	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	√	BAF 1, BAF 2 BAF 3, BAF 4 BAF 7, BAF 8	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√	CRR 15	
	For noting			
	For information	√		
	For consent			
Presented to:	Approved by Maternity Clinical Governance and the Quality and Safety Assurance Committee prior to submission to the Board of Directors			
Dependent upon	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. This culminates in sign-off by The Board of Directors in June 2022, but the Board must receive regular updates and items for sign-off throughout the year. Full scrutiny of such updates is made on behalf of the BoD by the Quality and Assurance Committee, but some items require direct review and discussion by the BoD; these are attached as appendices. The full set of appendices received by THE BOARD OF DIRECTORS are included separately in the information pack.			
Appendices	1. Safety Champions Locally Agreed Dashboard (December 2021) 2. Saving Babies Lives Elements 2 and 5 Audits Quarter 3 2021 3. Quarter 3 2021-22 Perinatal Mortality Review Tool report			
Lead Executive				

1.0 Introduction

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

1.2 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:

1.2.1 Maternity Clinical Governance.

1.2.2 Maternity and Neonatal Safety Champions Group.

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

1.2.4 Maternity Transformation Assurance Committee.

1.2.5 Quality and Safety Assurance Committee.

1.3 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.

1.4 The purpose of this report twofold:

1.4.1 To provide the Board with reports associated with Safety Actions 2 and 6 (appendices 1 and 2, for review and discussion)

1.4.2 To provide an update on specific elements of Safety Actions 1, 3 and 4 (for information and assurance and, where stated, approval)

1.5 The Trust has so far embedded around 4% of the required evidence, with a further 20% gathered but not yet validated. It should be noted that the bulk of the evidence cannot be finalised until June (due to the nature of the requirements). The delivery plan is on track, but not without risks, which are expounded at Section 4.

2.0 Pause in CNST Reporting published by NHS Resolution in December 2021

2.1 This was announced in a letter and circulated to LMNS and Trusts who are members of the MIS, stating that most reporting requirements can be paused, with immediate effect, for at least 3 months, with an update clarifying this expected from NHSR in February 2022.

2.2 The letter sets out an expectation for best efforts to continue to deliver the Safety Actions.

2.3 Clear guidance has been issued at Trust and Divisional level for SaTH to continue to deliver the original plan in compliance with the latest guidance, published in October 2021, as the actions are calculated to reinforce safe and effective care for our service users.

3.0 Appendices

3.1 **Appendix 1: Safety Champions Locally Agreed Dashboard (December 2021)**

3.1.1 This dashboard evinces compliance with Safety Action 9, standard b)[1]. Although it is a quarterly requirement, on the advice of our partnered NHSEI specialist midwife, SaTH is updating the dashboard on a monthly basis.

3.1.2 The Board of Directors are asked to take assurance from the fact the Trust is compliant with PMRT and HSIB reporting standards and that meaningful engagement with service users and staff is being achieved via the Maternity Voices Partnership and Maternity and Neonatal Safety Champions respectively.

3.1.3 The Board of Directors is asked to:

3.1.3.1 Review and discuss the dashboard.

3.1.3.2 Indicate to Women and Children's Divisional Leadership any areas for which further detail or clarity is required.

3.2 **Appendix 2**: **Saving Babies Lives Elements 2 and 5 Audits Quarter 3 2021 (Small for Gestational Age and Foetal Growth Restriction Reports and Reviews of Pre-Term Births).**

3.2.1 These are provided for information and assurance and relate to Safety Action 6 ("Can you demonstrate compliance with all five elements3 of the Saving Babies' Lives care bundle version two?").

3.2.2 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.

3.2.3 Regarding Element 2 (Risk assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction (FGR)): a data review of babies born in SaTH Small for Gestational Age in Quarter 3 2021/2022 and Accumulative graphical data commencing from October 2020 report is included in the appendix.

3.2.3.1 The Board of Directors is requested to take assurance (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") that babies <10th centile delivered on or after 40+0 weeks and babies <3rd centile delivered on or after 38+0 weeks remain lower than the Perinatal Institutes national GAP average. These

[1] 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.

are standards within element 2. This suggests we are maintaining a good standard of detection and management.

3.2.4 Regarding Element 5 (Reducing Preterm birth): Preterm data, Quarter 3 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") that a linear trend line demonstrates a slight increase in singleton preterm births between 24 and 36+5 weeks at SaTH; this now puts us slightly above (falling short of) the government target of 6% by 2025 and this is an increase compared with the previous Quarter. SaTH is still achieving better results than the national average, however.

3.2.5 Additionally, and in accordance with the CNST Safety Action 6 "technical guidance" referenced in paragraph 2.6.2, The Board of Directors is asked to:

3.2.5.1 Take assurance from the evidenced compliance rate of 99% (exceeding target of 90%) of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance) (relates to Element 5 Standard D. for Safety Action 6 (Saving Babies' Lives).

3.2.5.2 Take assurance that the Trust has undertaken a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review sought to identify themes that can contribute to FGR not being detected (e.g., components of element 2 pathway and/or scanning related issues). SaTH has a rate of 2.9%, which is better than the national average of 4.7%. for this period. The Board of Directors are asked to take assurance from evidenced compliance with reporting requirement 7 of standard 2 of Element 2 of Safety Action 6 (Saving Babies' Lives).

3.3 **Appendix 3: PMRT Report for Quarter 3 2021**. This report is shared with The Board of Directors in its entirety, in compliance with Safety Action 1 (Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?) standard d): "Quarterly reports will have been submitted to the Trust Board from 8 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".

3.3.1 The Board of Directors are requested to:

3.3.1.1 Take information from the Report.

3.3.1.2 Take assurance that the Trust has achieved 100% compliance with PMRT reporting in quarter 3 2021-22.

3.3.1.3 Note that this information has also been provided to the Maternity Safety Champions. Hence to date, we are fully compliant with Safety Action 1.

4.0 **Update on progress on CNST SA4 Standard a) Part 1 (as at January 2022**).

4.1 This relates to Safety Action 4 ("Can you demonstrate an effective system of clinical workforce planning to the required standard?") has, as part of Standard a), the following two evidence requirements:

4.1.1 **Standard a) Part 1**: "The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service".

4.1.2 **Standard a) Part 2**: "Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS."

4.1.3 A detailed paper outlining the Trust's current level of compliance with this standard was produced by the Clinical Director of Obstetrics and has been received by QSAC, who were assured by the findings and confirmed that they are satisfied with compliance as highlighted below.

4.1.4 Taking assurance from QSAC's confirmation, the Board of Directors are asked to record in the minutes of this meeting that they hereby Sign off Part 1 to standard a) of Safety Action 4 by recoding in the minutes of their February 2022 meeting to the effect that:

4.1.4.1 The Board of Directors acknowledge the engagement and compliance of obstetric services with the RCOG document titled '*Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'*.

4.1.4.2 The Board of Directors acknowledge that the Ockenden Report Action Plan Case-Notes Pilot audit indicates compliance with attendance of the clinical situations listed in the said document but to state that they require to see the findings of the follow-up audit, and, dependent on these findings, an action plan to address any findings of non-compliance.

4.1.5 The Board of Directors will also be provided, no later than April 2022, with evidence of an agreed plan to satisfy Part 2 of standard a) of Safety Action 4, i.e., ongoing, monthly compliance if consultant attendance for the clinical situations

listed in the afore-mentioned document when a consultant is required to attend in person.

5.0 ATAIN Report for Quarter 3 2021

5.1 A report was received and approved by QSAC at their January meeting, which evidenced compliance with several standards within 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?"), specifically the guidance issued under the 'relevant time lines' section for Standard g) "Evidence of progress with the [ATAIN] action plan being shared with the neonatal, maternity safety champion, Board level champion and LMNS and ICS quality surveillance meeting each quarter following sign off at the Board".

5.1.1 The Board of Directors are asked to take assurance from the fact that term admissions have exceeded the performance target of below 5% for the last seven consecutive months.

6.0 Appendix 4 Transitional Care Report Jul-Sep 2021.

6.1 Also linked to Safety Action 3, CNST requires Trusts to report on transitional care. SaTH conduct a quarterly 'Transitional Care Audit' The report covering July to September 2021 and written by the Postnatal Ward Manager on 30th September 2021 was provided to QSAC at their January 2022 meeting to provide assurance; the October to December report has subsequently been provided and will be shared with QSAC at their March meeting.

6.1.1 The Board of Directors is asked to take assurance that the evidence requirements for standard b) ("The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting. each quarter") have been complied with and that the audit itself shows 100% compliance with the Transitional Care Policy.

6.1.2 The Board of Directors are also asked to take assurance that, as validated bv QSAC, the quarterly audit findings shared with the Maternity and Neonatal Safety Champions Group and Local Maternity and Neonatal System Board, as well as the Perinatal Clinical Quality Surveillance Group.

7.0 Risks and Issues to Highlight.

7.1 The following risks (as set out in Table 1 on the next page) were flagged to the Maternity Transformation Assurance Committee in December 2021 (1 and 2 only) and to the Divisional Risk Meeting in January 2022, and are in the process of being uploaded formally into the divisional and corporate risk logs.

7.2 The Board of Directors is asked to note that compliance with CNST by June 2022 cannot be guaranteed due to the risks outlined in the table, but also to take assurance that proactive mitigation is already underway and is a major priority for the Women and Children's Division.

There is a risk that…	The risk is caused by…	The potential impact of the risk is…	The mitigation in place is…
BoD reporting dates might be overlooked	The complexity of the CNST requirements and competing priorities and operational pressures at divisional level	Failure of one or more Safety Actions due to missed reporting	1. Dedicated CNST governance officer started in post 2. Plan in Monday.com 3. Board and Committee secretariats in receipt of reporting dates
The Maternity Services Data Set may be incomplete (SA2)	Badgernet data formatting being incompatible with MSDS in its current configuration,	A failed data set for the month of January (submitted in April) causing failure of Safety Action 2	1. Performance lead and data warehouse team aware and working to correct 2. DDO and Head of Performance meeting with data warehouse to confirm fix is imminent 3. Digital Midwife liaising with other Badgernet Trusts to seek solution
Trust may miss SBL CO testing targets for mothers at booking (a minimum of 80% compliance over a 6 month for the 36 week CO monitoring). (SA6)	The fact that Medway cannot accept this data and it has to be recorded in handheld notes, which is very cumbersome and difficult to audit	If we don't achieve a minimum of 80% compliance over a 6 month for the 36 week CO monitoring the Trust will fail Safety Action 6.	1. SBL lead midwife and public health midwife conducting manual checks and educating staff 2. QI Governance team to support audits 3. (Longer term, Badgernet will fix the issue)
Trust might miss PROMPT training targets. (SA8)	The fact that we aim to provide PROMPT face-to-face: COVID-19 measures restrict the number of colleagues who can be present at any given session	We do not hit the 90% threshold of staff being in date for PROMPT by the June 2022 deadline, thereby failing Safety Action 8.	1. Funds set aside for more faculty time 2. Proactive training room booking 3. Board of Directors have been notified that eLearning may be employed for up to 10% of in-scope staff.

Table 1: Risks and Issues associated with delivery of CNST MIS Year 4 as at Jan 2022

8.0 **Conclusion.** The Board of Directors are asked to note the following:

8.1 CNST MIS Year 4 delivery is on track, but risk to delivery and overall compliance does exist nonetheless

8.2 A reporting pause letter has been issued, but clear guidance regarding revised timelines has not yet been published. For this reason and to work towards the best possible service, the Trust will stick to the original delivery plan.

8.3 The actions requested of the Board of Directors as set out in this paper (items for approval) must be recorded formally in the minutes in order to demonstrate compliance with CNST to inform final submission in June 2022.

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	Previously reported 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.		Qtr 3 report submitted (Oct, Nov, Dec 2021). • x4 stillbirths attributed to SaTH for PMRT, 2 of which are being processed. 2 stillbirths that occurred in December are pending PMRT review. • x1 early NND in November died at another Trust therefore not to be reviewed by SaTH. • x1 NND was born at SaTH but died at another Trust so this will be a joint PMRT review led by the other Trust with SaTH involvement. • x2 NND to be reviewed by SaTH using PMRT. All NND's have commenced the PMRT review process. 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.		All cases have been reviewed in relation to criteria for reporting to HSIB and all appropriately referred. One case initially declined by HSIB has now been accepted by HSIB following their discussion with family. This has been through RALIG and reported as an SI in line with protocol
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	A total of 164 incidents were reported in November, 4 were logged as moderate harm, severe = 1 (death = 0) Note: Incidents are reviewed and grading can be amended following a review. Incidents are expected to be reviewed within 30 days, and 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 5 have been initially identified as moderate harm or above in the go global report (extracted 07.01.2022) this number may have been higher or lower following the reviews of care.	A total of 146 incidents were reported in December, 3 were logged as moderate harm (severe = 0, death = 0) Note: Incidents are reviewed and grading can be amended following a review. Incidents are expected to be reviewed within 30 days, and 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 3 have been initially identified as moderate harm in the go global report (extracted 07.01.2022) this number may have been higher or 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.		Final prototype of Birth Preference visual card produced in UX Cycle 2 (which will also serve as evidence for IEA 7.2) C:\Users\harrisma\Downloads\Visual Birth Preferences
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.	Feedback from Oswestry MLU staff that staffing levels do not allow sufficient time for results review. There remains a significant learning gap for Badgernet – more superusers are required, particularly for out of hours. Smoking at the time of delivery has fallen below 10% for the first time. Claims, complaints and incident data were reviewed and latest local dashboard agreed. The level of information required for future reports has also been clarified. More detail is available from the AAA on request to Safety Champions group via Mr. Bristlin.
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.			No new concerns or requests received.
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		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.		In progress – all data validated monthly. No concern.

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)

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Saving Babies Lives Element 2

Review of Small for Gestational Age births at SaTH in Quarter 3 2021/2022

and

Accumulative graphical data commencing from October 2020

Lindsey Reid
Lead Midwife for Saving Babies' Lives

Reported January 2022

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.

Definition

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

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

Aims and standards

Aim

To monitor compliance with standards contained within SBLCBv2.

Standards

Monitoring of babies born after 39+6 and between the 10th and 3rd centile to provide an indication of detection rates and management of SGA babies (SBLCBv2 Element 2).

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

Methodology

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

Time period– 1/10/21 – 31/12/21 (Quarter 3)

Cases analysed– 1098 babies (live born and stillborn from 24 weeks gestation)

Method of analysis – Microsoft Excel

Results

The next slide shows SaTH's internally reviewed data.

The Perinatal Institute's (PI) Quarter 3 national GAP (Growth Assessment Protocol (ref 2)) user average data is included for a comparative measure.

Quarter 2 2021/2022		SaTH reviewed data	Perinatal Institute National GAP user average Data Comparison
Total inclusive births	N	1097	-
SGA rate <10th – 0 centile	N %	139 12.6	13.8
SGA detection rate (<10th – 0 centile)	N %	59 42.4	41.2
Babies <10th centile delivered on or after 40+0 weeks	N %	32 23.0	28.5
SGA rate (<3rd centile)	N %	45 2.9	4.7
SGA detection rate < 3rd centile	N %	33 75.0	60.1
Babies <3rd centile delivered on or after 38+0 weeks	N %	22 50.0	51.9

Conclusion

All Babies born <10th centile **12.6 %**, is slightly better than the PI national average of 13.8%.

Antenatal detection (suspected by ultrasound assessment) rate of all babies <10th centile is **42.4%,** slightly better than the PI national average of 41.2%

Babies <10th and >3rd centile, delivered on or after 40+0 weeks **23.0%** which is better than the PI national average of 28.5%. This suggests good antenatal management and detection.

Babies born <3rd centile **2.9%** which is better this quarter than the PI national average of 4.7%.

Antenatal detection (suspected by ultrasound assessment) rate of all babies <3rd centile is **75.0%** better than the PI national average of 60.1%.

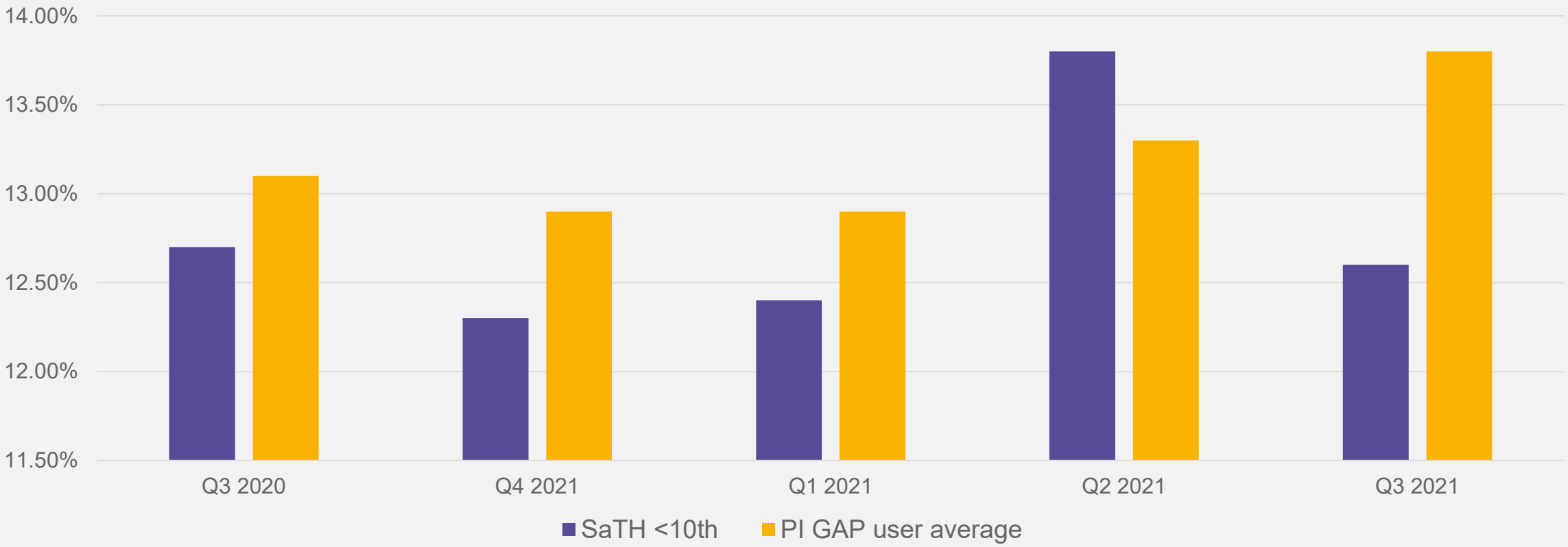
Babies <3rd centile delivered on or after 38+0 weeks **50.0%,** PI national average of 51.9%. This suggests comparative to slightly better antenatal management and detection.

Overall, Quarter 3 SaTH internally reviewed data appears to be better than the national PI GAP user average data.

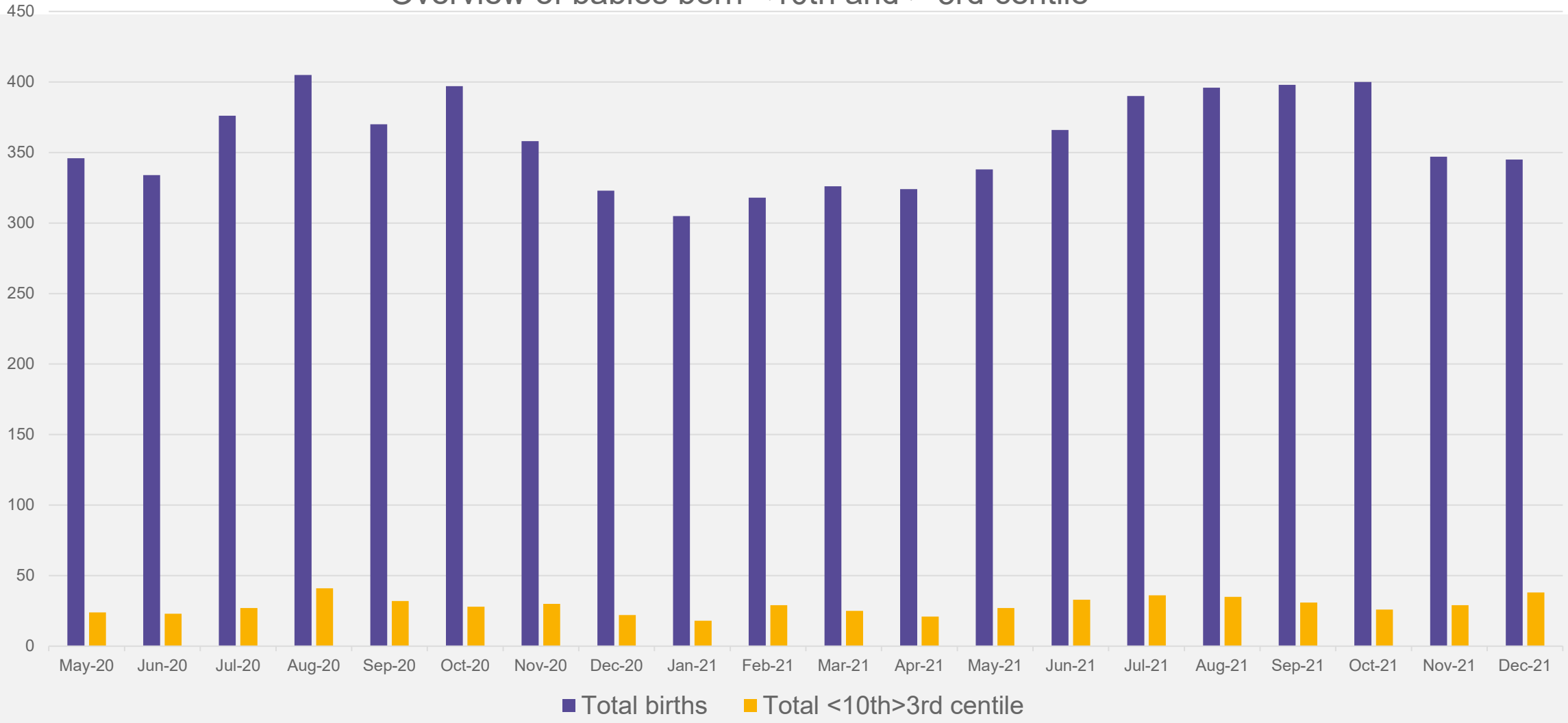
The following slides show accumulative data of:

- All babies born <10th centile at SaTH compared to PI national GAP average
- Babies born <10th >3rd centile
- Expand <10th >3rd centile data
- Babies born < 3rd centile
- Expand <3rd centile data

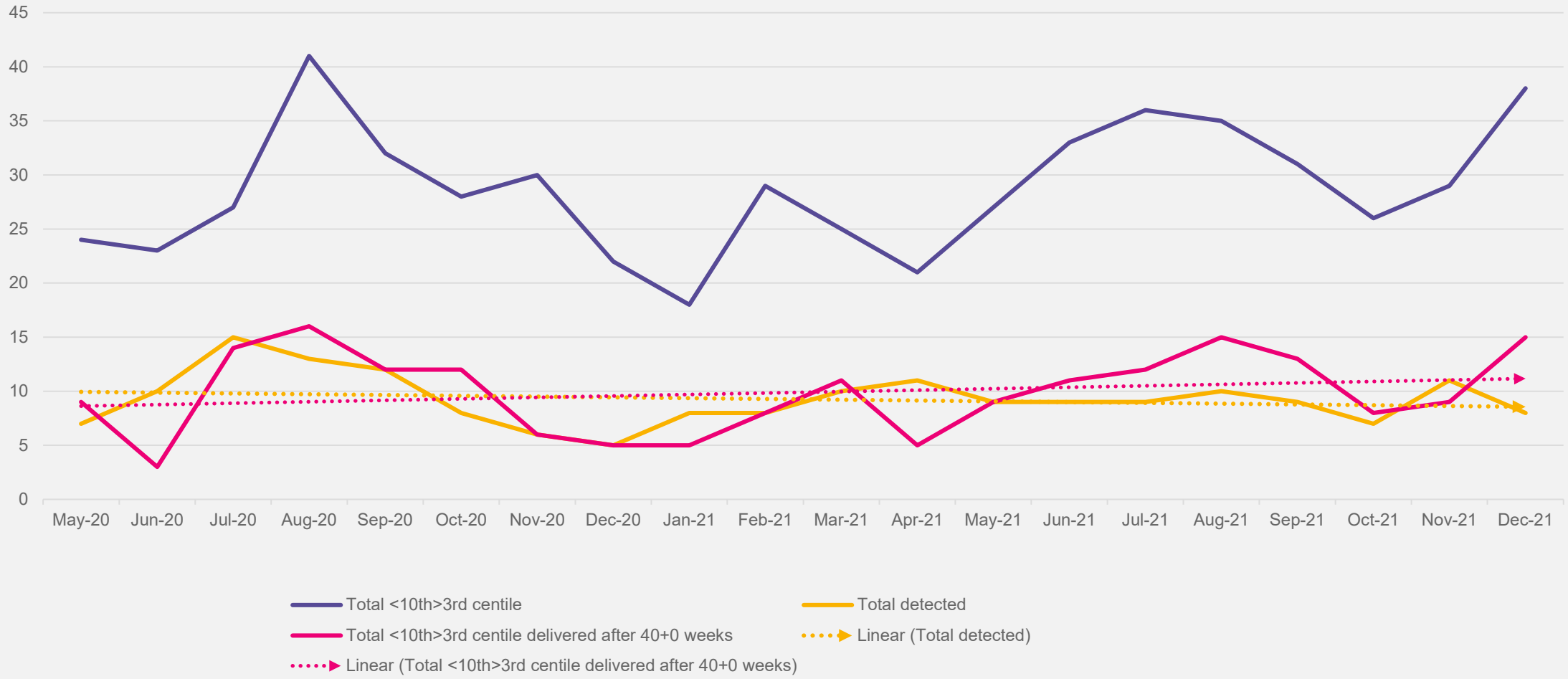
Babies born below the 10th centile at SaTH compared to Perinatal Institutes national GAP user average



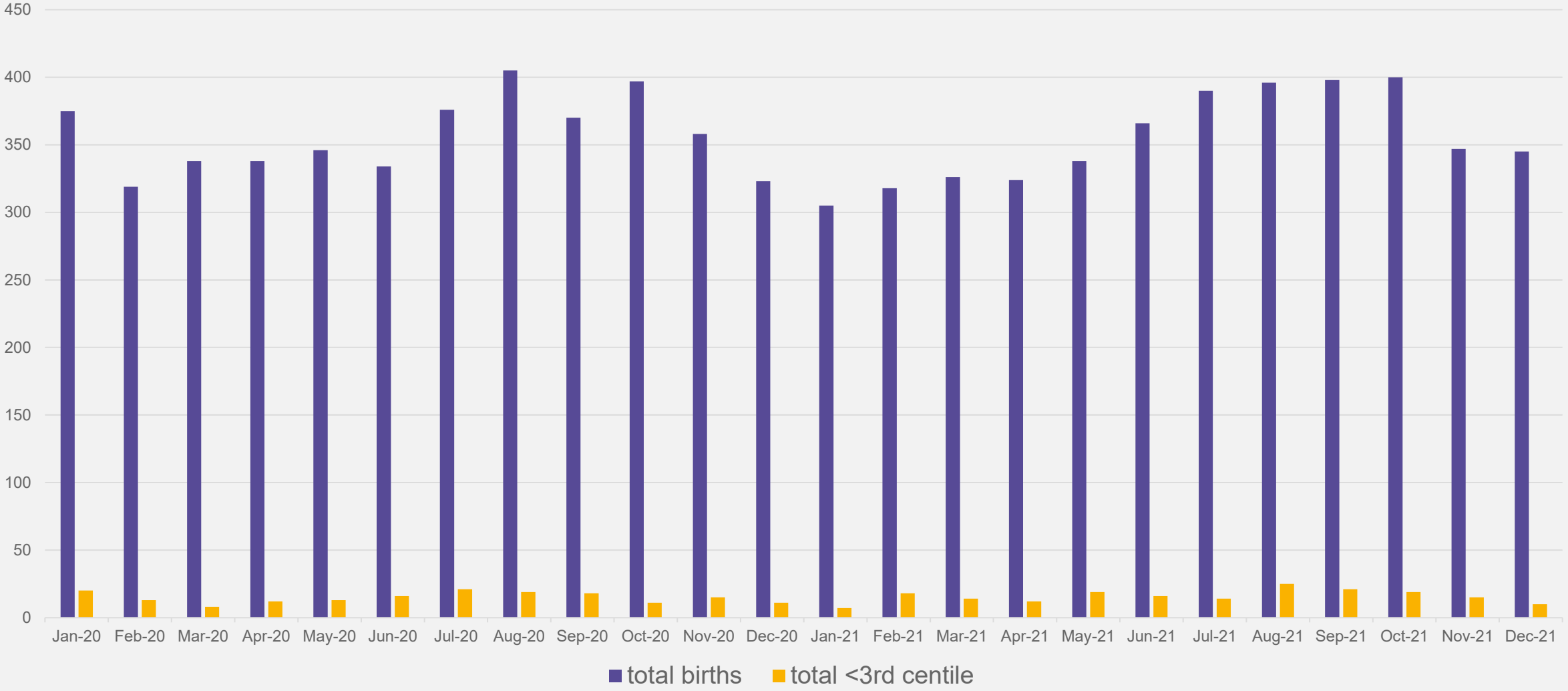
Overview of babies born <10th and > 3rd centile



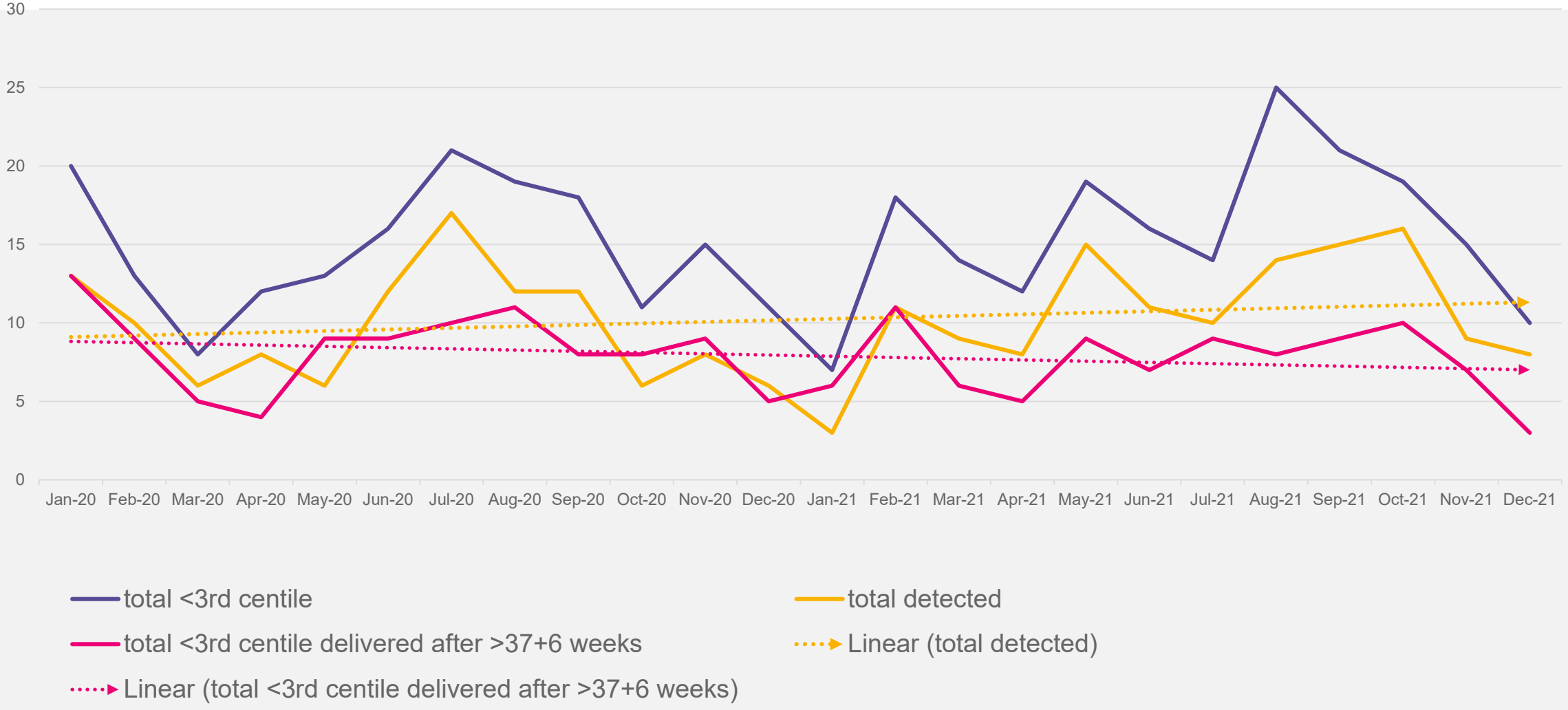
Expanded <10th to >3rd centile



Overview of babies born < 3rd centile



Expanded <3rd centile birth data



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. GAPguidance.pdf (perinatal.org.uk)

The Shrewsbury and Telford Hospital NHS Trust

Quarter 3 2021/2022 Review of Preterm Births

Lindsey Reid
Lead Midwife for Saving babies' Lives
Data collated January 2022

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.

Aim

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

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

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

Standards

The Shrewsbury and Telford Hospital NHS Trust

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

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

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

Optimum Place of birth

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.

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).

Methodology

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

Time period – 1/10/21 – 31/12/21

Cases analysed –1097 total births extracted from Medway and Badgernet (Maternity Information Systems)

Method of analysis – Microsoft Excel

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=15

Table 1

Percentage of singleton live births (24 - 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth (n=14)			
Number of cases in review	14		
Number of cases standard not applicable	0	Total number cases assessed for standard	14
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	9	5	64%

3 cases received a single dose –All born before 2nd dose due. No missed opportunities identified.

1 case received a full dose but born after 7 days (see next slide)

1 case did not receive any antenatal steroids – born at 25+3 weeks, sadly neonatal death. PMRT (Perinatal Mortality Review Tool) not fully completed at time of reporting, but no issues found with care given before birth.

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=14

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=14)			
Number of cases in review	14		
Number of cases standard not applicable	4	Total number cases assessed for standard	10
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	1	9	7%

Case 1 – full course at 28 weeks following premature preterm rupture of members (PPROM) . Further single dose at 33+6 weeks prior to birth

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=4

Table 3

Percentage of singleton live births (24 - 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth (n= 4)			
Number of cases in review	4		
Number of cases standard not applicable	0	Total number cases assessed for standard	4
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	1	75%

1 case born at 25+3 weeks, sadly neonatal death. PMRT (Perinatal Mortality Review Tool) not fully completed at time of reporting, but no issues found with care given before birth (as No 1)

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=1098

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	1097		
Number of cases standard not applicable	4 Stillbirths 4 births between 16 and 22+6 weeks 1 Born before arrival at home (BBA) at 23+1 take direct to Level 3 unit	Total number cases assessed for standard	1090
Criteria	Yes	No	Total %
Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).	1087	3	99%

Case 1– 23+2 presented in 1st stage of labour, transfer agreed but birthed before transfer to a level 3 unit possible.

Case 2 – 25+3 sadly neonatal death. PMRT not fully completed at time of reporting, but no issues found with care given before birth

Case 3 – 26+3 known uterine anomaly, previous pre term emergency caesarean section (EmCS), arrived in labour, proceeded to EMCS

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=1097

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	1097		
Number of cases standard not applicable	24 (12 x Twins)	Total number cases assessed for standard	1073
Criteria	16+0 to 23+6 weeks	> 24 weeks	Total % of 16+0 to 23+6 weeks
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)	6	1067	0.5%

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=1097

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	1097		
Number of cases standard not applicable	30 (24 Multiples and 6 x 16-23+6 week births)	Total number cases assessed for standard	1067
Criteria	24+0 to 36+6 weeks	> 37 weeks	Total % of 24+0 to 36+6 weeks
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)	78	989	7%

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 **64%** (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 **7%** (table 2)

Percentage of singleton live births (24 - 30+0 weeks) receiving magnesium sulphate (MgSO4) within 24 hours prior to birth **75%** (table 3)

Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance) **99%** (table 4)

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

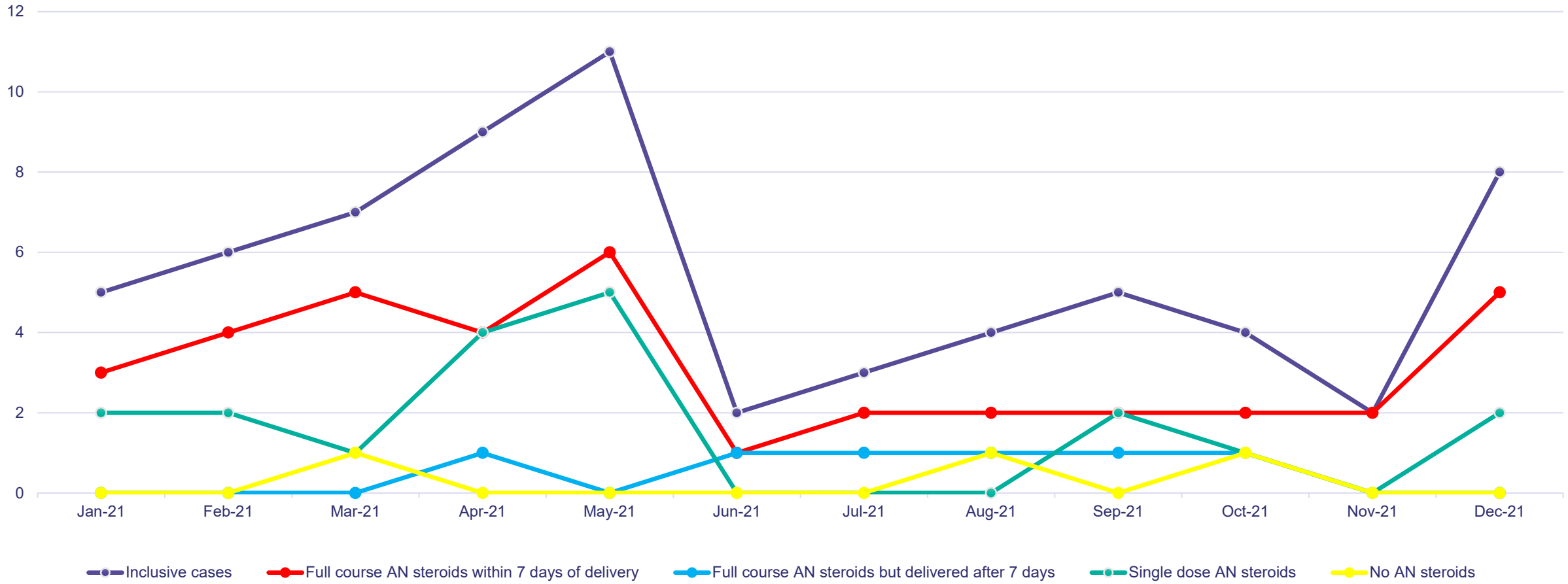
a. In the late second trimester (from 16+0 to 23+6 weeks) **0.5%** (table 5)

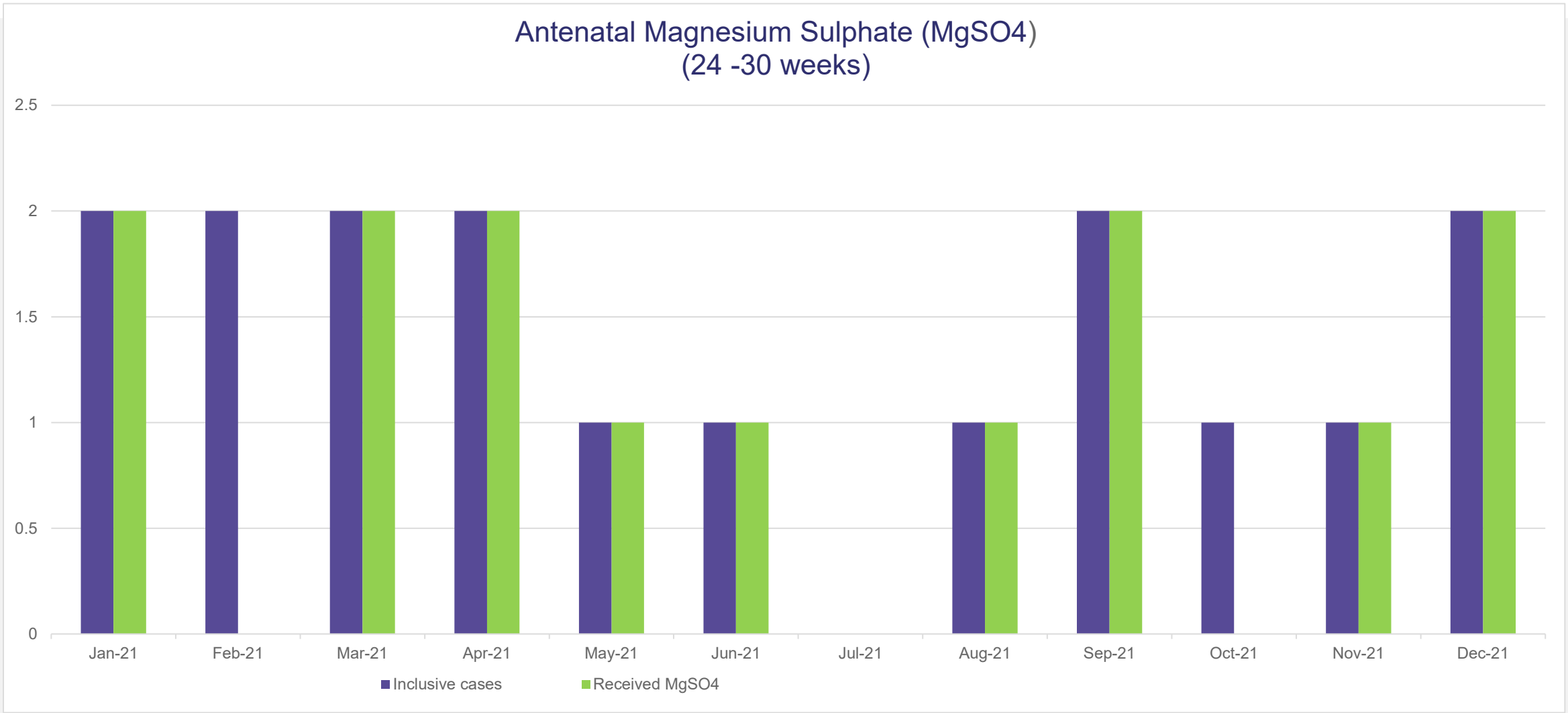
b. Preterm (from 24+0 to 36+6 weeks) **7%** (table 6)

Accumulative Data

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

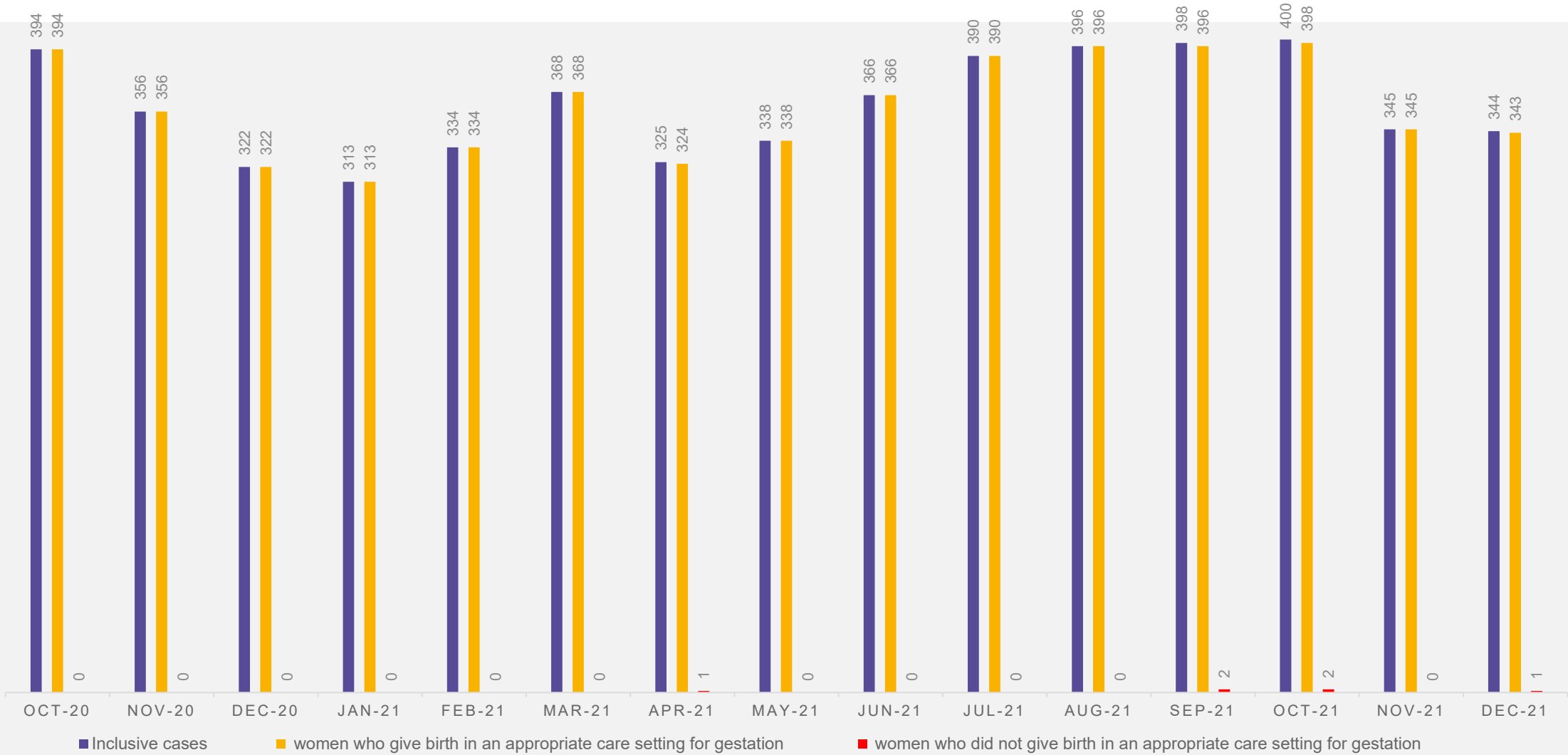
Antenatal Steroids (24 to 34+0 weeks)




Antenatal Magnesium Sulphate (MgSO4)
(24 -30 weeks)
2.5
2
1.5
1
0.5
0
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Inclusive cases
Received MgSO4

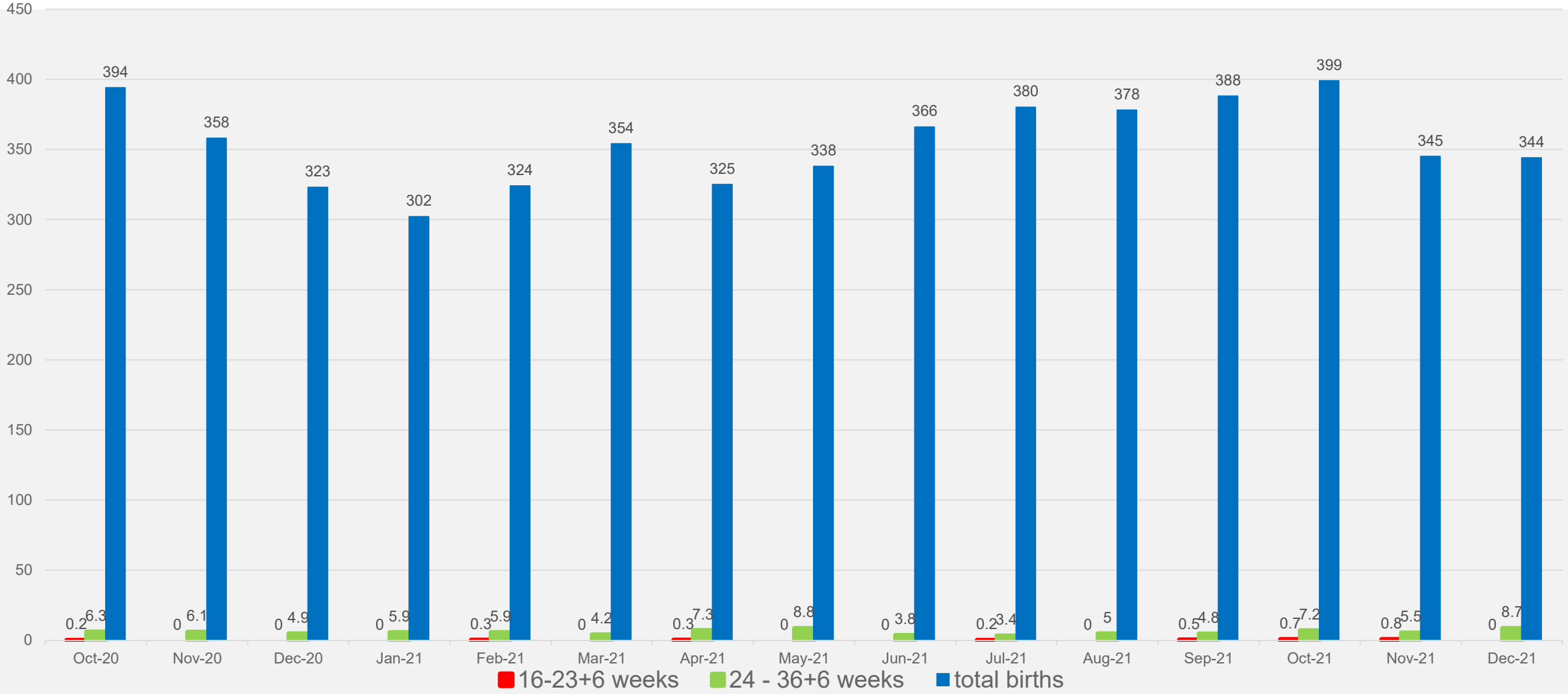
WOMEN WHO GAVE BIRTH IN AN APPROPRIATE CARE SETTING (SINGLETON AND MULTIPLE LIVEBIRTH)

The Shrewsbury and Telford Hospital NHS Trust



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

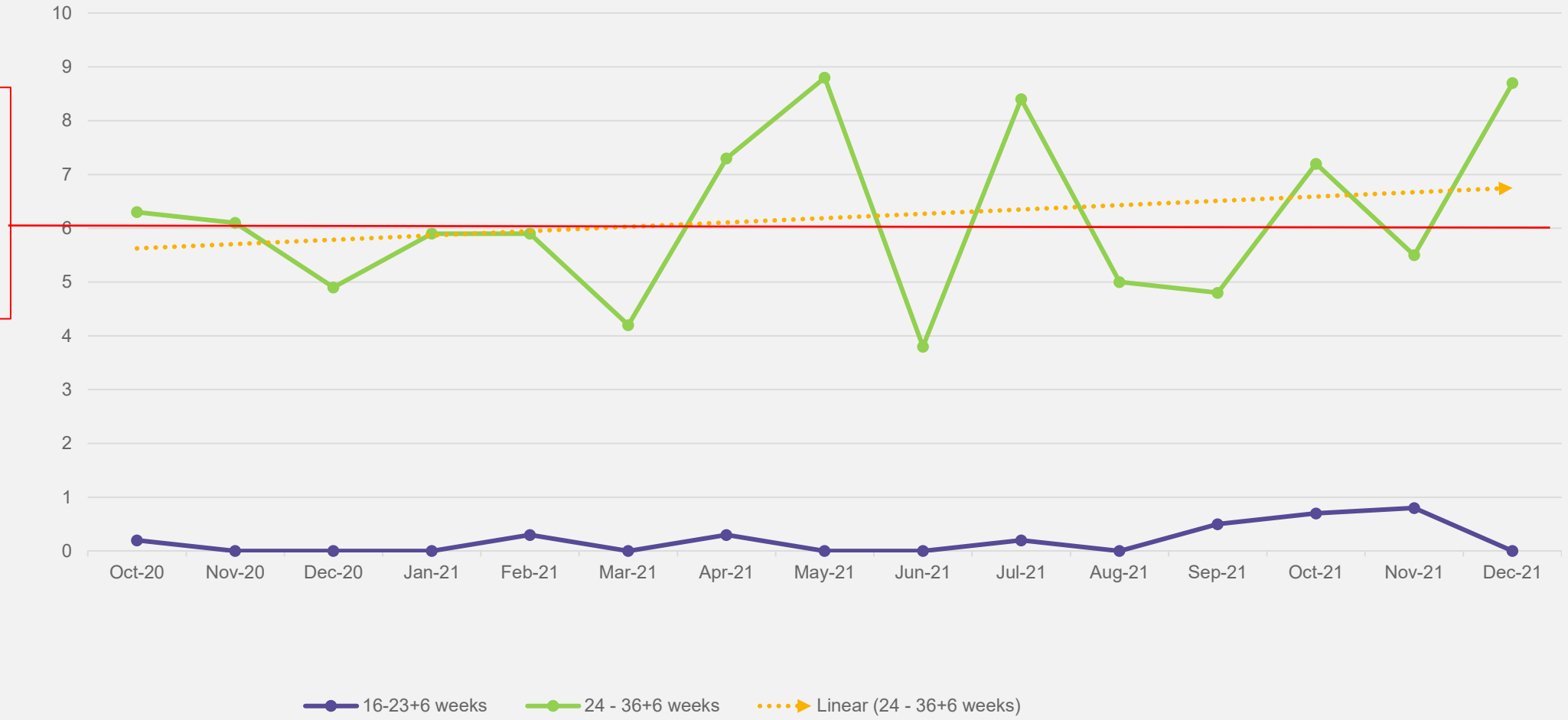
The Shrewsbury and Telford Hospital NHS Trust



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

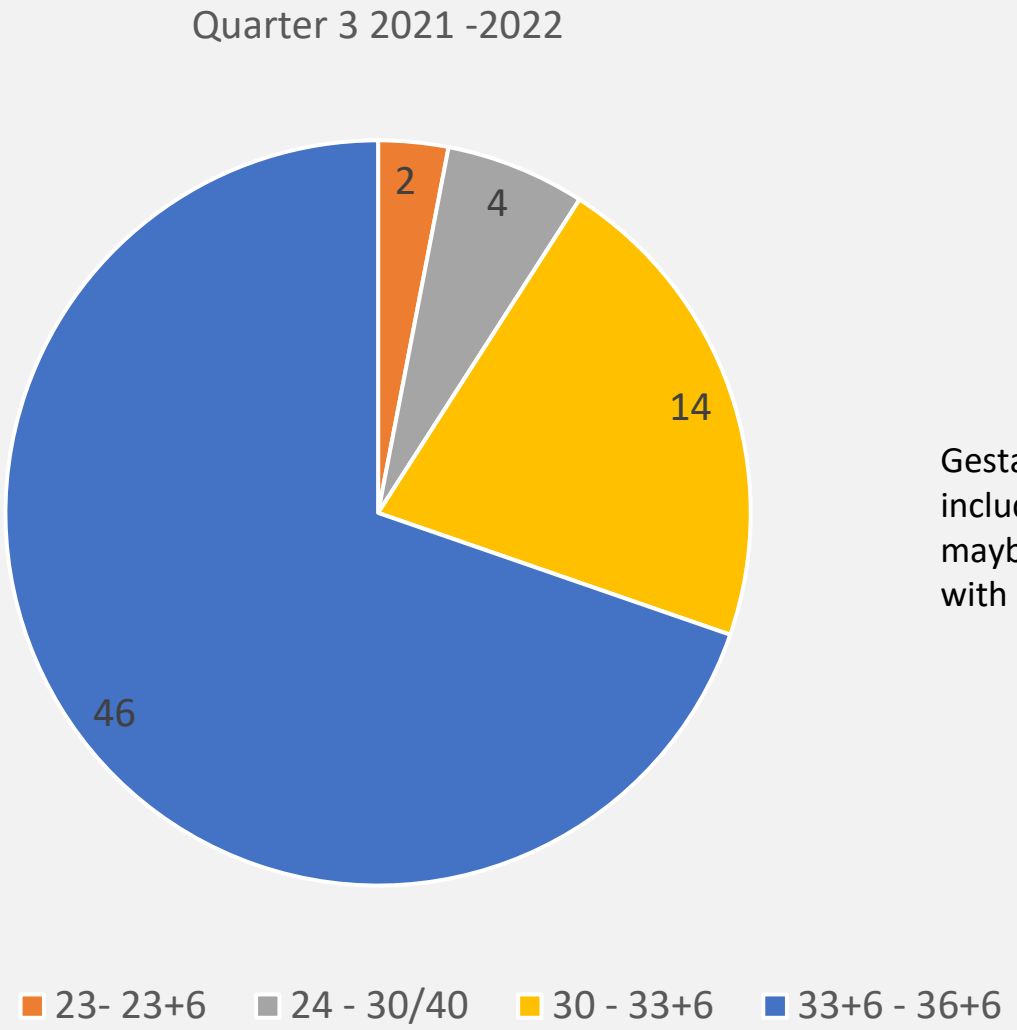
The Shrewsbury and Telford Hospital NHS Trust

Government target of 6% by 2025



Quarter 3 preterm gestation breakdown

The Shrewsbury and Telford Hospital NHS Trust



Gestations between 23 and 23+6 included as active management at birth maybe requested following discussion with a senior Neonatal Doctor

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 3

Case 1 23+1 IUT for threatened preterm labour. Born at 23+4, Neonatal death at 27 days old.

Case 2 23+2 IUT for threatened preterm labour. Unable to update outcome as no identifiable details.

Case 3 31+4 IUT for fetal heart condition/unwell mother. Birthed, returned to SaTH care and later discharged home.

Case 3 24+6 IUT for Preterm premature rupture of membranes (PPROM). Birthed and then transferred to Birmingham Women's Hospital.

Case 4 25+5 IUT for PPROM. Born at 28 weeks and returned to SaTH care.

Case 5 25+3 PPROM and antenatal haemorrhage. Still pregnant (33+6) at time of report writing.

Case 6 26+0 PPROM. Returned to SaTH care and still pregnant (32+3) at time of report writing.

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)