Board of Directors' Meeting
10 March 2022

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	041/22			
Report	Ockenden Review of Maternity Services – One Year On			
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	√	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:	Maternity Clinical Governance			
Dependent upon	Continued implementation of CNST Year 4 actions within deadlines			
Executive summary:	On 25 January 2022, NHS Trust CEO's were sent with a letter from the Chief Operating Officer and the Chief Nursing Officer for England entitled 'Ockenden review of maternity services – one year on'. The letter issues a requirement that the Board of Directors is expected to discuss progress with implementation of the seven Immediate and Essential Actions outlined in the first Ockenden report as well as Maternity services workforce plans, before the end of March 2022. The Board of Directors is requested to receive this paper and approve the actions as set out in section 5 of the report.			
Appendices	1. Letter: 'Ockenden review of maternity services – one year on' 2. Progress with the Kirkup and Ockenden Report Actions 3. Workforce overview (Obstetrics, Neonatal and Anaesthesia) 4. Midwifery Staffing Paper			
				

1.0 Introduction

1.1 On 14 December 2020, all NHS trusts were issued with a letter from NHS England/Improvement's (NHSEI) medical, nursing and operations leads entitled 'Ockenden Review of Maternity Services – Urgent Action' [1]

1.1.1 This set out a requirement to complete an associated assurance tool to demonstrate the level to which trusts were compliant with the standards set out in the report's 'Immediate and Essential Actions' (IEA's).

1.1.2 This was received by the Board of Directors in January 2021.

1.2 In May 2021, trusts were instructed further by NHSEI to provide an upload of data ('minimum evidence requirements') against parameters set out by them to provide a baseline assessment of their implementation of the IEA's at that juncture, as well as information on maternity workforce planning.

1.2.1 This was completed by the deadline set. Feedback from NHSEI indicated >90% completion of IEA's by SaTH at that time.

1.3 On 25th January 2022, the Trust received a follow-up letter from the Chief Operating Officer and Chief Nursing Officer for England entitled 'Ockenden review of maternity services – one year on' (**Appendix 1**). This letter requires trusts discuss progress at their Board meeting in public before the end of March 2022, with the expectation that the discussion should cover:

1.3.1 Progress with implementation of the 7 IEA's outlined in the Ockenden report and the plan to ensure full compliance

1.3.2 Maternity services workforce plans.

1.4 On advice from the Programme Director for Maternity Assurance as well as Women and Children's Divisional Leadership, the Trust has inferred that 'maternity services' in this context should include midwifery, obstetrics, obstetrics anaesthesia and neonatal services.

1.5 The Board of Directors receives progress against all fifty-two of the actions from the first Ockenden Report every time it meets in public, the latest version of which has just been presented. However, whilst this paper contains some repetition from the monthly report, it was felt prudent to set this paper out as a separate document to meet the very specific requirements of the national letter, as it applies to all NHS England providers of maternity services. These requirements are now described.

[1] "Ockenden Review of Maternity Services – Urgent Action", 14 December 2020 (no Public approval reference), available at: https://www.england.nhs.uk/wp-content/uploads/2021/01/Ockenden-Letter-CEO-Chairs-final-14.12.20-1.pdf

2.0 Progress with the implementation of the & Immediate and Essential Actions outlines in the Ockenden Report to ensure full compliance, and the actions form the Morecombe Bay Report

2.1 In order to review and monitor progress and assurance across all NHS providers of maternity care in England, NHSEI developed a standard template for all trusts to complete. This is to capture progress against the Immediate and Essential Actions and a separate assessment of progress with the actions that arose from 'The Report of the Morecombe Bay Investigation'[2], which was led by Dr Bill Kirkup CBE.

2.2 **Appendix 2** provides this completed assessment tool, the results of which are summarised, as follows:

2.2.1 A cover page which includes the Board of Directors' approval of the documents (this will be filled out and returned to NHSEI once the following documents have been discussed by the Board of Directors at this meeting). This partly-completed sign-off section of template is included here for reference. On completion of the Board of Directors' discussion and review of the appendices, consent is sought for the CEO to sign off this return on its behalf.

2.2.2 A self-assessment detailing the level of completion of the Ockenden Report IEA's and associated workforce development actions, based on the criteria set out by that organisation (note that this reflects the position as at December 2021):

2.2.2.1 The completed self-assessment (generated automatically by the template) indicates an overall completion rate of 95% of the IEAs:

2.2.2.1.1 IEA 1 (Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks) - 94%

2.2.2.1.2 IEA 2 (Maternity services must ensure that women and their families are listened to with their voices heard) - 100%

2.2.2.1.3 IEA 3 (Staff who work together must train together) -100%

2.2.2.1.4 IEA 4 (There must be robust pathways in place for managing women with complex pregnancies) - 86%

2.2.2.1.5 IEA 5 (Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway) - 100%

2.2.2.1.6 IEA 6 (All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with

[2] Gov.UK – 2015 - Bill Kirkup, CBE - The Report of the Morecombe Bay Investigation

demonstrated expertise to focus on and champion best practice in fetal monitoring) - 100%

2.2.2.1.7 IEA 7 (All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery) - 85%

2.2.2.2 The self-assessment indicates 70% compliance with the evidence requirements set out for workforce planning

2.2.2.3 The self-assessment indicates an overall compliance of 83% with the evidence requirements set out for this section of the return template.

2.2.2.4 The Board of Directors are reminded that they have received monthly updates detailing the delivery and progress updates of all LAFLs and IEAs since the 'Emerging Findings' report was published.

2.2.3 A self-assessment of SaTH's level of compliance with the recommendations and actions as set out in the 2015 '*Report of the Morecambe Bay Investigation'* by Dr Bill Kirkup CBE.

2.2.3.1 SaTH's return indicates 'green status' (full compliance) with 29 (94%) of the 31 actions and 'amber status' (partial compliance with action plan in place to achieve full compliance) with the remaining 2 (6%). The two partial compliance actions are:

2.2.3.1.1 Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area. (SaTH is largely compliant, and further education on this will be brought into the scope of the Maternity Transformation Workstream 2 for delivery within 2022).

2.2.3.1.2 Ensure that Confidential Enquiry reports are reviewed following publication, and that an action plan is developed and monitored to ensure that high standards of care are maintained. (Whilst SaTH 'horizon-scan' to identify and act on such publications, the Women and Children's division is working on a more formal receipt and planning process, which will rest with the Deputy Director of Operations and the Quality Governance Team. This is to be in place by Summer 2022).

3.0 Workforce overview (Obstetrics, Neonatal and Anaesthesia). This is provided at Appendix 3 and consists of three sub-appendices, one for each area:

3.1.1 Obstetrics (Prepared by Dr Mei-See Hon, Clinical Director – Obstetrics)

3.1.1.1 The Board of Directors has already received (at the February 2022 meeting) an obstetrics workforce paper that proves compliance with the Clinical Negligence Scheme for Trusts (CNST) Safety Action 4 ("Can you demonstrate an effective system of clinical workforce planning to the required standard?") Standard a) ("Obstetrics Workforce") 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").

3.1.1.2 Accordingly, this section of the paper is a high-level description of the obstetrics workforce template, actual complement, and ongoing structure and recruitment planning.

3.1.2 Obstetrics Anaesthesia (Prepared by Dr Lorien Branfield, Lead Consultant for Obstetrics Anaesthesia).

3.1.2.1 Obstetrics Anaesthesia at the Trust is the topic of seven Local Actions for Learning within the Ockenden Report

3.1.2.2 Linked to this, there is ongoing work to re-configure the rota system for anaesthetics consultants at the RSH and PRH sites to optimise the service.

3.1.2.3 This is closely monitored and is being supported by the Acting Medical Director for the Trust. A full update on this will be brought to the Board of Directors in due course.

3.1.3 Neonatal Unit (both medical and nursing). (Prepared by Dr Sanjeev Deshpande (Neonatal Consultant) Julie Plant (Divisional Director of Nursing) and Tina Kirby (Centre Manager, Maternity and Neonatal Unit).

4.0 Midwifery Staffing Paper (Workforce Overview). This is provided at **Appendix 4**, and has been kept separate from the other parts of maternity services set out in section 3, as it is the main focus of the letter. The report was prepared by Shirley Jones, Interim head of Midwifery.

4.1.1 Provision of this document also concludes delivery of CNST Safety Action 5 ("Can you demonstrate an effective system of midwifery workforce planning to the required standard?"), specifically standard d ("Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting

period”). The previous report was accepted by the Board of Directors at their meeting in November 2021.

5.0 Next Steps

Subject to the Board of Directors’ approval of this report, it will then be shared with the Local Maternity and Neonatal System and. Also. The HSEI Regional maternity team.

6.0 Actions requested of the Board of Directors.

The Board of Directors is requested to:

6.1.1 Review and discuss this paper and its appendices.

6.1.2 Authorise the CEO to sign the front cover to the NHSEI template return (first section of appendix 2) and to pass to LMNS Chairperson for counter-signing.

6.1.3 Take assurance that SaTH is more than 90% compliant with the delivery of the Ockenden Report Immediate and Essential Actions based on feedback and self-assessment using the NHSEI tool.

6.1.4 Decide if any further information and/or assurance is required

To: NHS Trust and Foundation Trust Chief Executives

cc. Trust Chairs and Directors of Nursing
ICS, CCG, LMS Leaders,
Regional Directors,
Regional Chief Nurses,
Regional Chief Midwives,
and Regional Obstetricians

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

25 January 2022

Dear colleagues,

Ockenden review of maternity services – one year on

Thank you for all your efforts in response to the Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust published in December 2020, and for your continued focus on the Immediate and Essential Actions (IEAs) despite the sustained pressure on your services throughout the pandemic. As well as ensuring progress continues, we need to prepare for the publication of further reports into maternity services during 2022.

The national response to the Ockenden report included a £95.6M investment into maternity services across England including funding for:

- 1200 additional midwifery roles,
- 100 wte equivalent consultant obstetricians,
- backfill for MDT training
- International recruitment programme for midwives
- Support to the recruitment and retention of maternity support workers

In our letter of 14 December 2020, we asked you to use the Assurance Assessment Tool, which includes the recommendations from the Morecambe Bay investigation report and the Ockenden report, to support a discussion at your trust public Board. One year on, we are asking that you again discuss progress at your public Board before the end of March 2022.

We expect the discussion to cover:

- Progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance,
- Maternity services workforce plans,

Ensuring local system oversight of maternity services was a key element in the Ockenden review and therefore you should ensure progress is shared and discussed with your LMS and ICS. Progress must also be reported to your regional maternity team by 15 April 2022.

As you will no doubt agree, women and families using our maternity services deserve the best of NHS care. We recognise the huge efforts being made across the system and thank you for your continued commitment and support in driving the improvements required.

Yours faithfully

Sir David Sloman
Chief Operating Officer
NHS England and NHS Improvement

Ruth May
Chief Nursing Officer, England
NHS England and NHS Improvement

Completion Guidance:

1. Overview tab – please complete in full
2. Ockenden return tab – this mirrors earlier returns and requires updating on progress to 31/12/2021
3. Kirkup return tab – please note some recommendations have been greyed out – these do not require completion as they are superseded by information in the Ockenden recommendations. (There is a 4th tab which details the Kirkup recommendations as a helpful reminder – this doesn't require any completion)

Internal trust governance

	Confirmation of / or planned Public Trust Board update on progress against the Ockenden action plan	Date of Public Board update	Executive sign off of this return		
	Yes/No	please insert date	**Date**	**Name**	**Role**
SaTH		Feb-22		Louise Barnett	Trust CEO
Insert Trust Name					
Insert Trust Name					
Insert Trust Name					

LMNS sign off of the combined trust returns

LMNS Name	Executive sign off		
	Date	**Name**	**Role**
Shropshire, Telford and Wrekin		Dr Deborah Shepherd	Chair - Shropshire, Telford and Wrekin Local Maternity and Neonatal System

Ockenden Inital Report Actions
Results of Regional Update - Jan 2022

The Shrewsbury and Telford Hospital NHS Trust

IEA	Question	Action	Evidence Required	SHREWSBURY AND TELFORD HOSPITAL	SaTH update / commentary as of December 2021
IEA1	Q1	Maternity Dashboard to LMS every 3 months	Dashboard to be shared as evidence.	100%	
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	100%	
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	0%	SOP to be completed by February 2022
			Submission of minutes and organogram, that shows how this takes place.	100%	
		Maternity Dashboard to LMS every 3 months Total		**75%**	
	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place.	100%	
			Policy or SOP which is in place for involving external clinical specialists in reviews.	100%	
		External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total		**100%**	
	Q3	Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	100%	
			Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	100%	
			Submit SOP	100%	
		Maternity SI's to Trust Board & LMS every 3 months Total		**100%**	
	Q4	Using the National Perinatal Mortality Review Tool to review perinatal	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	100%	
			Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.	100%	
		Using the National Perinatal Mortality Review Tool to review perinatal deaths Total		**100%**	
	Q5	Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	100%	
		Submitting data to the Maternity Services Dataset to the required standard Total		**100%**	
	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	100%	
		Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total		**100%**	

The Shrewsbury and Telford Hospital NHS Trust

IEA	Question	Action	Evidence Required	SHREWSBURY AND TELFORD HOSPITAL	SaTH update / commentary as of December 2021
	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	100%	
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	100%	
			Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	100%	
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total		**100%**	
IEA1 Total				**94%**	
	Q11	Non-executive director who has oversight of maternity services	Evidence of how all voices are represented:	100%	
			Evidence of link in to MVP; any other mechanisms	100%	
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	100%	
			Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	100%	
			Name of NED and date of appointment	100%	
			NED JD	100%	
		Non-executive director who has oversight of maternity services Total		**100%**	
	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%	
		Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total		**100%**	
IEA2	Q14	Trust safety champions meeting bimonthly with Board level champions	Action log and actions taken.	100%	
			Log of attendees and core membership.	100%	
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	100%	
			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	100%	
		Trust safety champions meeting bimonthly with Board level champions Total		**100%**	
	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	
		Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services Total		**100%**	

IEA	Question	Action	Evidence Required	SHREWSBURY AND TELFORD HOSPITAL	SaTH update / commentary as of December 2021
	Q16	Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	100%	
			Name of ED and date of appointment	100%	
			Role descriptors	100%	
		Non-executive director support the Board maternity safety champion Total		**100%**	
IEA2 Total				**100%**	
	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	100%	
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	100%	
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%	
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%	
		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total		**100%**	
	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	100%	
			SOP created for consultant led ward rounds.	100%	
		Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total		**100%**	
	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance	100%	
			Evidence from Budget statements.	100%	
			Evidence of funding received and spent.	100%	
			Evidence that additional external funding has been spent on funding including staff can attend training in work time.	100%	
			MTP spend reports to LMS	100%	
		External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total		**100%**	
IEA3	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	
			Attendance records - summarised	100%	
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%	
		90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total		**100%**	

The Shrewsbury and Telford Hospital NHS Trust

IEA	Question	Action	Evidence Required	SHREWSBURY AND TELFORD HOSPITAL	SaTH update / commentary as of December 2021
	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	100%	
		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total		**100%**	
	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	100%	
		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total		**100%**	
IEA3 Total				**100%**	
	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	0%	Cannot audit this fully until Summer 2022; intended go-live for West Midlands MMC is April 2022
			SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	100%	
		Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total		**50%**	
	Q25	Women with complex pregnancies must have a named consultant lead	Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	100%	
			SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	100%	
		Women with complex pregnancies must have a named consultant lead Total		**100%**	
	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	0%	Audit had still not been completed as of December 2021, but has subsequently been conducted and confirms compliance with this involvement and consultation.
			SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	100%	
		Complex pregnancies have early specialist involvement and management plans agreed Total		**50%**	

The Shrewsbury and Telford Hospital NHS Trust

IEA	Question	Action	Evidence Required	SHREWSBURY AND TELFORD HOSPITAL	SaTH update / commentary as of December 2021
IEA4	**Q27**	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.	100%	
			Guidelines with evidence for each pathway	100%	
			SOP's	100%	
		Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total		**100%**	
	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.	100%	
			Submission of an audit plan to regularly audit compliance	100%	
		All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total		**100%**	
	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Agreed pathways	100%	
			Criteria for referrals to MMC	100%	
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	100%	
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total		**100%**	
IEA4 Total				**86%**	
	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	How this is achieved within the organisation.	100%	
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	
			Review and discussed and documented intended place of birth at every visit.	100%	
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	100%	
			What is being risk assessed.	100%	
		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total		**100%**	
	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	100%	
			Out with guidance pathway.	100%	
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	
			SOP that includes review of intended place of birth.	100%	

IEA	Question	Action	Evidence Required	SHREWSBURY AND TELFORD HOSPITAL	SaTH update / commentary as of December 2021
IEA5		**Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total**		**100%**	
	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	100%	
			How this is achieved in the organisation	100%	
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	100%	
			Review and discussed and documented intended place of birth at every visit.	100%	
			SOP to describe risk assessment being undertaken at every contact.	100%	
			What is being risk assessed.	100%	
		A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total		**100%**	
IEA5 Total				**100%**	
	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Copies of rotas / off duties to demonstrate they are given dedicated time.	100%	
			Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	100%	
			Incident investigations and reviews	100%	
			Name of dedicated Lead Midwife and Lead Obstetrician	100%	
		Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total		**100%**	
	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	100%	
			Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	100%	
			Improving the practice & raising the profile of fetal wellbeing monitoring	100%	
			Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	100%	
			Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	100%	
			Keeping abreast of developments in the field	100%	
			Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	100%	
			Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	100%	

IEA	Question	Action	Evidence Required	SHREWSBURY AND TELFORD HOSPITAL	SaTH update / commentary as of December 2021
IEA6		**The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total**		**100%**	
	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Audits for each element	100%	
			Guidelines with evidence for each pathway	100%	
			SOP's	100%	
		Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total		**100%**	
	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	
			Attendance records - summarised	100%	
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%	
		Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total		**100%**	
IEA6 Total				**100%**	
	Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery.	100%	
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	
		Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total		**100%**	
		Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.	0%	

IEA	Question	Action	Evidence Required	SHREWSBURY AND TELFORD HOSPITAL	SaTH update / commentary as of December 2021
IEA7	Q41		CQC survey and associated action plans	0%	CQC Survey had not been published by December 2021, but results received in February 2022 showed SaTH performing at above expectation and very much above expectation for 'listening to women in the intrapatrum phase'. Additionally, MVP are running a workshop on informed consent / shared decision making with service users from the Birth Options Clinic in answer to IEA 7.2 in the coming months (independently from SaTH)
			SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.	100%	
		Women must be enabled to participate equally in all decision-making processes Total		**33%**	
	Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	100%	
			SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	100%	As communicated to regional team on 12/11/2022, SaTH confirm compliance with this, having provided as evidence: 1. Booking for Maternity Care (Including referral for care) v3.3 dated October 2019 2. Patient Information Guideline – Maternity v5.1 3. Maternity Personalised Care and Support Planning Meeting Minutes (anonymised) - showing how data is recorded
		Women's choices following a shared and informed decision-making process must be respected Total		**100%**	
	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%	
		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total		**100%**	
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	100%	
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	100%	
			Information on maternal choice including choice for caesarean delivery.	100%	
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total		**100%**	
IEA7 Total				**86%**	

The Shrewsbury and Telford Hospital NHS Trust

IEA	Question	Action	Evidence Required	SHREWSBURY AND TELFORD HOSPITAL	SaTH update / commentary as of December 2021
WF	Q45	Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	0%	
			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	0%	
			Most recent BR+ report and board minutes agreeing to fund.	0%	
		Demonstrate an effective system of clinical workforce planning to the required standard Total		**0%**	
	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	100%	
		Demonstrate an effective system of midwifery workforce planning to the required standard? Total		**100%**	
	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	100%	
		Director/Head of Midwifery is responsible and accountable to an executive director Total		**100%**	
	Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Action plan where manifesto is not met	100%	
			Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	100%	
		Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total		**100%**	
	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.	100%	
			Evidence of risk assessment where guidance is not implemented.	100%	
			SOP in place for all guidelines with a demonstrable process for ongoing review.	100%	
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total		**100%**	
WF Total				**70%**	

Kirkup Report Recommendations and Actions
Regional Update as at December 2021

The Shrewsbury and Telford Hospital NHS Trust

Those that are greyed out are superseded by Ockenden and do not need completing on this tab.

				Shrewsbury Telford and Wrekin
Kirkup Action no.	**Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)**	**Action**	**Suggested documents that may support Trust assurance.**	**SHREWSBURY AND TELFORD HOSPITAL**
1	**R1, R13, R24**	Ensure that an open and honest approach is taken to any incident	Critical friend is allocated for every level 4/ 5 incident (SI's)	
			Women and their families are kept informed of the progress of the	
			Women and their families are invited to contribute to the investigation	
			Offering an apology	
			Ensure that all nurses and midwives are aware of their responsibilities in	
2	**R1, R13**	Review the current processes for obtaining feedback from the public to increase the information received	Offering women and their families the opportunity to make suggestions	
			Ensuring that national/ local awareness opportunities are utilised	
			Continue to support the LSA in the feedback mechanism to staff from	
			Share patient stories	
3	**R2**	Review the current skills and drills programme across the directorate to ensure that a wide range of scenarios are included across all clinical settings, including bespoke skills drills for different clinical areas	Ensure a high quality training scheme is delivered	
4		Foster a culture of shared learning between clinical departments that supports effective communication and practice development	Minutes of meetings showing MDT working	
5	**R2**	Review the current preceptorship programme	Midwives/ Nurses are allocated a buddy in each clinical area and that this is supported by the clinical team.	Green
			The buddy midwife is allocated time to support the preceptee	Green
			Midwives are supported throughout the programme, progress is monitored and there is a clear plan developed for any midwife that is	Green
			Midwives are confident and competent to go through the gateway within the agreed timeframe	Green
6	**R2**	Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme	Utilise PMA feedback	Green
7	**R2, R3**	Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce	Develop a robust support package for new band 6 midwives	Green
			Completion of the Mentoring module	Green
			Suturing competency	Green
			IV therapy competency	Green
			Care of women choosing epidural anaesthesia.	Green
8		Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care	Practice educator reports and feedback	Green
9	**R2**	Review the current induction programme for locum doctors	Locum policies	Green
10		Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group.		Green
11	**R2**	Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session.	Practice educator meeting notes, discussion with DoMS/HoMs	Green

The Shrewsbury and Telford Hospital NHS Trust

Kirkup Action no.	Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)	Action	Suggested documents that may support Trust assurance.	SHREWSBURY AND TELFORD HOSPITAL
12	R2	Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford	Practice educator reports and feedback	Green
13	R2	Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition	Incident review and feedback, related lessons learnt, training opportunities	Green
14	R2	Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news		Green
15	R3	Review the current process for staff rotation to ensure that a competent workforce is maintained in all clinical areas.		Green
16	R2, R3, R4	Review and update the Education Strategy		
17	R3	Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations		Green
18	R3	Offer opportunities to other heads of service for staff from other trusts to broaden their experience by secondment or supernumerary status		
19	R5	Develop a list of current MDT meetings and events and share with staff across the directorate		
20	R8	Develop and implement a recruitment and retention strategy specifically for the obstetric directorate		Green
21		Review the current midwifery staffing establishment to ensure appropriate staffing levels in all clinical areas		
22		Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention		Green
23		Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns		Green
24	Only applicable to multi-site trusts.	Improve working relationships between the different sites located geographically apart but under the same organization.		
25	R9	Reiterate to all staff via email and team meetings the roles and responsibilities of the consultant obstetrician carrying the hot week bleep.		
26	R11, R12	Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents.		Green
27	R11, R12	Including a review of the processes for disseminating and learning from incidents		
28		Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively	All consultants to have completed RCA training	Green
			Identified midwives to have completed RCA training	Green
			Staff who have completed RCA training undertake an investigation within	Green
			Develop a local record of staff who have completed RCA training and the	Green
29	R12	Ensure that the details regarding staff debriefing and support are completed on the Trust incident reporting system for all level 4 and 5 incidents		

Kirkup Report Recommendations and Actions
Regional Update as at December 2021

The Shrewsbury and Telford Hospital NHS Trust

Kirkup Action no.	Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)	Action	Suggested documents that may support Trust assurance.	SHREWSBURY AND TELFORD HOSPITAL
30	R12	Ensure that all Serious Incidents (SI's)are fedback to the staff		
31	R12	Identify ways of improving attendance of midwives at SI's feedback sessions		
32	R13	Maternity Services Liaison Committee involvement in complaints	Collation of complaints reports	
33	R14	Review the current obstetric clinical lead structure		
34	R15	Review past SI's and map common themes	Thematic reviews	
35	R23	Ensure that maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths are reported, reviewed and an investigation undertaken where appropriate	Maternal deaths, stillbirths and early neonatal deaths reports	
36	R26	Ensure that all staff are aware of how to raise concerns	Whistle blowing staff policy	Green
37	R31	Provide evidence of how we deal with complaints		Green
38	R31	Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area	Identifying situations where local resolution is required	Amber
39	R32	Develop a plan to maintain a supervision system beyond the decommissioning of the LSAs once national recommendations have been agreed.	Implementation of the A-AQUIP model	
40	R38	Ensure that all perinatal deaths are recorded appropriately	Sending the completed form to the Deputy Director of Nursing/ Head of Midwifery and the Divisional Clinical Effectiveness Manager	
41	R39	Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained	MBRRACE action plan	Amber

Sub-Appendix 1 to Appendix 3

Obstetric Workforce Overview as at February 2022

- The current budgeted WTE is 22.82 WTE for consultants across obstetrics and gynaecology.
- The budget has not been formally reviewed in the last 24 months due to COVID pressures and senior leadership vacancies.
- The SLT is now fully established and a review of requisite levels of consultant staffing is underway.
- The division is currently working through budget-setting and the likely figure will be in the region of 30 WTEs; this will include the resident night consultants, and factors in some consultants who are on more than 10 PA's.

Gynaecology only	Obstetric only	Obstetric and Gynaecology hybrid	Resident night consultants (Obstetrics and Gynaecology)	Total
5 full-time, 1 part-time	6 full-time	7 full-time	8 (2 of which currently locum)	27 consultants

- SaTH's current obstetrics and gynaecology consultant cohort comprises 27 consultants:
    - The Trust has invested in a cohort of eight full-time obstetric consultants to cover night on-calls, thereby achieving 24/7 resident obstetric cover.
    - All of these posts have been recruited to since January 2021, with six colleagues in post. The remaining two positions are covered by locum consultants, although one of these posts has recently been recruited to substantively. The second locum post is likely to be filled substantively by Autumn 2022.
- At present all multi-disciplinary training and Electronic Foetal Monitoring (EFM) sessions are being delivered with all day Practical Obstetrics Multi-Professional training (PrOMPT) at least every other week and an EFM study day at least monthly with regular weekly lunchtime sessions too. By the summer with new substantive consultants these will be fixed into to job plans but currently are being delivered by consultants on an ad hoc basis at present.

Prepared Dr Mei-See Hon, Clinical Director – Obstetrics and Mr Martyn Underwood, Medical Director, Women and Children's Division.

28 February 2022

Sub-Appendix 2 to Appendix 3

Obstetric Anaesthesia Workforce Overview as at February 2022

1. Current establishment

The Trust is budgeted for 8 anaesthetics consultants with an interest in obstetric anaesthesia. The service currently has 7 in post.

This enables the Trust to partially but not fully fulfil Royal College guidelines on consultant coverage of all elective caesarean section lists, Monday to Friday labour ward sessions, and obstetric anaesthesia clinics. (Audit results show almost 100% coverage of elective lists and clinics by consultants, but approximately 50% coverage of labour ward).

After several years of failure to recruit, we have successfully recruited 2 consultants to obstetric anaesthesia in the last year (one started in August 21; the second started in November 2021).

All afterhours on maternity is covered by a group of 6 middle grade anaesthetists. In the last year 5 out of the 6 of them have progressed on to the Specialist Grade level, which deems them equivalent to consultants in that area of specialty with respect to clinical autonomy. This group also fills in gaps in labour ward coverage when consultants are away, so there is in effect almost 100% coverage of maternity by consultant or consultant equivalent anaesthetists.

The first Ockenden report recommends increased involvement by consultants in systems improvement, such as audit, quality improvement and multi-disciplinary training. In the last few months, amongst the middle grade and new consultants we now have specific leads in QI (Quality Improvement), Teaching and training, Guidelines, and Audit. There is still a gap in risk management, which could be filled by unused SPA time in current consultant job plans.

2. Vacancies

We have one unfilled consultant post in obstetric anaesthesia. We are not advertising for this yet, as rota reconfiguration options are under currently negotiation. It is hoped that the new configuration will make recruitment to this post more attractive.

We are interviewing for a band 5 2 days/ week audit officer to help with the audit requirements of the Ockenden report in obstetric anaesthesia.

3. Use of bank/ agency staff

None

4. Business cases in train for workforce

None

Lorien Branfield
Consultant Anaesthetist – lead for obstetric anaesthesia, SaTH
17 February 2022

Sub-Appendix 3 to Appendix 3

Neonatal Nursing and Medical Workforce Overview as at February 2022

Area	Budg-eted WTE	Con-tracted WTE	Outstanding funded developments	Actions
Neonatal consultant	6.8	5.8 (1.0 va-cancy)	Ockenden funded 7th consultant post adver-tised and currently in recruitment.	Recruitment to the new (7th) con-sultant post and replacement of a retiree
Tier 2			3 Tier 2 ANNPs to en-able full separation of tier 2 rotas between Neonates and general paediatrics. Two ap-pointees in post and in supervised role before commencing inde-pendent tier 2 role and 3rd due to commence in April 2022..	Ensure full fulfil-ment of tier 2 trainees by HEE and recruitment of an additional Specialty doctors to enable full sep-aration of tier 2 rotas
Neonatal nursing	44.32	42.64 (1.68 va-cancy)	5.6 WTE funded through birthrate plus for transitional care out to advert 0.5 WTE band 6 coun-sellor funded through MTP to be recruited	Regularly review compliance of ne-onatal nurse es-tablishment against delivered activity to ensure that the service meets BAPM nursing standards for current levels of activity

- A SAS (Specialty [Doctors] and Associate Specialist) paediatric doctor is being recruited alongside additional ANNP's (Advanced Neonatal Nurse Practitioners). This is to support the following associated Ockenden Report Local Actions for Learning:
    - 4.99 "The neonatal unit should not undertake even short- term intensive care, (except while awaiting a neonatal transfer service), if they cannot make arrangements for 24 hour on-site, immediate availability at either tier 2, (a registrar grade doctor with training in neonatology or an advanced neonatal nurse practitioner) or tier 3, (a neonatal consultant), with sole duties on the neonatal unit."

        - The additional recruitment will support a split of the paediatric and neonatal Tier 2 overnight rota with ANNP, Advanced Clinical Practitioners (ACPs) in Paediatrics and Specialty doctors participating alongside Paediatric trainees in tier 2 rotas.

    - 4.100 “There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit”

        - This rotation has already been achieved for consultants and is underway for ANNPs. The additional recruitment will free up staff to attend these attachments more easily.

    - The Dinning tool is regularly completed to ensure adequate nursing cover for the service. The unit achieves BAPM nursing standards for current levels of activity. Recruitment is underway against Business cases for Transitional care and Counselling support for parents. Recent recruitment has allowed neonatal nursing outreach to be extended to a 7-day service.

As part of the overarching neonatal service review, the recently appointed Divisional Director of Nursing will be requesting a specific focus on nursing workforce to ensure that high quality, safe care is provided by optimal numbers of staff of differing roles, who are educated and competent to care for the given case mix of babies and families. This is likely therefore to require further workforce development in the short-medium term.

Prepared by Dr Sanjeev Deshpande (Consultant Neonatologist) and Tina Kirby (Centre Manager – Maternity, Obstetrics and Neonatology) and Julie Plant, Divisional Director of Nursing.

February 2022

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
10 March 2022

Agenda item	041/22			
Report	Head of Midwifery Report			
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	√	BAF204	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion			
	For noting			
	For information	√		
	For consent			
Presented to:	Maternity Governance 17th February 2022, Extra-ordinary Sign off due to Governance being stood down. 22nd February 2022.			
Dependent upon (if applicable)**:**				
Executive summary:	The purpose of this paper is provide an update on the :- • Current clinical midwifery vacancy position • Progress update on implementation of 90/10% skill mix • Acuity tool data and maternity safer staffing red flags Also, contained within this report is an overview of oversight and monitoring of maternity staffing by senior midwifery leaders. **Shirley Jones,** **Interim Head of Midwifery** **February 2022**			
Appendices	**Appendix 1- Maternity red flag events, NICE (2015)**			

Introduction

The activity within maternity services is dynamic and can change rapidly. It is therefore essential that there is adequate staffing in all areas to provide safe high quality care by staff who have the requisite skills and knowledge. Regular and ongoing monitoring of the activity and staffing is vital to identify trends and causes for concern, which must be supported by a robust policy for escalation in times of high demand or low staffing numbers.

Birthrate Plus provides an evidence based methodology for calculating midwifery staffing requirements based on the case mix for women and babies accessing the service. This staffing report will focus on the recommendations of the BirthRate plus Report (2021) and how safer staffing is facilitated by adoption of the recommendations, as outlined in the previous staffing papers presented in July and October 2021.

NICE (2015) published guidance on safer midwifery staffing and identifies red flags where further action is required to ensure safety of women and babies. This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags.

The report also provides an accurate account of the current clinical workforce status and includes an update from recommendations within the paper presented in November 2021. In addition, gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this. A clear breakdown of Birth Rate Plus or equivalent calculations to demonstrate how the required establishment has been calculated.

In order to comply with the requirements of clinical negligence scheme for Trusts (NHSLA, 2021) the following standards are addressed: -

Safety action number 5 of the Maternity Incentive Scheme asks:

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

The required standard for this is detailed below:

- *A systematic, evidence-based process to calculate midwifery staffing establishment is complete.*
- *The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service*
- *All women in active labour receive one-to-one midwifery care*
- *Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board.*

Background/Context

There are two models of maternity care currently in place within the SaTH maternity service. Firstly, there is a traditional model, where midwives provide care in the specific area of the service where care is required. Secondly, there is a continuity of carer model (Better Births, 2016), where small teams of midwives provide care throughout the maternity pathway, antenatal, intrapartum, and postnatal, for a defined caseload of women.

A full Birth Rate Plus assessment was completed by the service with a final report shared in February 2021. The Trust is currently working to the previous Birth Rate plus report which was implemented into funded establishment in 2019. Funding has now been agreed for the maternity services to work to the latest Birth Rate plus 2021 recommendations and work has progressed to reset budgets and midwifery templates to reflect this. Work for inpatient areas on templates has been completed, further work on community templates to be finalised still. Once completed this work will provide accurate fill rates within Health roster.

Birthrate Plus Report – BR+

The BR+ (2021) refers to the numbers of both clinical and non-clinical midwives. Non clinical midwives that is those in specialist and managerial roles comply with the recommendations of Birth Rate Plus. This paper, therefore, will focus on the numbers of midwives required for provision of clinical care.

One of the findings of BR+ (2021) is that clinical staffing can be adjusted to include a varied skill mix to support the midwifery workforce suggesting that this is a local decision dependent upon the configuration of services. Many maternity services utilise the skills of maternity support workers to support in this way.

Although the role of the maternity support worker has been prevalent for some time, Health Education England (HEE) has provided resources to standardise this role nationally. SaTH has been fortunate to be able to utilise these resources to plan how the introduction of this role to complement the workforce and improve skill mix to optimise care.

Representatives from SaTH have joined regional network groups to ensure we have followed national guidance to introduce the role of the maternity support worker, using national job profile and national competence framework to ensure safe clinical competency is achieved.

It is therefore proposed that the clinical maternity workforce will consist of band 5 and 6 clinical midwives, supported by band 5 neonatal nurses and maternity support workers within the postnatal area. In addition, band 3 maternity support workers will support care in the community area. In line with BR+ and the RCM (2016) there is no role for a maternity support worker in intrapartum care or inpatient antenatal care.

Table 1 - January 2022

Funded BR+ (2021) clinical midwives WTE after implementation of 90/10 skill mix.	Contracted WTE clinical midwives	Variance
180 WTE	186.60 WTE	*+6.60 WTE*

At the end of January 2022 there were 0 WTE clinical midwife vacancies against a baseline of the above clinical midwives.

Whilst recognising that the 90/10% skill mix is not yet fully embedded, based on January 2022 data, it is envisaged there will be an over establishment of the midwifery clinical workforce of 6.6 WTE.

This will provide the workforce with a degree of resilience over the next few months whilst the skill mix is implemented in full and new roles are embedded into the clinical midwifery workforce.

This transitional phase is anticipated to be completed by April, early May 2022 with band 3 MSW fully embedded into clinical workforce. With the newly recruited band 5 neonatal nurses recruited and in post on the postnatal ward.

Table 2

Breakdown of 10% workforce – current situation

Funded Birth Rate Plus 10% skill mix	Current in post	Out to recruitment
Band 3 establishment BR+ recommendation = 14.25 WTE	11.45 WTE	2.8 WTE – shortlisting arranged.
Band 5 establishment = 5.8 WTE	0 – interviews 02/03/22	

Table 3

Contracted Clinical workforce against Clinical workforce available for duties.

Contracted WTE clinical midwives	Clinical midwives available WTE	Variance
186.60 WTE	169.7 WTE	16.9 WTE

Currently the service is experiencing staffing pressures due to the transitional phase introducing the 90/10 skill mix into the clinical workforce along with the unavailability of clinical midwives with the deficit of 16.9 WTE, these are accounted for in long term sickness and maternity leave. These clinical pressures are being felt operationally daily and are causing challenges in opening the alongside MLU at Wrekin. This is being managed by the escalation policy and twice daily management huddles to ensure services are safely maintained and the MLU opened when acuity and staffing is allowing.

Table 4

Clinical Midwife unavailability over past 12 months.

Month	Unavailability WTE
Jan 2021	6.4 WTE
April2021	9.0 WTE
June 2021	11.6 WTE
Sept 2021	17.5 WTE
Jan 2022	16.9 WTE

Table 4 indicates an increase in unavailability from April 2021, this is clinical midwives that have been recorded as not working any hours per month due to Long-term sickness and maternity leave. Short term sickness is in addition to this, if above the tolerance built into midwifery templates, which is 3.9 %.

It has been agreed to interview upcoming band 5 midwifery students and recruit an additional 20 WTE from this September 22 intake. This will place the clinical midwifery WTE in a strong position moving forwards against the 11.2 WTE planned retirements that are pending later this year and the annual attrition rate.

Table 5

Final position of funded establishment as per Birth Rate Plus report (2021)

Funded BR+ clinical midwives WTE	Number of wte clinical midwives required following implementation of 90/10% skill mix split	10% skill mix, that is, band 3 and non-midwives above band 3.
200.55 WTE	184.22WTE	20.05 WTE

Options proposed by BR+ are that 11.6 WTE maternity support workers are utilised within the postnatal inpatient area, with the remaining 8.45 WTE across the community areas. In this respect, work has been done in collaboration with neonatal colleagues to strengthen the transitional care service which is situated within the postnatal ward area. This work has recommended that we the skill mix of neonatal nurses to develop our transitional care service. See table below.

Table 6

Area	WTE skill mix breakdown in accordance with BR+	Total WTE
Postnatal ward	11.6 WTE to include local decision of 5.8 WTE maternity support workers and 5.8 WTE band 5 neonatal nurses.	
Community services	8.45 WTE	=20.05 WTE

The band 3 roles were launched on 15th November 2021. They are currently in a transitional period, whilst working towards full competency sign off and implementation of the 90/10% skill mix from joining the MSW and Neonatal nurses into the clinical midwifery workforce.

To provide further assurance regarding safety of the maternity service data has been collected from the last three months to provide oversight of the impact of recent staffing challenges. The following staffing metrics have been reviewed

Maternity Safer Staffing Red Flag Events 2021

Table 7

Month	Nov 21	Dec 21	Jan 22
Red flags from Acuity Tool	46	62	51
Red flag events reported via datix	12	14	15

A maternity red flag (NICE, 2015) event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the area of care should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed. (See appendix 1)

The leadership team continue to monitor and review the critical red flags to gain a greater understanding of data highlighted on the maternity dashboard.

Red flags are currently reported via the Birth Rate plus acuity intrapartum tool every four hours on delivery suite and 3 times daily on inpatient wards. There is oversight of the presenting red flags, reported via the acuity tool, at twice daily maternity safety huddles. Senior midwives direct staffing resource to areas of higher need and to prioritise one to one care in labour. In addition to reporting of red flags via the acuity tool, datix requires the highlighting of red flags in any incident reported relating to maternity staffing enabling a triangulation of data.

Numbers of red flags, reported via the acuity tool have historically been reported monthly via the maternity dashboard. Recent discussions at governance meetings have highlighted a limited understanding of the number of women impacted by red flag, highlighting the need to undertake an in depth review.

On review, of the 51 red flag events in January 22 and due to four hourly reporting, it was clear that multiple reports had been submitted for individual women. Hence, 41 red flag events related to 18 women who were affected by a delay of more than 8 hours for artificial rupture of membranes (ARM)/augmentation.

In mitigation, however, as the women are maternity inpatients during the delay there is ongoing monitoring of maternal and fetal wellbeing. If there are any issues arising then care would be reprioritised. Decision making and prioritisation of care involves the multidisciplinary team, which provides assurance that any delay has not put them at additional risk of harm.

Provision of one to one care of women in labour

Table 8

Month	Nov 21	Dec 21	Jan 22
Data taken from dashboard	97.7 %	98.4 %	98.5%
Number of occasions where one to one care has not been provided, reported via datix reported.	3	0	3

Provision of one-to-one care for women in labour is a maternity safer staffing standard and inability to adhere to this standard is a red flag (NICE, 2015). Provision of one to one care of women in labour is reported on the maternity dashboard monthly. Compliance of this standard is prioritised to maintain safety and care for women in labour.

Shift co-ordinator not able to maintain supernumerary status

Table 9

Month	Nov 21	Dec 21	Jan 22
Number of occasions recorded via BR+ acuity tool where co-ordinators reported not being able to maintain supernumerary status	10	5	3

Numbers datix incident reports where co-ordinators reported not being able to maintain supernumerary status	2	0	0

Safer Staffing Standards for Delivery Suite (RCOG, 2007) states that services should organise their delivery suite staffing to enable supernumerary status for the delivery suite coordinators to enable capacity to maintain oversight of delivery suite activity and be available to support other members of staff providing care for women.

During January 22 the reasons for the delivery suite coordinator not being able to maintain supernumerary status is explained as follows: -

- On 1 occasion the coordinator was briefly unable to be supernumerary as she was caring for a woman in recovery. A midwife from another ward was redeployed to relieve her, as per escalation policy.
- On 2 occasions coordinator needed to support woman in labour whilst on call midwife on way in to take over 1:1 care, as per escalation policy.

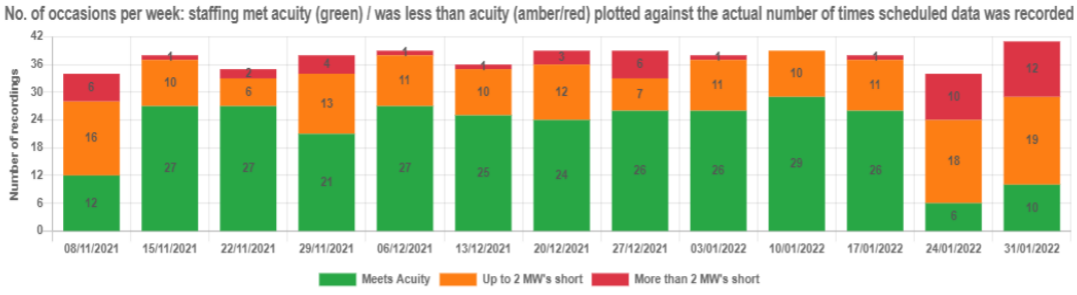
There is an expectation that the coordinator would escalate not being able to maintain supernumerary status to the manager on call if it was anticipated that this would be for a prolonged period which does not have a plan to resolve the situation in place. In summary, the co-coordinators were using their supernumerary status to support and provide indirect care.

A further measure of safe staffing is utilised within SaTH and consists of BR+ acuity tool in all inpatient areas to measure safe staffing levels and advises co-ordinators when care needs of women and babies are unable to be met with current staffing levels in any particular area. This tool informs our escalation policy and supports oversight and scrutiny of staffing levels.

Data from all areas is shared twice daily acuity tools in all areas at senior management safety huddles to inform flexible deployment of staff when required to maintain safety across the unit and is also presented monthly on the dashboard from Delivery suite only to provide oversight and monitoring of safety in wider forums for scrutiny.

In addition to highlighting maternity safer staffing red flags on the maternity dashboard, monthly, Birth Rate Plus acuity tool data is presented. See 13 week report below. This is taken from Delivery Suite data alone currently.

2.0



Overall during the data period for weeks commencing 08/11/2021

% of recordings where staffing level more than 2 MW's short	8.8%
% of recordings where staffing level is up to 2 MW's short	28.2%
% of recordings where staffing level meets acuity	52.4%
Data collected for the period covered by this summary provides	89.4% compliance

It is important to recognise that this is a measure of Delivery Suite acuity only, currently. Further assessment of the acuity within all inpatient areas is carried out at twice daily senior management team Safety Huddles, which are captured on proforma along with actions taken to mitigate risk across all areas.

- The table above highlights percentage of times the ward area is in positive acuity and when amber and red acuity is registering and alerting actions to be taken to maintain safety levels.
- There is an escalation policy for staff to use in the event of staffing short falls

Conclusion

As discussed earlier, midwifery safe staffing is complex due to its ability to rapidly change based on care needs and complexities of maternity cases and more recently due to national pandemic challenges over the past year, with staff isolations and increased pressures on the workforce.

A full Birth Rate plus report (2021) was commissioned and findings shared with Trust Board via an earlier staffing paper in September 2021.This staffing paper, demonstrates significant progress from the earlier paper with a clearer workforce position and a plan, as recommended, to apply the use of the 90/10% skill mix. This will complement the current workforce, whilst strengthening overall vacancy position to reach the recommended workforce establishment early in 2022.

It is anticipated that there will be improved acuity levels in all areas across the service and in turn numbers of red flags generated will be reduced.

Finally, this the paper highlights additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance.

With clear and robust escalation policy in place and twice daily oversight of the maternity unit's acuity verses staffing being monitored, early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are maintained and safety is a priority for the service.

In addition to this monthly monitoring internally and externally via the perinatal Quality Surveillance group and other Board level meetings trends, areas of concerns can be identified and enacted upon.

The report highlights that despite a challenging year, the service now has improved oversight of staffing vacancies and oversight of safety metrics with a clear plan in place to

address these. It also has a clear workforce plan that utilises a more diverse skill mix, which will enhance care provision and strengthen the clinical workforce.

1. ACTIONS REQUIRED OF THE BOARD OF DIRECTORS

The Board of Directors are requested to

- Receive this report
- Decide if any if any further actions and/or information are required

Reference list

Better Births a five year forward view for Maternity care https://www.england.nhs.uk/wpcontent/uploads/2016/02/national-maternity-review-report.pdf

Safe Midwifery Staffing for Maternity Settings NICE 2015 NG4 www.nice.org.uk/guidance/ng4

Royal College of Midwives 2016 Guidance on implementing the NICE safe staffing guideline on Midwifery staffing in maternity settings

Maternity Incentive Scheme- year Four. NHSLA (2021) NHS resolution.

RCOG 2007 Safer Childbirth – Minimum standards for the organisation and delivery of care in Labour (RCOG 2007)

Appendix 1

Maternity red flag events, NICE (2015)

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Other midwifery red flags may be agreed locally