Board of Directors' Meeting
8 December 2022

Agenda item	240/22			
Report	CNST MIS Year 4 Progress Update – November 2022			
Executive Lead	Hayley Flavell, Director of Nursing			
Report Author	Carol McInnes, Director of Operations, Women & Children's Division Annemarie Lawrence, Director of Midwifery, Women & Children's Division			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	1,2,8,13	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion		103, 104 and 105	
	For noting			
	For information			
	For consent			
Presented to:	Appendices submitted to 2022.11.23 Quality & Safety Assurance Committee			
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. In October 2022, the self-declaration deadline was moved from 5 January 2023 to 2 February 2023. This paper sets out SaTH's completion status against the ten identified safety actions to date and includes information to evidence the closure or partial completion of several safety actions which must be approved by the Board of Directors.			
Appendices	Various, see section 3.3. of the Summary section of the attached report.			
Executive Lead				

Any numbers that are less than 5 have been indicated as such in this report.

1.0 Introduction

1.1 SaTH is a member of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), which is regulated by NHS Resolution (NHSR) and is designed to support the delivery of safer maternity care.

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

1.3 The latest guidance was published in October 2022 and includes a revised self-declaration deadline of **noon on Thursday 2 February 2022.**[1]

1.4 The purpose of this paper is to provide Trust board with:

- 1.4.1 An updated position for SaTH's compliance against the standards it is obligated to have attained by now.
- 1.4.2 Details of the standards that must be evidenced as being presented to Trust Board via the attached appendices.
- 1.4.3 A proposal including next steps for the final elements of the programme.

2.0 Overall Progress Status

2.1 The current status of the safety actions has been updated further to the most recent Quality, Safety and Assurance Committee (QSAC). Progress against each of the actions is provided in the table overleaf.

Table 1: Summary of Safety Action Completion Statuses

Safety action #	Status reported to QSAC in 23 November 2022	Completion status as at 28 November 2022	Rationale for status change
1	On track	Complete	Q2 board report presented to QSAC demonstrating compliance against this safety action
2	Complete	Complete	n/a
3	On track	Complete	Q2 board reports for transitional care and Attain presented to QSAC demonstrating compliance against this safety action. Confirmation has been provided that data for action E is available for commissioners.
4	On track	Complete	The last outstanding item regarding the neonatal nursing workforce position and action plan has been completed. Compliance with this safety action has therefore been achieved.
5	Complete	Complete	n/a
6	At risk	On track	Progress against this safety action has been made. It is anticipated that this will be fully delivered in line with the given timescales.
7	Complete	Complete	n/a
8	At risk	On track	Progress against this safety action has been made. It is anticipated that this will be fully delivered in line with the given timescales.
9	Complete	At risk	While this action has been reported previously as fully complete, a further review of the technical guidance has identified a risk to delivery of one item regarding the trust's claims scorecard. This will be reviewed as part of the Trust Board Seminar Session.
10	On track	On track	n/a

3.0 Summary

3.1 Subject to a final review of the status of each of the safety actions against the timescales and requirements outlined within the technical guidance, SaTH is mostly on track to achieve CNST MIS Year 4. To note, some risk to delivery has been identified against safety action 9 as well as the potential impact on declaration of the HSIB immediate action letter, as referenced within the paper submitted to QSAC in November 2022.

3.2 At the time of writing this report, the Trust can report that 6 actions are 'complete', 3 are 'on track' for completion within the given timescales and one is 'at risk'.

3.3 A number of appendices are attached to this paper as follows:

Appendix 1:	Quality & Safety Assurance Committee, 23 November 2022
Appendix 2:	PMRT – Perinatal Mortality Reviews Summary Report 1/1/2022 – 30/9/2022
Appendix 3:	Maternity Governance Meetings triple A Report for meetings held in July, August and September 2022
Appendix 4:	PMRT – Audit information regarding compliance of PMRT letters sent to parents
Appendix 5:	Maternity Governance Meeting held on 21 October 2022 - Audit information regarding compliance of PMRT letters sent to parents
Appendix 6:	Transitional Care Audit Q2 2022-23
Appendix 7:	Maternity Governance Meeting held on 21 October 2022 - Transitional Care Audit Q2 2022-23
Appendix 8:	ATAIN (Avoiding Term Admissions into Neonatal Units) Q2
Appendix 9:	Maternity Governance Meeting held on 21 October 2022 - ATAIN (Avoiding Term Admissions into Neonatal Units)
Appendix 10:	Saving Babies Lives update, including Q2 Reports
Appendix 11:	Maternity Governance Meeting held on 21 October 2022 - Saving Babies Lives update, including Q2 Reports
Appendix 12:	Saving Babies Lives Element 2 (PowerPoint presentation)
Appendix 13:	Review of PreTerm Births (PowerPoint presentation)
Appendix 14:	Locally Agreed Safety Intelligence Dashboard Q2

These papers are included as within the CNST technical guidance, it states that certain items need to be shared with the Trust Board in order to meet the safety standard minimum evidence requirement. Board members can be assured that these papers have been discussed and reviewed in detail by QSAC in November 2022 prior to submission to the Board.

3.4 A board seminar session is scheduled for 1st December 2022 which includes representation from the Integrated Care System. The purpose of this session is for the Director of Midwifery and the Clinical Director of Obstetrics to present a summary status of the evidence collated for each of the safety actions to Trust board members for their review.

3.5 Further to this review, an agreed position regarding the status of the final submission will be presented to QSAC in December 2022 for ratification, prior to sign off from the Trust Chief Executive Officer (CEO) and the identified system CNST Accountable Officer.

4.0 Recommendations for Trust Board

4.1 Accept the recommendations within the paper submitted to QSAC in November 22 including the attached appendices.

4.2 Note the contents of this paper and take assurance that while there are some risks for non-delivery, that these have been mitigated as much as possible in advance of the final deadline for delivery of key items.

4.3 Note that there is a board seminar session scheduled for the 1st of December 2022 for the Director of Midwifery and the Clinical Director of Obstetrics, supported by the Women & Children's Senior Leadership Team, to present the status of each of the safety actions with the correlating evidence to confirm the delivery status of each of the safety actions.

4.4 Agree that due to the timing of Trust Board against the relevant time period for reporting CNST requirements that Quality, Safety and Assurance Committee (QSAC) which is scheduled for the 28th of December 2022 has final, delegated authority to receive and approve the updated position against safety action 6, 8 and 9 prior to the final submission on behalf of the Trust Board.

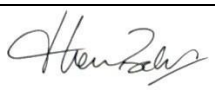
4.5 Agree that the paper required to achieve safety action 10, which cannot be produced until after the 5th of December 2022, is presented to QSAC which is scheduled for the 28th of December 2022 and that QSAC has final, delegated authority to approve this submission on behalf of the Trust Board.

4.6 Agree that QSAC which is scheduled for the 28th of December 2022, has delegated authority to confirm the final status of the Trust's year 4 CNST MIS submission on behalf of the Trust Board, prior to formal sign off by the Trust Chief Executive Officer and the CNST System Accountable Officer on the 1st of February 2023 in advance of the final formal submission to NHS Resolution, that must be completed by 12 noon on the 2nd of February 2023.

Appendix 1

Quality and Safety Assurance Committee
23 November 2022

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	/21			
Report	CNST MIS Year 4 Progress Update – November 2022			
Executive Lead	Hayley Flavell, Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	8 and 13	
	For decision / approval		**Link to risk register:**	
	For review / discussion		103, 104 and 105	
	For noting			
	For information			
	For consent			
Presented to:	Maternity Governance, 21 October 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. In October 2022, the self-declaration deadline was moved from 5 January 2023 to 2 February 2023. This paper sets out SaTH's progress to date and includes information to evidence the closure or partial completion of several Safety Actions, which the committee is asked to receive on behalf of the Trust's Board of Directors.			
Appendices	1. PMRT - Perinatal Mortality Reviews Summary Report 1/1/2022 to 30/09/2022 2. Audit information regarding compliance of PMRT letters sent to parents. 3. Transitional Care Audit Q2 2022-23 4. ATAIN (Avoiding Term Admissions into Neonatal Units) report Quarter 2 2022-23 5. Saving Babies' Lives update, including Quarter 2 reports 6. Locally Agreed Safety Intelligence Dashboard – Qtr 2 2022-23			
	 Tom Baker Acting Deputy Director of Ops, W&C Division 25/10/2022			

1.0 Introduction

1.1 SaTH is a member of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), which is regulated by NHS Resolution (NHSR) and is designed to support the delivery of safer maternity care.

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

1.3 The latest guidance was published in October 2022 and includes a revised self-declaration deadline of **noon on Thursday 2 February 2022.**[1]

1.4 The purpose of this paper is to provide QSAC with:

1.4.1 Assurance that SaTH is compliant with the standards it is obligated to have attained by now.

Details of the standards that must be evidenced between now and the new reporting deadline.

2.0 Overall Progress Status

2.1 The below chart shows a CNST completion rate as at October 2022 (including compliance with the standards and accrual of supporting evidence) of 64.6% 'Evidenced and Assured', 26.4% 'Delivered, Not Yet Evidenced' and 9% 'Not Yet Delivered'.

2.2 This status supersedes the most recently reported position to QSAC (August 2022) which displayed 39% Evidenced and Assured, 38% Delivered, Not Yet Evidenced and 23% Not Yet Delivered.

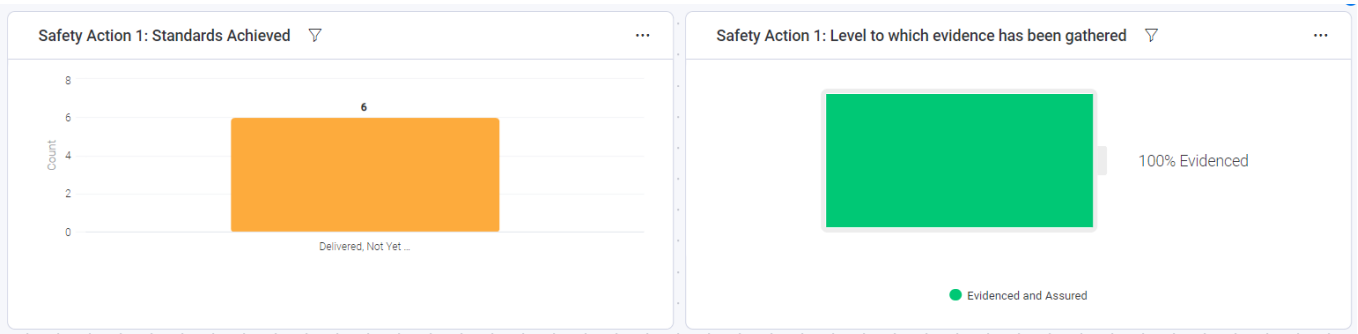
2.3 The plan is on track for delivery within the deadline of noon on Thursday 2 February 2023, and no change is required for the primary evidence sign-off session which has

[1] https://resolution.nhs.uk/services/claimes-management/clinical-schemes/clinical-negligence-scheme0for-trusts/maternity-incentive-scheme

been scheduled for 1 December 2022. However, QSAC are requested to propose to the Board of Directors that the final sign-off session for the Trust's CEO and a representative from the ICB be postponed from 4 January 2023 to a suitable date between Friday 27 January 2023 and Wednesday 1 February 2023.

2.4 Additionally, some risks to delivery do still exist, and these are highlighted below in section 10.

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.

3.2 The Board of Directors (BoD) has received a report each quarter since August 2021 that includes details of the deaths reviewed and the consequent action plans.

3.3 The most recent report (which covers the whole of 2022 calendar year to date, including Quarter 2, 2022-23) is attached to this paper at Appendix 1, along with an audit to prove compliance with standard c) ("For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought").

3.4 In terms of evidence gathering, Quarter 2 is the last reportable quarter for CNST MIS Year 4, hence this action is largely complete. A final confirmation that the standard has been maintained up to the end of the required timeframe (5 December 2022) will be conducted and confirmation passed to the signatories (CEO and ICB representative) prior to their final declaration.

3.5 **Progress Status: On Track, virtually completed.**

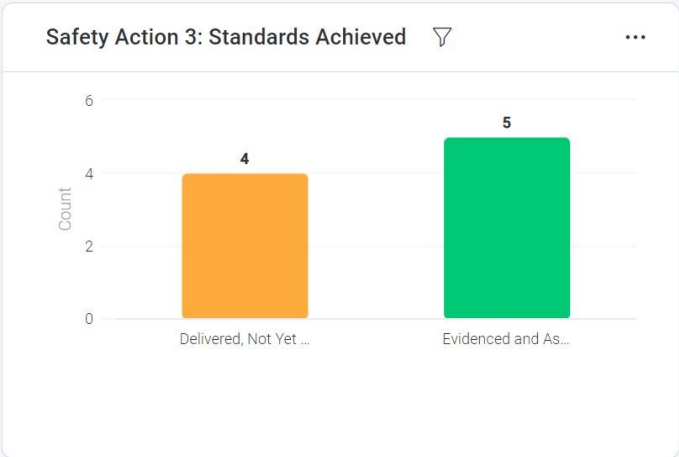
4.0 Safety Action 2: "Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?"

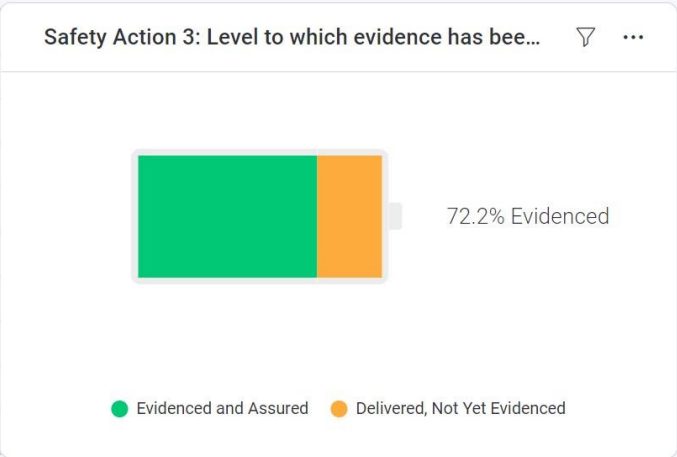
4.1 NHS Digital, who oversee this Safety Action, have confirmed that SaTH have uploaded all required data points to the Maternity Services Data Set (including the 11 Clinical Quality Information Metrics) at the required standard of data quality, for the month of July (which is the month against which the standard is tested).

4.2 The final step required is to attest to completion as part of the final declaration,

4.3 **Progress Status: Virtually complete**.

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 a Transitional Care service and associated pathway and continues to meet the national target of Avoiding Term Admission into the Neonatal Unit (ATAIN).

5.2 A new standard was introduced in the May 2022 update to the effect that a data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place. This was implemented within the mandatory deadline of 16 June 2022.

5.3 Standard b) requires there to be a monthly audit of transitional care; the report for Quarter 2 2022-23 is provided **Appendix 3**. The paper also evidences compliance with standards d) (confirmation that a database exists in which all transitional care activity is recorded).

5.3.1 On behalf of the Board of Directors, QSAC are requested to **take assurance** that transitional care is correctly implemented within the maternity and neonatal services, and, as this is the last reportable full quarter for CNST MIS Year 4, **approve** the evidence for standards b) as complete.

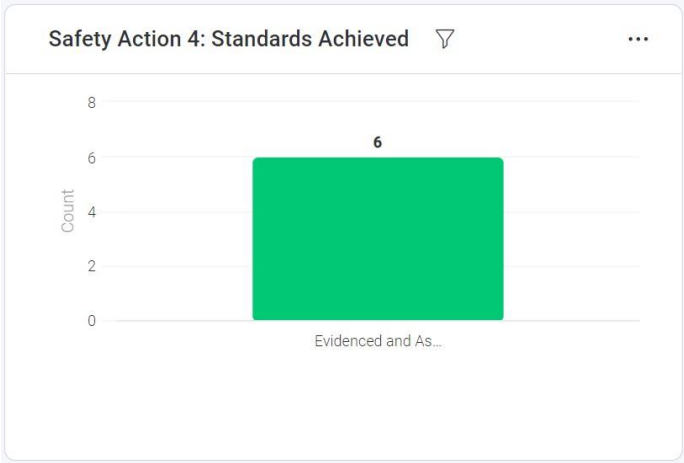
5.4 Similarly, Standard f) requires a quarterly audit of 'Avoiding Term Admission into the Neonatal Unit' (ATAIN) to be conducted – the report for Quarter 2 2022-23 is given at **Appendix 4**.

5.5 On behalf of the Board of Directors, QSAC are asked to **take assurance** from the fact that SaTH continue to achieve the national target of below 6% of term babies being admitted to the neonatal unit and **approve** completion standard f)

5.6 There remain a further few items of evidence which include confirmation that Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity are available on demand, and that the action plan to further improve ATAIN standards has been fully implemented. This assurance will be brought to the Board Seminar Session on 1 December 2022.

5.7 **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 **Standard a**). The Obstetrics workforce paper was delivered to QSAC at their February 2022 meeting, and the associated audit of consultant attendance where required has been conducted and found to be compliant; this completed Standard a) Parts 1 and 2. Under the terms of the May 2022 CNST MIS update, the data therein was refreshed by the Clinical Director for Obstetrics and found still to be compliant. Hence, standard a) is complete.

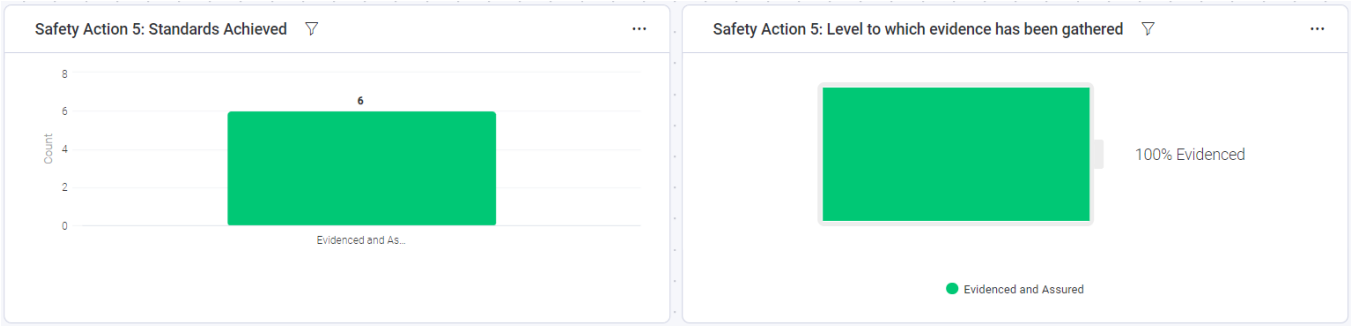
6.2 **Standard b).** Evidence of achieving ACSA Standard 1.7.2.1 was provided to QSAC in the April 2022 and August 2022 updates; hence standard b) is also complete.

6.3 **Standard c)**. The evidence to show that SaTH has a BAPM-compliant Neonatal Medical Workforce has already been provided to QSAC in April 2022. There has been no change to this standard in the May 2022 re-launch hence it remains complete.

6.4 **Standard d)** A separate paper outlining the level of compliance with Safety Action 4 standard d) (Neonatal Nursing Workforce) was provided directly to the Board of Directors' meeting in November 2022. The reason this did not come to QSAC first is that the October update to CNST MIS guidance suggested that this document should be presented to the Board prior to 5 December, hence this direct submission was necessary in order to comply with the timeframe.

6.5 **Progress Status: Complete (once Appendix 5 has been approved).**

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



7.1 As reported to QSAC in August 2022, two full midwifery workforce papers have been provided to the Board of Directors; these included a full explanation of the pause in further rollout of Midwifery Continuity of Carer. This action is therefore complete.

7.2 **Progress Status: Complete**

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

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

7.3.1 Reducing smoking in pregnancy.
7.3.2 Risk assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction (FGR)
7.3.3 Raising awareness of reduced foetal movement (RFM)
7.3.4 Effective fetal monitoring during labour.
7.3.5 Reducing preterm birth.

7.4 Pertaining to Element 1, and as highlighted in the April 2022 update to QSAC, the Trust is still experiencing difficulty in achieving the standard required of >80% women receiving CO monitoring at 36 weeks

7.4.1 Encouragingly, CO monitoring booking is now routinely being monitored to for above 80% of women (i.e. the target has been attained for the last four consecutive months), and in July 2022 this target was also reached for the 36 week appointment.

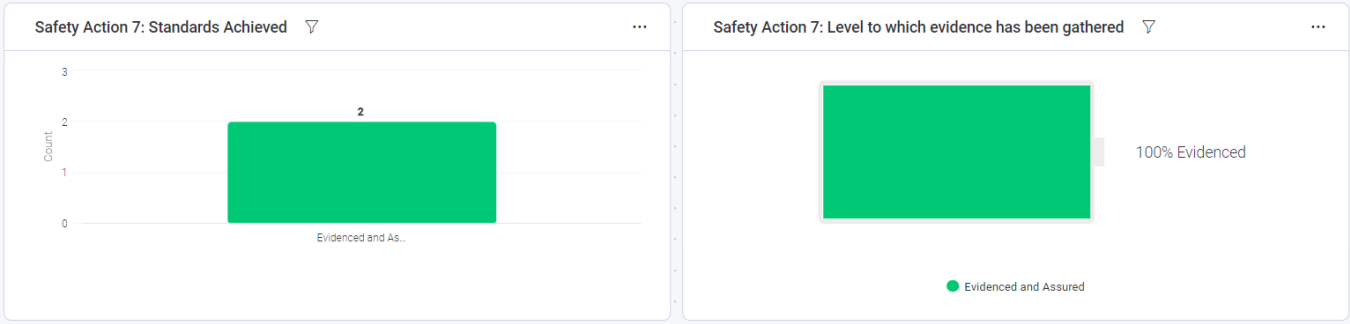
7.4.2 In order to achieve compliance with this standard, SaTH must achieved >80% on both metrics for four consecutive months before the end of the reporting period in February 2023. Therefore, whilst the trajectory is positive, this action must still be considered 'at risk'.

7.5 In accordance with the requirements of Elements 2 and 5, the quarterly audits are attached at **Appendix 6** (forming part of the most recent Saving Babies Lives report).

7.5.1 QSAC is asked to take assurance that at SaTH, detection and management of babies less than the 3rd centile remains better than the Perinatal Institutes national GAP user average.

7.6 **Progress Status: At Risk (due to the above-mentioned risk relating to CO testing targets for mothers at 36 weeks; all other actions are 'on track').**

8.0 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?"



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

8.2 As reported to QSAC in the August 2022 update, all of the evidence requirements for Safety Action 7 has now been secured, with the receipt of the following two items:

8.3 **Progress Status: Complete**

9.0 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?

9.1 It was reported in the April 2022 QSAC update that this action was at risk. Due to successful mitigation since this report and the extended CNST deadline announced in the May 2022 update, the action is back on track, and most groups are compliant to at least the 90% level. However, due to new starters and expiry, some groups have fallen back in compliance with some training; this is being remediated on priority.

9.2 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 31 July 2022, SaTH has achieved the following statuses, and is on track to reach the 90%:

9.2.1 Midwives: 95%
9.2.2 Obstetrics Consultants: 100%
9.2.3 Other doctors: 100%
9.2.4 Obstetrics anaesthetists: 100%
9.2.5 Healthcare assistances / midwifery service assistants: 90%

9.3 The training must also include antenatal and intrapartum foetal monitoring and surveillance, starting from the launch of MIS year four in August 2021. As above, statuses as of 9 June 2022 are:

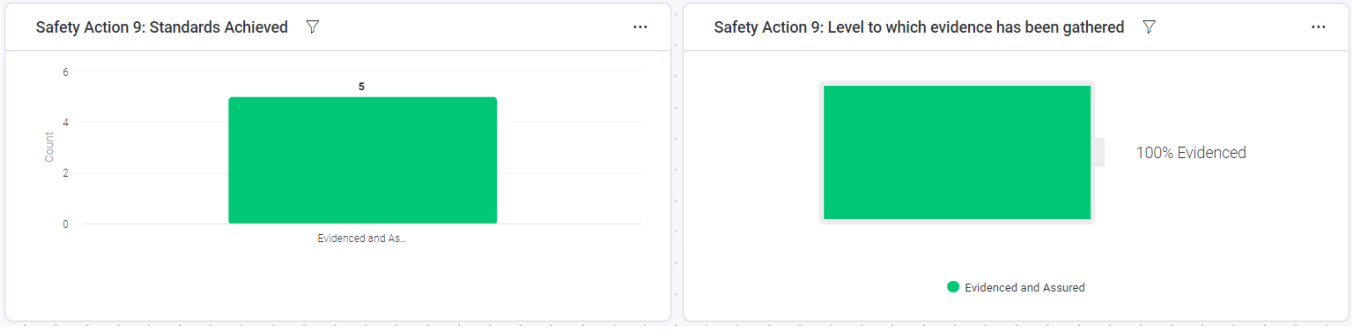
9.3.1 Midwives: 95%
9.3.2 Obstetric Consultants: 100%
9.3.3 Other Doctors: 78% (training underway to bring this back to above 90%)

9.4 Neonatal Life Support (NLS) training rates have also all exceeded the 90% minimum limit for Neonatal Nurses and Doctors at this time, but has fallen to 79% for in-scope midwives. A plan to bring this back to above 90% is underway.

9.5 A full report, to include line-by-line evidence, will be brought to the Board of Directors' at their seminar session on 1 December 2022, to inform final declaration.

9.6 **Progress Status: Mainly on track, some items 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?



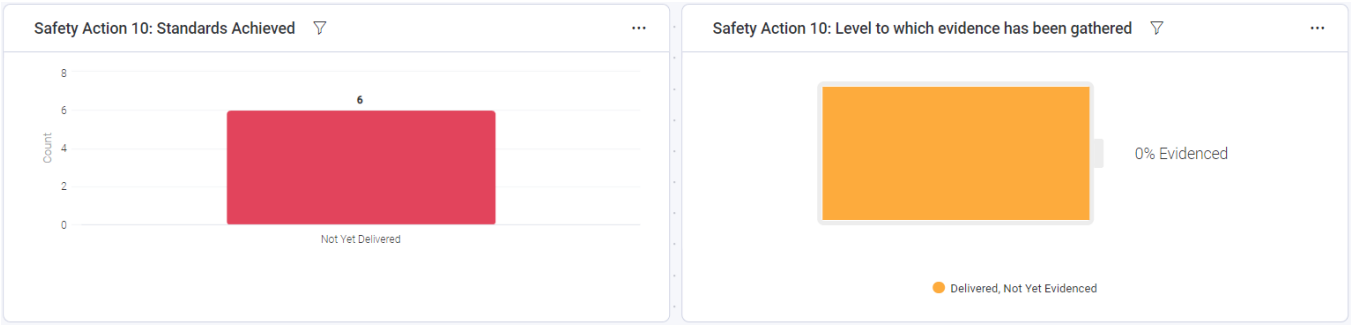
10.1 This action has now been fully evidenced, with the group having been apprised with all necessary CNST documentation and reporting to date.

10.2 The Group continue to meet on a monthly basis, with a 'walkabout' of a clinical area conducted at least every second month.

10.3 The most recent 'Locally Agreed Safety Intelligence Dashboard' as produced by the Safety Champions, is provided at **Appendix 7** for **information** and **consent** to share this document with the BoD directly, as required under the CNST guidance.

10.4 **Progress Status: Complete**

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?



10.5 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'.

10.6 Notwithstanding this, the action was presented as having been closed out in the April 2022 report to QSAC, there having been evidence of compliance with HSIB and ENS reporting and Duty of Candour for the period concerned, namely financial year 2021-22.

10.7 The reporting period has been extended up to and including 5 December 2022 under the terms of the May 2022 update. Accordingly, a refreshed paper evidencing compliance will be brought QSAC at their meeting on 28 December 2022.

10.8 **Progress Status: On Track**

11.0 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…
Trust may miss SBL CO testing targets for mothers for the 36-week CO monitoring). (SA6)	Configuration issues between the Badgernet and Medway EPRs; a shortage of breathing tubes in Spring 2022.	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. CO testing at booking now achieved routinely 2. In June 2022, CO monitoring target was also achieved for 36- week point. 3. If this trajectory or level continues for a further 3 months, standard will be achieved.
Trust may miss 90% target for Neonatal Life Support training for midwives and for fetal monitoring for 'other doctors'.	Training having expired for some colleagues within these groups	Failure of Safety Action 8	1. Training scheduled for these colleagues within deadlines 2. SaTH expect to achieve this Safety Action, but cannot guarantee this at this time.
The requirement for the Trust to The Trust must declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission may result in NHS Resolution not awarding the rebate, even if the Trust can evidence compliance with all ten safety actions	The fact that SaTH received an immediate action letter (which the Trust complied with) from HSIB in February 2022. The Trust cannot be certain whether this will affect the NHS Resolution decision on rebate.	Failure to obtain the rebate.	1. The Trust must declare this letter as part of the declaration form signature. It will be the decision of NHS Resolution as to what effect this has on the Trust's CNST position.

12.0 Summary

12.1 SaTH is mostly on track to achieve CNST MIS Year 4 in its latest format, though some risk to delivery for Safety Actions 6 and 8 remains as well as well as the potential impact on declaration of the HSIB immediate action letter as referenced in section 11.

12.2 In the April update to QSAC, under the October 2021 guidance, SaTH was able to evidence that three of the of the ten actions had been completed, four were on track, and three at risk (mitigation in place).

12.3 The latest status (die to amended standards and revised deadlines, with associated requirement to evidence for a longer period of time), the Trust can report that eight actions are 'on track' (of which three are nearly complete), and two are 'at risk'.

Summary of Safety Action completion Statuses:

Safety Action #	Completion Status
1	On Track
2	Complete
3	On Track
4	On Track
5	Complete
6	At Risk
7	Complete
8	At Risk
9	Complete
10	On Track

13.0 Actions Requested of QSAC:

13.1 **Review and discuss** this paper and advise the Women's and Children's divisional leadership team of any further detail required.

13.2 **Note** the contents for upwards reporting to the Board of Directors and **consent** for the relevant appendices to be forwarded to them.

13.3 **Note** the ongoing risks to delivery but **take assurance** that the likelihood of these occurring has further reduced since the last report in June 2021.

13.4 Be prepared to **support** the Board Seminar session on 1 December 2022 at which the CD for Obstetrics and DoM will be required to provide a summary of CNST evidence in its entirety to guide Board of Directors sign-off.

13.5 **Propose** to the Board of Directors that the final sign-off session for the Trust's CEO and a representative from the ICB be postponed from 4 January 2023 to a suitable date between Thursday 26 January 2023 and Wednesday 1 February 2023.

END OF MAIN PAPER

Appendix 2

The Shrewsbury and Telford Hospital NHS Trust

Appendix 1 to CNST MIS Year 4 Progress Update – November 2022:

PMRT - Perinatal Mortality Reviews Summary Report 1/1/2022 to 30/09/2022

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

The Shrewsbury and Telford Hospital NHS Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/1/2022 to 30/9/2022

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *20*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
18	<5	10	5	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
5	<5	<5	0	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

** Post-neonatal deaths can also be reviewed using the PMRT

*** Reviews completed and have report published

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 5)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	<5	--	--	--	--	<5
Stillbirths total (24+ weeks)	0	0	<5	0	<5	0	<5
Antepartum stillbirths	*0*	*<5*	*<5*	*0*	*<5*	*0*	*<5*
Intrapartum stillbirths	*0*	*<5*	*0*	*0*	*0*	*0*	*<5*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	0	0	0	0
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	<5	<5	0	<5	0	5
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	<5	<5	0	<5	0	5
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	<5	<5	0	<5	0	5
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	<5	<5	0	<5	0	5
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	0	0	0	0
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	0	0	0	0	0

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 5)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	<5	<5	0	<5	0	5
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	<5	<5	0	<5	0	5
Hospital post-mortem declined	0	<5	0	0	<5	0	<5
Hospital post-mortem carried out:							
Full post-mortem	0	<5	<5	0	0	0	<5
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	0	0	0
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	<5	<5	0	0	0	<5
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	<5	<5	0	<5	0	5
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation

Role	Total Review sessions	Reviews with at least one
Chair	3	60% (3)
Vice Chair	4	80% (4)
Admin/Clerical	0	0%
Bereavement Team	18	100% (5)
Community Midwife	0	0%
External	18	100% (5)
Management Team	4	40% (2)
Midwife	30	100% (5)
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	10	100% (5)
Other	0	0%
Risk Manager or Governance Team	11	100% (5)
Safety Champion	5	80% (4)

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Bereavement Team	0	0%
Community Midwife	0	0%
External	0	0%
Management Team	0	0%
Midwife	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	0	0%
Other	0	0%
Risk Manager or Governance Team	0	0%
Safety Champion	0	0%

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 5)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	<5	0	0	0	0	<5
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	<5	<5	0	<5	0	<5
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	<5	<5	0	<5	0	5
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 5)

Timing of death	Cause of death
Late fetal losses	<5 causes of death out of <5 reviews
	[redacted]
	[redacted]
Stillbirths	<5 causes of death out of <5 reviews
	[redacted]
	[redacted]
	[redacted]
Neonatal deaths	0 causes of death out of 0 reviews
Post-neonatal deaths	0 causes of death out of 0 reviews

Table 7:Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
The baby had to be transferred elsewhere for the post-mortem	<5	No action entered
		No action entered
		No action entered
The opportunity to take their baby home was not offered to the parents	<5	No action entered
		No action entered
		Joint meeting to take place to look at writing a SOP to support families who wish to take their baby home and to support staff involved in the families request with APT Mortuary, Clinical Site Manager, Senior Management Team and Bereavement Midwives. Meeting to take place in early May
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	<5	To highlight themes on all Midwifery Training Days by Specialist Midwives - Bereavement starting 27/1/2022
		No action entered
Although indicated this mother was not offered postnatal investigations relating to maternal substance misuse	<5	Contact Safeguarding and Improving Women's Health Midwife to clarify what the recommended course of action would be in a case where substance may be suspected. 18/3/2022
It is not possible to tell from the notes if the parents were provided with written support information around emotional issues before they left hospital	<5	No action entered
It is not possible to tell from the notes if the parents were told where their baby was being taken to and why when he/she was taken to the mortuary	<5	To highlight themes from PMRT to all Midwives on Mandatory Training Days presentation given Specialist Midwives - Bereavement starting 27/1/2022
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	<5	25/1/2021 email sent to all Ward Managers, Senior Midwifery Team and Specialist Midwives with themes from PMRT reviews. PMRT themes displayed on PMRT board in Training area and information requested to be shared at all ward huddles and themes to be highlighted on all Midwifery training days by the bereavement specialist midwives
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened because carbon monoxide testing was paused due to COVID-19	<5	No action entered
This baby was small for gestational age at birth, but appropriate growth surveillance had not been carried out	<5	Triage, Antenatal Ward and Community Midwives , Delivery Suite - documentation of SFH and abdominal palpation
This mother had pre-eclampsia/eclampsia during her pregnancy and there was a delay in the diagnosis	<5	Feedback at O&G feedback session

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors

Appendix 3

The Shrewsbury and Telford Hospital NHS Trust

Maternity Governance Meeting - Perinatal Mortality Review Tool (PMRT) Report Quarter 2 (July August and September in line with MBRRACE reporting) Key Issues Report		
Report Date: 17/10/2022		**Report of:** Perinatal Mortality Review Tool Meeting
Date of meetings:		21/07/2022 18/08/2022 22/09/2022
1	**Agendas**	The Committee considered the following: 5 stillbirths, <5 neonatal death and <5 late fetal losses that fitted the criteria for reporting to MBRRACE and lead reporting from Shrewsbury and Telford Hospitals (SaTH). The total cases reported by SaTH for the period of reporting 01/01/2022 to 30/09/2022 includes 11 stillbirths and <5 late fetal losses and <5 neonatal deaths
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	There is a continued significant delay in the completion of post-mortems and placental histology from our Perinatal Pathology Service at Birmingham Women's Hospital.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	CNST Safety Action 1 criteria met 100% of reviews completed had external panel members including Consultant Obstetricians. 100% of reviews had Obstetricians, Governance and Bereavement Midwives present.
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	All cases were graded either A or B following the panel review, therefore we identified some care issues which the panel considered would have made no difference to the outcome. There have been updates to the Hypertension Guideline following panel reviews this quarter and a Standard Operating Policy (SOP) is in development to support staff out of hours if parents wish to take their baby/babies home. Learning has been disseminated to staff regarding the discussion to be held with families offering the opportunity to take their baby/babies home, and the requirement for carbon monoxide monitoring at booking to be completed and recorded.

2d	**Actions** ***Significant*** *follow up actions*			
3	**Report compiled by**	Elizabeth Pearson Quality Governance Lead	**Minutes availablefrom**	Bereavement Midwives/Quality Governance Lead

Appendix 4

Appendix 2 to CNST MIS Year 4 Progress Update – November 2022:

Audit information regarding compliance of PMRT letters sent to parents.

Appendix 5

The Shrewsbury and Telford Hospital NHS Trust

Maternity Governance Committee
21st October 2022

Agenda item	Audit information regarding compliance of PMRT letters sent to parents.			
Report	In conjunction with PMRT Governance Report			
Executive Lead	Director of Nursing			
√ tick only those applicable	**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	√
√ tick / input only those applicable, usually only one	**Report recommendations:**		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√		
	For noting	√		
	For information	√		
	For consent	√		
Presented to:	Maternity Governance Committee Meeting 05/10/2022			
Dependent upon (if applicable)**:**	Nil			
Executive summary:	**Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS)** **CNST Safety Action 1 – Updated May 2022** *For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought.* 'Audit of letter sent to parents regarding PMRT to explain that a review will be taking place and seek their input about care' **Data collected and reviewed** Data has been collected by the Bereavement Midwives and displayed on an excel spreadsheet for the set criteria of notifying families regarding the PMRT review and seeking their feedback. Data reviewed between 1st January 2022 – 30th September 2022			

	19 cases met the required criteria, and all families were informed of PMRT review either by a face to face meeting or letter posted to their home address - **100% compliance.** 4 feedback forms were returned.

Background

CNST Safety action 1:
'Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?'

Which perinatal deaths must be reviewed to meet safety action one standards?

The following deaths should be reviewed to meet safety action one standards:

Deaths eligible for notification from 1st January 2013 onwards are:

- Late fetal losses – the baby is delivered between 22+0 and 23+6 weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
- Stillbirths – the baby is delivered from 24+0 weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.
- Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.
- Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.
- Post-neonatal deaths – We are no longer collecting information for post-neonatal deaths because of the difficulty in ensuring complete data collection from the wide variety of places of death for these cases.
- Note: Terminations of pregnancy: We only collect limited information about terminations of pregnancy that are late fetal losses, stillbirths or neonatal death. Therefore ALL terminations from 22+0 weeks are cases which should be notified plus any terminations of pregnancy from 20+0 weeks which resulted in a live birth ending in neonatal death.

Reported to MBRRACE but not part of the PMRT process

Terminations of pregnancy: We are only interested in collecting information about terminations of pregnancy that are cases of late fetal loss, stillbirth or neonatal death.

Data collected at SaTH

Data has been collected by the Bereavement Midwives and recorded on an excel spreadsheet capturing the date the letter was sent to families notifying them about the PMRT review and feedback received.

MBRRACE Number	Date case reported to	Date letter sent to parents
79170	29/12/2021	04/01/2022
79199	30/12/2021	04/01/2022
79345	07/01/2022	14/01/2021
79457	14/01/2022	17/01/2022
79515	18/01/2022	24/01/2022
79702	28/01/2022	01/02/2022
80890	04/04/2022	11/04/2022
81192	20/04/2022	25/04/2022
81691	23/05/2022	30/05/2022
81807	30/05/2022	06/07/2022
82059	16/06/2022	23/06/2022
83272	06/06/2022	08/07/2022
82804	02/08/2022	10/08/2022
82953	10/08/2022	19/08/2022
83295	25/08/2022	05/09/2022
83333	30/08/2022	05/09/2022
83399	05/09/2022	09/09/2022
83398	05/09/2022	09/09/2022
83490	09/09/2022	14/09/2022

1st January 2022 to 30th September 2022

Data reviewed between 1st January 2022 – 30th September 2022
19 cases met the required criteria, and all families were informed of PMRT review either by a face to face meeting or letter posted to their home address - **100% compliance**.
4 pieces of feedback were returned.

Feedback from families:

Care during pregnancy:
"Within one week of GTT I had been looked after exceptionally well"

"I was left waiting an hour or so to be seen which was torture"

"Our expectations were greatly exceeded in the quality of care we received".

"Why was I only checked twice 3 times a day on his heart beat not more"

Care during the birth:
"The rest of our birth experience was honestly faultless"

"When we arrived at the hospital, we learned that the room had been given to somebody else and had to wait for another room to be made ready for us but it was not a bereavement room"

"I was scared I could not support my partner but one glance from the midwife helped me to carry on"

"Should the bed have already been changed to a delivery bed in preparation"

Care for family following birth:
"We were allowed as much time as we needed…our families were welcomed"

"I don't think we could have been treated any better and we can only thank you all"

"Concerned that she was sent to triage postnatally, to where she was told she had lost her baby and was surrounded by babies crying"

Charlotte Tongue and Michelle Powell
Specialist Midwife - Bereavement

Appendix 6

Appendix 3 to CNST MIS Year 4 Progress Update – November 2022:

Transitional Care Audit Q2 2022-23

Appendix 7

The Shrewsbury and Telford Hospital NHS Trust

Maternity Governance
21st October 2022

Agenda item				
Report Title	Transitional Care Audit Q2			
Executive Lead	Annemarie Lawrence- Director of Midwifery			
Report Author	Sarah Whitehead – Antenatal and Postnatal Ward Manager, Lauren Taylor Antenatal and Postnatal Matron			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners		Well Led	
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval		**Link to risk register:**	
	For review / discussion	√		
	For noting			
	For information	√		
	For consent			
Presented to:	Maternity Governance			
Executive summary:	This is the second quarter report of 2022. This paper is to provide assurance that transitional care is audited in line with the standards as directed by BAPM and reflected in the maternity guideline. In line with the CNST maternity incentive scheme safety point three this paper supports the process of auditing Transitional Care Services The aim of this report is to understand what our compliance is and to detect if there are any recommendations required to improve our compliance The report provides assurance of the following: A. Compliance rate is in line with the Transitional care guideline. B. 96% of babies noted in the audit were seen daily by the appropriate neonatal team. C. All babies received NIPEs within the allocated time frame of 72 hours as per guideline D. 100% of the sample had the appropriate NEWTT observations E. 100% of the sample had discharge letters generated.			

Appendices	Appendix 1: Reason for Admission to TC from birth Appendix 2: TC Audit July 2022. Appendix 3: TC Audit August 2022 Appendix 4: TC Audit September 2022
Executive Lead	Annemarie Lawrence

1.0 Situation.
Transitional care is not a place but a service and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting.

Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.

The philosopy of transitional care is to keep mothers and babies together, mothers become the primary care provider for their babies with care requirements in excess of normal newborn care but do not require admission in a neonatal unit and ensures a smooth transition to discharge home.

The monthly transitional care audit will be inline with the standards set out in the guideline:

- ❖ Reason for admission to Transitional care
- ❖ Reason Recorded and appropriate as guidance
- ❖ Observations and investigations as guidance and documented appropriately
- ❖ The use of green discharge proforma
- ❖ Daily neonatal team review
- ❖ Appropriate NIPE examination
- ❖ Coded inline with HRG criteria
- ❖ Outcomes

This audit will be done based on the monthly transitional care audit of 8 transitional care babies per month which is approximately 20-25 % of babies who are admitted under the transitional care pathway, recommendations will be shared on a quarterly basis.

2.0 Background
The transitional care guideline has recently been amalgamated with the neonatal guideline and updated, we have introduced NEWTT (Newborn Early Warning Trigger and Track) on 14/09/2020 which gives a clearer definition of babies requiring transitional care as below:

Criteria for transitional care from birth

- Late Preterm babies from 34 – 35+6 weeks gestation
- Babies receiving intravenous antibiotics or other intravenous medications

- Babies at risk of neonatal abstinence syndrome (NAS) requiring observations
- Congenital anomaly likely to require tube feeding (eg cleft lip/palate)
- Low birth weight (< 2nd Centile but more than 1.8 kgs)

Care for transitional care from NNU

- Baby who is having ‘step down care’ following admission to NNU who is more than 1.6 kgs and maintaining temperature
- Step down care tolerating a minimum of 3 hourly feeds

Transitional care babies are cared for in a four bedded bay and 2 side rooms on the postnatal ward, with a staffing model of 1 Band 6 midwife and 1 WSA to support.

3.0 Assessement

Data Collection

24 sets of neonatal records were used to complete this audit, Medway System EPR was also used over the three months.

Analysis

Overall, the audit has highlighted a 96% compliance rate in line with the Transitional Care guideline.

96% of babies noted in the audit were seen daily by the appropriate neonatal team with clear documentation and plan of care, in one patient there was no documentation that the baby had been seen by the neonatal team on one instance.

All babies received NIPEs within the allocated time frame of 72 hours.

100% of the sample had the appropriate NEWTT observations completed and documented onto Medway Maternity System. 100% of the sample had discharge letters generated.

4.0 Conclusion

The audit highlighted a 96% compliance rate in line with updated Transitional Care guideline. A recommendation would be to continue with the monthly audit to ensure assess compliance in accordance with the TC guideline and to communicate with the neonatal team in relation to review and documentation in the notes.

Appendix 8

Appendix 4 to CNST MIS Year 4 Progress Update – November 2022:

ATAIN (Avoiding Term Admissions into Neonatal Units) report Quarter 2 2022-23

Appendix 9

Maternity Governance Meeting 21/10/22

Agenda item				
Report Title	ATAIN (Avoiding Term Admissions into Neonatal Units) report Quarter 2- 2022-23			
Executive Lead				
Report Author	Rachel North, Women and Children's Quality Governance Officer Jill Whitaker Delivery Suite and Triage Matron			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√		
	For noting	√		
	For information	√		
	For consent	√		
Presented to:	Maternity and Maternity and neonatal governance			
Executive summary:	• Rates of admissions to the Neonatal Unit of babies >37 weeks is 4.16% for quarter 2 • This has decreased from the last quarter and is below the national target of 6 %. • In September the rate was 2.8% which is below our stretch target of 3% • Respiratory conditions remain the largest reason for admission.			
Appendices	Appendix 1: Appendix 1 Action tracker Appendix 2: Appendix 2 Audit form template.			
Executive Lead	Hayley Flavell, Director of Nursing			

ATAIN (Avoiding Term Admissions into Neonatal Units) Report for Q2, 2022-23

Background

Admission to a neonatal unit can lead to unnecessary separation of mother and baby. There is overwhelming evidence that separating mother and baby at or soon after birth can affect the positive development of the mother-child attachment process and adversely affect maternal perinatal mental health.

Preventing separation except for compelling medical indications is essential in providing safe maternity services.

NHS providers of maternal and neonatal care can use the data collected through ATAIN reviews as a resource to:

- improve the safety of care
- keep mothers and babies together whenever it is safe to do so
- identify local improvement priorities
- develop an action plan to ensure any relevant resources are introduced into clinical practice

Improving the safety of maternity services is a key priority for the NHS and the number of unexpected admissions of full-term babies (i.e., those born at 37 weeks or more), is seen as a proxy indicator that harm may have been caused at some point along the maternity or neonatal pathway.

ATAIN focuses on four key clinical areas that represent a significant amount of potentially avoidable harm to babies:

- respiratory conditions
- hypoglycaemia
- jaundice
- asphyxia (perinatal hypoxia-ischaemia)

Review Systems

Multi-Disciplinary team (MDT) meetings have now been established to review all cases which may meet the ATAIN criteria. Term admissions to the neonatal unit are currently monitored utilising Neonatal BadgerNet digital system, Datix submissions and a manual check of the Neonatal Unit admission book. A cross reference is made with all three systems as a failsafe to ensure that no case is missed. This information is presented monthly at both Maternity and Neonatal Governance meetings. Any safety concerns are immediately escalated, and any learning is shared with the multi-disciplinary teams.

Rates

Term admission numbers for Q2 (July, August September 2022) have decreased to 4.16% per quarter.
The numbers of babies admitted each month were
July 17
August 19
September 9

Quarter 2 Data.

Reason for admission	Number of babies >37/40
Respiratory conditions	29
Infection	6
Hypoglycaemia	<5
Known congenital abnormalities	<5
Gastrointestinal disorders	<5
Jaundice	<5
Birth trauma	<5
Babies were transferred out for therapeutic hypothermia	Nil

Respiratory Conditions.

Respiratory issues continue to make up the majority of admissions, with twenty-nine babies this quarter, of which eleven were born by caesarean birth.
The length of stay for these babies ranged from two days to eleven days with the majority being three days.

Hypoglycaemia.

In this quarter there were three babies admitted with hypoglycaemia. Two were babies of diabetic mothers and one had blood sugar monitoring because of the use of beta blockers to control maternal hypertension.
All babies were managed in line with guidelines, hand expression of colostrum was used, and glucose was administered before transfer to the neonatal unit.

Neonatal Jaundice/NAS.

There was one admission for jaundice treatment this quarter. The baby was admitted within twelve hours of birth and the cause was haemolysis.

No babies required Neonatal Abstinence Syndrome treatment.

Hypothermia.

No term babies had a temperature of 36.4 degrees centigrade or below on admission during this quarter. This reflects a huge improvement on previous quarter's data of all babies admitted at term.

Congenital Abnormalities.

Three babies were admitted and found to have congenital abnormalities.

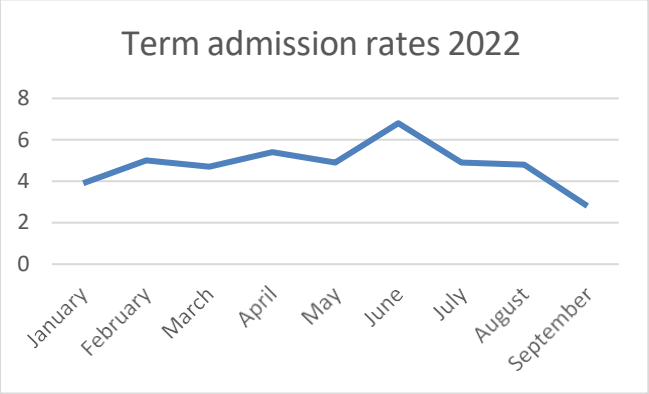
One baby had Pierre Robin Syndrome.
One baby had a bowel obstruction.
One baby had an upper gastrointestinal tract disorder.

Birth Injury.

[redacted]

The baby was returned to mother on the postnatal ward on day three. Following review of this case it has been raised as a divisional investigation.

Summary of Term admission rates for 2022 up to September



The rates of term admissions remain below the national target of 6% except for June when It reached 6.8%. September data reveals a drop to 2.8% which is below the stretch target of 3%.

Challenges to ATAIN reporting.

There have been challenges this quarter to maintain quoracy in meetings. This has been caused by medical staffing shortages. Meetings have continued and learning has been shared via the three-minute brief and staff huddles.

Data collection has presented difficulties because of the variety of electronic records used across the division. Moving forward the introduction of the new neonatal electronic record will make this easier.

Plan for Q2 2022/2023

- To maintain regular MDT review meetings and to ensure failsafe processes are in place to confirm all eligible cases are captured for review.
- To monitor and review more closely the babies admitted with respiratory conditions with a view to establishing if admission the neonatal unit can be avoided by alternative methods of treatment.
- To present the report to Maternity and Neonatal Governance meetings.
- To review and monitor the action tracker at each meeting.

Appendix 2 - Audit form template.

The Shrewsbury and Telford Hospital NHS Trust

To be completed for all admissions to the Neonatal Unit with birth gestation >37 weeks gestation

ATAIN Audit tool, v2 April 2022

NHS no.			**Gestation**			
DOB			**Birth weight (gms)**			
Transfer / Admission date		**Discharge date**	**Date of Review**			
Transfer / Admission from	Labour Ward / Postnatal Ward / Midwifery Led Unit /Homebirth / Community / Other.....		**Category of care on admission**	ITU	HDU	SCBU

TRANSFERS OR ADMISSIONS IN THE FOLLOWING CATEGORIES CAN BE EXCLUDED FROM THE REVIEW PROCESS

☐ *Any admission that is already subject to a formal incident investigation being undertaken elsewhere in the organisation. Learning from reviews undertaken elsewhere in the organisation in relation to a term admission must be incorporated into the actions and improvement work undertaken as part of this process.*

FOR ALL OTHER TRANSFERS / ADMISSIONS – please answer all questions below

Changes in **Antenatal** management may have prevented this transfer / admission? No☐ Yes ☐

Learning points

Changes in **Perinatal** Management may have prevented this transfer / admission? No☐ Yes ☐

Learning points

Changes in **Postnatal** management may have prevented this transfer / admission? No☐ Yes ☐

Learning points

If you have/had Transitional Care Facilities (virtual or real) could this baby have been cared for in a TC setting?

No☐

Comments:

CTG Reviewed? No☐ Yes ☐

To be completed for all admissions to the Neonatal Unit with birth gestation >37 weeks gestation

ACTIONS POINTS	**NB. These action points will be transferred into a local SMART action plan template.**
	Circle the PRIMARY reason for transfer / admission

1	Management of a respiratory problem requiring ventilation/ CPAP /oxygen/ observation (circle)
2	Hypothermia or need for temperature monitoring requiring: hot cot/ incubator/ normal care (circle) Temp on admission:
3	Hypoglycemia or need for intervention to maintain blood glucose: IV fluids/ NG feed/ BF only (circle) Blood sugar on admission:
4	Observation following resuscitation: level of care IC/ HD/ SC (circle)
5	Suspected sepsis requiring: IV antibiotics / septic screen / observation only (circle)
6	Administration of antibiotics with no additional requirement for care.
7	Requires short period of observation: up to 4 hrs., 4-8hrs, 8-12 hrs.

	(circle)
8	Admission for single procedure: venepuncture, lumbar puncture, cannulation, Sa02 monitor/cardiac assessment (circle)
9	Management of HIE and or seizures requires cooling Yes/ No
10	Management of jaundice requires phototherapy / IV fluids/ exchange transfusion (circle)
11	Management of congenital abnormality known before delivery Yes/ No
12	Diagnosed NAS: requires drug therapy/ urine toxicology only/ observation only (circle)
13	Feed intolerance/ vomiting/ abdominal distension/ GI factors (circle): requires IV fluids Y / **N**
14	Social issues: safeguarding, awaiting adoption/foster care. No clinical factors for admission
15	None of the above, this baby was admitted for: *write reason below*

Names and job titles of the review leads. As a minimum the care should be reviewed by representation from both maternity and neonatal staff groups:

Midwifery: .....

Obstetric: .....

Neonatology/ Paediatric: .....

Neonatal Nursing .....

Appendix 10

Appendix 5 to CNST MIS Year 4 Progress Update – November 2022:

Saving Babies' Lives update, including Quarter 2 reports

Appendix 11

Maternity Governance
October 2022

The Shrewsbury and Telford Hospital NHS Trust

Report	Saving Babies Lives: Brief update of progress			
Executive Lead	Annemarie Lawrence, 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 Governance			
Dependent upon	n/a			
Executive summary:	The Saving Babies Lives Care Bundle is an evidence-based package of measures designed to reduce perinatal mortality. Reviews conducted to date suggest that implementation of this care bundle has been effective in achieving this vital aim, but that more needs to be done. The importance attached to Saving Babies Lives is reflected in the fact that it forms one of the ten Safety Actions of the Clinical Negligence Scheme for Trusts. This scheme mandates regular updates on delivery progress must be provided to the LMNS; this is the purpose of this paper.			
Appendices	1. Quarter 2 2022-23 SGA and FGR review 2. Quarter 2 2022-23 Preterm review			
	Lindsey Reid, Lead Midwife for Saving Babies' Lives, The Shrewsbury and Telford Hospital NHS Trust 12th October 2022			

1.0 **Introduction**.

1.1 The Saving Babies Lives (SBL) care bundle is designed to reduce perinatal mortality, and its implementation constitutes Safety Action 6 of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), of which SaTH is a participant.

1.2 The Trust was able to prove full compliance with the requirements of SBL as part of Year 3 (2020-21) of CNST, support and assurance provided by an external Maternity Improvement Adviser from NHS England / Improvement and specialist midwife from the SaTH's partner, Sherwood Forest Hospitals NHS Foundation Trust.

1.3 SaTH is now part-way through delivery of CNST year 4 (2021-22), which includes continued implementation of SBL. The purpose of this paper is to:

1.3.1 Provide updates to the Maternity Governance committee
1.3.2 Provide quarterly reports of information which require sharing (as per SBLCBv2) with the Trust Board and LMNS

2.0 **Background.**

2.1 The first version of the Saving Babies' Lives Care Bundle (SBLCB) was published in March 2016 and focussed predominantly on reducing the stillbirth rate[1]. The care bundle was designed to deliver the then Secretary of State for Health's announced ambition to halve the rates of stillbirths, neonatal and maternal deaths, and intrapartum brain injuries by 2030, with a 20% reduction by 2020. The care bundle consisted of four standards:

2.1.1 Element 1: Reducing smoking in pregnancy
2.1.2 Element 2: Risk assessment and surveillance for Fetal Growth Restriction (FGR)
2.1.3 Element 3: Raising awareness of Reduced Fetal Movement (RFM)
2.1.4 Element 4: Effective Fetal Monitoring during labour

2.2 In November 2017, as part of the National Maternity Safety Strategy, the national ambition was extended to include reducing the rate of preterm births from 8% to 6% and the date to achieve the ambition was brought forward to 2025[2]. This is reflected in the NHS Long Term Plan.[3]

2.3 The second (current) version of the care bundle was published in 2019 and includes a fifth element: 'Reducing preterm birth' (and to improve outcomes when preterm birth is unavoidable, to further decrease perinatal mortality) as well as slightly amended wording for element 2 to: 'Risk assessment, prevention**,** and surveillance of pregnancies at risk of fetal

[1] https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf
[2]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf
[3] https://www.longtermplan.nhs.uk/

growth restriction (FGR)'.[4]

2.4 According to an evaluation conducted by the Tommy's Stillbirth Research Centre at the University of Manchester, the first version of the Saving Babies' Lives Care Bundle appears to have contributed to the stillbirth rate in England falling to a historical low – a 20% decrease was recorded in Trusts that have implemented the care bundle.[5] Detection of small for gestational age (SGA) babies during the antenatal period increased by 59% in participating Trusts during the implementation period. The review noted, however, that more progress has to be made – Britain has the 24th worst stillbirth rate out of 49 high income countries within Europe.

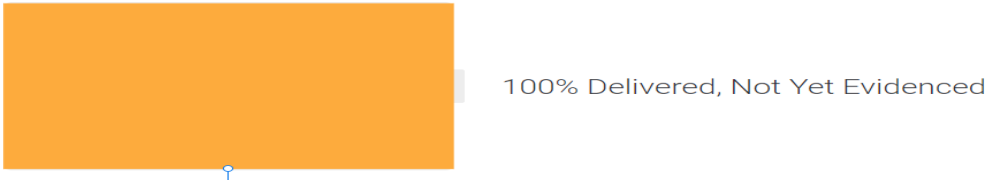
2.5 The second version of the care bundle ("SBLCB v2) includes a greater emphasis on continuous improvement with a reduced number of process and outcome measures. The implementation of each element will require a commitment to quality improvement with a focus on how processes and pathways can be developed and where improvements can be made.

2.6 The introduction of any new pathway carries a risk of 'intervention creep' and the increases in induction of labour, preterm birth and caesarean section suggest that there are opportunities to reduce obstetric intervention. The development teams for each element have made changes to improve the effectiveness of their elements and minimise unwarranted intervention.

2.7 SBLCBv2 includes sections which reference the importance of other interventions outside of the remit of the care bundle, such as continuity of carer models, following NICE guidance, delivering 'healthy pregnancy messages' before and during pregnancy and offering choice and personalised care to all women. These are not mandated by the care bundle but reflect best practice care and are recommended to be followed in conjunction with the care bundle itself.

3.0 **Progress update on Element 1: Reducing smoking in pregnancy**.

3.1 Element 1 contains 8 standards (awaiting senior team approval to change to green evidenced and assured)



3.2 SBL mandates the following standards:

3.2.1 CO testing should be offered to all pregnant women at the antenatal booking appointment, with the outcome recorded.

3.2.1.1 CO testing at booking remains compliant (CNST - minimum 80% compliance required over a consecutive 4-month period). Graph demonstrating compliance on the next page.

[4] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf
[5] https://www.tommys.org/research/research-topics/stillbirth-research/saving-babies-lives-care-bundle

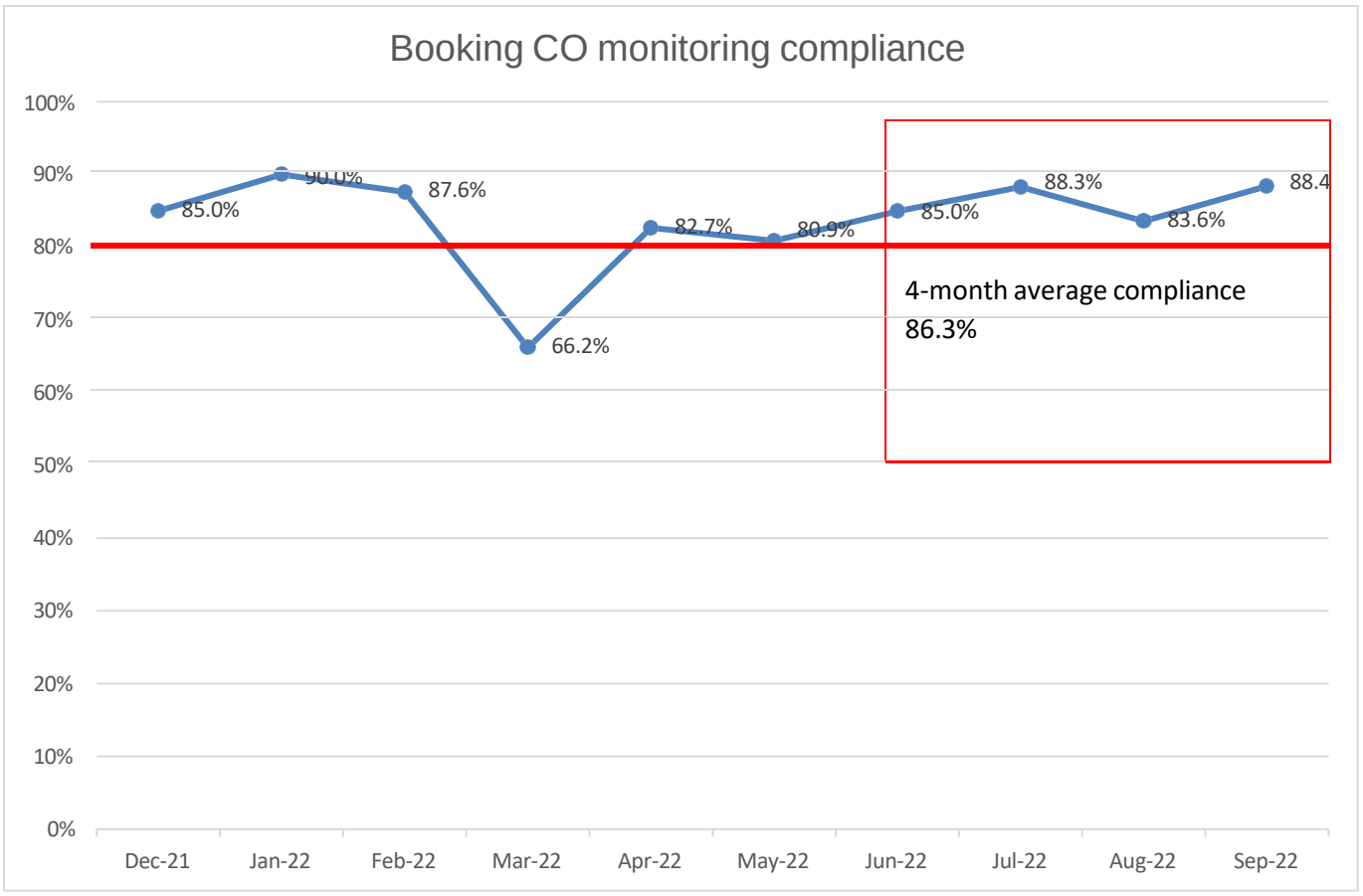
3.2.2 CO testing should be offered to all pregnant women at the 36 week antenatal appointment, with the outcome recorded.

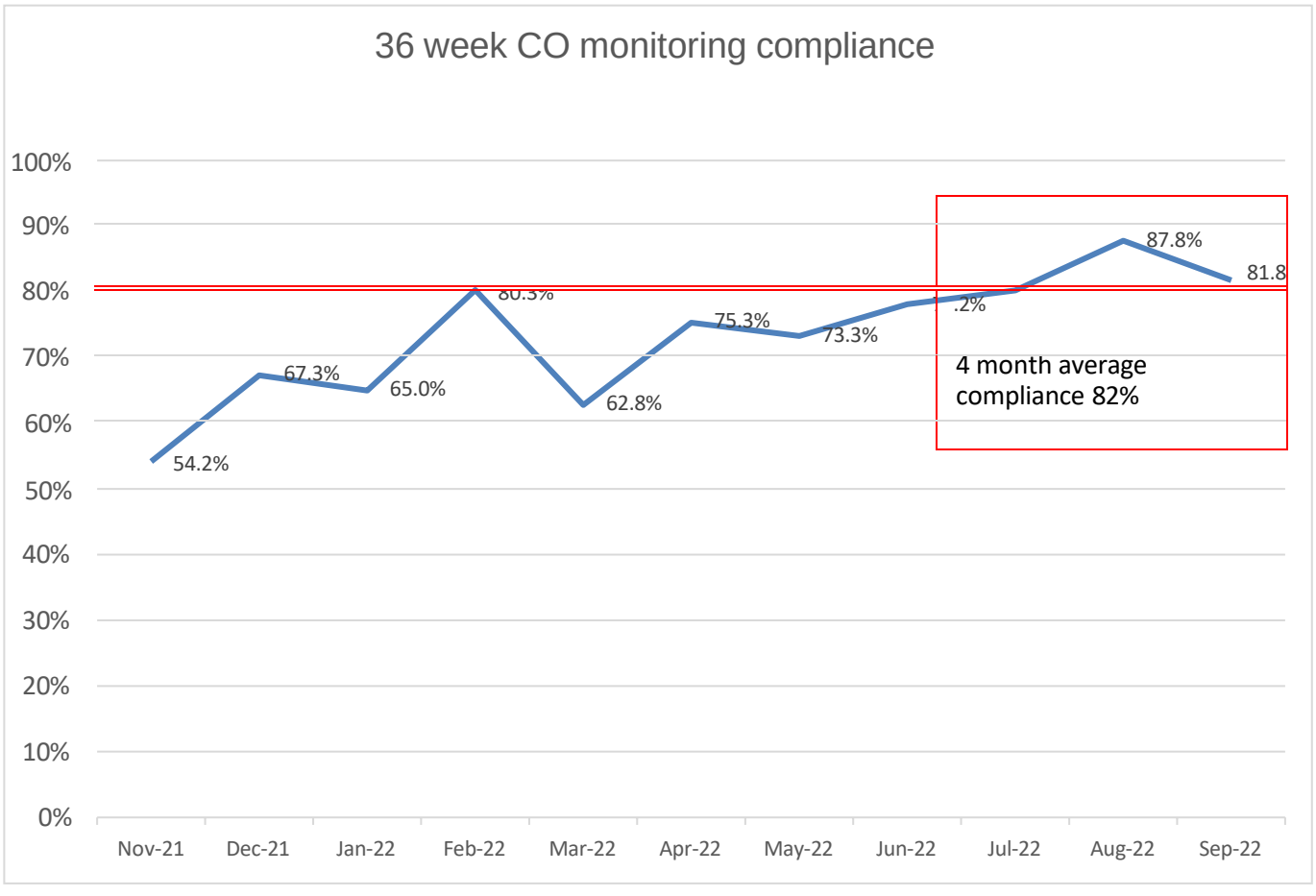
3.2.2.1 We are now compliant with the mandatory CO standards. (CNST compliance minimum average 80% over a consecutive 4-month period). Graph demonstrating an average compliance of 82% on the next page.

3.2.3 If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95% (CNST).

3.2.3.1 Action plan

- compliance monitored by Healthy Pregnancy Support Service
- Noncompliance episodes investigated and reported to area Manager/Matron if required
- CO monitoring at every contact to include Maternity scan department, Antenatal ward, Triage, DAU and at initial assessment for intrapartum care from 1/11/22 (NICE guidance Tobacco: preventing uptake, promoting quitting, and treating dependence/ Recommendations on treating tobacco dependence in pregnant women Nov 2021)
- Review of consumables: CO monitor tubes. Difficulty in procuring from company that supplies the SaTH's CO monitors. Escalated to Midlands Preterm Network. Contact returned from James Gillies (Programme Manager – Tobacco Control NHS Long Term Plan (Midlands)) aware the problem has been flagged by other maternity providers. MD Diagnostics (SaTH's CO monitor/tube supplier) are said to be addressing their supply issues


Booking CO monitoring compliance
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
85.0%
87.6%
66.2%
82.7%
80.9%
85.0%
88.3%
83.6%
88.4
4-month average compliance
86.3%
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22


36 week CO monitoring compliance
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
54.2%
67.3%
65.0%
62.8%
75.3%
73.3%
87.8%
81.8
4 month average
compliance 82%
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22

3.2.4 Referral for those with elevated levels (4ppm or above) for support from a trained stop smoking specialist, based on an opt-out system. Referral pathway must include feedback and follow up processes.

3.2.4.1 CNST required audit of women with a Carbon Monoxide measurement of 4ppm and above to determine the proportion that were referred to smoking cessation service demonstrated (reported to Obs and Gynae audit meeting October 2022)

Results

Rag rating based on CNST requirements	90 – 100% compliance	75 – 89% compliance	Less than 75% compliance

NHS The Shrewsbury and Telford Hospital NHS Trust

Standard Number	Standard Assessed	Compliance	Comments
1	Had the woman with a CO level ≥4ppm had contact from the Trust's Healthy Pregnancy Support Service (HPSS)	20/20 100%	13 women declared themselves non smokers or former smokers at booking. All were provided with support and safety advice.
2	Was the HPSS contact provided before 16 weeks	19/19 100%	Excluded- 1 woman booked at 30+4 weeks, however, she was still contacted within 24 hours.

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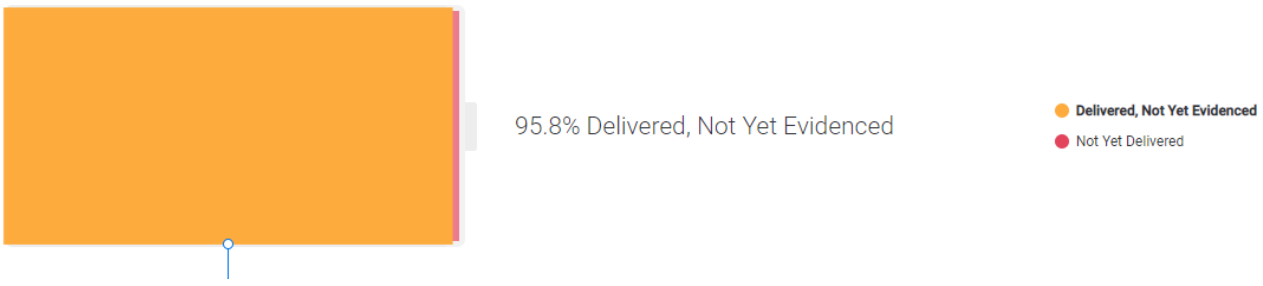
4.0 Progress update on Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)

4.1 Element 2 contains 16 standards



4.2 CNST required audit of 40 consecutive cases (reported to Obs and Gynae audit meeting October 2022)

"Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan" (SBLCBv2 Process indicator), demonstrated the following good practice.
Audit conclusion extract

Conclusion

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Percentage of pregnancies that were risk assessed for fetal growth restriction (FGR) booking - 100%

All eligible pregnancies booked at SATH were risk assessed

Percentage of pregnancies that were correctly risk status for fetal growth restriction (FGR) is identified and recorded at booking (low, moderate or high) - 97.5%

Most women were correctly risk assessed. 1 case identified as low risk but changed to appropriate moderate risk before 20 weeks. (care was not compromised)

Percentage of pregnancies that were identified as having a change in risk status between booking and the 20-week scan and care pathway arranged

No missed opportunities identified

Percentage of pregnancies identified at high risk that were offered and received uterine artery doppler screening by 24 weeks – 100%

NB. Small sample

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Percentage of pregnancies that were referred for serial growth scans in accordance with SaTH's current guidance -100%

All women that met the criteria for serial growth scans had their care pathways arranged according to the Trust pathway

SBL additional standards

Assessment of women at booking to determine if a prescription of aspirin is appropriate– 100%

All women assessed and aspirin recommended when appropriate

Assessment of smoking status at booking – 100%

All women assessed

Efforts for the pregnancy to be smoke free before 16 weeks

Referral to and contact by stop smoking support service before 16 weeks for self identified smokers and women with CO level ≥4ppm at booking – 100%

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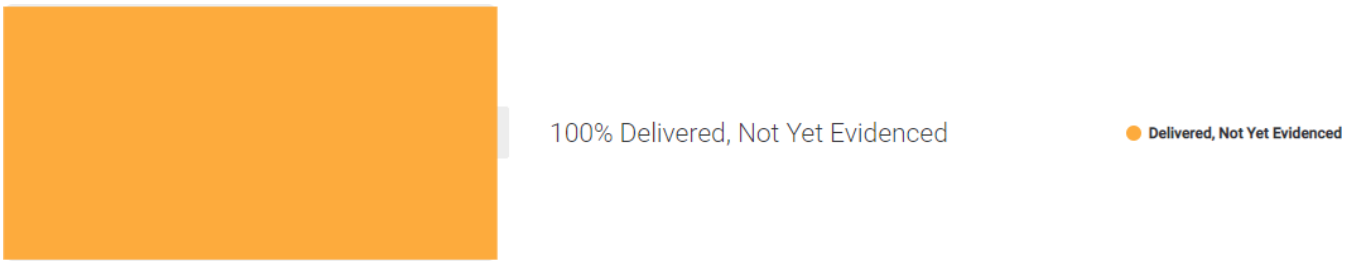
4.3 In line with the requirements of CNST, a review of Small for Gestational Age births at SaTH is carried out on a quarterly basis by the SBL lead midwife. The most recent review is for Quarter 2 2022/2023 and attached for reference as appendix 1. The review provided the following highlights:

4.3.1 Detection and management of babies less than the 3rd centile remains better than the Perinatal Institutes national GAP user average. This is reassuring.

4.3.2 A review of babies that were born <3rd centile >37+6 weeks' gestation in quarter 2 did not identify any themes relating to FGR not being detected (CNST monitoring standard). No cases occurred from low-risk surveillance (Symphysis fundal height). This is reassuring.

5.0 Progress update on Element 3: Raising awareness of reduced fetal movement (RFM). SBL mandates that the following measures must be implemented. Updates against each are provided below with confirmatory audit evidence to follow in due course.

5.1 Element 3 contains 5 standards (awaiting senior team approval to change to green evidenced and assured)



5.2 Information from practitioners, accompanied by an advice leaflet (for example, RCOG or Tommy's leaflet) on RFM, based on current evidence, best practice, and clinical guidelines, to be provided to all pregnant women by 28+0 weeks of pregnancy and RFM discussed at every subsequent contact.

5.2.1 CNST required audit September 2022 (reported to Obs and Gynae audit meeting October 2022)

"An in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators" demonstrated 100% compliance of leaflet provision and discussion by 28 weeks.

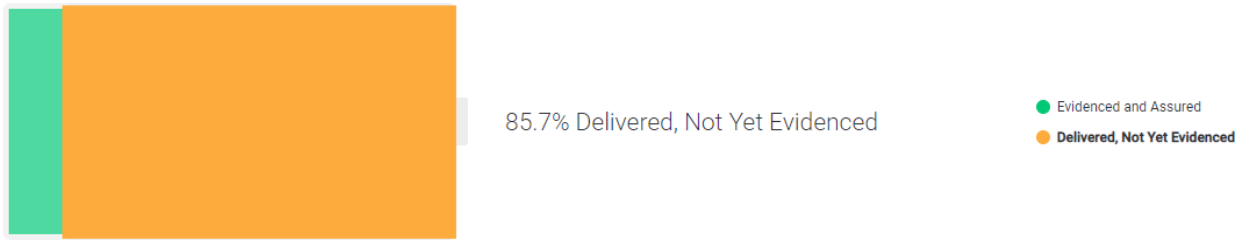
5.3 Use provided checklist (on page 33 of Saving Babies' Lives document) to manage care of pregnant women who report RFM, in line with national evidence-based guidance (for example, RCOG Green-Top Guideline 57).

5.3.1 The above audit also demonstrated an 85% compliance for completing the RFM checklist.

5.3.1.1 Until recently the RFM checklist was signposted within the Triage RFM BSOTS. The link was removed by Clevermed (Badgernet) as not part of BSOTS. Consequently, compliance has fallen with Trusts using the system. Request to return link registered with Clevermed
Compliance has increased from 45% in July 2022 to the current 85% (same size cohort)

6.0 Progress update on Element 4: Effective fetal monitoring during labour. This element focusses on the provision of sufficient numbers of adequately trained staff, able to provide and interpret cardiotocographs (CTGs). SaTH benefits from two fetal monitoring lead midwives, and a lead Consultant. This element closely compliments CNST[6] Safety Action 8[7], specifically section c).[8]

6.1 Element 4 contains 7 standards (awaiting senior team approval to change to green evidenced and assured)



6.2 There is a system agreed with local commissioners (CCG) based on the advice of the Clinical Network to assess risk at the onset of labour which complies with NICE

6.2.1 Recent audit of Continuous Electronic Fetal Monitoring in Labour demonstrated a compliance of 97.5%

[6] https://resolution.nhs.uk/wp-content/uploads/2022/05/MIS-year-4-relaunch-guidance-May-2022-converted.pdf
[7] "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?"
[8] [Can you evidence that] "90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multi-professional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four"

6.3 Regular (at least hourly) review of fetal wellbeing to include: CTG (or intermittent auscultation (IA)), reassessment of fetal risk factors, use of a Buddy system

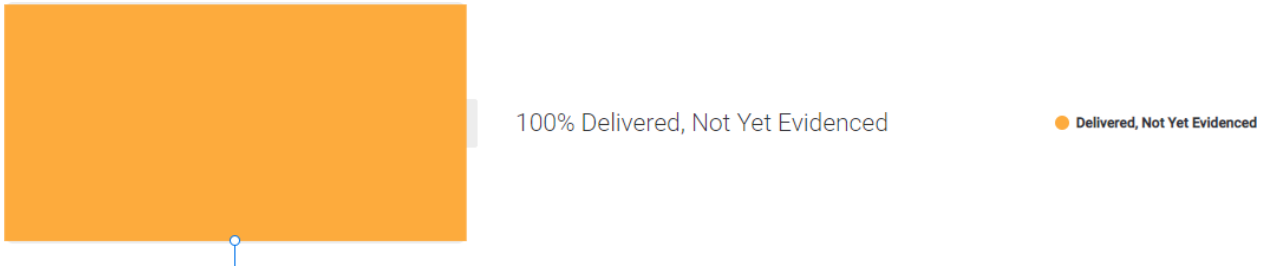
6.3.1 The above audit demonstrated compliance for hourly 'fresh eyes' of 94%.

6.4 There should be Trust board sign off that staff training on using their local CTG machines (CNST year 4)

6.4.1 CTG training presentation created and cascaded to all Midwives that attend the Fetal Wellbeing Study day. Online self-certification being used to capture compliance. Managers have been asked to promote compliance.

7.0 Progress update on Element 5: Reducing preterm birth.

7.1 Element 5 contains 19 standards (awaiting senior team approval to change to green evidenced and assured)



7.2 CNST mandates that a quarterly review of pre-Term Care must be conducted. The most recent review, for Quarter 2 of financial year 2022-23 is attached for reference at appendix 2.

7.2.1.1 The key highlight is that SaTH is close to maintaining the national target of 6% or below of total births being pre-Term an average percentage figure of preterm births (24 to 36+6 weeks). For the period in question, SaTH achieved a rate of **5.1%**. The mean average since quarter 4 2021 to date is 5.65%, with a peak of 7% and a low of 4.4%.

7.2.1 The administration of a full course antenatal steroids (birth within 7 days fell in this quarter but the linear trend remains predicting an increase. Case reviews, reassuringly, did not find any missed opportunities.

7.2.2 The administration of Magnesium Sulphate (MgSO4) for neuroprotection of the baby was **100%**

8.0 Actions requested of the Maternity Governance Committee:

8.1 Note the overall Saving Babies' Lives progress update.

8.2 Relating to SBL Element 1:

8.2.1 Note that we are currently have achieved the requisite consecutive 4 month average >80% of CO monitoring for pregnant women 36

8.3 Relating to Element 2:

8.3.1 Take assurance from the fact that detection and management of babies less than the 3rd centile remains better than the Perinatal Institutes national GAP user average.

8.3.2 Take assurance that no trend or missed opportunity was identified for undetected <3rd centile babies

8.4 Relating to Element 3:

8.4.1 Note that we continue to be able to provide evidence that we offer and discuss information regarding Reduced Fetal Movement to service users

8.5 Relating to Element 4:

8.5.1 Note that we are monitoring compliance for risk assessment at the onset of labour and hourly fetal wellbeing assessment labour.

8.6 Relating to Element 5:

8.6.1 Take assurance from the fact that SaTH is close to achieving the target for percentage of pre-term births as a proportion of total births.

8.6.2 Take assurance that we are reviewing the care of all <34 week preterm babies

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Appendix 12

Saving Babies Lives Element 2

Review of Small for Gestational Age births at SaTH in Quarter 2 2022/2023

and

Accumulative graphical data commencing October 2020

Lindsey Reid
Lead Midwife for Saving Babies' Lives

Data collated October 2022

Introduction

Fetal Growth Restriction (FGR) is the most important condition associated with stillbirths;
excluding congenital abnormality, FGR accounts for about 50% stillbirths and neonatal deaths (ref 1 and 2).

A fetus affected by FGR has a 5-11 fold increased risk of in-utero death (ref 3)

FGR is a precursor of cerebral palsy (ref 4)

Introduction

Version two of the Saving Babies' Lives Care Bundle (SBLCBv2 (ref 5)), has been produced to build on the achievements of version one. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice.

Element 2

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

Definitions and Abbreviations

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

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

Estimated fetal weight (EFW) - fetal weight estimated from ultrasonic fetal biometry (measurements)

Induction of labour – IOL

Perinatal mortality review tool (PMRT)- national standardised perinatal mortality review

≥ - equal to and above

≤ - equal to and below

This report does not include slowing growth detected on babies born above 10th centile

Aims

To monitor compliance with the standards contained within SBLCBv2 and the Maternity Incentive scheme (CNST) year 4

Standards

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

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

Maternity care providers caring for women with FGR identified prior to 34+0 weeks must have an agreed pathway for management which includes network fetal medicine input (for example, through referral or case discussion by phone).

CNST year 4

Undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems

Methodology

A retrospective quarterly data review of babies born below the 10th centile

Time period– 1/7/22 – 30/9/22 (Quarter 2)

Cases analysed – 1109 babies (live born and stillborn from 24 weeks gestation)

Cases excluded – women who received the majority of their antenatal care/fetal growth surveillance outside of the Trust

Data extracted from Badgernet (Maternity Information Systems)

Method of analysis – Microsoft Excel

Results

The next slide shows SaTH's internally reviewed data.

The Perinatal Institute's (PI) Quarter 2 national GAP (Growth Assessment Protocol (ref 6)) user average data is included as a comparative data.

Quarter 2 2022/2023		SaTH reviewed data	Perinatal Institute National GAP user average Data Comparison
Total births	N	1109	-
SGA rate <10th – 0 centile	N %	145 13.7	13.7
SGA detection rate (<10th – 0 centile)	N %	68 46.9	42.8
Babies <10th centile (10th-3rd) delivered on or after 40+0 weeks	N %	40 27.5	26.5
SGA rate (<3rd centile)	N %	61 5.5	4.7
SGA detection rate < 3rd centile	N %	43 70.5	61.7
Babies <3rd centile delivered on or after 38+0 weeks	N %	37 (see review of cases) 60.6	50.7

Conclusion

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All Babies born <10th centile **13.7%**, was the same as the PI national average of 13.7%.

Antenatal detection (suspected by ultrasound assessment) rate of all babies <10th centile was **46.9%,** this had **exceeded** the PI national average of 42.8%.

Babies <10th and >3rd centile, delivered on or after 40+0 weeks was **27.5%** which is just above the PI national average of 26.5%.

Babies born <3rd centile **5.5%** which was just above the PI national average of 4.7%.

Antenatal detection (suspected by ultrasound assessment) rate of all babies <3rd centile was **70.5%** this had **exceeded** the PI national average of 61.7%.

Babies <3rd centile delivered on or after 38+0 weeks **60.6%** is above the PI national average of 50.7% (see review of cases in next few slides).

< 3rd centile Quarter 2 birth review

The Shrewsbury and Telford Hospital NHS Trust

< 3rd centile cases are reviewed to try to identify any themes that require further investigation and improvement plans

The majority of the < 3rd centile births (all the <3rd centile born > 37+6 weeks) are reviewed for care provided from booking to birth

The following slides are broken down into

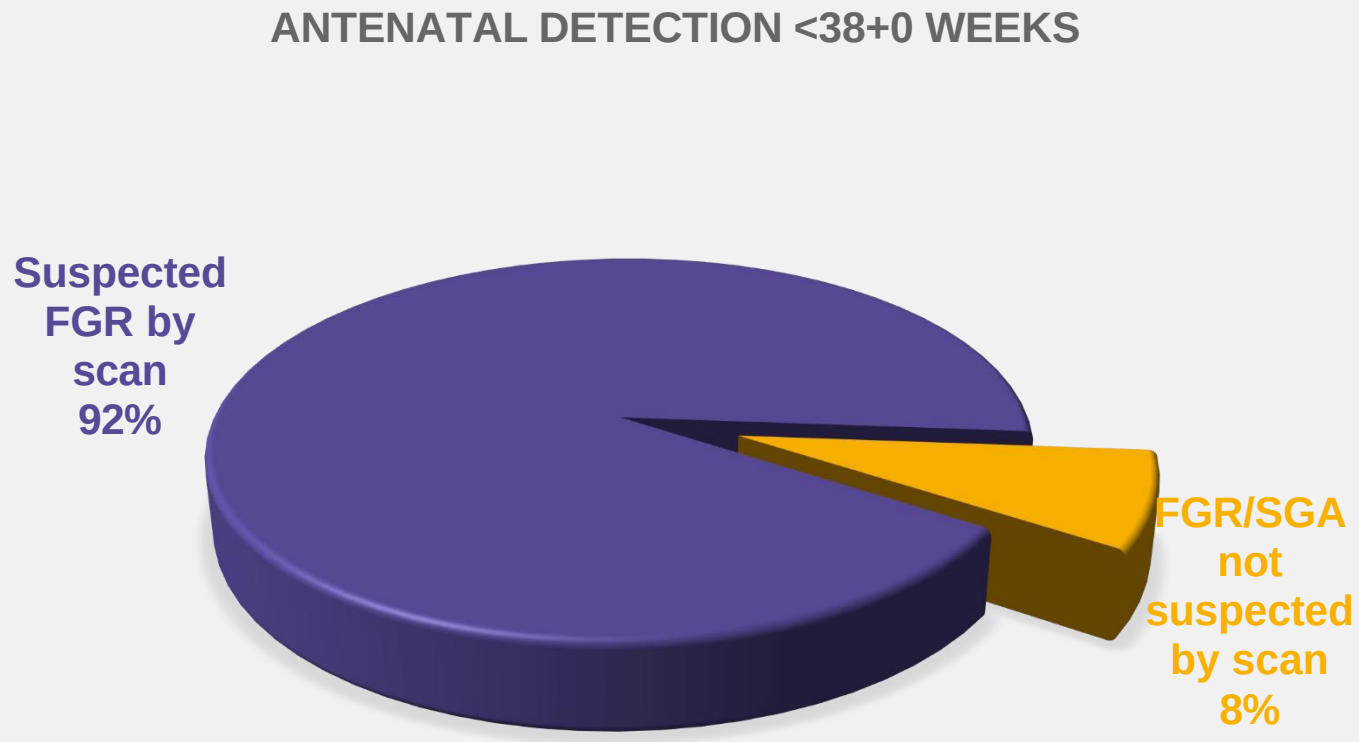
- births ≤ 37+6 weeks
- births > 37+6 weeks

They give an overview of detection and a brief description of cases

< 3rd centile cases born <38 weeks gestation

The Shrewsbury and Telford Hospital NHS Trust

25 cases
■ detected by scan
<5 not suspected by scan
<5 antenatal stillbirth at 26 weeks – fetal surveillance had not commence in accordance with Trust pathway



<3rd centile cases born >37+6 weeks n=37

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Quarter 2 had 37 babies born >37+6 weeks < 3rd centile

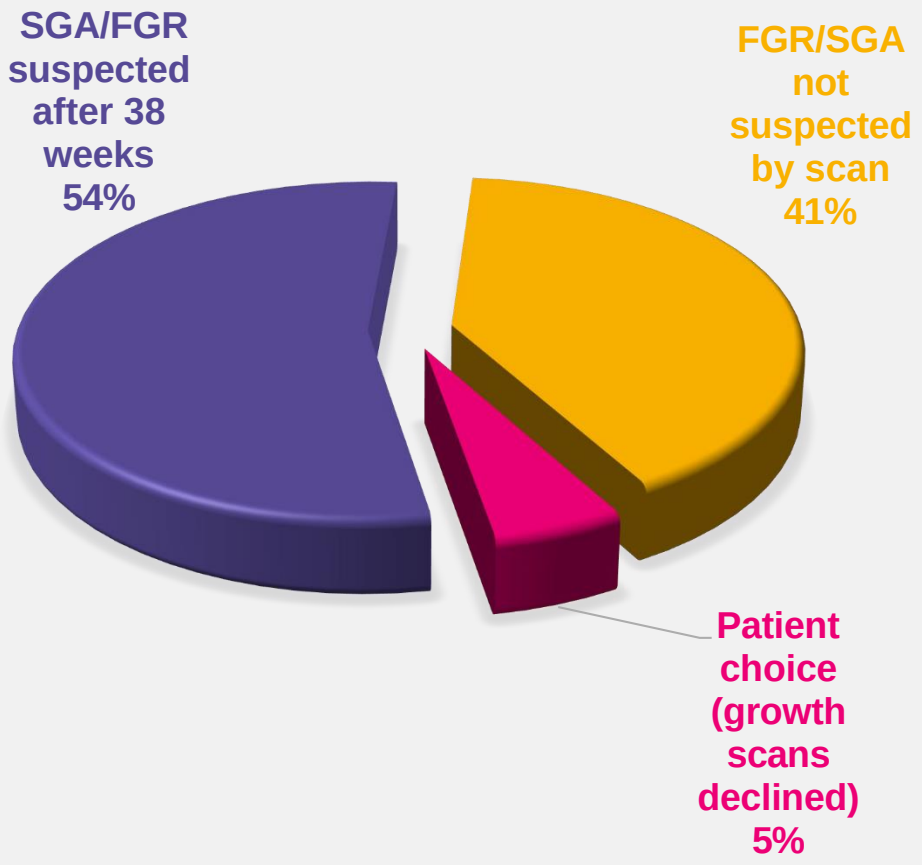
<5 were detected <37+6, commenced IOL <37+6 but did not birth until >37+6 weeks therefore were detected in line with SBLCBv2 guidance

16 were not detected <37+6 but;

- <5 detected as < 3rd >37+6 weeks and IOL appropriately offered and arranged according to Trust guidance
- 15 were suspected between 10th and 3rd centile or slowed growth and IOL appropriately offered and arranged according to Trust guidance

15 cases not suspected

- These cases included women having serial growth scans and scans following a referral from a Community Midwife



Fetal medicine referral/advice

The Shrewsbury and Telford Hospital NHS Trust

Babies with an antenatal suspicion of growth problems before 34 weeks should have had a referral or plan of care discussion with a Fetal Medicine Specialist

Quarter 2 inclusive cases – 12

All cases had documented Fetal Medicine involvement

Evaluation

Within the total quarter 2 births (1109),17 cases < 3rd centile were not identified before birth – 1.5%

- No cases occurred from low risk surveillance (Symphysis fundal height) only
- No adverse trends identified

Ultrasound detection

Ultrasound surveillance using EFW is a screening tool and **not** diagnostic due to the inherent issues in calculation of EFW formulas

The most accurate model is Hadlock 3 which is used in SaTH

Reported standard deviation for Hadlock formula is 7.3%, which means;

- **95% of babies have a measured birth weight within 15% of EFW**
- However 1 in 20 babies have a measured birthweight more than 15% of EFW

Additional consideration

- SaTH currently do not save 3rd trimester growth ultrasound images electronically, therefore, complete case evaluation not possible. This has also been highlighted from PMRT case reviews

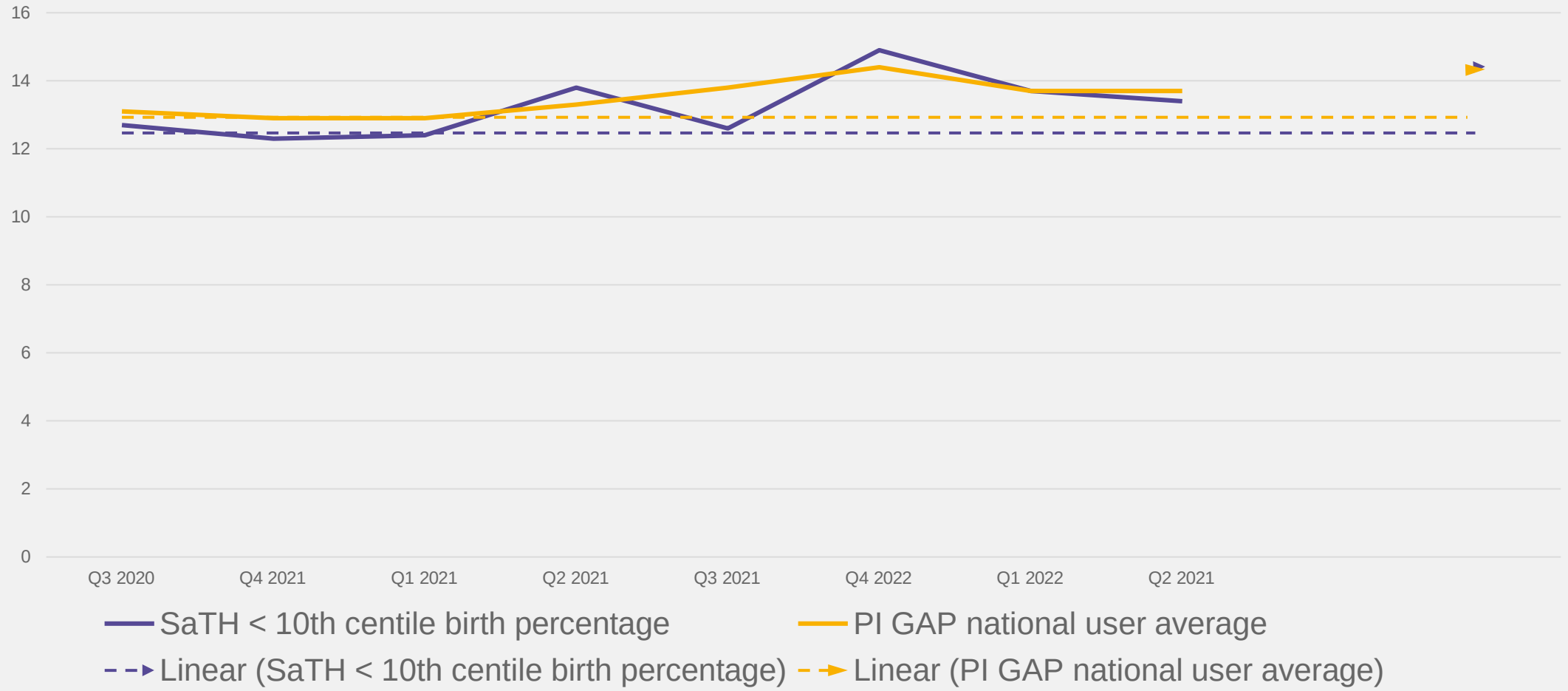
Recommendation

- Consider implementation of electronic storage of 3rd trimester growth scan images

The following slides show accumulative data of:

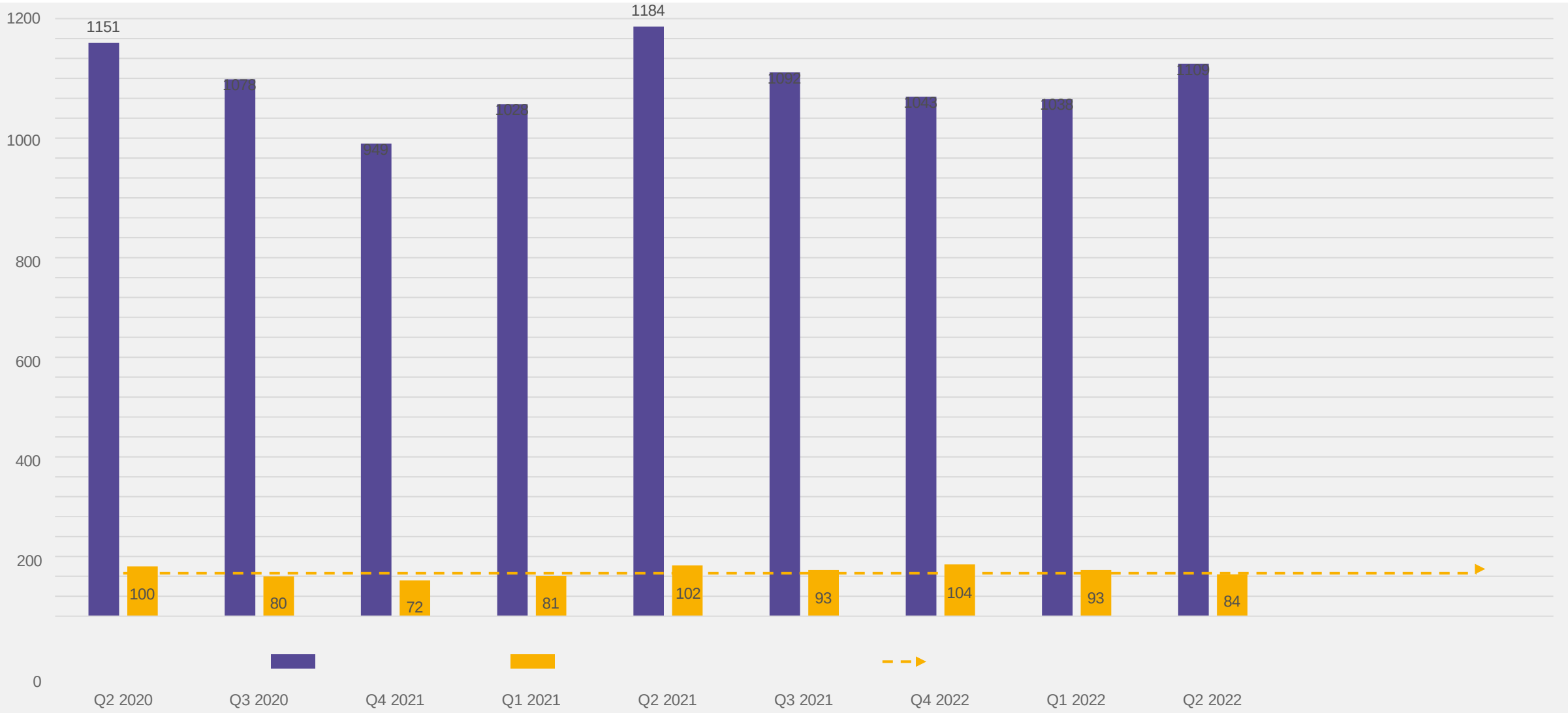
- All babies born <10th centile at SaTH compared to PI national GAP average
- Babies born <10th >3rd centile
- Expanded <10th >3rd centile data
- Babies born < 3rd centile
- Expanded <3rd centile data

Babies born < 10th centile at SaTH compared to the Perinatal Institute's national GAP User average



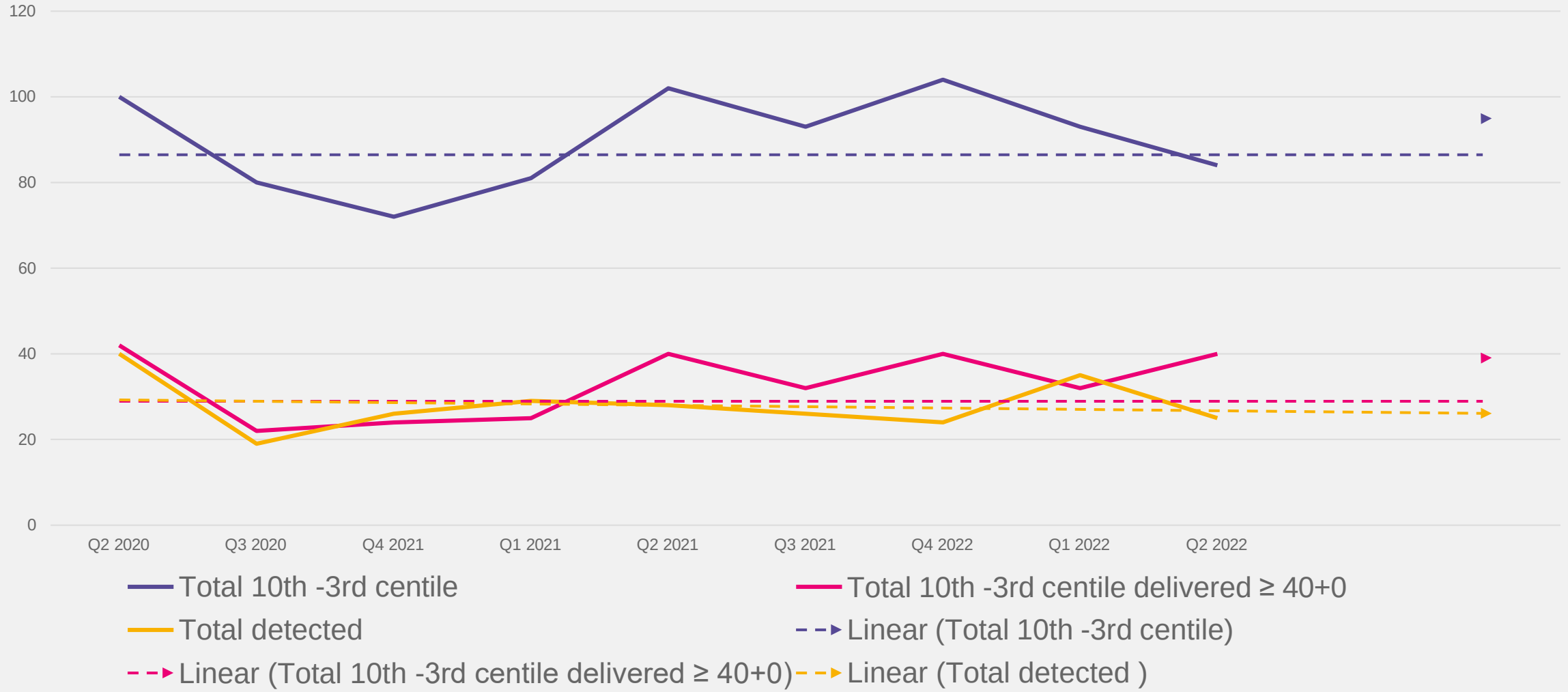
SaTH appears to be reflecting the national average trend of increasing numbers of babies born <10th centile

Overview of babies born between the 10th and 3rd centile

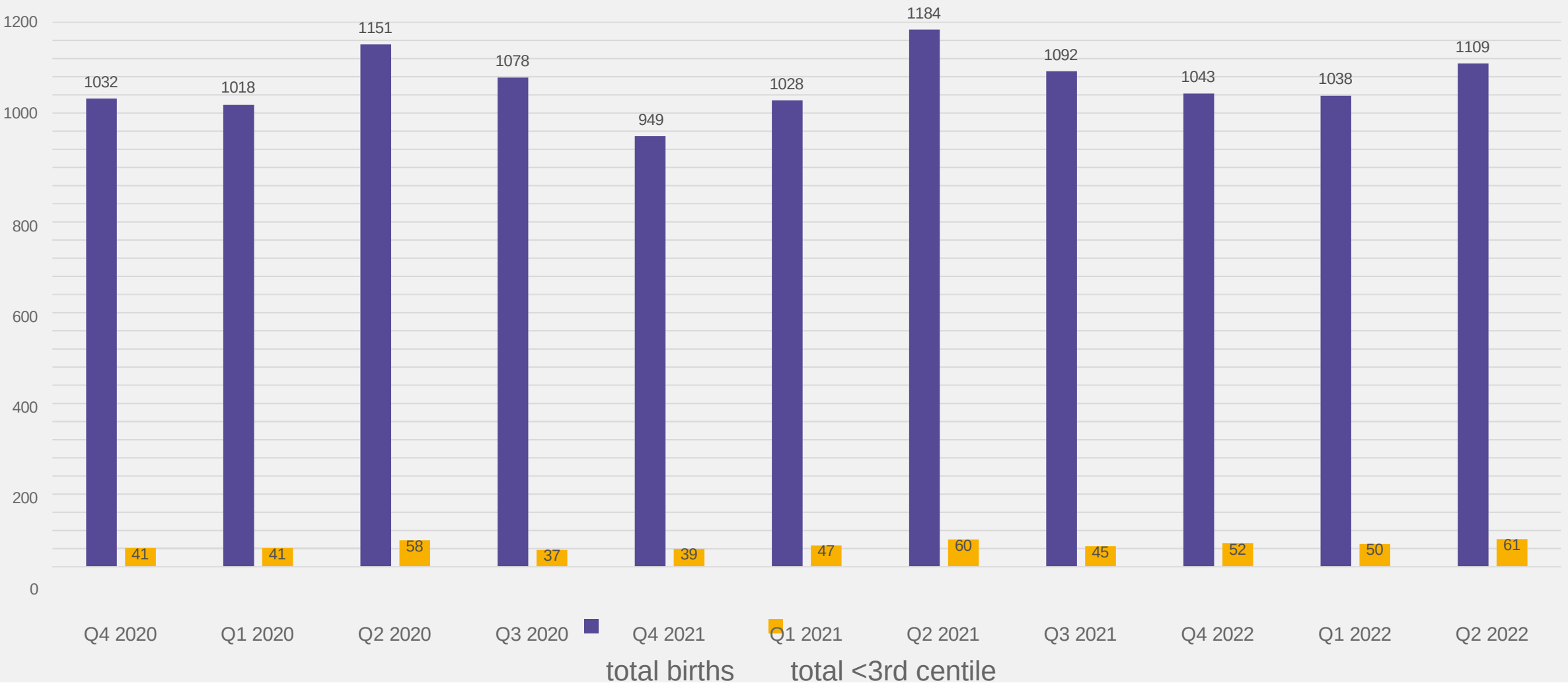



Total births
Total 10th -3rd centile
Linear (Total 10th -3rd centile)

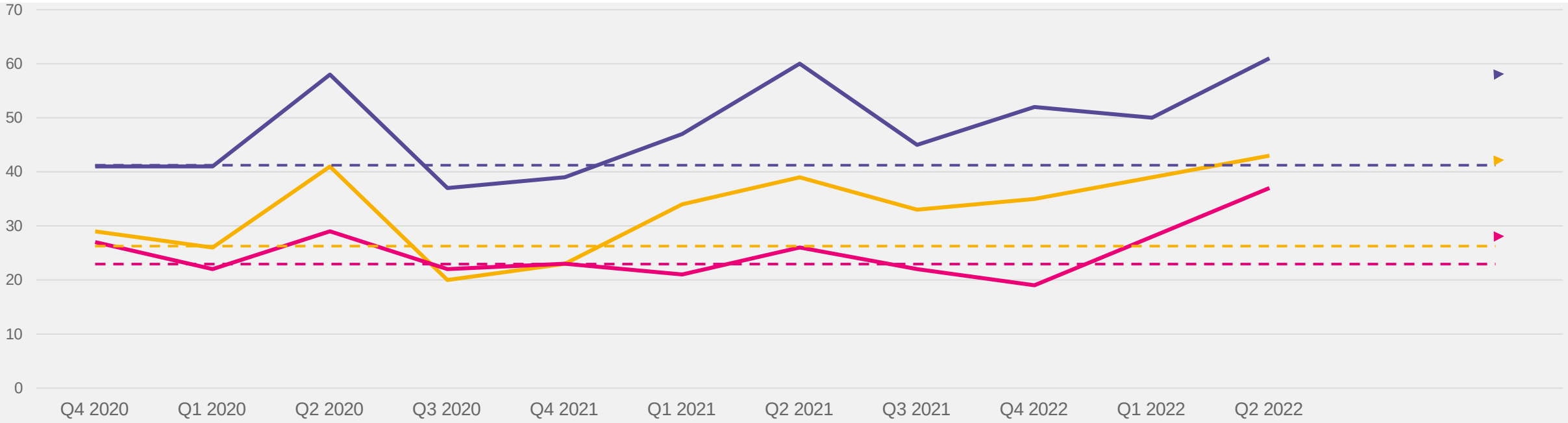
Expanded 10th to 3rd centile data



Overview of babies born < 3rd centile



Expanded < 3rd centile data



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1. Gardosi J, Kady SM, McGeown P, Francis A, Tonks A. Classification of stillbirth by relevant condition at death (ReCoDe): population based cohort study. *Br Med J* 2005;**331**:1113-1117.
2. Beamish N, Francis A, Gardosi J. Intrauterine growth restriction as a risk factor for infant mortality. *Arch Dis Child Fetal Neonatal Ed* 2008;**93**(Suppl I):Fa83.
3. Clausson B, Gardosi J, Francis A, Cnattingius S. Perinatal outcome in SGA births defined by customised versus population based birthweight standards. *Br J Obstet Gynacol* 2001;**108**:830-4.
4. Jacobsson B, Ahkin K, Francis A, Hagberg G, Hagberg H, Gardosi J. Cerebral palsy and restricted growth status at birth: population based case-control study. *Br J Obstet Gynacol* 2008;**115**:1250-1255
5. NHS England (2019) Saving Babies' Lives A care bundle for reducing perinatal mortality version 2 https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

Reference

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

6. GAPguidance.pdf (perinatal.org.uk)

The Shrewsbury and Telford Hospital NHS Trust

Appendix 13

Quarter 2 2022/2023 Review of Preterm Births

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

Background

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

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

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

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

Aim

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

Standards

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

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

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

Antenatal Steroids

Explanation

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

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

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

Benefits of steroids do not exceed 7 days

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

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

Standards

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

Magnesium Sulphate

Explanation

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

Similar effects across a range of gestations including extreme preterm infants

Optimum level is at least 4 hours after loading dose

Benefit remains if given under 4 hours where birth is imminent

Standards

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

ODN – Operational Delivery Networks

Optimum Place of birth

Explanation

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

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

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

Standards

- Outcome indicator (ref 1)

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

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

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

Methodology

A retrospective review of preterm births under 36+6 weeks using Badgernet (maternity information system)

Time period – 1/07/22 – 30/09/22

Cases analysed –1109 total births

Method of analysis – Microsoft Excel

Results

The Shrewsbury and Telford Hospital NHS Trust

1. Percentage of singleton live births (under 34+0 weeks, including babies who have received active management 22-23+6 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth

Cases in review period n=17

Table 1

Percentage of singleton live births (under 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth (n=17)			
Number of cases in review	17		
Number of cases standard not applicable	0	Total number cases assessed for standard	17
Criteria	Received full dose within 7 days	Did not receive full dose or over 7 days	Total %
• Percentage of singleton live births (under 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth	9	8	52.9 %

In 4 cases, births expedited prior to 2nd dose. No missed opportunities identified.

In 3 cases, spontaneous births before 2nd dose due. No missed opportunities identified.

1 case, Full course given due to PPROM, delivered over 7 days after. Care followed guideline.

2. Percentage of singleton live births (under 34+0 weeks including babies who have received active management 22-23+6 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids

Cases in review period n=17

Table 2

Percentage of singleton live births (under 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids (n=17)			
Number of cases in review	17		
Number of cases standard not applicable (received single doses)	7	Total number cases assessed for standard	10
Criteria	after 7 days	by 7 days	Total % after 7days
Percentage of singleton live births (under 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids	<5	6	10%

1 case, Full course given due to PPROM, delivered over 7 days after. Care followed guideline.

3. Percentage of singleton live births (under 30+0 weeks including babies who have received active management 22-23+6 weeks) receiving magnesium sulphate (MgSO4) within 24 hours prior to birth

Cases in review period n=4

Table 3

Percentage of singleton live births (under 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth (n= 3)			
Number of cases in review	<5		
Number of cases standard not applicable	0	Total number cases assessed for standard	<5
Criteria	Received MgSO4	Did not receive MgSO4	Total %
• Percentage of singleton live births (24 - 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth	<5	0	100%

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

The Shrewsbury and Telford Hospital NHS Trust

Cases in review period n=1109

Table 4

Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). (n=1109)			
Number of cases in review	1109		
Number of cases standard not applicable	<5 [redacted]	Total number cases assessed for standard	1108
Criteria	Yes	No	Total %
Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).	1107	<5 [redacted]	99.9%

Case 1 – 27+4 week twin pregnancy, Powys. 27+1 Attended Triage with a PV bleed. IUT to Arrow park. Discharge home. 27+4 call from Newtown MW. PV bleed, on route to PRH. Arrived 22.00, delivered by emergency CS 23.01. 2nd IUT not possible as obstetric emergency.

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

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

Cases in review period n=1109

Table 5

The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a. In the late second trimester (from 16+0 to 23+6 weeks)			
Number of cases in review	1109		
Number of cases not applicable	34 (Twins)	Total number cases assessed	1075
Criteria (Termination of pregnancy's excluded)	16+0 to 23+6 weeks	> 24 weeks	Total % of 16+0 to 23+6 weeks
The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a. In the late second trimester (from 16+0 to 23+6 weeks)	8	1067	0.7%

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

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

Cases in review period n=1109

Table 6

The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: b. Preterm (from 24+0 to 36+6 weeks).			
Number of cases in review	1109		
Number of cases not applicable	34 (Twins)	Total number cases assessed	1075
Criteria	24+0 to 36+6 weeks	> 37 weeks	Total % of 24+0 to 36+6 weeks
The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: b. Preterm (24+0 to 36+6 weeks)	55	1015	5.1%

Conclusion of Quarter 2 2022/2023

The Shrewsbury and Telford Hospital NHS Trust

Percentage of singleton live births (under 34 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth ↓**52.9%** (table 1)

Percentage of singleton live births (under 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids ↑**10%** (table 2)

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

Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance) ↑**99.9%** (table 4)

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

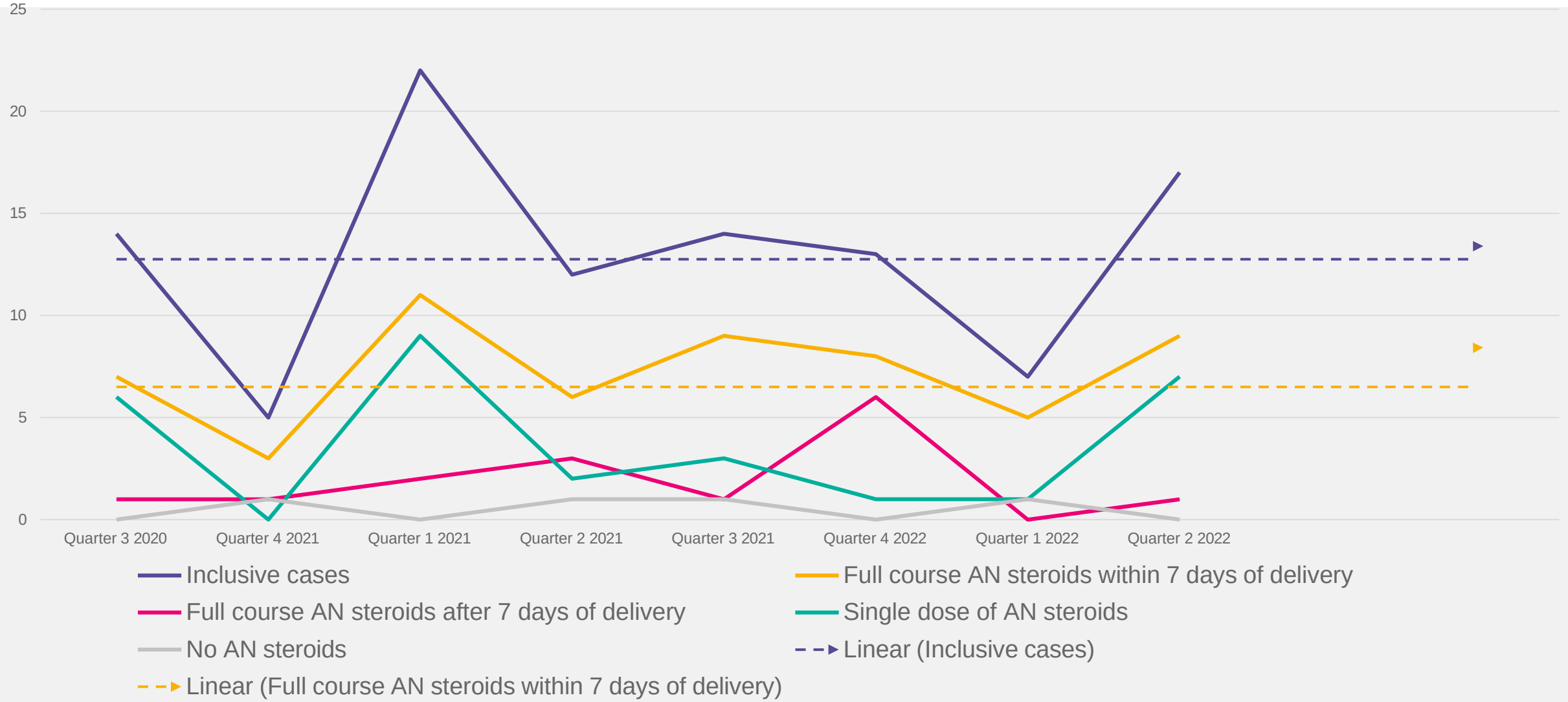
a. In the late second trimester (from 16+0 to 23+6 weeks) ↓**0.7%** (table 6)

b. Preterm (from 24+0 to 36+6 weeks) ↑**5.1%** (table 7)

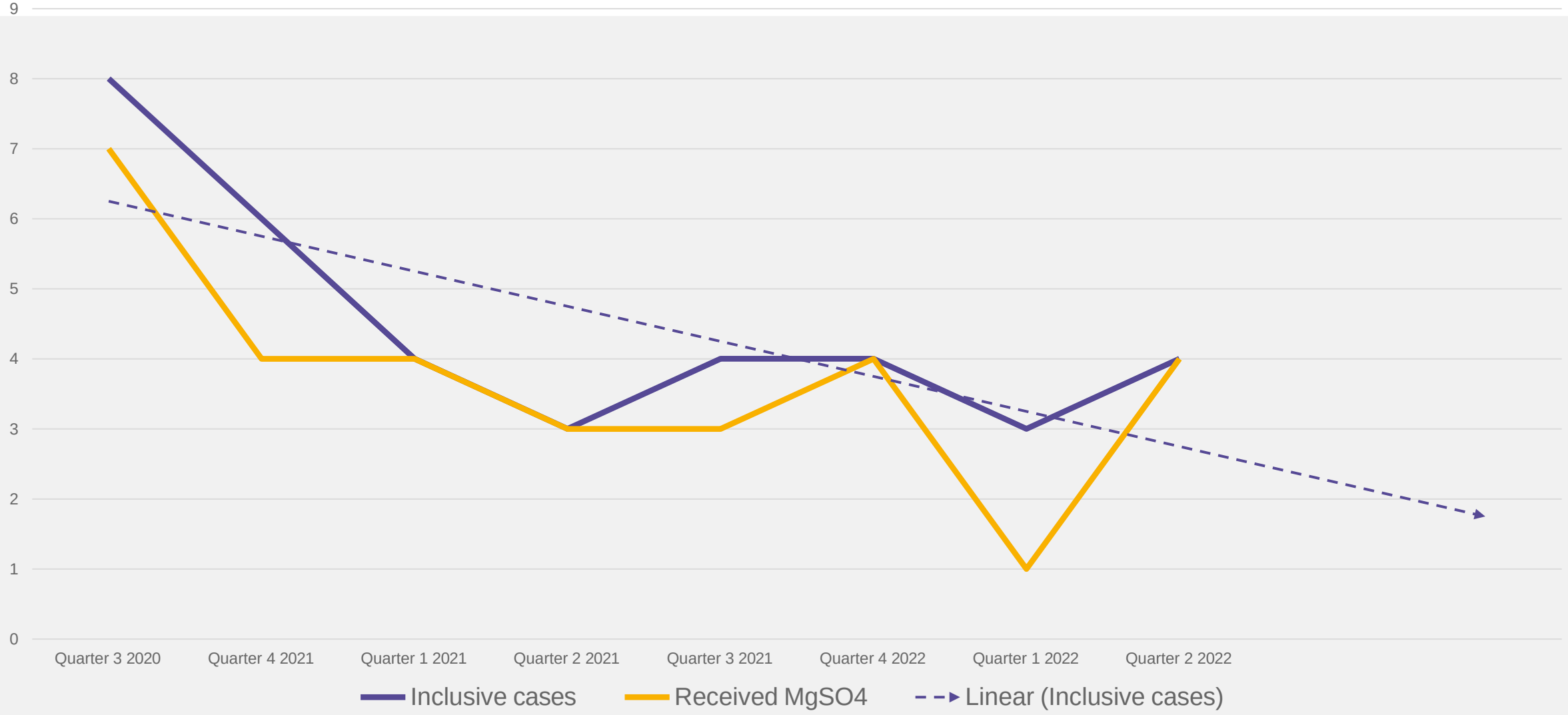
Accumulative Data

The following set of slides show accumulative Standards data graphs

Antenatal Steroids



Antenatal Magnesium Sulphate (MgSO4) administer for neuroprotection (up to 30 weeks gestation)



Women who give birth in an appropriate care setting for gestation

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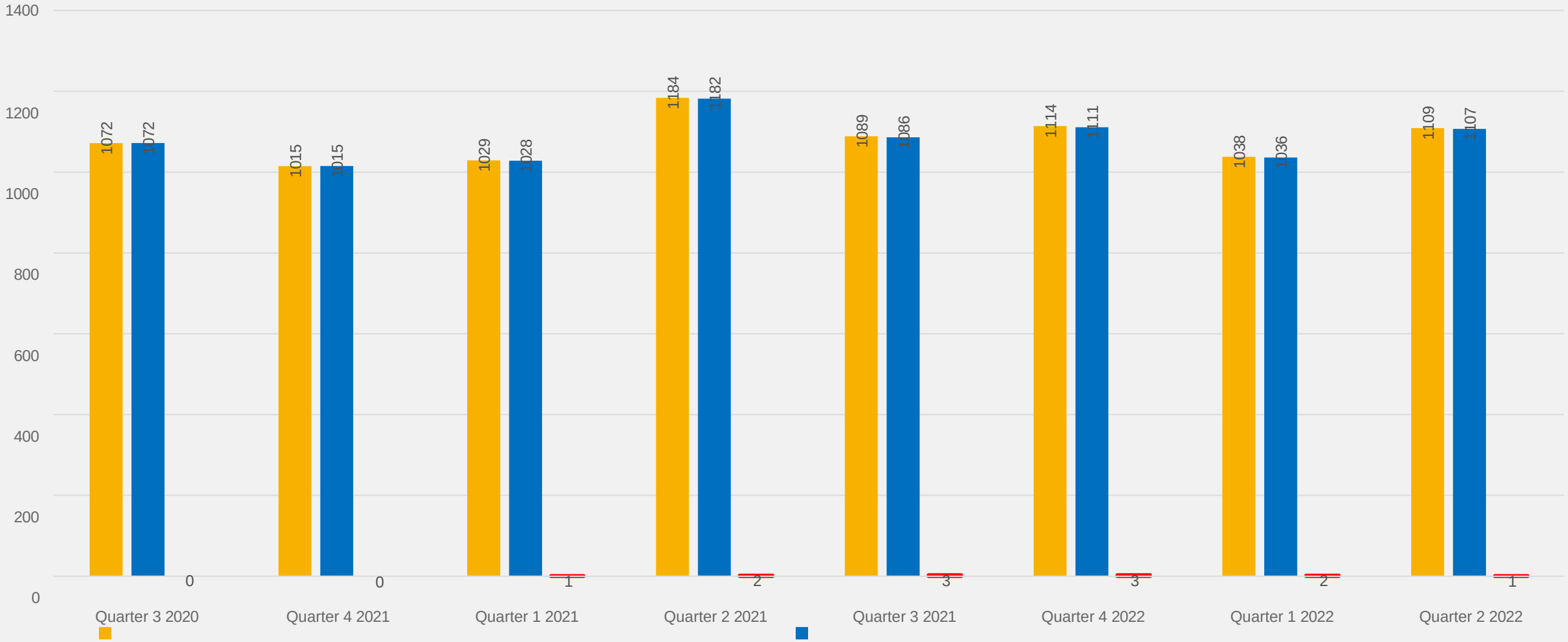
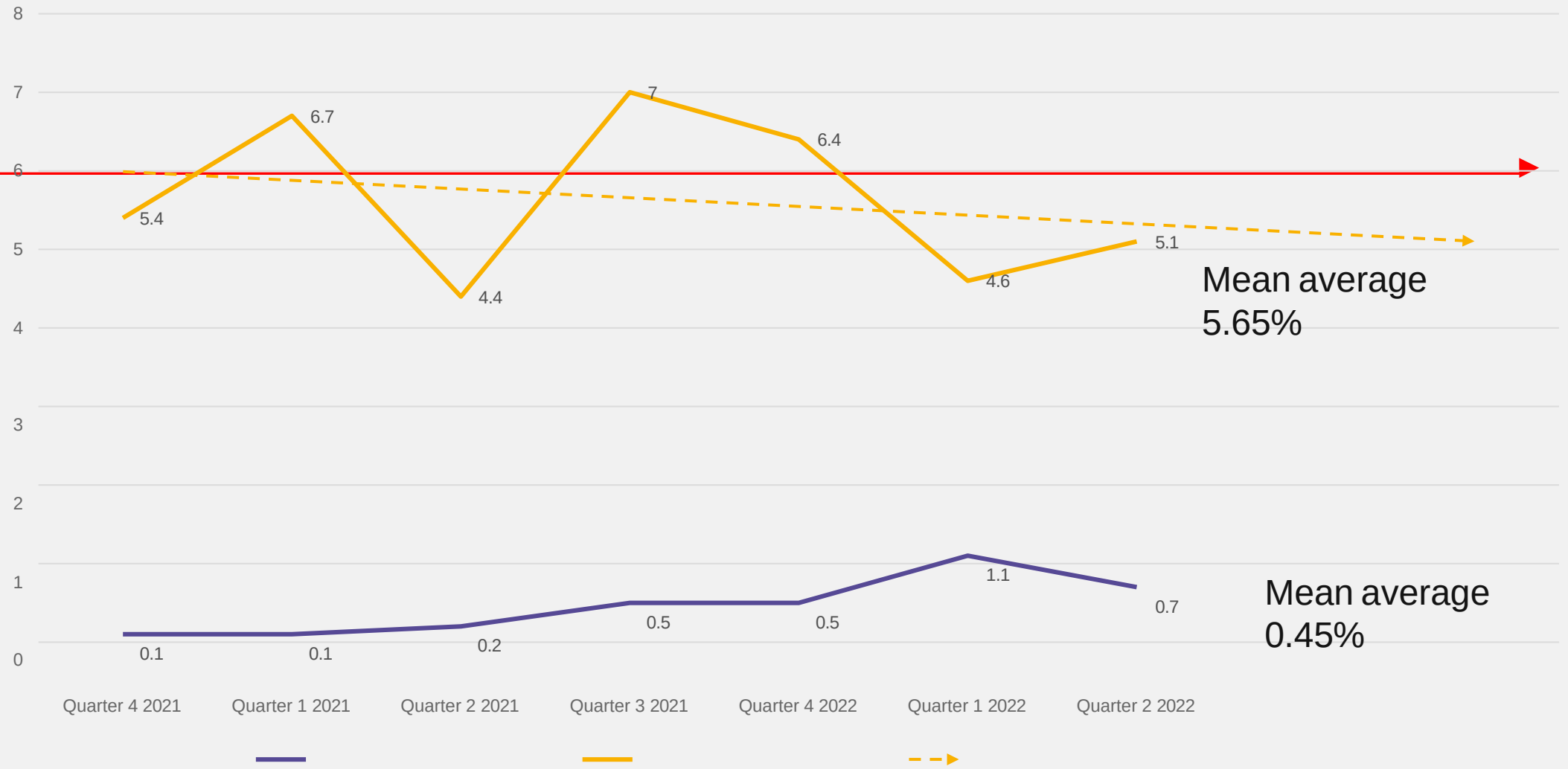


Births that were not in an appropriate care setting for gestation

Incidence of preterm births at SaTH
Quarter 4 2021 - Quarter 2 2022

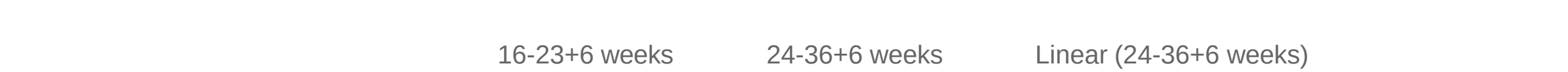
The Shrewsbury and Telford Hospital NHS Trust

Government target of 6% by 2025

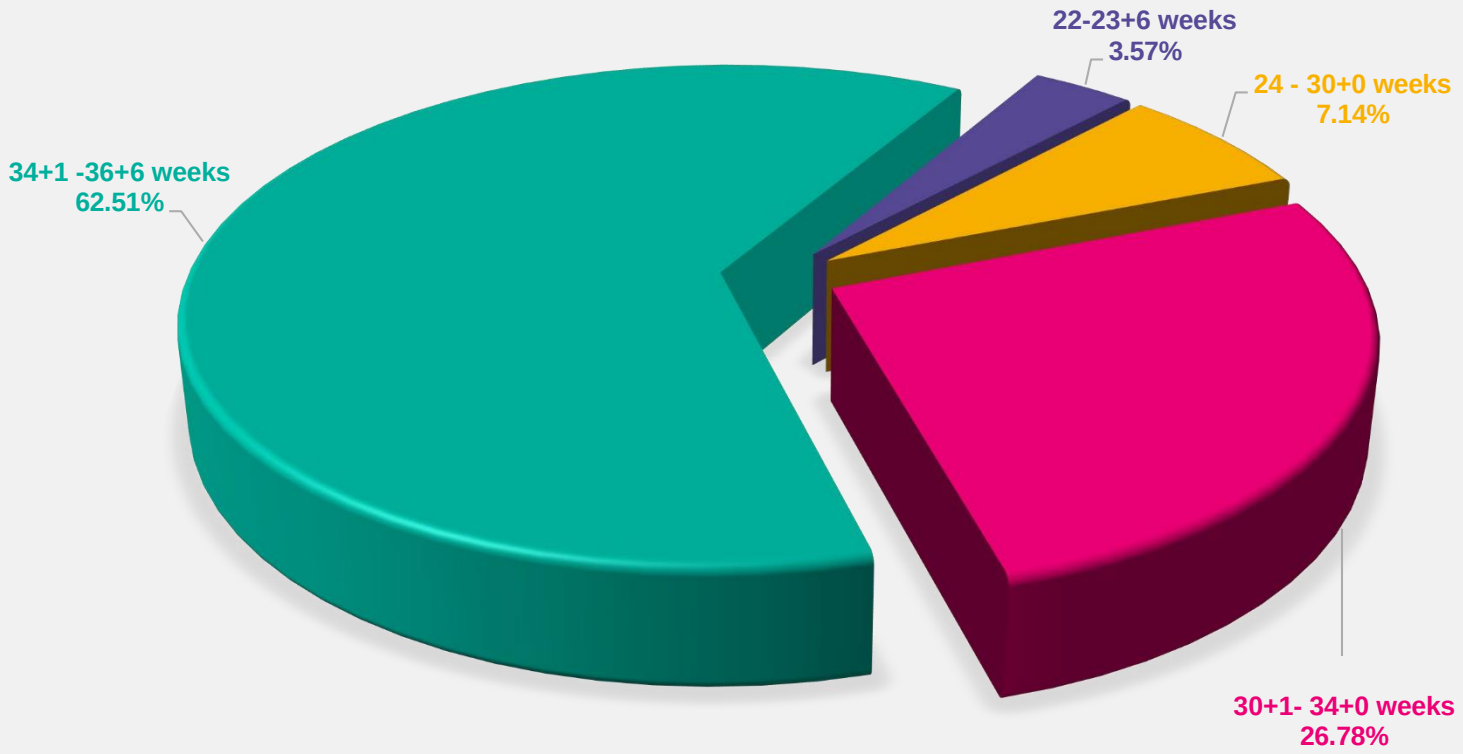


Mean average 5.65%

Mean average 0.45%


16-23+6 weeks
24-36+6 weeks
Linear (24-36+6 weeks)

Quarter 2 singleton (livebirth) preterm gestation breakdown



Total inclusive cases 56

Gestations between 22 and 23+6 included as active management at birth maybe requested

Reference

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

Aooendix 14

Appendix 6 to CNST MIS Year 4 Progress Update – November 2022:

Locally Agreed Safety Intelligence Dashboard – Qtr 2 2022-23

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

Maternity Safety Support Programme	Yes	

QUARTER 2 - 2022						Jul	Aug	Sep	Comment
1.	**PMRT**	Findings of review of all perinatal deaths using the real time data monitoring tool	Stillbirths			0	<5	<5	All families were informed of PMRT review either by a face-to-face meeting or letter to home address. 100% compliance. Feedback from families recorded in PMRT quarterly report and shared Maty Gov mtg.
			Late fetal losses >22 wks			<5	<5	0	
			Neonatal Deaths			0	<5	<5	
2.	**HSIB**	Findings of review of all cases eligible for referral to HSIB				✓	✓	✓	All legible cases were reviewed and referred to HSIB within the required 7-day deadline
3a.	**INCIDENTS**	The number of incidents logged, graded as moderate or above and what actions are being taken	Moderate Harm or above reported			<5	14	<5	Where level of investigation is serious (SI) action is taken to progress as internal/external. A rise in Aug data is due to cross-referencing data on Badgernet highlighting multiple trigger incidents for one Datix which can be included in one report. Trg underway for reporter's estimation of harm level.
			Serious Incidents reported			0	0	<5	
3b.	**TRAINING**	Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training – PROMPT Training	Obstetricians			100	95	90	Clinical Education Midwife reports that August figures for 'Other Drs' dropped due to the new intake of Drs starting at the beginning of August.
			Midwives			95	97	92	
			Other Drs			100	38	42	
			WSAs			93	93	95	
3c.	**STAFFING**	Minimum safe staffing in maternity services to include Obstetric cover on the Delivery Suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	Obstetric Cover on D Suite %			100	100	100	<u>Obs unit for Drs - Minimum safe staffing level on Delivery Suite</u>: Tier 1: One from FY2, GPVTS 1-2, ST1-2, equivalent/higher grade Tier 2: One from ST3-7, equivalent/higher grade Tier 3: Consultant covering obstetrics only <u>Maternity Fill rates and acuity on the Delivery Suite:</u> Reviewed at least twice daily, and staff redeployed as required. Regional OPEL escalation document completed 7 days a week and escalation framework followed.
			Maty 1:1 care in labour			100	99.7	98	
			Maty Del Suite positive acuity %			60	55	58	
			Fill rates Del Suite	RM%	Day	85	95	93	
					Night	84	88	85	
				WSA%	Day	107	101	106	
					Night	75	85	99	
4.	**SERVICE USER FEEDBACK**	Service User Voice Feedback from MVP and UX system achievements				Birth preferences posters displayed in birth rooms	MVP/midwives working collaboratively for next batch of cards	IOL in process of being filmed	**Other developments**: • UX system shortlisted as finalists for Patient Exp National Network • Development of new maternity website underway • Updated bereavement website section (new aesthetics and information up to date)
5.	**STAFF FEEDBACK**	Staff feedback from Bi-monthly frontline champion and walkabouts *(CNST requirement quarterly)*				Obstetric Theatres ✓	No walkabout (Bi-monthly)	Postnatal Ward ✓	Plan in place for next walkabout in November and ahead for 2023 aligned with MVP 15 steps visits
6.	**EXTERNAL**	HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust				(tbc)	(tbc)	(tbc)	Awaiting confirmation
7.	**Coroner Reg 28**	Coroner Regulation 28 made directly to Trust				None	None	None	Reported in the Trust's IPR
8.	**SA 10 CNST**	Progress in achievement of CNST Safety Action 10				✓	✓	✓	All qualifying cases reported to MBRRACE and PMRT commenced in line with CNST - compliant within timeframe. Duty of Candour up to date w/all cases or in progress.

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	Data tbc
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	87% *(source GMC National Trainee Survey 2022)*