SaTH Board of Directors – Meeting in Public
12 May 2022

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	085/22			
Report	Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 4 Progress Update as at April 2022			
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:	Women and Children's Divisional Committee (26 April 2022) Quality and Safety Assurance Committee (27 April 2022)			
Dependent upon	n/a			
Executive summary:	SaTH is a participant in year 4 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), which is operated by NHS Resolution (NHSR) and supports the delivery of safer maternity care. The Trust has been informed by NHS Resolution (NHSR), which administers the Scheme, that the submission deadline (originally June 22) will be moved to the end of this calendar year or later, with updated guidance expected imminently. The reports required for BoD receipt by April 2022 under the latest guidance yet published are detailed in this paper.			
Appendices	*For patient confidentiality reasons, the appendices will be provided to the Board of Directors meeting in private* 1. Quarter 4 2021-22 PMRT report 2. Safety Action 10 completion evidence			
			Hayley Flavell, Director of Nursing 28 April 2022	

1.0 Introduction

1.1 The purpose of this paper is to provide the Board of Directors with assurance that SaTH is compliant with the elements of CNST that are due to have been evidenced by April 2022

1.2 NHS Resolution launched year four of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) on 9 August 2021, to continue to support the delivery of safer maternity care.[1] SaTH is working to the most recent guidance as published in October 2021 and is complaint with all reporting deadlines to date[2].

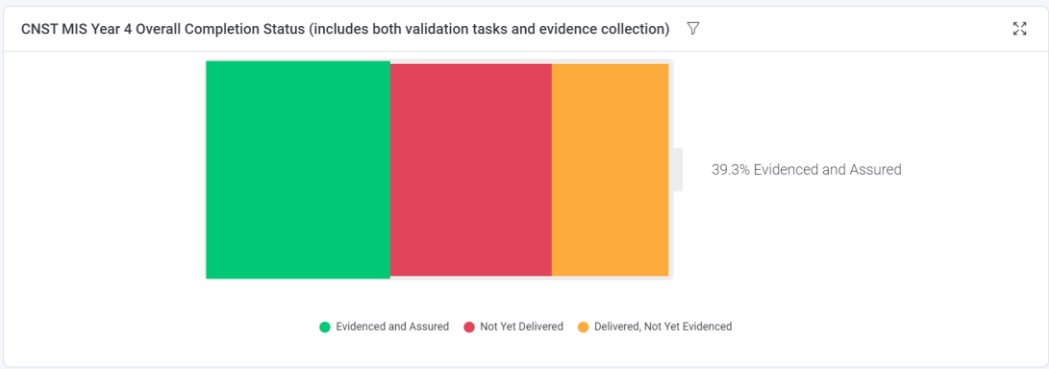
1.3 However, in an announcement in December 2021, NHSR allowed Trusts to pause the majority of CNST reporting for at least three months.[3] SaTH is awaiting updated guidance from NHSR but has been advised that the reporting deadline will be extended until at least December 2022.

2.0 Overall Progress Status

2.1 SaTH utilises project management software to manage the CNST delivery plan and embed completion evidence. The following progress diagrams are taken from this tool.

2.2 Each Safety Action comprises standards that must be attained and minimum evidence requirements associated with each standard. These two requirements are reflected separately in the progress charts against each Safety Action but combined in the overall status.

2.3 The below chart shows a CNST completion rate (including compliance with the standards and accrual of supporting evidence) of 39% Evidenced and Assured, 26% Delivered, Not Yet Evidenced and 35% Not Yet Delivered.

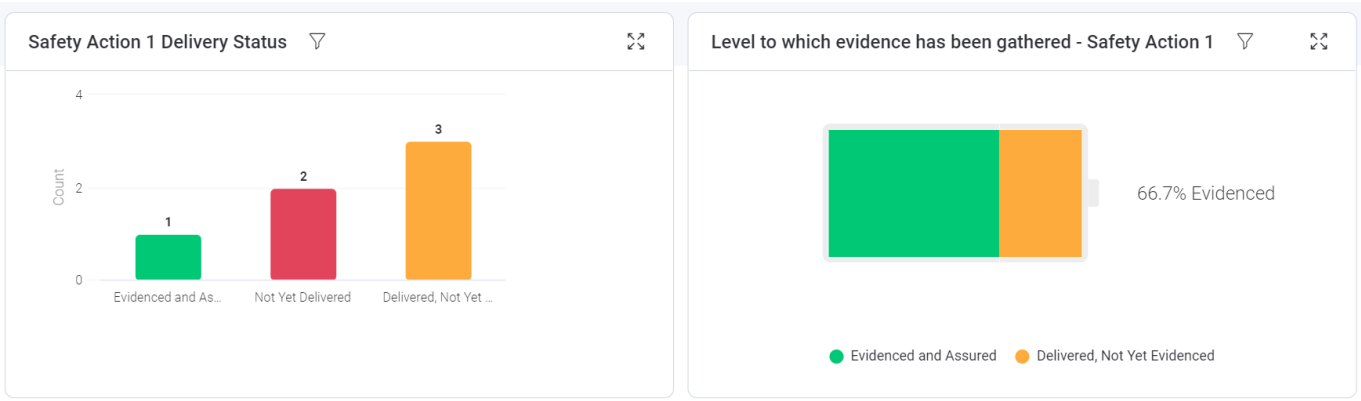


2.4 This completion rate has fallen behind planned progress as regards Safety Actions 2, 6 and 8 and there are ongoing risks to delivery associated with all of these. These risks have already been highlighted to the Board of Directors are re-articulated in section 12.0.

[1] NHS Resolution publishing statement available at: https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/
[2] Latest guidance (October 2021) available at: https://resolution.nhs.uk/wp-content/uploads/2021/10/16092021-MaternityIncentiveSchemeYEAR4-Revised-timeframe-October-2021-updated.pdf
[3] Letter entitled 'Pause in reporting procedure regarding the maternity incentive scheme' co-signed by Chief Executive NHSR, Chief Midwifery Officer and National Clinical Director, 23 December 2021, available at: Pause-letter-MIS-y4-Dec-2021-23122021..pdf (resolution.nhs.uk)

2.5 The anticipated revised guidance and accompanying reporting deadline extensions mentioned in section 1.0 may bring these actions back on track, however it is not possible at this stage to be certain of this.

3.0 Safety Action 1: "Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?"

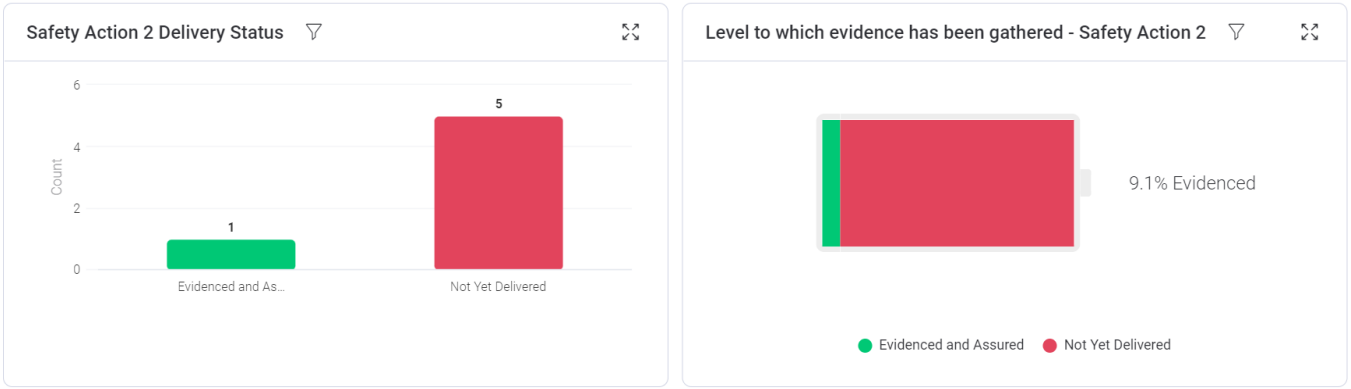


3.1 SaTH is compliant to date with reporting to the MBRRACE-UK website (this is one of the actions which NHS Resolution has asked Trust's to focus on during the 'pause' outlined in their December letter).

3.2 The latest quarterly report (Quarter 4, 2021-22) will be provided separately to the Board of Directors at its meeting in private, to protect patient confidentiality. The report has been approved by the Women and Children's Divisional Committee and noted (though not yet validated) by QSAC.[4]

3.3 **Progress Status: On Track**

4.0 Safety Action 2: "Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?"



4.1 As communicated in the February 2022 update, SaTH are experiencing difficulties with the upload of data to the Maternity Services Data Set. Much progress has been made under the leadership of the Trust's Head of Business Intelligence (BI):

[4] This is a requirement of Safety Action 1, 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".

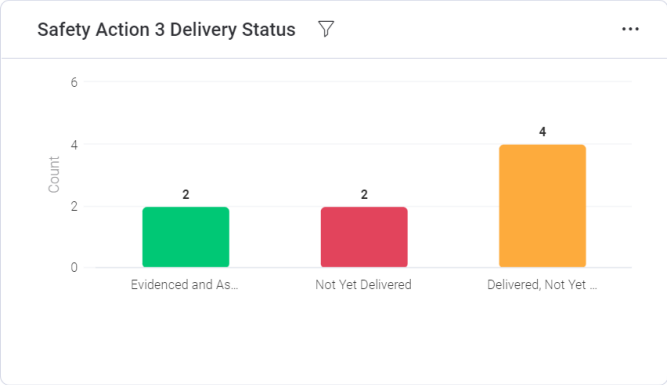
4.1.1 The Head of BI has contacted NHS Digital (who administer this Safety Action) to advise that organisation of SaTH's upload difficulties, and the Trust is being guided by NHS Digital to help resolve the issues.

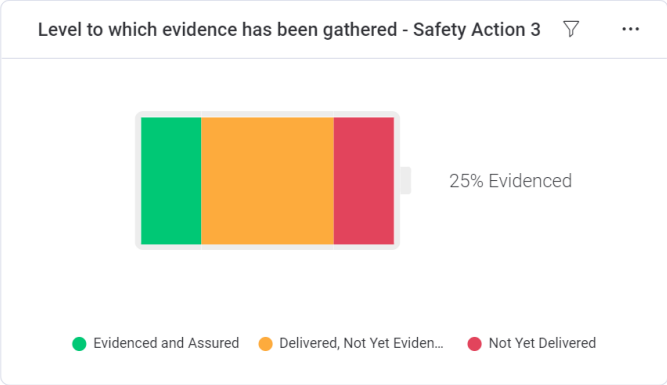
4.1.2 Of the 41 sub-items of Clinical Quality Improvement Metrics (CQIMs), SaTH is 'meeting expectations' for 39, but 'requires improvement' in the remaining three.

4.2 Safety Action 2 requires 9 of 11 Clinical Quality Improvement Metrics (CQIMs) to have passed the associated data quality criteria on the national Maternity Services Dashboard for data submissions relating to activity in January 2022. It should be noted that the data is always uploaded two months in arrears.

4.3 **Progress Status: At Risk**

5.0 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?"



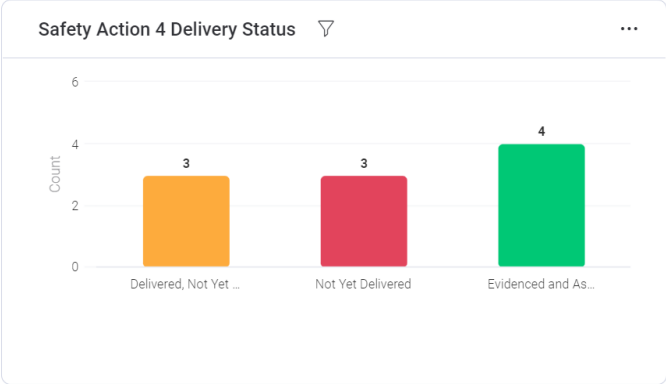


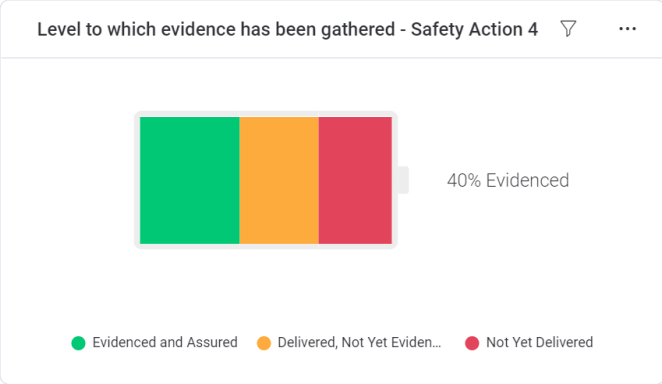
5.1 The Trust operates an effective Transitional Care service and associated pathway and continues to exceed the national target of Avoiding Term Admission into the Neonatal Unit (ATAIN).

5.2 A number of associated audits are due to be shared with the Maternity and Neonatal Safety Champions Group in the coming weeks, which should take a lot of the sub-actions to 'Evidenced and Assured Status'.

5.3 **Progress Status: On Track**

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





6.1 The Obstetrics workforce paper has been delivered to and accepted by the Board of Directors, and the associated audit has been conducted and found to be compliant; this completed Standard a) Part 1. Ongoing audit will be provided automatically from the Badgernet System (standard a) Part 2) and the results will be communicated to QSAC (and a summary to the Board of Directors) prior to closure of the CNST reporting year.

6.2 Compliance with Safety Action 4, standard b[5] (anaesthetic medical workforce) has also been confirmed, with evidence ratified by the Women and Children's Divisional Committee and a copy shared with QSAC.

6.2.1 A rota audit conducted by Dr Lorien Branfield, obstetric anaesthesia lead, shows that there has a dedicated anaesthetist to labour ward (no other duties outside of maternity) 24/7 every day of the year to date. There is a consultant that can be called every day/ night. The Trust is therefore compliant with this standard.

6.3 **Compliance with Safety Action 4, Standard c[6] (Neonatal Medical Workforce) has also been confirmed by Women and Children's Divisional Committee, and the evidence shared with QSAC.**

6.3.1 The evidence took the form of a document prepared by Dr Patricia Cowley, Clinical Director of the Neonatal Unit, which details how the Unit meets the staffing requirements as set out by BAPM for a Local Neonatal Unit. The Trust can therefore prove compliance with this standard.

6.4 A separate paper outlining the level of compliance with Safety Action 4 standard d) (Neonatal Nursing Workforce) us being produced by the Matron for the Neonatal Unit and

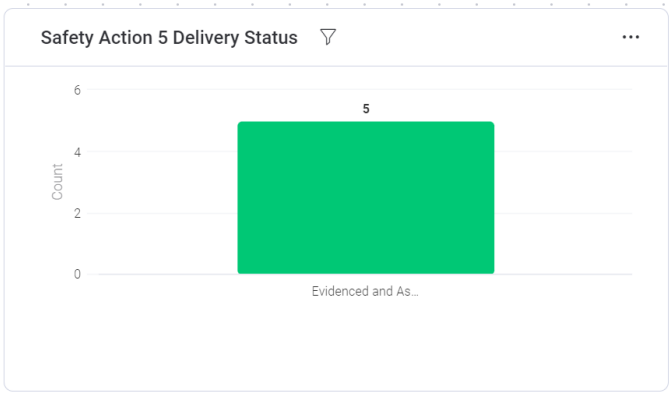
[5] A duty anaesthetist [must be] immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1)

[6] The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address 31 deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies.

will be provided to the Divisional Committee in May, once it has been received by Neonatal Governance. Once ratified, it will be shared with QSAC and confirmation sent to the Board of Directors.

6.5 **Progress Status: On Track**

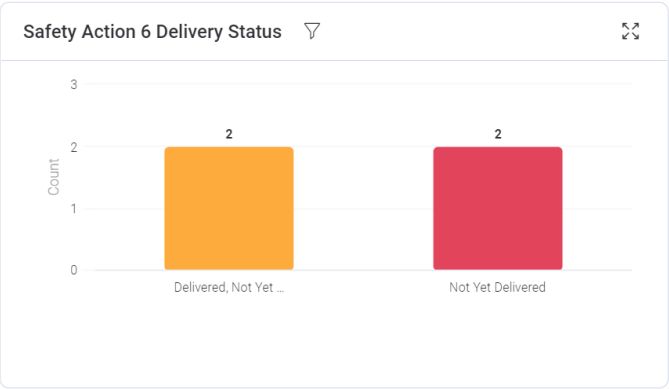
7.0 Safety Action 5: "Can you demonstrate an effective system of midwifery workforce planning to the required standard?"

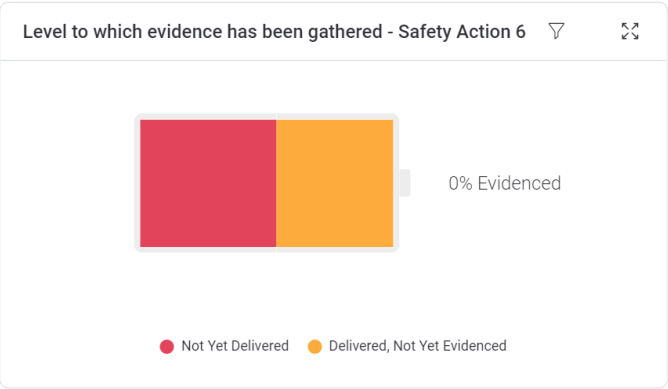


7.1 This action has already been accepted as closed by the Board of Directors, it having bene provided with the two midwifery workforce papers set out in the evidence requirements.

7.2 **Progress Status: Complete**

8.0 Safety Action 6: "Can you demonstrate compliance with all five elements of the Saving Babies' Lives (SBL) care bundle version two?"





8.1 This is one of the largest and most complex of all the Safety Actions because it comprises the five elements of SBL:

8.1.1 Reducing smoking in pregnancy.
8.1.2 Risk assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction (FGR)
8.1.3 Raising awareness of reduced foetal movement (RFM)

8.1.4 Effective foetal monitoring during labour.

8.1.5 Reducing preterm birth.

8.2 Testing the level to which the Trust is achieving these elements is dependent on multiple, continuous audits. The reason that the bar graph shows a large proportion of the deliverables as 'Not Yet Delivered' (red) is that most of these audits cannot be completed until end of the reporting cycle.

8.3 Regrettably, at this time, the Trust has not been able to achieve a process indicator level of above 80% for CO monitoring of women at booking and at 36 weeks.

8.3.1 This is due to a number of factors including a nationwide shortage of equipment consumables for the measuring device. >80% rates had been achieved in February but for March we down to <70%, as well as issues that have been encountered in uploading the data to the Maternity Services Data Set as a result of the Trust running both the Badgernet and Medway Electronic Patient Record Systems concurrently prior to April 2022 (this was necessary to ensure smooth transition to the new system).

8.3.2 Because Element 1 evidence requires >80% compliance for a period of six months, based on the original reporting deadline of June 2022, the Trust would have already failed on this Safety Action. The Trust awaits the updated NHSR guidance, wherein it is expected the deadline will be delayed until at least December 2022. If the CO monitoring period is extended accordingly, it may be possible for the Trust yet to pass this action, **but unfortunately this cannot be assured at this time.**

8.4 The Board of Directors has already received audit reports for Quarter 2 and Quarter 3 of 2021/22 on specific topics (Small for Gestational Age and Foetal Growth Restriction Reports and Reviews of Pre-Term Births) as mandated in the CNST technical guidance; these show compliance in these areas.

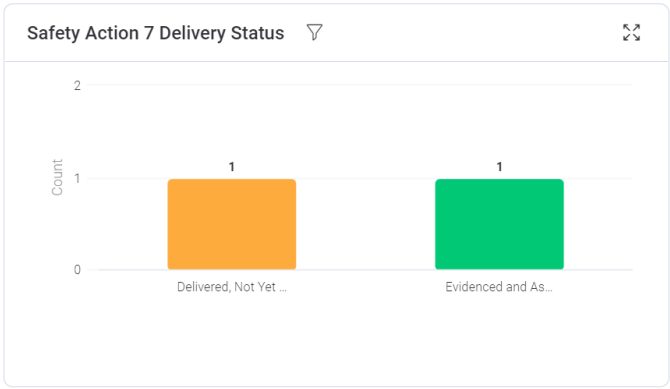
8.4.1 The same reports for Quarter 4 2021-22 have been ratified by the Women and Children's Divisional Committee and shared with MTAC. To be compliant with the evidence requirements for Elements 2, 3 and 5, the Board of Directors must be apprised of the following key points:

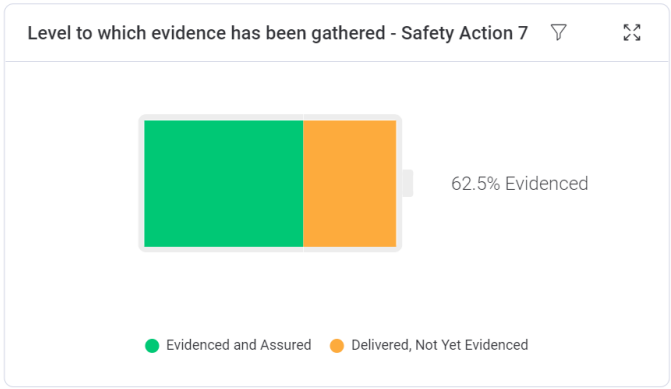
8.4.1.1 SaTH's detection and management of babies less that the 3rd centile remains better that the Perinatal Institutes national GAP user average, although Detection and management of babies born between the 10th and 3rd centile is below the Perinatal Institutes national GAP user average – this must be a focus for 2022/2023

8.4.1.2 SaTH is close to achieving the national target for pre-term births of below 6% by 2015 – the Trust's current rate is 6.1%.

8.5 **Progress Status: At Risk (due to the above-mentioned risk relating to CO testing targets for mothers at booking; all other actions are 'on track').**

9.0 Safety Action 7: "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 (MVP) to coproduce local maternity services?"





9.1 The productive partnership between SaTH and the Maternity Voices Partnership continues to yield important outcomes for service users and staff alike

9.2 Most of the evidence requirements for Safety Action 7 has now been secured, with two outstanding items:

9.2.1 **"**Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including childcare costs in a timely way**".**

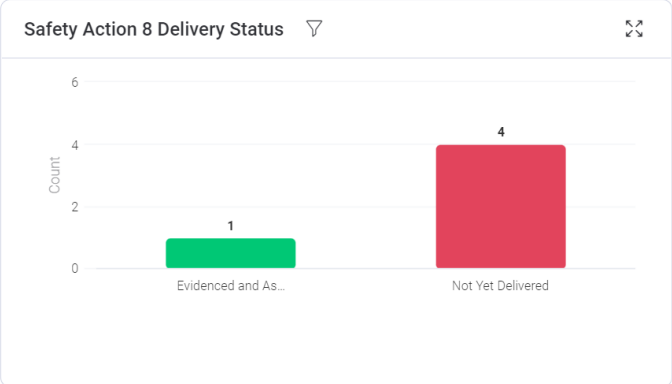
9.2.1.1 Though MVP volunteers are remunerated for expenses, there is currently no provision for childcare costs incurred. SaTH understands from regional partners that remuneration of this natures is not the norm. The MVP arranges its meetings in a child-friendly way and the Development Co-Ordinator has opined that remuneration for childcare is therefore probably not needed. On behalf of SaTH, the LMNS are seeking confirmation from NHSR and the Regional Chief Midwife that this is acceptable for the purposes of CNST.

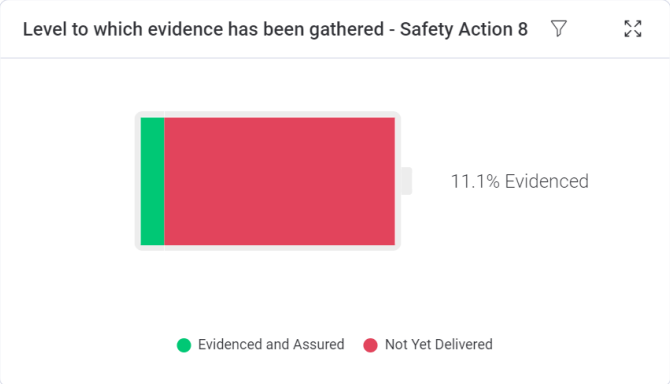
9.2.2 Trust must evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.

9.2.2.1 The MVP Development Co-Ordinator has authored a paper titled '*Engagement with Seldom Heard Groups, including the Black, Asian and Minoritised Ethnic communities*.' This paper included a number of proactive proposals for LMNS consideration. Once the paper has been approved by LMNS governance it will be shared with this committee as evidence for this standard.

9.2.2.2 **Progress Status: On Track**

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





9.3 This action remains a concern and is currently off-track. An action plan to formally schedule in the training time and monitor attendance more robustly has been put in place.

9.4 In compliance with standard a), the Trust has an approved training plan to deliver the Core Competency Framework (training to address significant areas of harm are included as minimum core requirements for every maternity and neonatal service).

9.5 There is a requirement that 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include maternity emergencies starting from the launch of MIS year four in August 2021. As of March 2022, SaTH has achieved the following statuses.

9.5.1 Midwives: 64%
9.5.2 Obstetrics Consultants: 79%
9.5.3 Other doctors: 97%
9.5.4 Obstetrics anaesthetists: 73%
9.5.5 Healthcare assistances / midwifery service assistants: 35%

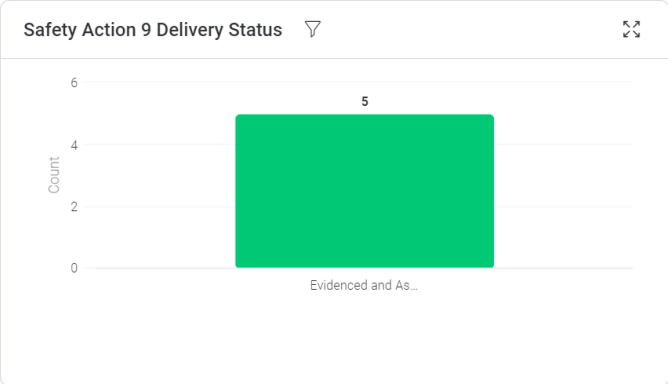
9.6 Compliance with the Neonatal Life Support training is at 47% for midwives, and 84% for Neonatal colleagues (including nurses, ANNP's and doctors).

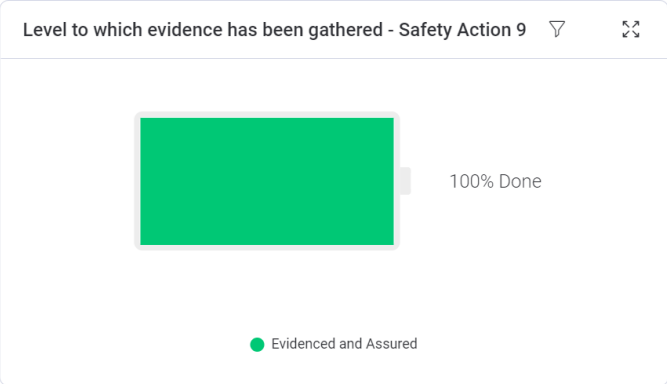
9.7 Based on this trajectory, it is very likely the Trust will not achieve the 90% target by the original June 2022 deadline, but the revised guidelines may extend the timeframe and / or reduce the requirement, so it may yet be possible to achieve this Safety Action, **but unfortunately this cannot be assured at this time.**

9.8 Multiple training sessions will continue to be offered from May onwards, and steps have been taken to formally roster this training into staff work plans rather than place a partial reliance on overtime, which should improve compliance.

9.9 **Progress Status: At Risk**

10.0 Safety Action 9: "Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?





10.1 The Maternity and Neonatal Safety Champions group continue to meet monthly for their walkabout and action meetings. The group's minutes show they have seen and / or approved the following CNST-related reports and actions:

10.1.1 Revised pathway implemented and published.

10.1.2 Ongoing safety intelligence discussions and reporting to the Board of Directors.

10.1.3 Publishing of issues raised by staff during the walkabouts and associated actions to address these.

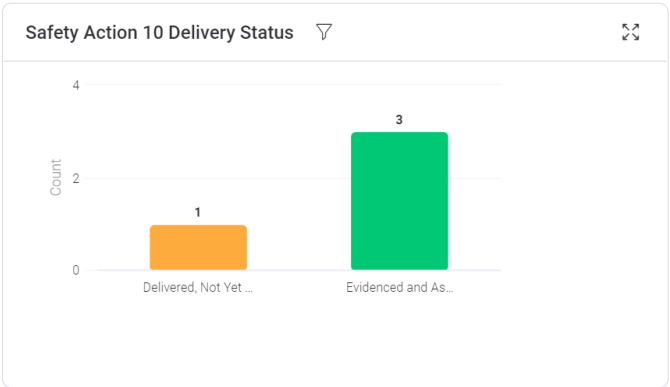
10.1.4 Sight of the Trust claims scorecard and accompanying description from Head of Legal Services to inform the group's understanding of Safety matters.

10.1.5 Sight of an acceptance of the latest Continuity of Carer plans.

10.1.6 Active support and involvement with the regional MatNeo partnership.

10.2 **Progress Status: Complete**

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



11.1 This Safety Action relates principally to the work of the Divisional Quality Governance Team, supported by the Assistant Director of Nursing, Quality Governance. As with Safety Action 1, the need to report appropriately to the (HSIB) and the NHS Resolution Early Notification Scheme (ENS) is ongoing, hence this action is never 'completed'.

11.2 However, Under Safety Action 10 Standard A), CNST Year 4 requires evidence that all qualifying cases for reporting to the Healthcare Safety Investigations Branch (HSIB) for financial year 2021-22 have been correctly submitted. Evidence of this has been ratified by the Women and Children's Divisional Committee and shared with QSAC. This evidence will be provided for information to the Board of Directors at their meeting in private; as per the PMRT report mentioned in the Safety Action 1 section the report would not be appropriate for sharing at Public meeting due to the potential for patient confidentiality breach.

12.0 Ongoing Risks to Delivery

There is a risk that…	The risk is caused by…	The potential impact of the risk is…	The mitigation in place is…
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. Data warehouse team working to fix; accuracy now >90% 2. Interim Information Development office assigned to W&C full time pending start date of permanent postholder 3. Trust Head of BI engaging with NHS Digital
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. The nationwide shortage of CO monitor tubes from February 2022 to date has further impacted upon delivery.	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 CNST Year 4 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. 4. Proactive rostering in place

13.0 Summary

13.1 SaTH is continuing to adhere to the requirements of CNST MIS per the latest full guidance as published in October 2021 and have not paused any reporting.

13.2 Three of the of the ten actions has been completed, four are on track, and three at risk.

13.3 Further guidance is expected from NHSR imminently; the Trust's plans will be updated accordingly, and any changes conveyed to the Board of Directors.

14.0 Actions Requested of the Board of Directors:

14.1 **Review and discuss** this paper.

14.2 **Note** the high-level version of the Quarter 4 2021-22 PMRT report (**Appendix** 1 – to be shared at the Board of Directors meeting in private)

14.3 **Take assurance** from the level of achievement of care applicable to babies with Fetal Growth Restriction or who are Small for Gestational Age as well as the Pre-Term Care measures as articulated in section 7.0

14.4 **Note** the evidence provided in this and earlier papers to demonstrate completion of Safety Actions 9 and 10 (further to Safety Action 5, which has already been accepted), and take **assurance** from this – as regards Safety Action 10, take **assurance** from **Appendix 2**, to be shared at the Board of Directors meeting in private.

14.5 **Note** the ongoing risks to delivery as articulated in Section 13.0 and **note** the possibility of failing to achieve Safety Actions 2, 6 and 8, which would mean overall failure to achieve CNST Year 4.

14.6 Be prepared to **receive** the remaining compliance confirmations for Safety Actions between May and December 2022 and be prepared to authorise the CEO to sign the self-declaration form on behalf of the Trust on or before the revised self-certification date, likely to be in December 2022 or January 2023.