The Shrewsbury and Telford Hospital NHS Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC

Thursday 14 December 2023

AGENDA ITEM 162/23 INTEGRATED MATERNITY REPORT

APPENDIX 2 - CNST INFORMATION PACK

Paper No.	Name of Report	Appendices Included
1	CNST MIS Year 5 progress report – October 2023	• Appendix 1: PMRT Quarterly Report Q2 2023-24 • Appendix 2: ATAIN Report Q2 2023-24 • Appendix 3: Transitional Care Audit Report Q2 2023-24 • Appendix 4: Obstetric Clinical Workforce Plan • Appendix 5: Neonatal Workforce position against BAPM standards • Appendix 6: Maternity 6-month Staffing Report • Appendix 7: Saving Babies Lives: Progress Report • Appendix 8: Black Maternal Health – Gap Analysis • Appendix 9: Maternity Training Needs Analysis • Appendix 10: Safety Action 8 Training Compliance Report • Appendix 11: Maternity & Neonatal Safety Champions Locally Agreed Dashboard • Appendix 12: Maternity & Neonatal Safety Champions Meeting Minutes • Appendix 13: Saving Babies Lives Care Bundle Version 3 – Preterm Team ToR and Element 6 Divergence Document
2	CNST MIS Year 5 progress report – November 2023	• Appendix 1: Obstetric Clinical Workforce Plan • Appendix 2: Anaesthetic Rota • Appendix 3: Neonatal Nursing Workforce Action Plan / Strategy • Appendix 4: Maternity & Neonatal Safety Champions Locally Agreed Dashboard • Appendix 5: Our Staff Said, We Listened March-April 2023 • Appendix 6: Minutes of the second Quad/Safety Champions Quarterly Meeting

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14 December 2023

Agenda item		162/23 Paper 1 within CNST INFORMATION PACK		
Report Title		CNST MIS Year 5 Progress Update - October 2023		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Annemarie Lawrence/Kimberly Williams		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF4,
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners		
Consultation Communication		Maternity Governance Committee, October 2023 W&C Divisional Committee Meeting, October 2023 Quality and Safety Assurance Committee, October 2023 LMNS/PNQSG, November 2023		
Executive summary:		SaTH is a participant in year 5 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), which is operated by NHS Resolution (NHSR) and supports the delivery of safer maternity care. The self-declaration deadline is 1 February 2024. This paper sets out SaTH's progress to date and includes information to evidence the risks to delivery of the Safety Actions.		
Recommendations for the Board:		The Board is asked to: Review and discuss this paper and advise the Director of Midwifery of any further detail required. Note the risks to delivery for the scheme. The Board is asked to declare that the Trust has an established Preterm Team in line with the SBLCBv3. The Board is requested to acknowledge LMNS/ICB agreement and accept the divergence panel's recommendations.		

Appendices:	Appendix 1: PMRT Q2 Report Appendix 2: ATAIN Q2 Report Appendix 3: Transitional Care Q2 Report Appendix 4: Obstetric Clinical Workforce Plan Appendix 5: Neonatal workforce position against BAPM standards Appendix 6: Director of Midwifery bi-annual staffing paper Appendix 7: SBL progress report Appendix 8: Black Maternal Health Report Appendix 9: TNA Appendix 10: SA8 Training Compliance Appendix 11: Safety Champions Dashboard Appendix 12: Safety Champions Minutes Appendix 13: Saving Babies Lives v3 Preterm Team TOR and Element 6 divergence document.

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 Year 5 guidance was published on 31 May 2023, with version 1.1 and references a relevant time period of 30 May 2023 until 7 December 2023 for delivery of the scheme.

1.4 This also includes a self-declaration deadline of **noon on 1 February 2024.**

1.5 **Following further guidance pertaining to safety actions 3 and 9, a second iteration of the guidance was published on the 19th of July 2023.**

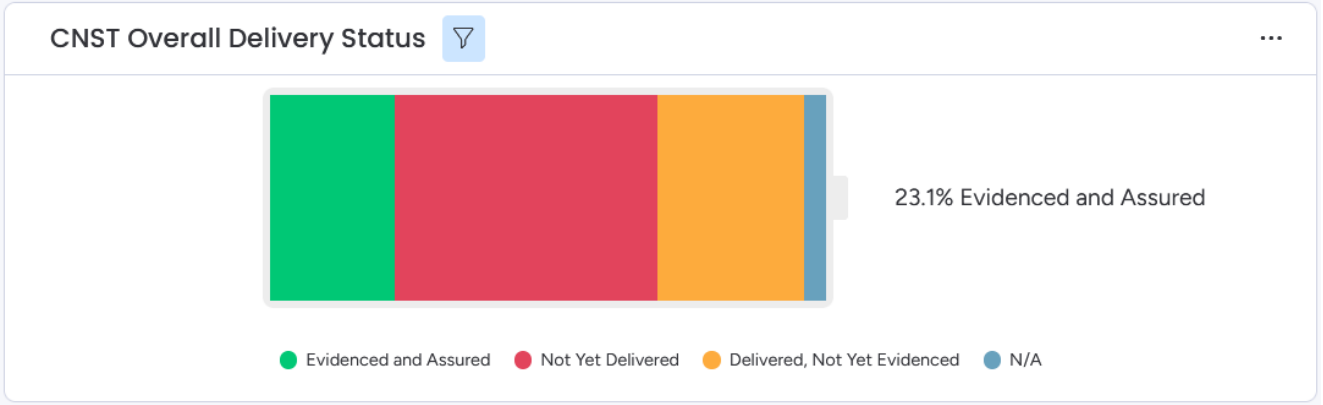
1.6 This new guidance includes updates for safety actions 1,3,6,7,8,9 and 10, with safety action 9 updates being extensive additions to the first iteration of the guidance. The additions centre mainly on the requirements for perinatal clinical quality surveillance and board safety champions.

1.7 The purpose of this paper is to provide the Committee with:

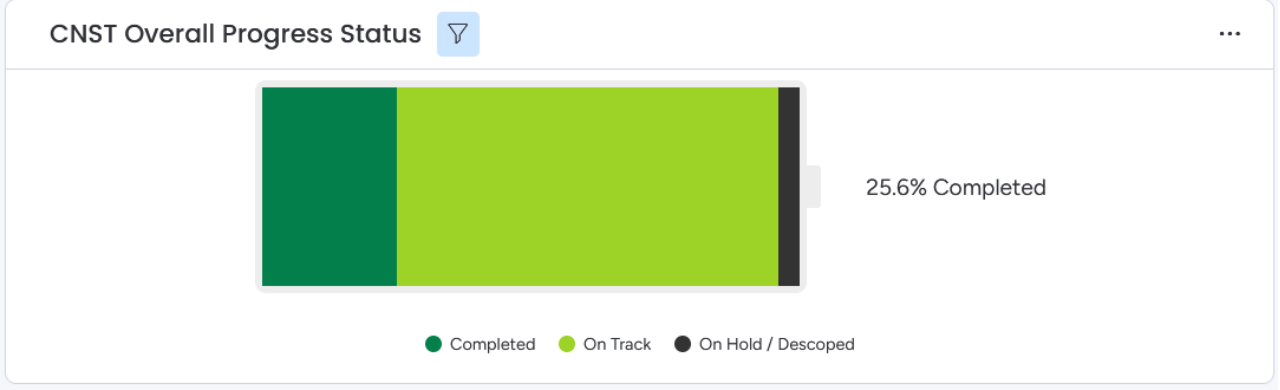
- 1.7.1 Details of the standards within year 5 of the scheme that must be evidenced between now and the reporting deadline.
- 1.7.2 An update on progress.

2.0 Overall Progress Status

2.1 The below chart shows a CNST completion rate as of October 10th 2023 (including compliance with the standards and accrual of supporting evidence) overall compliance as indicated in the delivery status battery below highlights; 23.1% 'Evidenced and Assured', 25.6% 'Delivered Not Yet Evidenced', and 46.2% 'Not Yet Delivered'.

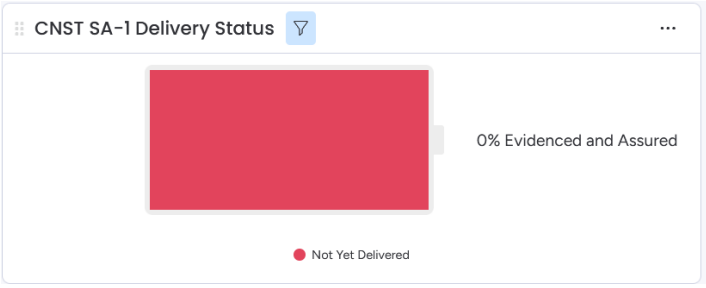


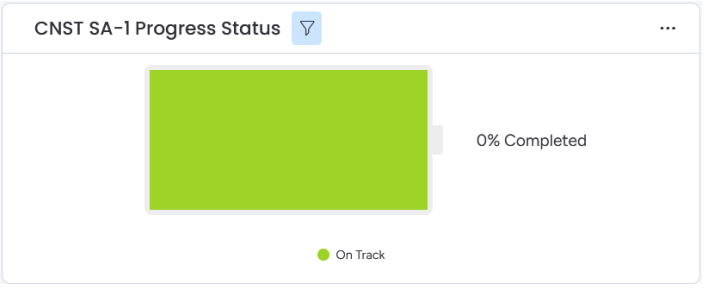
2.2 The above battery should be viewed in conjunction with the below progress battery which evidences the overall status of progress which is predominantly on track.



2.3 While there are elements in the above progress battery that are on-hold/descoped, these relate to Midwifery Continuity of Carer (MCOC) which is currently paused in line with the National letter published in September 2022.

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.

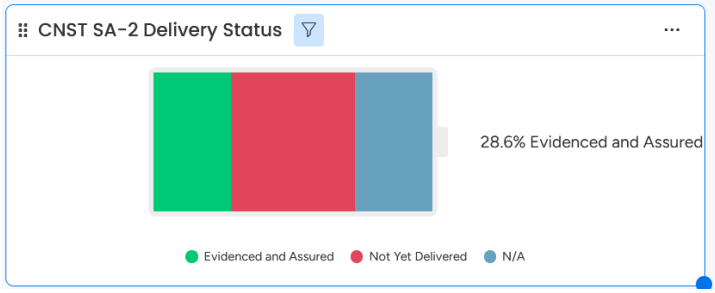
3.2 The Board of Directors (BoD) via the delegated authority of QSAC has received a report each quarter since August 2021 that includes details of the deaths reviewed and the consequent action plans. **Appendix 1** includes the PMRT Quarterly report for Quarter 2.

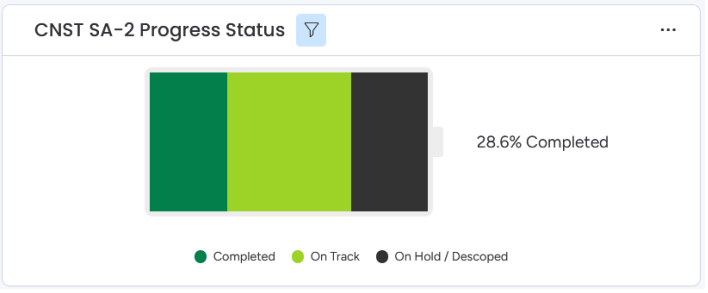
3.3 Compliance with standard b) is ongoing, with 100% of parents being informed that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought").

3.4 The team are on track to achieve the required standards of c).

3.5 **Progress Status: On Track**

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





4.1 NHS Digital, who oversee this Safety Action, will confirm whether 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; this will be confirmed in October 2023 based on the data submitted in the month of July 2023 (which is the month against which the standard is tested).

4.2 This safety action is not at risk based on the information known to date however this will not be known until the July data is published at the end of October 2023.

4.3 The battery above contains the on-hold/descoped elements associated with the pause of MCoC in line with the national letter as described above.

4.4 The latest CNST Safety Action 2 scorecards were published in August, confirming the Trust have passed March to May and our provisional scores for June and July 2023 are also a pass.

4.5 **Progress status: On Track**

5.0 Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

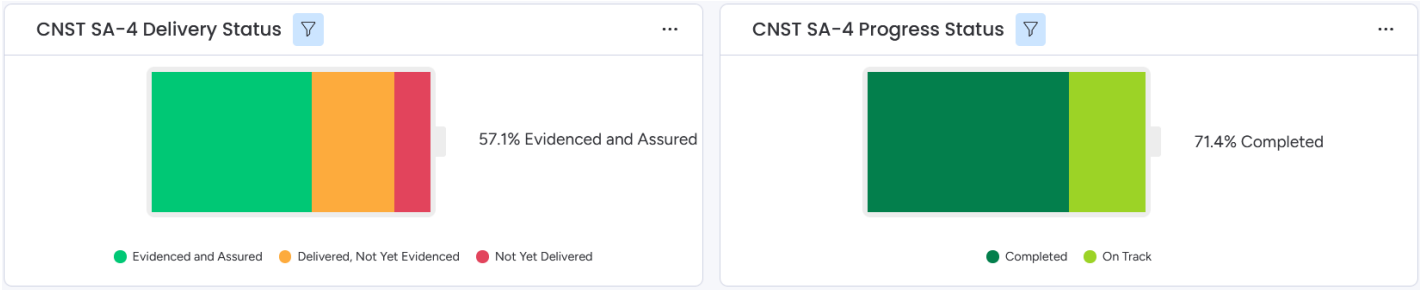
5.1 The Trust operates a Transitional Care service and associated pathway that continues to meet the national target of Avoiding Term Admission into the Neonatal Unit (ATAIN).

5.2 The BoD via the delegated authority of QSAC has continued to receive a report each quarter since August 2021 that includes details of all term admissions, including avoidable admissions and any associated action plans evidencing the required standards for b). **Appendix 2.** (Quarter 2 ATAIN report).

5.3 The BoD via the delegated authority of QSAC has continued to receive a report each quarter on transitional care activity and any associated actions evidencing the requirements for standard c). See **Appendix 3** for Quarter 2 Transitional Care report.

5.4 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 gap analysis paper was previously presented to QSAC on 1 September 2023 detailing the position and identifying any gaps including the business continuity plans required to evidence an effective system of workforce planning. A highlight report has been included to evidence progress with 3 out of 4 actions, the final action will follow in due course **(Appendix 4).**

6.2 Standard a) also requires an audit of 6 months activity to measure compliance and this is being undertaken currently and will be brought as an appendix in due course.

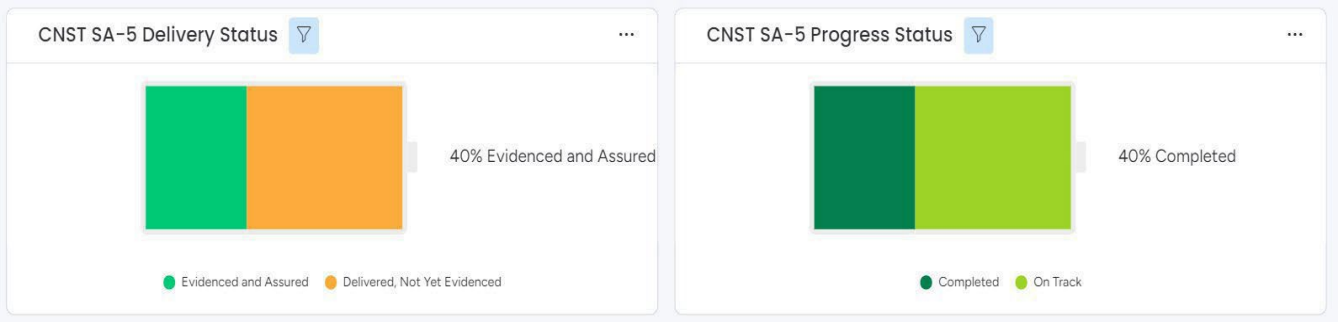
6.3 Standard b) evidence of achieving the ACSA Standard 1.7.2.1 has been requested.

6.4 Standard c) evidence to show that SaTH has a BAPM-compliant Neonatal Medical Workforce has already been provided to QSAC in April 2022 and September 2023

6.5 Standard d) QSAC were appraised of the neonatal nursing workforce action plan in year 4 of the scheme, with the action plan also submitted to the LMNS and the Neonatal Operational Delivery Network (ODN) in line with the technical guidance. There has been no change to standard d) in year 5 therefore it remains complete however an updated action plan has been requested for completeness which will again be presented to QSAC **(Appendix 5)** illustrates the neonatal workforce position against BAPM standards using the workforce tool.

6.6 Progress Status: On Track

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



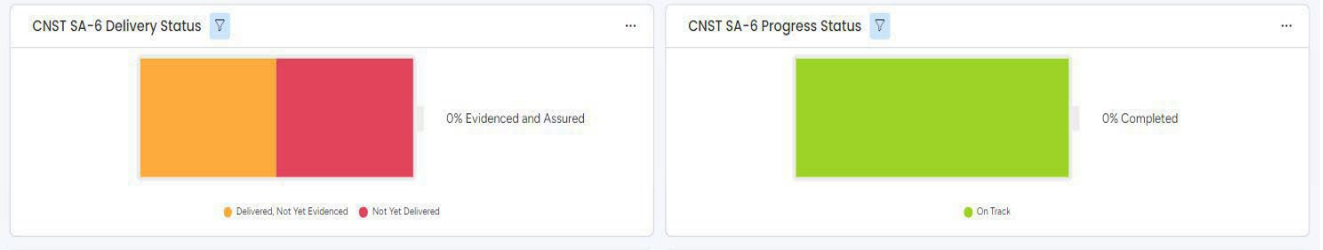
7.1 The BoD has continued to receive the bi-annual midwifery staffing paper since the year 4 scheme ended, with the last report being present to the Board in June 2023.

7.2 Additionally, the service submits a monthly midwifery staffing paper to the Trusts workforce meeting which captures standards c) and d) of safety action 5; this meeting is chaired by the Director of Nursing (DoN).

7.3 The next bi-annual staffing paper has been written using data from Q1/2 of 2023 see **(Appendix 6),** this will be received at Trust Board Autumn 2023.

7.4 Progress status: On Track

8.0 Safety Action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?



8.0 This is one of the largest and most complex of all the safety actions because it comprises the six elements of SBL care bundle **(Appendix 7)**.

- 8.0.1 Reducing smoking in pregnancy
- 8.0.2 risk assessment, prevention and surveillance or pregnancies at risk of fetal growth restriction (FGR)
- 8.0.3 Raising awareness of reduced fetal movements (RFM)
- 8.0.4 Effective fetal monitoring during labour
- 8.0.5 Reducing preterm birth
- 8.0.6 Management of pre-existing diabetes (New for version 3)

8.1 Trusts are asked to hold quarterly improvement discussions with the ICB using the new national implementation tool and there must be 2 meetings held before March 2024. The initial discussion meeting was held in August 2023, and the first formal meeting took place on the 6 September 2023, evidencing the Trust is on track to complete.

8.2 To achieve CNST year 5, each element within this safety action must have achieved a minimum of 50% compliance and have an overall compliance of 70% for all elements (The percentages are generated within the tool and are evidenced in the below table, the table will be updated after the next implementation tool review with system partners on 27th November 2023).

8.3 As can be evidenced, there are risks to element 6 primarily as this is a new introduction to the care bundle which requires financial support to implement the additional resources required for endocrinology services however the team are working closely with finance to agree this support using the year 4 rebate monies.

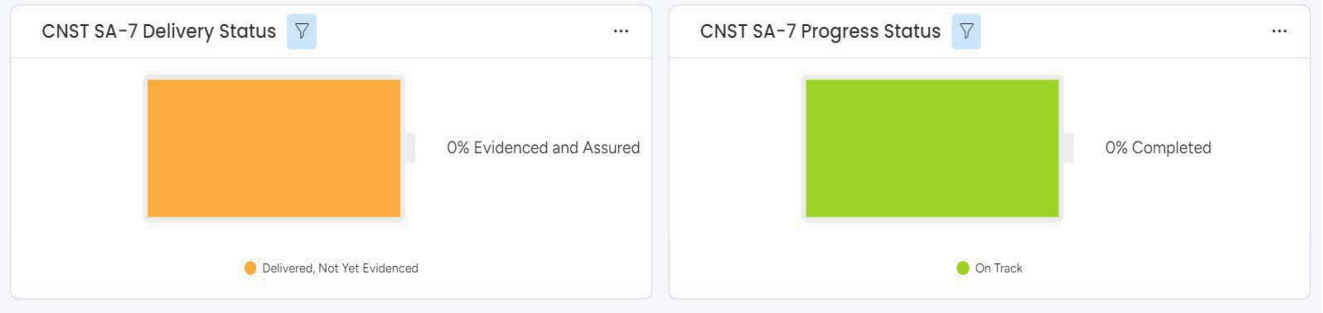
8.4 The Trust submitted a divergence request for the timing of HBA1C monitoring which is supported by our system partners. The review meeting was held 5th October, the panel have accepted SaTH's divergence request. The Trust Board are therefore asked to declare that the Trust has an established Preterm Birth Team in line with the SBCLBv3 and to acknowledge LMNS/ICB agreement and accept the divergence panel's recommendations **(Appendix 13).**

8.5 **Progress Status: At Risk**

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	60%
Element 2	Fetal growth restriction	Partially implemented	85%	Partially implemented	80%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%
Element 5	Preterm birth	Partially implemented	67%	Partially implemented	67%
Element 6	Diabetes	Partially implemented	17%	Partially implemented	17%
All Elements	TOTAL	Partially implemented	69%	Partially implemented	67%

9.0 Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.



9.1 The productive partnership between SaTH and the Maternity and Neonatal Voices Partnership continues to yield important outcomes for service users and staff alike; the MNVP have recently recruited to a number of new, key roles that will enhance the current offer and afford the capacity to extend the reach to the wider community. Community engagement events including an Open Day hosted by SaTH and the MNVP, facilitated open access to the community to ask questions and offer a tour of the Maternity Unit. Tours of Maternity services commenced in September 2023 following the Open Day, to invite parents and families to view services with the opportunity to raise questions, concerns, or suggestions.

9.2 The CQC maternity survey has a coproduced action plan which was presented at maternity governance meeting on the 17 July 2023; this will feed into the safety champions and LMNS board meeting taking place in August 2023, where progress will be monitored moving forward.

9.3 The UK has the lowest mortality ratios in the world however, there are persistent disparities in outcome for women depending on their ethnicity. In response to the publication of the Black Maternal Health Report (Women and Equalities Select Committee Report, 2023), a robust GAP analysis was undertaken reviewing the recommendations of the report and the current provision of maternity care at SaTH pertaining to Black, Asian and multiethnic communities in addition to women and families at risk of socio-economic deprivation **(Appendix 8)**.

9.4 The maternity and neonatal safety champions regularly seek feedback from staff in local areas as part of the scheduled walkabouts which are undertaken bi-monthly. These walkabouts are managed in conjunction with the 15 Steps walkabouts and subsequent action plans are monitored via safety champions, MNVP Hub meetings, and maternity governance meetings.

9.5 Progress Status: On Track

10.0 Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

10.1 The Trust has been fortunate to participate in the NHSE Pilot of version 2 of the Core Competency Framework (CCF) therefore our local training plan reflects the ask within the technical guidance to be aligned to the CCF v2.

10.2 The updated plan has been agreed by the quadrumvirate on 27 June 2023 and presented to QSAC and LMNS in August 2023, as part of the evidence requirements for this safety action **(Appendix 9).**

10.3 There is a risk to delivery in that all staff groups require 90% attendance over a 12-month consecutive period which is calculated from the end date used to inform percentage compliance to meet Safety Action 8 in the Year 4 scheme.

10.4 Figures at present are being affected by the junior doctor rotation in August, and the new midwifery cohort in September, both of which have contributed to lowering of our overall compliance rates.

10.5 The education team are working collaboratively with the management team to ensure all remaining staff are released to attend planned sessions, but this will again be dependent on the impact of planned industrial action and staff unavailability therefore delivery of this action overall remains at risk. **Appendix 10** provides evidence of current compliance.

10.6 Progress Status: At Risk

11. 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?

11.1 The Trust has a robust maternity and neonatal safety champions process in place which evidences ward to board escalation of any quality issues evidencing completion of element a).

11.2 The safety dashboard **(Appendix 11)** captures a minimum dataset which is reviewed monthly, and any issues escalated via the safety champions AAAA which is reported to Divisional Committee, QSAC and MTAC.

11.3 Standard b) refers to the Trusts claims Scorecard data which should be reviewed alongside incident and complaints data and used to agree targeted interventions aimed at improving patient safety which are then reflected in the Trusts Patient Safety Incident Response Plan. This should be undertaken at least twice in the MIS reporting year and was carried out at July 2023 Divisional Committee, and then additionally at safety champions in August and October 2023. Minutes pertaining to the October Safety Champions Meeting are included in **Appendix 12**.

11.4 Standard c) requires that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available by no later than 1 August 2023 *(was previously 1 July 2023 prior to the NHSR update issued on 30 June 2023).* ***This has been completed****.*

11.5 New guidance published in July 2023 stipulates additional minimum evidence requirements for the Board Safety Champions to meet with the Perinatal 'Quad' Leadership team on a quarterly basis, with at least 2 meetings before the end of the reporting period.

11.6 The first meeting took place on 21 August 2023, with the second scheduled for November 2023.

11.7 Progress Status: On Track.

12. Safety Action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?

12.1 This safety action relates principally to the work of the divisional governance team, supported by the legal team.

12.2 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 will not be evidenced as delivered/complete until after the reporting deadline of 7 December 2023.

12.3 Family information on the role of HSIB/NHSR ENS and Duty of candour is monitored weekly, and an audit will be produced to evidence compliance following the reporting deadline which is in keeping with Year 4 of the scheme.

12.4 Progress Status: On Track.

13.0 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 not achieve version 3 of the SBLCB	New additions to the updated guidance pertaining to elements 6 which relate to the endocrinology service, diabetes glucose monitors and dietician services.	Failure of safety action 6	The Trust has submitted a divergence request for the timing of HBA1C monitoring which is supported by our system partners. The outcome of the request will be notified to the Trust within 28 days (see appendix 2).
The Trust may miss the 90% target for training for midwives, Drs and support staff	The 12 months consecutive date range begins from the date used to inform compliance for the year 4 scheme therefore compliance must be achieved by October 2023.	Failure of safety action 8	There are a number of sessions planned to try and capture as many staff as possible however this is intrinsically linked with a high unavailability rate/planned industrial action therefore it is likely that our position will not be known until the qualifying period ends.

14.0 Summary

14.1 SaTH is mostly on track to achieve CNST MIS Year 5, although there remains a very significant risk to delivery for Safety Actions 6 and 8 for the reasons specified above. The team are working hard to mitigate these risks wherever possible and reduce the risk of non-compliance however this will not be confirmed until after the scheme ends.

15.0 Summary of safety action statuses

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

16.0 Actions requested of the Board of Directors

16.1 Review and discuss this paper and advise the Director of Midwifery of any further detail required.

16.2 Note the content, to ensure the Board oversees the quality of perinatal services at every meeting. 1

16.3 Note the significant ongoing risks to delivery of the scheme for safety actions 6 and 8 which may result in non-compliance for this year of the scheme.

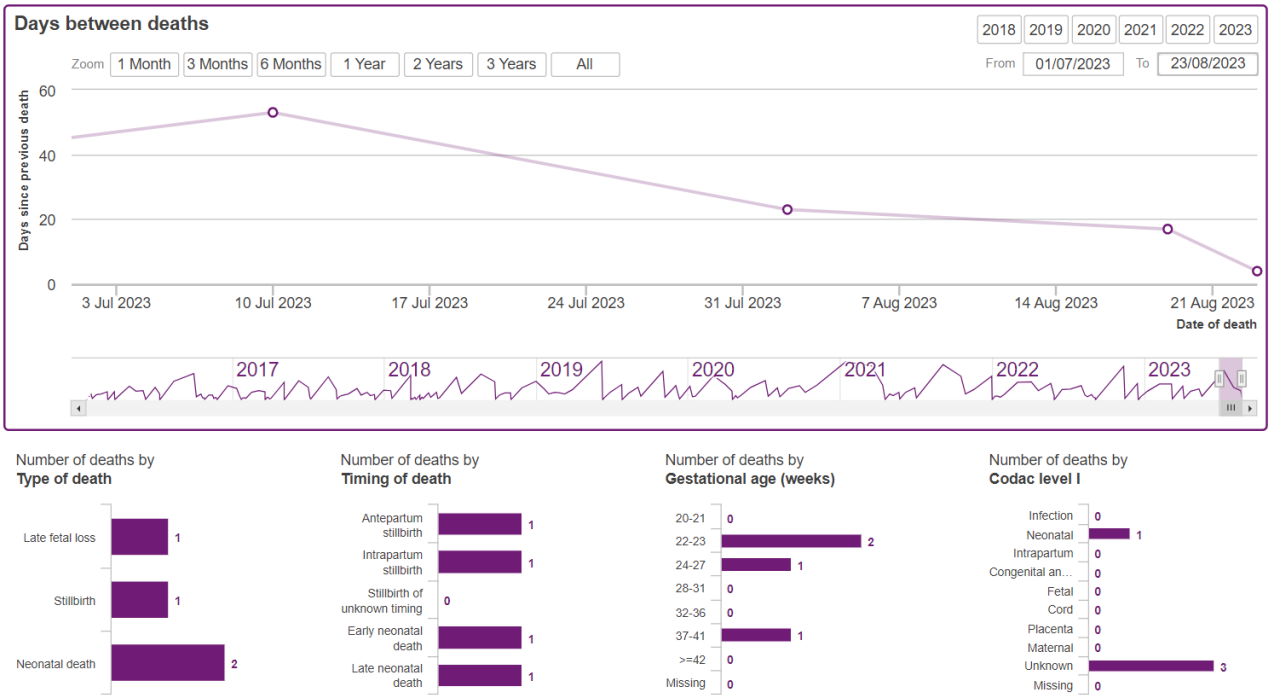
The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14 December 2023

Agenda item		162/23 Paper 1 within CNST INFORMATION PACK **Appendix 1**		
Report Title		Perinatal Mortality Review Tool (PMRT) Quarterly Report - Q2 (Jul-Sep 2023)		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Rachel North, Risk Manager Women and Children's Division		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people		
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Maternity Governance October 2023 W & C Divisional Committee October 2023 QSAC October 2023 LMNS November 2023		
Executive summary:		There was 1 stillbirth, 1 late fetal loss and 2 neonatal deaths that fitted the criteria for review using PMRT. External Obstetric Consultants have been present at each review of care. Compliance with CNST Safety Action 1 is confirmed in this report.		
Recommendations for the Board		The Board is asked to: Receive the report in line with CNST Safety Action 1.		
Appendices:		Appendix 1: PMRT Board Report		

1.0 Deaths reported to MBRRACE

In the time period from 1st July 2023 to 30th September 2023 there was 1 late fetal loss, 1 stillbirth and 2 neonatal deaths.



Stillbirths

1 Stillbirth at 24 weeks gestation was reported in July. This still birth was reported as Antepartum i.e., before there were any signs of labour.

88333/1 – draft report in progress.

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

- The review group identified care issues which they considered would have made no difference to the outcome for the baby.

Grading of care of the mother following confirmation of the death of her baby:

- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby.

Actions relating to issues identified as directly relevant to the death of this baby:
No actions identified relating to issues identified as directly relevant to the death of this baby.
Actions relating to issues identified as not directly relevant to the death of this baby:
No actions identified relating to issues identified as not directly relevant to the death of this baby.

Late Fetal Loss

1 late fetal loss at 22 weeks gestation was reported in August.

88737/1 – draft report in progress.

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

- The review group identified care issues which they considered would have made no difference to the outcome for the baby.

Grading of care of the mother following confirmation of the death of her baby:

- The review group identified care issues which they considered would have made no difference to the outcome for the mother.

Issue noted - Infection screening of the mother and baby was not carried out despite it being requested.
Action - Infection screening including TORCH is part of the routine bereavement blood tests. Learning to be shared in PMRT learning slides and on mandatory training.

Neonatal Deaths

One early neonatal death (within the first 6 days of life) was reported in August.

89086/1– draft report in progress.

Grading of care of the mother and baby up to the point of birth of the baby:

- The review group identified care issues which they considered would have made no difference to the outcome for the baby.

Grading of care of the baby from birth up to the death of the baby:

- The review group identified care issues which they considered would have made no difference to the outcome for the baby.

Grading of care of the mother following confirmation of the death of her baby:

- The review group identified care issues which they considered would have made no difference to the outcome for the mother.

The following action plans were identified -
Actions relating to issues identified as not directly relevant to the death of this baby:
Issue noted - The notes relating to the resuscitation of the baby were only partially adequate making it difficult to fully assess the quality of the resuscitation.
Action - Resuscitation Lead to review documentation prompts to ensure relevant information is recorded.
Issue noted - It is not possible to assess from the notes whether following the resuscitation of the baby a rapid safety focused resus de-brief with the staff involved was carried out.
Action - To feedback the importance of hot and cold debrief though governance feedback and to review processes within the organisation to ensure they are being completed and documented.
Issue noted - There was no Neonatal Death Summary created following the death of this baby.
Action - To review the existing neonatal death process guidelines and checklists to ensure this is added as part of the standard process following a neonatal death.

Issue noted - There could have been a further opportunity for a joint obstetric and neonatal MDT discussion with the family prior to this lady's self-discharge.
Action - Sharing importance of MDT discussions with families within PMRT learning slides and governance feedback meetings as well as huddles and labour ward forum.

1 Late Neonatal death was reported in August. Mother was booked/delivered Stepping Hill Maternity died at SaTH A&E. Baby born at 40+4 weeks, died day 21 of life.

PMRT review is in progress in conjunction with the unit where baby was delivered.

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

(Y5 Relaunch) All eligible perinatal deaths should be notified to MBRRACE-UK within 7 working days. For deaths from 30th May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.

In Quarter 2, (Jul, Aug and Sep 2023) there were there was 1 stillbirth1, 1 late fetal loss and 2 neonatal deaths that fitted the criteria for review using PMRT These cases were reported to MBRRACE within the timeframe.

Stillbirths Quarter 2	Notified to MBRRACE	Surveillance information completed
88333/1	Within 7 days	Within the same month
Late Fetal Loss Quarter 2	Notified to MBRRACE	Surveillance information completed
88737/1	Within 7 days	Within the same month
Neonatal Deaths Quarter 2	Notified to MBRRACE	Surveillance information completed
89086/1	Within 7 days	Within the same month
89060/1	Within 7 days	Within the same month

(Y5 Relaunch) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30th May 2023 onwards.

Stillbirths Quarter 2	Families informed	Source
88333/1	Yes	Bereavement Midwife
Late Fetal Loss Quarter 2	Families informed	Source
88737/1	Yes	Bereavement Midwife
Neonatal deaths Quarter 2	Families informed	Source
89086/1	Yes	Bereavement Midwife
89060/1	Yes	Bereavement Midwife

(Y5 Relaunch) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using PMRT should be carried out from 30th May 2023. 95% of reviews should be started within two months of the death and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.

Stillbirths Quarter 1	**Review started**	**Draft report stage**	**Published report**
88333/1	**The following month after the death**	**3 months after the death**	**Must be published by January 2024**
Late Fetal Loss Quarter 2	**Review started**	**Draft report stage**	**Published report**
88737/1	**The following month after the death**	**3 months after the death**	**Must be published by February 2024**
Neonatal deaths Quarter 2	**Review started**	**Draft report stage**	**Published report**
89086/1	**The following month after the death**	**3 months after the death**	**Must be published by February 2024**
89060/1	**The following month after the death**	**3 months after the death**	**Must be published by February 2024**

Each case reported in Quarter 2 has been reviewed and is on track to meet the criteria targets.

(Y5 Relaunch) Quarterly reports will have been submitted to the Trust Executive Board from 30th May 2023.

Quarter 2 report will be presented to Maternity Governance 20th October 2023 and on to the Maternity Safety Champions and Trust Executive Board following acceptance.

3.0 Conclusion

3.1 Compliance has been met with the CNST safety action 1 requirements, and this report concludes and provides evidence that the National Perinatal Mortality Review Tool is being used to review perinatal deaths to the required standard in Quarter 2.

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:

1/7/2023 to 30/9/2023

There are no published reviews for The Shrewsbury and Telford Hospital NHS Trust in the period from 1/7/2023 to 30/9/2023

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14 December 2023

Agenda item		162/23 Paper 1 within CNST INFORMATION PACK **Appendix 2**		
Report Title		ATAIN (Avoiding Term Admissions into Neonatal Units) report. Quarter 2 2023-24		
Executive Lead		Hayley Flavell, Director of Nursing		
Report Author		Rachel North, Women and Children's Quality Governance Officer		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Maternity and Neonatal Governance Meetings October 2023 W & C Divisional Committee October 2023 QSAC October 2023 LMNS November 2023		
Executive summary:		Rate of admissions to the Neonatal unit for babies >37 weeks is 6.0% for quarter 2 2023. This is at the national target of 6% and a slight increase from quarter 2. The most common reasons for admission for admission are respiratory conditions and infection. All cases are reviewed in a fortnightly meeting with MDT representation from Obstetrics, Neonatology, Maternity, and the Governance team.		
Recommendations for the Board:		The Board is asked to: Receive the report in line with Safety Action 3.		
Appendices:				

ATAIN (Avoiding Term Admissions into Neonatal Units) Report for Q2 2023

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 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-ischemia)

Review Systems

Multi-Disciplinary Team (MDT) meetings continue on a fortnightly basis to review all cases which meet the ATAIN criteria. Term admissions to the neonatal unit are currently monitored utilising the neonatal BadgerNet digital system, Datix submissions, and a manual check of the Neonatal Unit admissions book. A cross reference is made with all three systems as a failsafe to ensure that no case is missed. The metrics collated from these meetings are presented quarterly for assurance, at both Maternity and Neonatal Governance meetings. Any safety concerns are immediately escalated, and any learning is shared with the multi-disciplinary teams in both areas.

The rate of term admissions to the neonatal unit are calculated as a percentage of live, **term** births in line with the NHS Improvement “Reducing harm leading to avoidable admission of full-term babies into neonatal units” paper from 2017.

Rates

The term admission rate for Q2 (Jun-Sep 2023) was 6.0% of all births at >37 weeks, an increase from the previous Q4 figure of 5.0%. The year-to-date term admission rate is 5.0%. This rate remains below the national target of 5.6%.

A total of 59 term babies were admitted to the NNU in Q2 2023 (comparing with 45 in the previous quarter.)

The numbers of babies admitted each month were:
July 2023 – 5.7% of all births at >37 weeks (n = 19)
Aug 2023 – 6.5 % of all births at >37 weeks (n = 21)
Sep 2023 5.7% of all births at >37 weeks (n = 17)

Quarter 2 Metrics

Reason for admission	JUL	AUG	SEP	Total Q2 - Number of babies > 37/40
Respiratory conditions	11	11	10	32
Infection	4	2	2	8
Neonatal Abstinence Syndrome	0	0	0	0
Hypoglycaemia	3	0	2	5
Gastrointestinal disorders	0	2	0	2
Jaundice	3	0	1	4
Observations (inc. Failed oximetry)	2	2	2	6
Congenital abnormality	0	0	0	0
Social reasons	1	1	0	2
Babies who were transferred out for therapeutic hypothermia	0	2	0	2
Total	19	21	19	59

Respiratory conditions

Respiratory conditions continue to make up most admissions to the NNU, with 32 babies this quarter. 8 of which were elective caesarean births, 14 were emergency caesarean births (4 of which were not in labour) and 10 were vaginal births. Two of the respiratory admissions were a ventouse birth, 7 babies were born by forceps and 1 was spontaneous vaginal births. 25 of the babies received Antibiotics during their stay.

Mothers booked for elective caesarean sections prior to 39 weeks gestation are routinely offered the option of antenatal corticosteroids to reduce the risk of neonatal respiratory morbidity as per the ‘Caesarean Section – Emergency and Elective’ Guideline. The ATAIN review group monitor whether the parents received informed discussion regarding steroids and document this conversation and its outcome in the notes. One of the elective caesarean sections was conducted prior to 39 weeks gestation for appropriate reasons and parents received counselling.

Hypoglycaemia

During quarter 2, there were 5 babies (all born to diabetic mothers) admitted to the neonatal unit due to hypoglycaemia. 2 babies were admitted from the post-natal ward with low blood sugars and were promptly escalated to the neonatal team for review and management. 4 cases were deemed to be appropriate admissions, the fifth however was considered by the MDT to have been avoidable due to Thermoregulation Management issues. The learning from this has been shared via the 3-minute brief and with Neonatal team huddles.

Neonatal Jaundice

4 babies were admitted to the neonatal unit for treatment of jaundice in quarter 2, all were vaginal births. 3 babies were admitted form the post-natal ward, 1 from community.

Babies were admitted from the ward on between days1-3 when a capillary blood gas taken was over the exchange level. The babies were commenced on phototherapy treatment and screened for infection. The ATAIN MDT identified that for these babies, the NNU was the most appropriate place to receive this treatment.

Infection

Eight babies were admitted to the neonatal unit with suspected infection this quarter. All of these admissions were deemed to have been unavoidable, with no missed opportunities to expedite delivery. Babies were all discharged home and required no further follow up.

Gastrointestinal disorders

Two babies were admitted to the neonatal unit with suspected gastrointestinal disorders in quarter 2 2023. All were deemed to be have been unavoidable.

One baby's mother was a late booker. Baby was admitted with abdominal distention. Baby was discharged day3.

One baby was admitted under the category of GI but also had underlying congenital abnormalities and stayed for a short while on the NNU for monitoring.

Challenges to the ATAIN process

The significant previous challenges to maintain quoracy in the ATAIN meetings is now much improved with good representation from Obstetrics, Neonatology, Maternity, and the Governance team. Clinicians are attending on a rotational basis, with specific dates provided for all staff and a reminder sent out by the Governance team 1 week before the meeting.

At the time of writing the backlog of reviews has now been cleared to our aspirational target where we are undertaking timely and contemporaneous reviews.

A structured and robust process is in place to ensure that the MDT ATAIN reviews can be completed within a 14-day turnaround of incidents occurring. This allows for immediate learning from these incidents to be disseminated to all staff.

Plan for Q3 2023/2024

1. Continue two-weekly MDT meetings to review all eligible cases. These meetings will now be reviewing the most recent term admissions to the NNU.
2. Ensure failsafe processes are in place to confirm all eligible cases are captured for review.
3. Share learning from ATAIN reviews with all staff.
4. To monitor and review more closely the babies admitted with respiratory conditions and/or infection with a view to establish if admission to the neonatal unit can be avoided by alternative methods of treatment.
5. To present the report to Maternity and Neonatal Governance meetings.
6. To an action tracker and to review this regularly at ATAIN meetings.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14 December 2023

Agenda item		162/23 Paper 1 within CNST INFORMATION PACK **Appendix 3**		
Report Title		Transitional Care Audit Q2 Report		
Executive Lead		Hayley Flavell, Director of Nursing		
Report Author		Sarah Ellement, Maternity Transformation Matron		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Maternity and Neonatal Governance Meetings October 2023 W & C Divisional Committee October 2023 QSAC October 2023 LMNS November 2023		
Executive summary:		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 Transitional Care audit was completed for Q2 using electronic Badgernet records only from July – September 2023. The main findings of this report are: • All babies admitted had daily reviews by the neonatal team. • 100% of Newborn and Infant Physical Examination (NIPE) were completed with 72 hours of birth by the appropriate person. • 2 NIPE examinations were not documented on BadgerNet, but they were documented appropriately on NIPE Smart. • The main reason for admission to Transitional care was suspected infection and prematurity.		
Recommendations for the Board:		The Board is asked to: Receive this report in line with CNST Safety Action 3.		

Appendices:	Appendix 1 – Data Collection analysis

1.0 Introduction

The philosophy 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.

Transitional care is not a place but a service and this 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.

2.0 Data Collection

The monthly transitional care audit will be in line 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 Outcomes

This audit was taken on a random selection based on the monthly transitional care audit of 8 transitional care babies per month totaling 24 babies audits over a quarter which is approximately 20-25 % of babies who are admitted under the transitional care pathway, recommendations will be shared on a quarterly basis to the Director of Midwifery, Divisional Director of Nursing, Maternity and Neonatal Governance teams and the Neonatal Triumvirate.

3.0 Findings

All babies admitted to Transitional Care were seen daily by the neonatal team with a clearly documented plan of care (Appendix 1).

The NIPE was completed in the correct timeframe by the appropriate person, however this was not correctly documented on Badgernet on 2 occasions and was only documented on NIPE Smart.

83% of the notes audited had observations in line with local guidance. The 17% not completed in line with local guidance were delayed however they were completed within 1-2 hours of the observations being due. From the clinical narrative there were no adverse outcomes or changes to management in the babies whose observations were delayed.

All babies had a completed neonatal discharge summary on badgernet.

4.0 Conclusion

Monthly audits must continue to monitor and escalate any concerns with observation frequency whilst babies are in TC, this will identify any training needs or themes. There has been an increase of 2.7% in observations being performed outside of local guidance.

Communication will be shared with the maternity and neonatal teams undertaking the NIPE examination to ensure they are on Badgernet and NIPE Smart

Postnatal baby management plans should be in line with local guidance and visible on Badgernet to support in timely observations.

Action Plan
A robust action plan has been developed.

Action	Action owner	Date
Monthly Audits to continue to monitor and escalate concerns	Neonatal Lead	31.10.23
Communication to Neonatal team to remind about documenting NIPE on badgernet	Sarah Whitehead	31.10.23
Reminder at safety huddle and ward meetings about NEWTT observations to ensure they are complete at appropriate time	Ward Managers	31.10.23

Reason For Admission To TC from birth	Number	Percentage
Babies receiving IVAB	18	75%
Babies at risk of Neonatal Abstinence Syndrome	0	0%
Congenital Anomaly	0	0%
Low birth weight	0	0.00%
Preterm	6	25%

Reason For Admission to TC from NNU	Number	Percentage
Step down care' following admission from NNU who is more than 1.6kgs and maintaining temperature	0	0.00%
step down care' tolerating a minimum of three hourly feeds	0	0%

	Reason Recorded	Hospital Notes	Obs in line with GL	Green Proforma	NIPE	Seen Daily
Yes	24	0	20	24	24	24
No	0	0	4	0	0	0
Total Percentage - Yes	100%	0	83 %	100%	100%	100 %
Total Percentage - No	0%	0%	17%	0%	0%	0%

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14 December 2023

Agenda item		162/23 Paper 1 within CNST INFORMATION PACK **Appendix 4**		
Report Title		Obstetric clinical workforce plan		
Executive Lead		John Jones, Medical Director		
Report Author		Mei-see Hon, Obstetrics Clinical Director		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Maternity Governance Meetings October 2023 W & C Divisional Committee October 2023 QSAC October 2023 LMNS November 2023		
Executive summary:		We are required for CNST Safety Action 4 to demonstrate an effective Obstetric Clinical Workforce Plan. This report demonstrates compliance with RCOG requirements at all tiers of the medical workforce.		
Recommendations for the Board:		The Board is asked to: Receive the report in line with CNST Safety Action 4.		
Appendices:		Appendix 1 – Roles and responsibilities for Consultant on call in Obstetrics & Gynaecology		

CNST safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

For the Obstetric medical workforce there are 4 sub actions:

1. NHS Trusts / organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetric and gynaecology on tier 2 or 3 (middle grade) rotas:
   a. Currently work in their unit on the tier 2 or 3 rota or
   b. Have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory ARCP or
   c. Hold a RCOG certificate of eligibility to undertake short-term locums

   Minimum evidence requirement:

   Audit compliance via medical HR.

   If standards not met report to Trust Board, Trust board level safety champion and LMNS meetings that process and actions have been put in place to prevent deviation.

   Compliance demonstrated by completion of audit and action plan to address lapses.

   Relevant time period is six months after February 2023.

   Evidence: An audit was conducted of shifts that required Tier 2 locums between February 1st – July 31st 2023. In this time period there were there were 46 shifts that needed covering. All shifts were covered by doctors currently in post and no external locums were used. Therefore this standard was met.

2. Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level Safety champions and LMNS meetings.

   Minimum evidence requirement:

   Use the monitoring / effectiveness tool contained within guidance (p8) to audit compliance and have a plan to address any shortfalls in compliance. Action plan should be signed off by Trust Board, Trust Board level safety champions and LMNS

   Relevant time period is 6 months after Feb 2023

   Evidence: The RCOG document ‘Guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland & Wales’ refers to the employment of long-term locums who are working on the middle grade rota.

In this time period we did not employ any long-term middle grade locums therefore the standard has been met.

For completeness and transparency, we have applied the same standard to the employment of long-term locums on the Consultant rota. In this time period there have been 3 locums employed to work within Maternity. One is an NHS locum who was appointed through a competitive interview process with references. Two were agency locums. All three undertook a documented induction process within the Trust and the RCOG monitoring of compliance and effectiveness tool was completed. All three have received positive feedback and had their contracts extended / returned for another period of employment.

Therefore this standard has been met.

3. Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level Safety champions and LMNS meetings

   Minimum evidence requirements:

   Provide evidence of SOP and their implementation to assure Boards that those undertaking non-resident on calls OOH are not undertaking clinical duties following busy nigh on calls without adequate rests. Evidence of compliance could also be demonstrated by obtaining feedback.

   SOP in place by October 2023

   Relevant time period is 30 May – 7 Dec 2023

   Evidence: This action is not relevant as we do not have any non-resident Obstetric doctors. This SOP details the Roles and Responsibilities of the on call Obstetric consultant:

Roles and
responsibilities for Co

4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document ‘Roles and Responsibilities of the consultant providing acute care in obstetrics and gynaecology’ into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be

reviewed at unit level as an opportunity for departmental level with agreed strategies and action plans implemented to prevent further non-attendance.

Minimum evidence requirement:
Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS

Audit clinical situations / scenarios mandating presence in guidance.
Monitor adherence via incident reporting
Feedback / surveys may triangulate compliance.
Episodes where attendance has not been possible should be reviewed as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

Relevant time period is 30 May – 7 Dec 2023

This will be reported on in January 2024 after completion of the reporting period.

The Shrewsbury and Telford Hospital NHS
NHS Trust

Standard Operating Procedure (SOP)

SOP Title	**Roles and responsibilities for Consultant on call in Obstetrics & Gynaecology**		
SOP Number	3263		
Care Group	Women's & Children's Centre		
Version Number	2		
Effective Date	6/1/2022	Review Date	6/1/2027
Author	Mr Nibedan Biswas, Consultant Obstetrician/Gynaecologist Dr Mei-See Hon, Consultant Obstetrician		
Approved by	Agreed at the Consultant Meeting on the 27th September 2021 Ratified at Clinical Governance 9/11/2021 Present version agreed by W&C Divisional Committee Meeting on 30/11/21		
Approval date	30/11/2021		
Distribution	O & G consultants Switch board Ward 14, GATU, delivery suite, antenatal & postnatal wards		
Location	Shrewsbury & Telford NHS Trust		

Document Control				
Version	Date	Author	Status	Comments
1	30th Aug 2021	NB		Formatted following discussion at the strategy meeting on 25th June 2021 Updated based on feedback from MSH & MU 14/9/2021
2	30/11/2021	NB & MSH		Updated with NHS 7day working standards 30/11/2021

SOP Objectives	To provide clear responsibility for the different on call roles for the Consultant
Scope	This standard operating procedure aims to ensure that all the patients are seen in a timely manner.

Background

In June 2021 the RCOG published an updated Roles & Responsibilities of the consultant providing acute care in obstetrics and gynaecology.

https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/roles-and-responsibilities-of-the-consultant-workforce-report-june-2021.pdf

In the summary it states:

"The roles and responsibilities of the obstetrics and gynaecology consultant are diverse and wideranging. They extend beyond those of an experienced clinician, competent in both technical skills and complex decision-making. O&G consultants are required to role-model collaborative, inclusive and compassionate leadership thereby establishing positive cultural norms for their teams. They should cultivate a range of leadership styles and skills which they can flex between, allowing them to work across different teams and adapt to the varying challenges of the clinical workload. Adopting shallow authority gradients helps foster trust within teams and is key to developing respectful team relationships and providing safe patient care. Consultants are also required to provide clinical supervision and mentorship. This helps develop technical proficiency amongst junior colleagues and the wider multi-professional team as well as create a sense of psychological safety. Furthermore, consultants play a key role in ensuring consistency in the quality of care experienced by women. Their situational awareness, prioritisation skills and ability to take a helicopter view are critical to ensuring individual patient safety as well as to developing services to improve patient outcomes and experience. Their role as patient advocate means they have a responsibility to actively participate in incident investigations and contribute towards organisational learning. This requires a willingness and an ability to adopt a reflective approach towards one's own practice and to continually strive towards improving patient care and outcomes."

In addition, the NHSE document 'Seven Day Services Clinical Standards' published in September 2017 https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf needs to be embedded into every day practice.

The key points relevant to obstetrics and gynaecology are as follows:

1. Patients and where appropriate families and carers must be actively involved in shared decision making and supported by cleat information from health and social care professional to make fully informed choices about investigation, treatments and on-going care that reflects what is important to them. This should happen consistently, seven days a week.
2. All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital. All patients admitted during the period of consultant presence on the acute ward (normally at least 08.00-20.00) should be seen and assessed by a doctor promptly, and seen and assessed by a consultant within six hours.
3. All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours

4. Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.
5. All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

(Please note that this is not a complete list of the standards set out in the Seven Day Services Clinical Standards)

It is also important to acknowledge that women admitted in labour are NOT emergency admissions. Their admission is planned but unscheduled.

It is intended that this SOP is read in conjunction with both the RCOG roles and responsibilities and the NHSE seven-day standards documents in order to understand the background and context.

Roles and responsibilities of O&G consultants at SaTH

In September 2021 the Obstetrics and Gynaecology Consultant on call rotas split. At any one time, 24 hours a day 7 days a week, there is a separate consultant on call for Obstetrics and another for Gynaecology. We no longer have a 'first on' and 'second on' on call O&G Consultant.

This document aims to clarify the roles and responsibilities of each doctor on call.

Resident consultants over night

- The consultants who work resident night shifts may be pure Obstetricians or may be a 'hybrid Consultant' (both an Obstetrician and Gynaecologist.)
- If carrying the 334 bleep they are the on-call consultant for Obstetrics only.
- If carrying the 331 bleep they will have the support of both a non-resident consultant Obstetrician and a separate Gynaecologist and are not expected to conduct Gynaecology beyond the level of expected of a Tier 2 doctor. Even if more than capable to do so there is not the capacity to do this when carrying the 331 bleep.

Obstetrics

0830h-2100h seven days a week

- Resident consultant Obstetrician. Carries bleep 334.
- Responsible for all women on the Delivery Suite, Antenatal ward, Postnatal ward, Triage, Day Unit and any other obstetric patients in ED / outliers on medical and surgical wards.
- Responsible for supervision of Tier 1 and Tier 2 doctors.
- Does NOT have any other planned DCC
- Conduct regular ward rounds

Ward round times:

0830h Huddle, board round and handover followed by face-to-face review of all women under consultant led care on the Delivery Suite, followed by review of all women on the Antenatal ward and those identified as requiring review on the Postnatal ward.

1300h Board round on Delivery Suite with co-ordinating midwife.

1700h Board round and handover to oncoming consultant

1730h Face to face review of women on the Delivery Suite admitted under consultant care / AN ward or readmissions to the PN ward not yet reviewed by a Consultant.

2030h Huddle, board round and handover to oncoming team.

2100h Face to face review of women on the Delivery Suite admitted under consultant care / AN ward or readmissions to the PN ward not yet reviewed by a Consultant.

2030h-0830h seven days a week

- The night shift will always have 3 doctors available and will be one of the following:
  a) Resident Tier 1, resident Tier 2 (carries bleep 331) and non-resident consultant
  b) Resident Tier 1, resident consultant (carries bleep 331) and non-resident consultant
  c) Resident Tier 1, resident Tier 2 (carries bleep 331) and resident consultant (carries bleep 334)

- A non-resident obstetric consultant will attend within 30mins if required as per escalation poster (see appendix 1) or if requested to attend by the Delivery Suite co-ordinator or resident doctors. This is particularly important when the resident team are dealing with a complex situation and may not be in a position to maintain a helicopter view.
- If there is no resident consultant then the non-resident consultant will hand over to the incoming day consultant by telephone at 0830h.

Gynaecology – Resident Consultant

0800h-1800h Monday to Friday

0800h-1200h then 1800h -2000h Saturday and Sunday

- Carry Gynae on-call phone – 07710115244
- Responsible for Gynae ward, GATU, EPAS and any other emergency activities including covering RSH
- Does NOT have any other planned DCC

Activities

- Ward round of all Gynae patients including any outliers daily at 08:00am and then at the end of day
- Undertaking or supervising NCEPOD list cases in a timely manner
- Board round with ward 14 nurse in charge and or patient review at 4pm.

Daily triage

- Triage of all 62/7 referrals including phoning those that need a telephone consultation.
- Completing all advice & guidance.
- Responding to GP correspondences.

Physically reviewing

- All in patients
- All patients attending GATU (unless seen by Tier 2)
- Any admission during resident hours.
- Reviewing anyone starting on methotrexate
- Reviewing anyone on 3rd or more BHCG or asked to see by EPAS
- Reviewing patients in A&E within the hour if referred by Tier 1 or 2 who can't see them due to emergencies.

Responsibilities

- Responding to other speciality in timely & professional manner and accepting cases with Gynae or early pregnancy problems (<16 weeks pregnant and or >10days following delivery).
- Supervising Tier 1 & 2.
- All emergency admissions need to be seen at the point of admission by the senior most clinician (either Tier 2 or the consultant on call).
- No patient should be seen and discharged by the Tier 1 unless seen by Tier 2 or the on-call Consultant.

- To attend delivery suite if called by the on call Obstetric consultant to help with any other emergencies or excessive workload including:
    - Return to theatre
    - Caesarean/postpartum hysterectomy
    - Is not expected to interpret CTGs, conduct instrumental deliveries, or make complex intrapartum decisions if they are a pure gynaecologist
    - Can conduct CS, repair a perineum, review patients in triage, assist the obstetric team with whatever is needed

Gynaecology – Non -resident Consultant

1800h-0800h Monday to Friday

1200h-1800h and 2000h-0800h Saturday and Sunday

Available for:

- Gynae advice and support where needed
- Be the primary consultant to attend RSH if necessary
- To discuss with the Obstetrics Consultant if anticipating T1 or T2 assistance in the emergency theatre

Available to attend within 45 min of the call for

- To undertake all Gynae surgery
- Whenever requested to do so
- To attend delivery suite if called by the on call Obstetric consultant to help with any other emergencies or excessive workload including:
    - Return to theatre
    - Caesarean/postpartum hysterectomy
    - Is not expected to interpret CTGs, conduct instrumental deliveries, or make complex intrapartum decisions if they are a pure gynaecologist
    - Can conduct CS, repair a perineum, review patients in triage, assist the obstetric team with whatever is needed

Gynaecology handover

- Weekdays 0800h to oncoming GOD by phone (not text or WhatsApp)
- Weekdays 1800h to oncoming GON and to the rest of the on-call team as appropriate.
- Weekend - Friday at 06:00pm to the weekend Gynae on call.

Appendix 1:

The Shrewsbury and Telford Hospital NHS Trust

All staff are empowered and encouraged to contact the consultant obstetrician if concerned about the safety of a mother or baby

A consultant MUST attend for:	
Vaginal twins delivery	Eclampsia
Vaginal breech delivery	Intrapartum still birth
Caesarean for • Placenta praevia • <28/40 singleton • <30/40 twins • Transverse lie • BMI >45	Sepsis - Escalation if there is: • Reduced or altered conscious level in a pregnant/postpartum woman • Lactate ≥4mmol/l • Respiratory rate >25 on 2 occasions • No improvement in the hypotension (systolic BP remains <90mmHg) and/or the serum lactate level following a fluid bolus
• Ongoing PPH of 1500ml or more or if the patient is unstable	• Any 4th degree tear
• Patients who decline blood products i.e. Jehovah witness and others, who are having a C/section, MROP or where high blood loss is anticipated.	• Whenever requestedto by any member of staff due to complexity of cases, workload or high levels of activity e.g. a second theatre being opened
• Any return to theatre (O or G) both consultants to attend	• Maternal collapse e.g. septic shock, massive abruption, eclampsia
• **The consultant should always be called at the start of second stage for vaginal twins or any vaginal breech births** • **All handovers and communication should useSBAR**	

Situations when the consultant MAY attend (dependent on the *assessed* competencies of the resident obstetrician)	
• Trial of instrumental delivery in theatre	• Confirmation of intrauterine death
• Any Caesarean section if • in 2nd stage • BMI >40 • <32 weeks gestation	

Version 1.3 19 th May 2021 Martyn Underwood & Mei -See Hon

See also https://intranet.sath.nhs.uk/document_library/ViewPDFDocument.asp?DocumentID=11154

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14th December 2023

Agenda item		162/23 Paper 1 within CNST INFORMATION PACK **Appendix 5**		
Report Title		Neonatal Workforce Position Against BAPM Standards		
Executive Lead		Julie Plant - Divisional Director of Nursing		
Report Author		Louise Duce, Deputy Divisional Director of Nursing & Tina Kirby, Centre Manager		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF 859
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	684
Well Led	√	Our partners		
Consultation Communication		Maternity Governance Committee, October 2023 W&C Divisional Committee Meeting, October 2023 Quality and Safety Assurance Committee, October 2023 LMNS/PNQSG, November 2023		
Executive summary:		The Neonatal Workforce Tool is used at least annually to benchmark our position against BAPM standards. As of August 2023: • Staffing budgets are appropriate to meet standards based on recorded activity, however, there are currently 4.99wte registrant vacancies. • Against a target of 70% of registrants who are qualified in the neonatal specialty (QIS), there are currently 55% of nurses who hold the QIS qualification. • There is a trajectory to train a further 9 staff within the next 24 months to achieve the 70% target.		
Recommendations for the Board:		The Board is asked to: • Note that neonatal nursing does currently meet BAPM nursing standards with respect to a full establishment of budgeted quality nursing roles. • Note the requirement and trajectory to increase numbers of nurses qualified in speciality.		
Appendices:		Appendix 1: Neonatal workforce tool (previously submitted in February 2023)		

Background

The Neonatal Workforce Tool is used regularly to assess staffing requirements in the Neonatal service and was used in 2019 to secure additional investment of 5.5 wte nurses to meet nurse staffing requirements.

The workforce tool was completed in August 2023 based on activity for the preceding 12 months and results reviewed by the Divisional Director of Nursing.

The tool is based on BAPM standards for the number of nurses required to meet the planned activity.

Output of Tool

Budgeted wte

Staffing budgets are deemed appropriate to meet the standard based on recorded activity. To assure that all activity is being recorded appropriately, a clinical data validation post has been funded. Introduction of a full EPR as part of the rollout of the Badgernet IT system would facilitate this recording but is not currently included in the Trust's IT programme.

Vacancies

The vacancies against budgeted wte were noted as a shortfall of total staff in post at the time of the report of 4.99 wte. All vacant posts are in the process of being recruited to and bank and agency staff are being utilised to ensure that safe staffing levels are maintained on all shifts. Recruitment at a senior level has proved difficult and alternative strategies such as secondments and developmental roles are being utilised.

Unavailability has been consistently high due to high levels of sickness absence (in excess of 11.5%) and also maternity leave, both of which include high levels of senior registrants. A twice daily review of safe staffing levels during weekdays is undertaken by the Senior Nurse Leadership Team to ensure appropriate cross-divisional working arrangements and bank staff usage, and the request for the use of agency staff is escalated. Alternative options to backfill at registrant level are being undertaken; these include international recruitment and rotational post staff; these staff will be trained in neonatal care as part of succession planning.

Nursing staff qualified in speciality (QIS)

The number of nursing staff qualified in neonatal nursing as a speciality is significantly below the required the BAPM standard and this is significantly impacting on staffing rotas and compliance with safer staffing. To meet the required standard of 70% of nursing staff being QIS trained, the Unit requires an additional 9 wte to be speciality trained. This training requires 2 days per week attendance at university / a level 3 unit over a 6-month period plus consolidation. There are currently three staff in training; a QIS training programme has been developed to achieve required standards with 24 months. Funding for back fill and training costs has been secured. An ongoing training programme will then maintain this 70% of QIS registrants within the workforce.

Appropriate renumeration of staff with QIS training is to be included in the workforce strategy.

Staff requiring QIS training	Commence QIS training June 2023	Commence QIS training January 2024	Commence QIS training June 2024	Commence QIS training January 2025
12	3	3	3	3

Workforce Tool Issues	**Action**	**Timescale**
While the current workforce tool does not show a shortfall in budgeted nursing staffing against recorded activity, clinical data validation hours have been funded to assure that all activity is recorded accurately.	Monitor improvement in activity recording.	Monthly reporting via neonatal dashboard
There are currently 4.99 wte nursing vacancies which are currently going through stages of the recruitment process.	Recruitment strategies such as international recruitment, staff with a broader skill set and rotational posts are being explored as part of the development of a workforce strategy.	Strategy to be discussed at Division Committee in November 2023
There is a significant shortfall in QIS nursing staff of 9 wte	There are currently 3 staff undertaking training with an ongoing training programme in place.	24 months and ongoing to address attrition

Additional BAPM guidance roles

A number of additional quality and coordination roles are identified in BAPM guidance documents. These are not contained within the workforce tool and are not required to meet the CNST standards. These are additional posts which will further enhance the quality of care to our neonatal services at SaTH. Plans to progress these posts are being taken forward as part of a wider workforce strategy and business case.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14 December 2023

Agenda item		162/23 Paper 1 within CNST INFORMATION PACK **Appendix 6**		
Report Title		Maternity 6-month staffing report		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Annemarie Lawrence, Director of Midwifery		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community		BAF4, BAF3
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	67, 87
Well Led	√	Our partners		
Consultation Communication		Maternity Governance Meetings October 2023 W & C Divisional Committee October 2023 QSAC October 2023 LMNS November 2023		
Executive summary:		Midwifery staffing is complex; acuity can often change rapidly based on individual care needs and complexities of cases; maintaining safe staffing levels continues to be complex due to increased pressures on the workforce. Despite these challenges, the service has seen an improvement in our overall staffing position, moving from a position of significant vacancies to a position of no vacancies which is due to a forward-thinking workforce plan that has enabled us to become proactive rather than reactive and actively plan for a known attrition rate. Finally, this paper highlights additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance.		
Appendices:		Appendix 1: Midwifery red flags		

1.0 Introduction

1.1 The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels for Q1 and 2 of 2023 inclusive. This is a requirement of the NHS Resolution Clinical Negligence Scheme Trusts (CNST) Maternity Incentive Scheme (MIS) for safety action 5 where the following standards are used:

Table 1

a	A systematic, evidence-based process to calculate midwifery staffing establishments is complete
b	The midwifery coordinator in charge of delivery suite has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of support for all midwives within the service.
c	All women in active labour receive one to one midwifery care
d	A quarterly midwifery staffing oversight report that covers the staffing/safety issues is submitted to the Board

1.2 The report also provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented in April 2023.

2.0 Background

2.1 The previous 2021 Birthrate Plus (BR+) assessment recommended a total clinical whole time equivalent workforce (WTE) requirement of 200.55 registered midwives (RMs) and postnatal (PN) midwifery support workers (MSWs), rising to 205.53 WTE with the rollout of Midwifery Continuity of Carer (MCoC) to 51%.

2.2 The updated 2022 BR+ assessment recommends a WTE of 199.80 RM's & PN MSWs which is in-keeping with the previous assessment however it does not include any uplift for the rollout of MCoC as the National Midwifery team no longer support the use of BR+ for this workforce model.

2.3 Instead, they advise using the MCoC toolkit which has been designed by the National team however it is worth noting that this is not currently available due to undergoing modifications on the advice of BR+ to ensure it is fit for purpose.

2.4 This does mean that there is a risk that the 199.80 WTE mentioned above may increase in the future once the toolkit becomes available, but for the moment, the rollout of MCoC is currently paused in line with guidance from the national team around safe staffing.

3.0 Current Position

3.1 The below table presents the current workforce position for clinical midwives and MSWs and includes those recruited to but not yet in post. It does not include any specialist midwives, midwifery management roles grade 8a and above, or midwife sonographers. It is also exclusive on any staff on fixed term secondments to support the Maternity Transformation Programme.

Table 2

	Establishment*	In post	Recruited to but not in post	Vacancy
Midwives Bands 5-7	179.82	178.98	7.4	+6.56
MSW's Band 3	20.00	18.79	1.21	0
Total	199.80	197.77	206.38	+6.56

*Does not include management roles 8a and above or midwife sonographers

3.2 Although the table above presents a healthy workforce position in terms of recruitment of clinical staff, these figures are impacted by unavailability which is on the rise.

3.3 The below table demonstrates that in Q2 and Q3 2022 and Q1 and Q4 2023 there has been a steady improvement in the number of staff taking maternity leave (the lowest rate seen in a number of years). However, in Q2 2023 there is a significant number of staff taking maternity leave (16.6wte). Long term sickness absence is significant with an increase in unavailability seen in Q1 2023 of 27.62wte and 21.7wte in Q2, which combined with the number on maternity leave, is a deficit of over 15% of the clinical workforce.

Table 3

	Q2 22	Q3 22	Q4 22/23	Q1 2023	Q2 2023
Maternity leave*	7.33wte	5.78wte	4.87wte	9.8wte	16.6wte
Long term sickness absence**	18.75wte	21.22wte	25.28wte	27.62wte	21.7wte
Total	26.08wte	27.0wte	30.15wte	37.42wte	38.3wte

It should also be noted that this unavailability is impacting on the day-to-day operational service delivery within the maternity unit and causing the senior leadership team to frequently enact the midwifery escalation policy to support safe staffing.

3.4 Weekly staffing meetings are in place to focus on a two week forward look ahead which provides a further opportunity to identify hot spot areas and action appropriate solutions to maintain safe staffing levels.

3.5 Each month the planned versus actual staffing levels are submitted to the national database and NHS Improvement using the information provided from the Healthroster Allocate rostering system and reported monthly to the workforce meeting.

3.6 The maternity leadership team have joined both Regional and National working parties/webinars to ensure the most up to date measures are in place to support staff back to work.

3.7 The service also benefits from a recruitment and retention midwife thanks to initial funding from Health Education England (HEE); this post has recently been extended as a commitment to continuing to supporting midwives in practice.

3.8 The below table presents the specialist midwives currently in post and does not include posts which are not yet recruited to:

Table 4

Specialist Role	WTE	Specialist Role	WTE
Fetal Monitoring Midwives	1.0	Public Health Lead Midwife	1.0
Bereavement Midwives	2.0	Professional Midwifery Advocate Lead Midwife	1.0
Continuity of Carer Lead	1.0	Perinatal Pelvic Health Midwife	0.6
Infant Feeding Lead	0.6	Improving Women's Health Midwife	1.0
Saving Babies Lives Lead	1.0	Lead Education Midwife	1.0
Digital Midwife	1.0	Clinical Practice Educators	2.0
Maternity Mental Health Midwife	0.6	Clinical Practice Facilitators	2.0
Antenatal Screening Midwife	1.0	EDI Midwife	1.0

4. Workforce Plan

4.1 Midwifery has an attrition rate of around 20wte each year in addition to continued long term unavailability made up from a combination of maternity leave and long-term sickness absence. While there is an element of funding available to cover maternity leave in the short term, historically, it has always been difficult for providers to recruit to temporary posts especially in the presence of a national midwifery workforce gap.
4.2 This required SaTH to be proactive from a workforce perspective, agreeing with finance to convert some of the funding from recurring temporary positions to 10wte substantive positions that would attract midwives looking for stability and job security.
4.3 The below table presents the planned recruitment currently in train as part of the workforce plan, the majority of which is either already advertised and in the process of being recruited to or about to be advertised.

Table 5

Planned Recruitment	WTE	Additional Info.
International midwives	10.0	Recruitment ongoing, some interviews have been held. 5 arrived in the UK, 5 due to arrive in October.
Midwifery apprentice programme	9.0 over next 3 years	3wte commencing training programme in September 2023, 3wte in 2024, 3wte in 2025
Midwifery support worker apprentice programme	6.0	3wte to commence September 2023 Uni intake, 3wte to commence Trust programme
Apprentice midwife sonographer	1.0	Rolling programme each year
Equality, diversity and inclusion midwife	1.0	Appointed
BFI lead midwife	1.0	14-month secondment funded by the LMNS to support the journey to BFI accreditation (Appointed).
Breastfeeding support midwife	0.6	Post to enhance current support offer
Frenulotomy lead midwife	0.4	Specialist post to strengthen current provision (Appointed)

Multiple pregnancy midwife	0.6	Funding for 12month secondment in first instance to improve service provision (Appointed)
Guideline Midwife	1.0	At interview stage
Transformation matron role	1.0	Appointed, due to start Oct/Nov

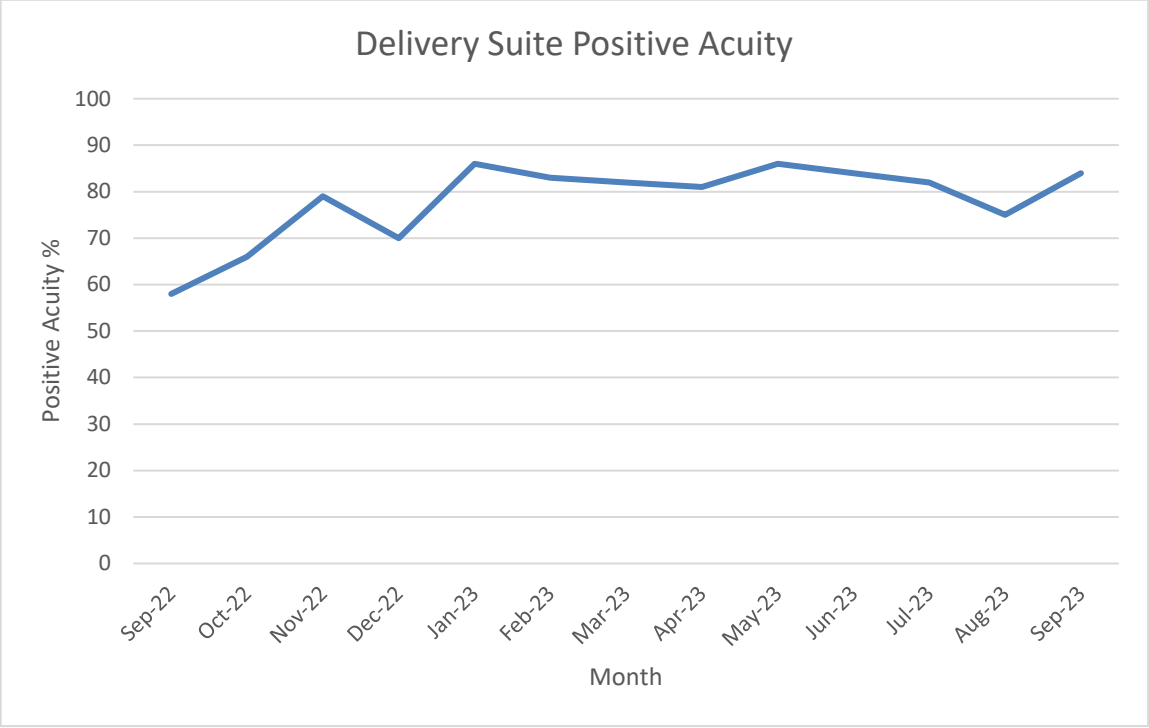
5. Acuity Data

5.1 For the purpose of this report, acuity is referencing intrapartum activity (the number of women being cared for on the delivery suite) and is measured using the BR+ acuity tool. BR+ defines acuity as “the volume of need for midwifery care at any one time based upon the number of women in labour and their degree of dependency”.

5.2 A positive acuity score means that the midwifery staffing is adequate for the level of acuity of the women being cared for on delivery suite at that time. A negative acuity score means that there may not be an adequate number of midwives to provide safe care to all women on the delivery suite at the time. In addition, the tool collects data such as red flags which are defined as a “*warning sign that something may be wrong with midwifery staffing.*”

5.3 The below graph presents the acuity data for Delivery Suite over the last 12 months (Sept 2022 – Sept 2023) inclusive:

Graph 1



5.4 In March 2022, the service was at its lowest safe staffing position, with only 45% positive acuity against a target of 85%. The introduction of some immediate actions (such as job planning specialist midwives to work clinically as part of a 80:20 or 60:40 split) saw an initial improvement, however, heading into peak holiday season in addition to a known seasonal peak meant that one offset the other with only minor improvements felt by the service and, by September 2022, we remained below 60% positive acuity.

5.4 Following a successful recruitment campaign in the spring of 2022, the Trust welcomed 26 newly qualified midwives, and 4 experienced midwives into the organisation from September 2022 onwards. These were introduced to the workforce gradually, benefitting from a robust supernumerary period upon appointment and supported by an excellent preceptorship programme that has seen the service retain 100% of our 2021 cohort of newly qualified midwives.

5.5 As it stands currently, we are on course to achieve this retention for the second year running which is testament to the benefits of the education team who truly go above and beyond to ensure our preceptee’s receive the right amount of supernumerary status and are supported at every opportunity.

5.6 Additionally, as can be evidenced within table 3, the number of midwives on maternity leave in Q3 2022 also reduced to its lowest level in 12 months which, in conjunction with the number of new starters to the service, meant we were able to see improvements within midwifery staffing levels. As can be seen in graph 1, there has been a steady improvement in positive acuity above 80% since January 2023.

6.0 Red Flags

6.1 The table below shows the number of red flags in month, followed by the percentage of shifts identified by the tool as red, amber, or green acuity.

Table 6

Month	Red Flags	1 to 1 Care not met	Coordinator Not Supernumerary	Positive (green) Acuity %	Acuity Red %	Acuity Amber %	Acuity Compliance Rate
October 2022	58	0	0	66%	5%	29%	82.8%
November 2022	23	0	0	79%	17%	5%	86.11%
December 2022	46	0	0	70%	19%	11%	90.32%
January 2023	24	0	0	86%	10%	5%	90.32%
February 2023	30	0	0	83%	16%	1%	89.29%
March 2023	25	0	0	82%	14%	4%	90.1%
April 2023	19	0	0	81%	4%	15%	88%
May 2023	24	0	0	86%	2%	12%	88%
June 2023	15	0	0	84%	2%	15%	91%
July 2023	23	0	0	82%	2%	16%	91%
August 2023	45	0	0	75%	2%	23%	95%
Sept 2023	33	0	0	84%	1%	15%	91%

6.2 In order to meet standards b and c of the CNST MIS safety action 5, the number of times when 1:1 care in labour has not been met is also reported, along with the status of 'coordinator not supernumerary'.

6.3 As can be evidenced from table 6 above, there service was able to maintain 1:1 care in labour for all women 100% of the time and there were no occasions whereby there was a loss of coordinator not supernumerary status as defined within the technical guidance of the CNST MIS.

6.4 The maternity service holds twice daily safety huddles during which all red flags are discussed from across the service areas. Where there is a shortfall, midwives will be rotated from one area to another to support any increase in acuity and facilitate safe care.

6.5 The escalation policy is implemented should any area require more midwifery staffing based on patient numbers and acuity/complexity.

7.0 Midwife to Birth Ratio

7.1 There is no national standard midwife to birth ratio however for years, the midwifery world has worked to the well cited ratio of 28 or 29.5 births to every 1wte.

7.2 The most recent BR+ assessment undertaken in 2022 advised an overall ratio for SaTH of 22.2 births to 1wte is based on extensive data from BR+ studies and is calculated from a detailed assessment for workforce planning purposes. The below table shows the WTE broken down by area:

Table 7

Type of care	WTE
Delivery suite births, all hospital care	29.9 births to 1wte
All hospital births, all hospital care	29.4 births to 1wte
Homebirths	33.1 births to 1wte
Community AN & PN Care, all hospital care	96.8 cases to 1wte
All community care including attrition and safeguarding	91.9 cases to 1wte
Overall ratio for all births	**22.2 births to 1wte**

7.3 The below table represents the midwife to birth ratio for all births which is determined by the number of births divided by the number of staff available each month. The figures are also impacted by staff unavailability through sickness or maternity leave.

Table 8

	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023
Midwife to Birth Ratio	1:25	1:25	1:25	1:25	1:25	1:24	1:23	1:24	1:24

7.4 The figures in table 8 are above the desired overall ratio of 1.22 detailed above and this is most likely due to the unprecedented amount of staff unavailability detailed in table 3.

8.0 Medical Staffing

8.1 The Trust operates a tier 3 rota system for obstetric medical staffing which means there is 24/7 on-site consultant presence as opposed to a consultant being on-call from home.

8.2 One of the many benefits of a tier 3 rota is that there is no delay out of hours when consultant attendance is required as they are already on site and therefore do not have to mobilise into the maternity unit.

8.3 From a rota perspective, the below table shows the number of medical staff supporting each tier of the rota currently:

Table 9

Rota Tier	No. of Medical Staff
Tier 1 (ST1-ST3)	13
Tier 2 (ST4-ST8)	16
Tier 3 (Consultant)	19

8.4 In respect of the tier 1 and 2 rota, there have been no rota gaps in the last 6 months for either which is encouraging however there are gaps currently within the tier 3 rota which has required the use of agency locums.

8.5 The specialty have a comprehensive locum induction package that sets out the requirements for all locums to undertake both PROMPT and fetal monitoring training prior to working clinically to reduce the risks to patient safety that are known to be linked to staff unfamiliar to the working environment/multidisciplinary team.

8.6 While the specialty have ongoing rota gaps within the tier 3 rota, 2 locum consultants have been appointed as the service recognises that the various gaps are currently being filled by existing staff as internal locums which is not sustainable in the long term.

8.7 Additionally, it is worth noting that the provision of obstetric care is always prioritised given that this is the acute service, however this does mean that there are often gaps within the gynaecology service as elective care is cancelled to release capacity to support obstetrics.

8.8 The knock-on effect of this on the gynaecology service is that the numbers of patients waiting for elective procedures continues to increase leading to a dip in referral to treatment (RTT) performance for this speciality area.

9.0 Midwifery Continuity of Carer

9.1 MCoC at SaTH remains paused in line with both the recommendations on safe staffing from the Ockenden Report, and the National letter published in September 2022.

9.2 The letter advised that any Trust that was unable to meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care.

9.3 As the Trust continues to improve its staffing provision, there will be an expectation from the LMNS, regional and national teams to review our position in terms of restarting MCoC as a model of care. However, although our vacancy position has improved significantly, we continue to have a very high unavailability which must be taken into consideration before any alterations are made to current service provision.

9.4 This unavailability rate will need to improve significantly, and we will need to evidence a sustained safer staffing position before any changes are made.

9.6 In the meantime, we are committed to implementing the building blocks of MCoC as this will ensure we have laid solid foundations that are safe to build upon.

10.0 Pre-registration Midwifery Programme

10.1 In the Autumn of 2020, concerns were raised regarding the quality of midwifery training at SaTH and following several visits by the HEE team over the spring and summer

of 2021, the service was placed onto HEE's Quality Improvement Register, Intensive Support Framework (ISF) at level 2.

10.2 Following a comprehensive action plan, the service was followed up in December 2021 and although there were no new significant concerns raised, it was acknowledged that staffing pressures within the department was impacting on student experience.

10.3 With the introduction of a new leadership team in early 2022, the service began to develop a number of new workstreams which enabled improvements in many areas and staffing levels continued to rise throughout the autumn of 2022.

10.4 In January 2023, HEE undertook a further quality intervention visit which identified that overall students reported a significantly improved experience whilst undertaking their practical placements at SaTH, with the HEE panel acknowledging that the actions implemented by the Trust to address previous concerns were translating into positive feedback being shared by Pre-registration Midwifery students.

10.5 The entire cohort of students were interviewed along with a number of practice educations and practice supervisors and the visiting panel reported that 100% of those interviewed said they would recommend SaTH as both a place to learn and a place to work.

10.6 As a result of this, based on the overall positive findings and the key areas of improvement identified, the panel recommended that SaTH was reduced from ISF Category 2 to ISF Category 1, and the concern was removed from the HEE Quality Improvement Register.

11. Conclusion

11.1 Midwifery staffing is complex; acuity can often change rapidly based on individual care needs and complexities of cases; maintaining safe staffing levels continues to be complex due to increased pressures on the workforce as a result of the Ockenden Report and other National Maternity reviews.

11.2 Despite these challenges, the service has seen an improvement in our overall staffing position, moving from a position of significant vacancies to a position of no vacancies which is due to a forward-thinking workforce plan that has enabled us to become proactive rather than reactive and actively plan for a known attrition rate.

11.3 Due to the improvements being made at every level as a result of the MTP and our commitment to the delivery of national drivers known to impact on patient safety such as the Saving Babies Lives Care Bundle and the CNST MIS, safety continues to improve as we evidence that these elements are embedded into everyday practice.

11.4 Finally, this paper highlights additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance. With a clear and robust escalation policy in place and twice daily oversight of the maternity unit's acuity verses staffing being monitored, early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are maintained and safety remains the priority for the service.

Appendix 1

Maternity red flag events, NICE (2015)

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

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

Other midwifery red flags may be agreed locally.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14th December 2023

Agenda item		162/23 Paper 1 within CNST INFORMATION PACK **Appendix 7**		
Report Title		Saving Babies Lives: Progress Report		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Lindsey Reid, Lead Midwife for Saving Babies' Lives		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF 1, BAF 2 BAF 3, BAF 4 BAF 7, BAF 8
Effective	√	Our people		
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	CRR 15
Well Led		Our partners		
Consultation Communication		Maternity Governance Committee, October 2023 W&C Divisional Committee Meeting, October 2023 Quality and Safety Assurance Committee, October 2023 LMNS/PNQSG, November 2023		
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 that regular updates on delivery progress must be provided to the LMNS; this is the purpose of this paper. The additional focus of this paper • Seek agreement on local target/timeframe ambitions as indicated within SBLCBv3 (appendix 1). This paper will also • Introduce the SBLCB Implementation tool • Outline some of the changes in version 3		
Recommendations for the Board:		The Board is asked to: Receive this report in line with CNST Safety Action 6.		

Appendices:	Appendix 1 Local agreements Appendix 2 Preterm passports – 2a Clinical 2b Parental

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 and year 4 of CNST.

1.3 SaTH is now part-way through delivery of CNST year 5 (2023-24), which includes implementation of new standards within SBLCB version 3. The purpose of this paper is to:

1.3.1 Provide quarterly reports of information which require sharing (as per SBLCBv3) 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.

2.2 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 version of the care bundle was published in 2019 and included a fifth element: 'Reducing preterm birth'.[4]

2.4 The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020. ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data shows there is more to do to achieve the Ambition in 2025 period (SBLCBv3).

2.5 The 3rd version of the care bundle (SBLCBv3)[5] was released in June of this year. Building on the achievements of the previous versions, Version 3 includes a refresh

[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/
[4] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf
[5] https://www.england.nhs.uk/publication/saving-babies-lives-version-three/

of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit.

There are now 6 elements of care:

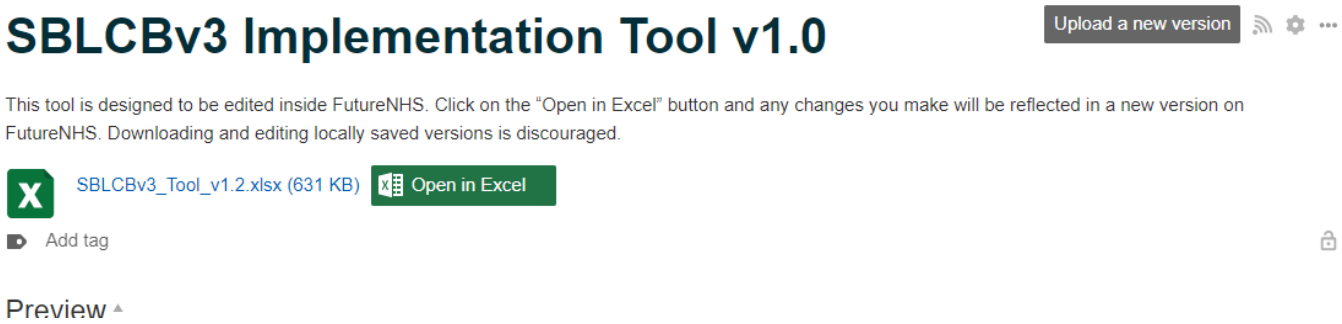
2.5.1 Element 1 Reducing smoking in pregnancy
2.5.2 Element 2 Fetal Growth: Risk assessment, surveillance, and management
2.5.3 Element 3 Raising awareness of reduced fetal movement (RFM)
2.5.4 Element 4 Effective fetal monitoring during labour
2.5.5 Element 5 Reducing preterm birth
2.5.6 Element 6 Management of pre-existing diabetes in pregnancy

2.6 The CNST year 5- Safety action 6 required standard reads

2.6.1 Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.

2.6.2 Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available

The tool has been released and accessed through FutureNHS



2.6.3 Implementation tool process

- Trusts will update progress, load evidence and declare a self-assessment status for each standard (continuous learning standards are not included and therefore not part of the CNST requirements) by a set date.
- LMNS colleagues will then review the tool and evidence. They will then validate the self-assessment status if agreed.
- A review meeting between the Trust and LMNS
- A report for the Trust Board and ICB can be produced from the tool
- There must be the minimum of 2 review meetings before March 2024
- To achieve CNST year 5, each element must have the minimum of 50% agreed compliance and an overall compliance of 70% for all elements (The percentages are generated within the tool).
- **NB.** This is now a peer review of compliance and there will be no external validation. The Midlands Perinatal Team will however continue to offer support.

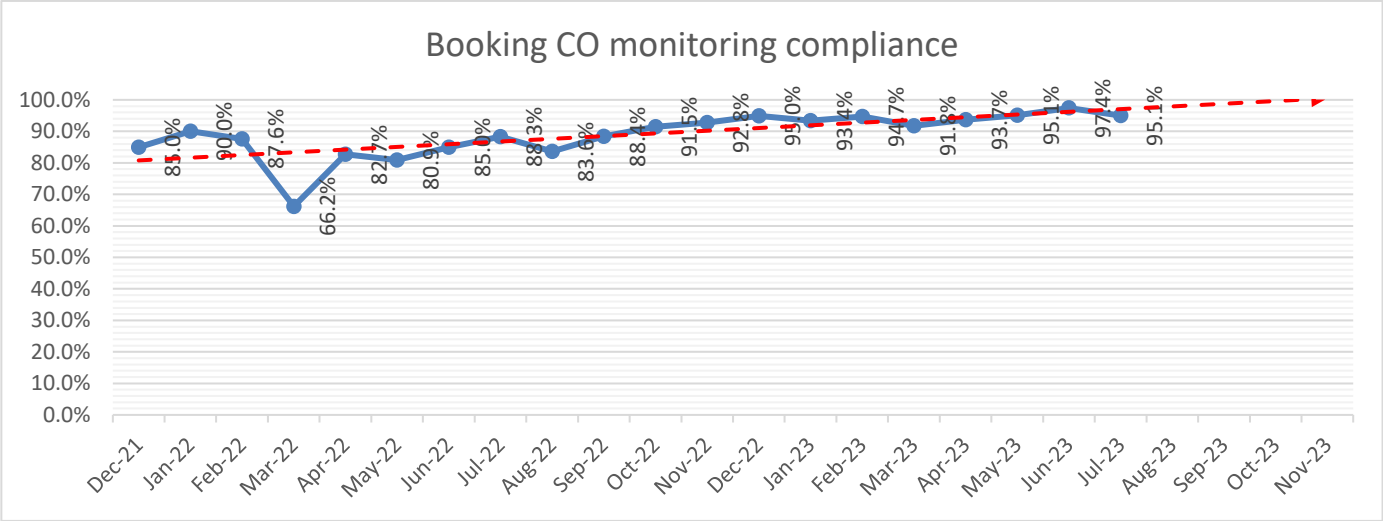
- The first review is planned for the week commencing 4/9/23

3.0 **Element 1: Reducing smoking in pregnancy**

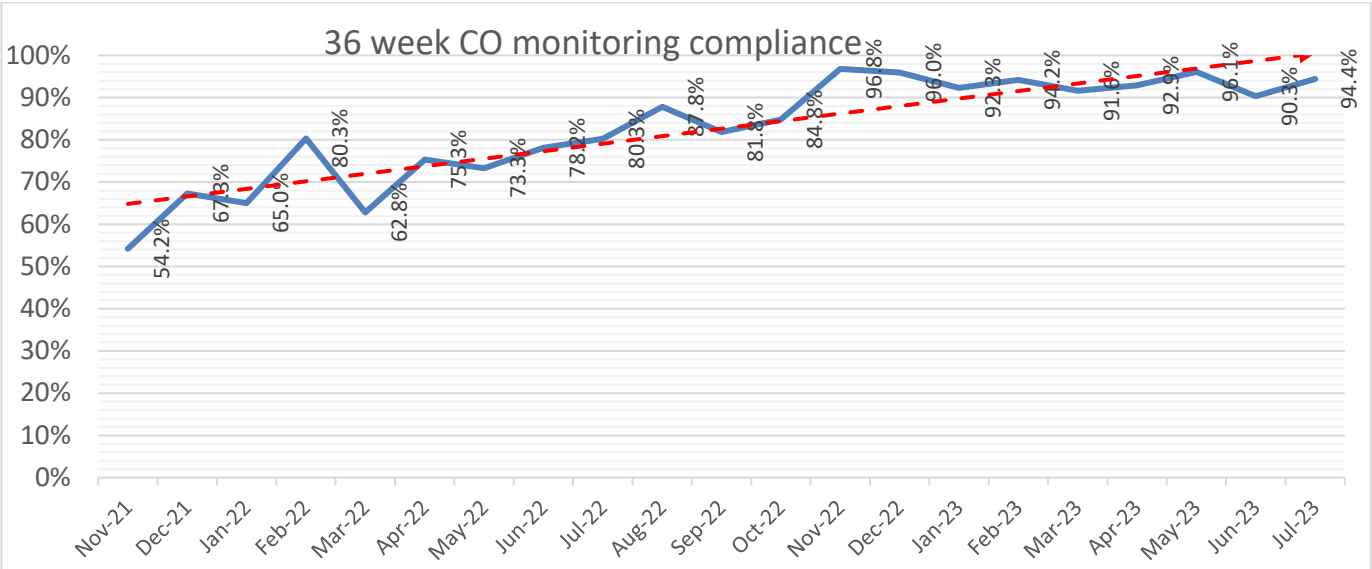
4.1 SBL mandates the following standards:

4.1.1. CO testing offered to all pregnant women at the antenatal booking and 36-week antenatal appointment. (2 standards combined in version 3)

Version 3 compliance change – minimum 90% (previously 80%) – with an action plan to reach 95% (unchanged). The Trust has reached and now exceeded the booking ambition for the last 3 consecutive months. This no long carries an action plan but will continue to be monitored monthly.



36-week antenatal appointment has exceeded 95% but appears to be slightly less consistently robust. The compliance, however, has maintained above 90% since December 2022. This standard will continue to be monitored monthly.



4.1.2 CO testing offered at all other antenatal appointments to groups identified within NICE Guidance NG209.

New phrasing to standard, applies to a pregnant woman with an elevated CO level (4ppm or above) **and** identifies themselves as a smoker.

The Trust reintroduced CO monitoring at every appointment for all women (post Covid-19) and will continue to offer to all.

Compliance has been monitored for all women since November 2022. It currently remains in the lower 80% region.

The ambition targets for this standard are to be set locally (see app1).

4.1.3 Whenever CO testing is offered, it should be followed up by an enquiry about smoking status with the CO result and smoking status recorded.

New standard. Compliance targets are the same as CO monitoring at 36 weeks.
Baseline review July 2023 41.4% (Staff updated to the requirement 23/6/23).
The timeframe targets for this standard are to be set locally (see app1).

5.0 Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)

5.1 In line with the requirements of SBLCBv3 and CNST year 5, a review of Small for Gestational Age births at SaTH is conducted on a quarterly basis by the SBL Lead Midwife. The most recent review is for Quarter 1 2023/2024 and is attached for reference as additional report (no.1).

5.2.1 The review provided the following highlights

A review of babies that were born <3rd centile >37+6 weeks' gestation in quarter 1 did not identify any themes relating to FGR not being detected (CNST monitoring standard). This is reassuring.

5.2 Additions to Element 2

5.2.1 Recommend Vitamin D supplementation to all pregnant women.

The ambition targets for this standard are to be set locally (see app1).

5.2.2 There are some additions to the Fetal growth surveillance algorithm. The new risk categories effect minimal service users and will be accommodated within current service capacity.

6.0 Element 3: Raising awareness of reduced fetal movements (RFM).

6.1 Some of the ambition targets for this element are to be set locally (see app1).

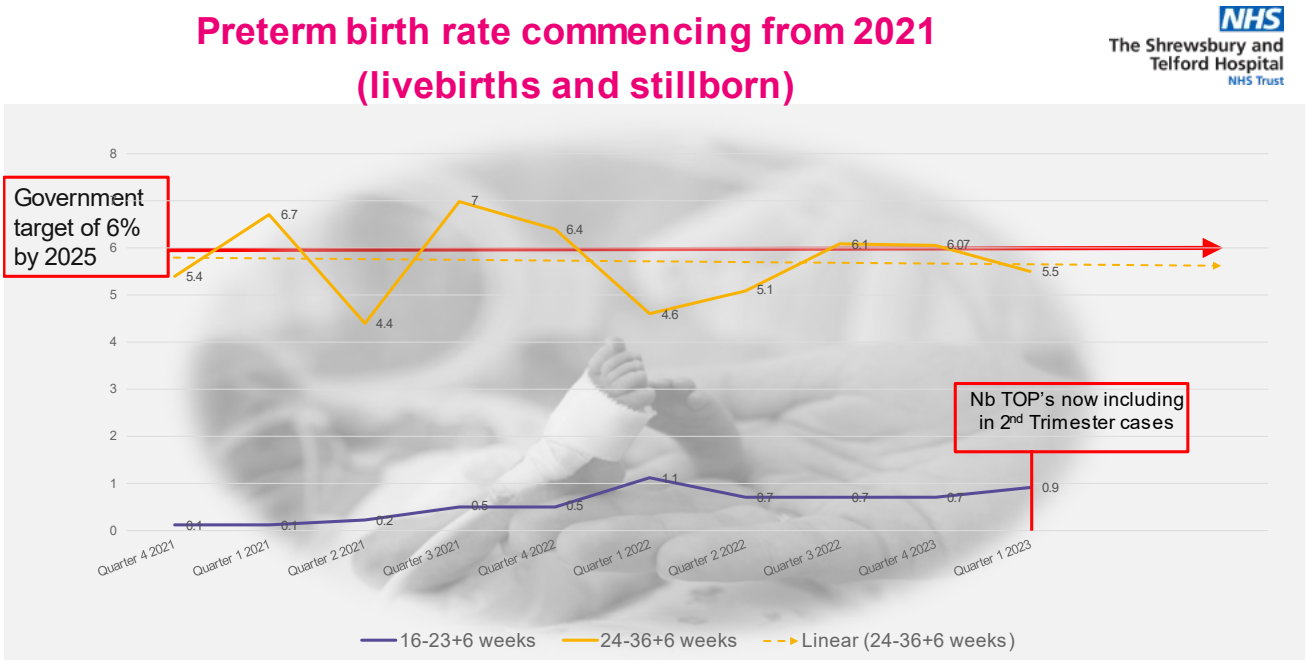
7.0 Element 4: Effective fetal monitoring during labour

7.1 No new local agreements required. Element standards remain targeted at staff education, risk assessment at the onset of labour and peer reviews.

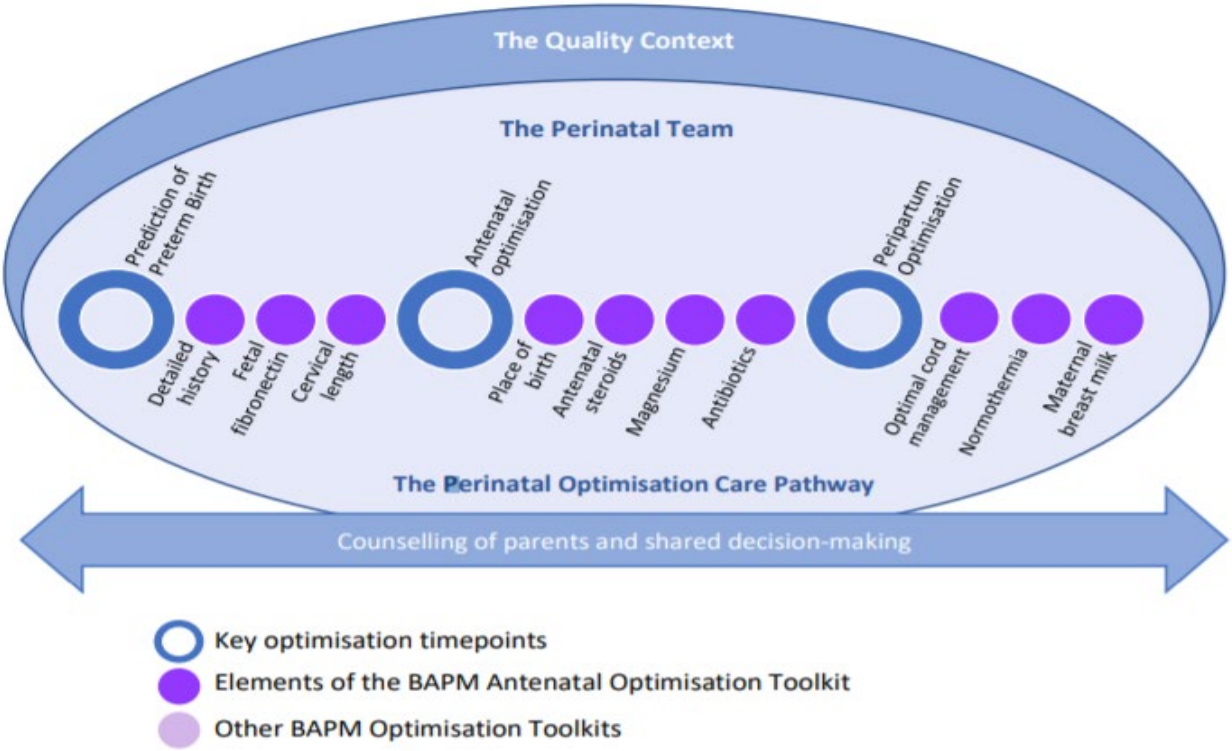
8.0 Element 5: Reducing preterm birth.

8.1 The most recent review, for Quarter 1 of financial year 2023-24 is attached as a separate report (no.2). This review provides information and performance data related to preterm birth rates and perinatal optimisation standards

8.1.1. The key highlight is that the Trust remains below the national preterm reduction target of 6% (8% to 6% by 2025)



8.2 SBLCBv3 has a strong focus in Element 5 of Perinatal Optimisation. This is aligned to the British Association of Perinatal Medicine (BAPM) optimisation pathway.



The Trust includes the above pathway in our local guidance. Although the Trust already provides all the antenatal and peripartum aspects of care, the focus will be providing optimal combined care (dependent on gestation) as gold standard. The more of the individual aspects provided in combination, potentially the better the neonatal outcome will be.

8.2.1 The Trust will introduce Preterm passports in September for women presenting with a risk of preterm birth. There are 2 documents, one clinical and one for the parents to help them understand and be an active part in care planning and decision making. The passport is part of the Perinatal Optimisation Pathway (BAPM).

8.2.2 To oversee the full pathway Trusts should have a Preterm Birth Team comprising of
a) An Obstetric Consultant lead for preterm birth, delivering care through a specific preterm birth clinic, or within an existing fetal medicine service.
b) An identified local preterm birth/perinatal optimisation Midwife Lead
c) A Neonatal Consultant lead for preterm perinatal optimisation
d) An identified Neonatal Nursing lead for preterm perinatal optimisation

The above team has been established and the Trust Board notified for assurance.

8.2.3 Some of the ambition targets for this element are to be set locally (see app1).

9.0 Element 6: Management of Pre-existing Diabetes in Pregnancy

9.1 Women with Type 1 and Type 2 diabetes have persistently high perinatal mortality with no improvement over the past 5 years. This has become the most significant modifiable risk factor for poor pregnancy outcomes.
Introducing management of Diabetes into the SBLCB allows improvement in two keyways:

- Ensuring there are standard pathways of care for MDT management of these women throughout pregnancy, with increased access to expert and 'joined-up' support for their complex care needs.
- Improving management of glucose control during pregnancy by focusing support on high-risk women who are not achieving safe pregnancy glycaemic targets and by ensuring consistent and high levels of uptake of digital glucose monitoring technology to facilitate this (SBLCBv3)

9.2 SBLCBv3 mandates:

9.2.1 Women with a diagnosis of pre-existing diabetes in pregnancy should be offered care in a one stop clinic, providing care to pre-existing diabetes only, which routinely offers multidisciplinary review and has the resource and skill set to address all antenatal care requirements. The multidisciplinary team should consist, as a minimum, of: Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife.

This standard carries a risk. Currently there is not a Diabetes Dietician within the team. Funding is being reviewed. Capacity from the Dietetic service may be a barrier.

9.2.2 Women with type 2 diabetes should have an objective record of their blood glucose recorded in their hospital records/EPR and be offered alternatives (e.g., intermittently scanned CGM) to blood glucose monitoring if glycaemic targets are not achieved.

Funding is being reviewed. Advice from the current team is that all Type 2 women are provided with a monitor to ensure a better understanding within the 1st year of monitoring.

9.2.3 Ambition targets for this element are set nationally but local compliance timeframes are required (see app1)

10.0 Actions requested of the LMNS Programme Board:

8.1 SBLCBv3 Implementation tool

8.1.1 Note the process of compliance for CNST year5

8.2 Relating to Element 1,3 and 4:

8.2.1 Note updates

8.3 Relating to Element 2:

8.3.1 Take assurance that no trends or missed opportunities were identified for undetected <3rd centile babies.

8.3.2 Note updates

8.4 Relating to Element 5:

8.4.1 Take assurance from the fact that The Trust is maintaining the national target for the percentage of pre-term births as a proportion of total births.

8.4.2 Take assurance that we are reviewing the care of all <34 week preterm babies to try to identify any missed opportunities, trends or themes.

8.4.3 Note that the Trust will implement the use of Preterm passports as an aid to increase preterm birth preparation and optimisation.

SBL Appendix 1- Saving Babies' Lives Version Three – targets to be set locally

A proportion of the SBLCBv3 standards ambitions are generated from best performing Trusts. There is a minimum target and a stretch target. To be compliant for CNST, Trusts need to achieve the minimum target.
Some of the newer or revised standards do not yet have a nationally acknowledged ambition. These standards are required to have a local agreement dependent on current service levels. The standards requiring an agreement have been collated below with Trust advice relevant to current service and/or following benchmarking.

Element 1 Reducing smoking in pregnancy

1. CO testing offered at all other antenatal appointments to groups identified within NICE Guidance NG209. (New)

   Requires – local ambition and improvement trajectory based on current system
   Denominator – number of pregnant smokers who have come to the end of their pregnancy

   Advise – based on the monitoring of all women minimum 80% with a stretch target to 90% for 1st year

2. Whenever CO testing is offered, it should be followed up by an enquiry about smoking status with the CO result and smoking status recorded. (New)

   Requires – locally agreed timeframe

   Advise – 6 months to achieve ≥80%

3. The tobacco dependence treatment includes behavioural support and NRT, initially 4 weekly sessions following the setting of the quit date then regularly (as required, however as a minimum monthly) throughout pregnancy to support the woman to remain smokefree.

   a. Number of pregnant smokers with an opt out referral documented who have set a quit date- LMNS to agree local ambition set on current performance- with an action plan to get to 60% and a locally agreed timeframe

   Requires – locally agreed ambitions and timeframe
   Advise- no action plan required. Q1 2023 69%. Minimum 55% with a stretch at 60%

   b. 4 week quit rates

   Requires – locally agreed timeframe
   Advise – There is a minimum set ambition of 50%, stretch of 60%
   On advice from the Trust's Lead PH Midwife – 4 week quits are normally around 30-40%.
   The LMNS can agree a variation. With the knowledge of our smoking population commencing pregnancy higher than the national average, the Trust suggests a minimum ambition of 35% and stretch of 45% with a 1 year timeframe.

4. Feedback is provided to the pregnant woman's named maternity health care professional regarding the treatment plan and progress with their quit attempt (including relapse). Where a woman does not book or attend appointments there should immediate notification back to the named maternity health care professional. (New)

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – no baseline data available as new to service. Suitable communication pathway under investigation. Consideration to service capacity required
   Suggest – minimum ambition 50% documented feedback with a review at 6 months to monitor service capacity.

Element 2 Fetal Growth: Risk assessment, surveillance, and management

1. Assess all women at booking to determine if prescription of Aspirin is needed using an appropriate algorithm (for example Appendix C) agreed with the local ICSs and regional maternity team

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Algorithm -NICE and SBLCB FGR risks already approved and in practice. Current performance- audit of 120 women demonstrated a correct aspirin risk assessment of **100%.**
   Therefore, minimum target 90% with no stretch. No improvement trajectory required. Review will continue through SBLCB monitoring/audit

2. Recommend Vitamin D supplementation to all pregnant women.

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

   Advise – no baseline data available as new standard. Minimum 80% with a stretch target to 90% for 1st year.

3. Women who are designated as high risk for FGR (for example see Appendix D) should undergo uterine artery Doppler assessment between 18+0 to 23+6 weeks gestation

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Current performance- (audit) demonstrated a **90%** compliance (CNST green rag rating).
   Target ambition maintain at ≥90%. No improvement trajectory required.

4. Women who are at low risk of FGR following risk assessment should have surveillance using antenatal fundal height (FH) measurement before 28+6 weeks gestation.

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

Advise – Current performance- (audit) demonstrated a **93.8%** compliance (CNST green rag rating).
Target ambition maintain at ≥90%. No improvement trajectory required.

5. All management decisions regarding the timing of FGR infants and the relative risks and benefits of iatrogenic delivery should be discussed and agreed with the mother. When the estimated fetal weight (EFW) is <3rd centile and there are no other risk factors (see 2.20), initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation.

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Current performance- (audit) demonstrated a **100%** compliance (CNST green rag rating). NB small cohort within the 120 audited
   Target ambition maintain at ≥90%. No improvement trajectory required.

6. In fetuses with an EFW between the 3rd and <10th centile, delivery should be considered at 39+0 weeks. Birth should be achieved by 39+6 weeks. Other risk factors should be present for birth to be recommended prior to 39 weeks

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Current performance- (audit) demonstrated a 100% compliance (CNST green rag rating). NB small cohort within the 120 audited
   Target ambition maintain at ≥90%

<u>Element 3: Raising awareness of reduced fetal movements (RFM).</u>

1. Women who report <u>recurrent</u> RFM are offered an ultrasound scan by the next working day (if no scan within the last 2 weeks)

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

   Advise – Scan timing a new addition – no benchmarking data to understand if capacity an issue.
   Minimum 80% with a 6 month target review

2. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation (Outcome Indicator)

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

   Advise – Previous monitoring has not identified an issue.
   Target ambition maintain at ≥80%. No improvement trajectory required.

Element 5: Reducing preterm birth

1. Maternity care providers will provide outcome data to the Trust Board and share this with the LMNS relating to 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).
   b) preterm (from 24+0 to 36+6 weeks).
   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Data already provided in a quarterly report evidences the Trust has reached and is maintaining the national ambition of 6%. Local ambition target should remain ≤ 6.9% (allowing for quarterly fluctuations).

2. Mortality to discharge in very preterm babies (NNAP definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner)

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

   Advise – new outcome indicator.
   Denominator – no of babies admitted to a neonatal unit whose birth gestation was 24+0 to 31+6 weeks
   Numerator – Deaths of babies 24+0 to 31+6 weeks before discharge from hospital to home or discharged for palliative care.

   Clarification on where the death occurred required (i.e., Birth at SaTH, died in another Trust).
   If the admission and death occurred within the Trust, the data available on Neonatal Badgernet suggests there were 65 admissions, 2 of which sadly died in the last financial year. Therefore 3.1% died.

   Suggest review of outcomes in 6 months, allowing for Perinatal optimisation pathway implementation and clarity on location.

3. Assessment of all women at booking for their risk of preterm birth and stratification to low, intermediate and high-risk pathways.

   Requires – locally agreed timeframe
   Advise – Ambition already set min 80% - stretch 90%
   Current performance- Monitoring of 100 bookings last month demonstrated a **100%** compliance (CNST green rag rating). Prior CNST audit in September 2022 also demonstrated a 100% result.
   Timeframe is not required as standard met.

4. Symptomatic women require assessment using quantitative fetal fibronectin (qfFN) measurements
   Num: Number of symptomatic women for preterm birth assessed using qfFN
   Den: Number of symptomatic women for preterm birth

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – new outcome indicator.
   National shortage of fFN cassettes from Hologic have temporarily stopped the supply. The Trust returned to using the former biochemical test, Partosure. Cassettes are now back in production, but supply is currently limited and regular supply erratic. The Trust will not return to full use until guaranteed regular stock.
   Suggest ambition min 80% - stretch 90% with a 6 month review to allow for recommencing the use of fFN.

5. Test for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Current performance- Monitoring of 100 bookings last month demonstrated a 100% compliance (CNST green rag rating). Prior CNST audit in September 2022 also demonstrated a 97.5% result.
   Timeframe is not required as standard met.
   Target ambition maintain at ≥90%. No improvement trajectory required.

6. Ensure the neonatal team are involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with parents prior to birth. This is especially important at earlier gestational ages.
   In the case of extreme prematurity where complex decision making is required (active survival focused care or comfort care), management should be as outlined in the 2019 BAPM Framework for Practice regarding Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation

   Num: number of women who deliver preterm that have a discussion with the neonatal team regarding care options.
   Den: number of women who deliver preterm

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Updated standard now requiring a compliance ambition.
   Baseline result in Quarter 1 2023 = 68.2% (all women with <34 week births included). Some cases were emergency situations not allowing for a full discussion).

   Ambition min 65% - stretch 80%. 6 month review

7. Women identified to be potentially at increased risk of imminent preterm birth, where active survival focused care is planned, should be made aware of optimisation interventions that may be offered. Families should also be offered information and support for families from charities such as Bliss.
   Num: Number of the relevant optimisation interventions
   Den: Total number of optimisation (calculated from total number of babies born <34 weeks multiplied by the number of appropriated elements (eligibility dependent on gestation)).

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – New standard requiring a compliance ambition.
   Baseline will be generated at the end of quarter 2 2023.

   Ambition min 50% - stretch 70%. 1 year review

8. Place of birth – Women who have symptoms suggestive of preterm labour or who are having a planned preterm birth:
   a) less than 27 weeks gestational age (in a singleton pregnancy)
   b) less than 28 weeks gestational age (in a multiple pregnancy)
   c) any gestation with an estimated fetal weight of less than 800g
   should be managed in a maternity service on the same site as a neonatal intensive care unit (NICU)

   Requires – locally agreed timeframe
   Advise – Ambition already set min 70% - stretch 85%.
   In version 3 there has been a change to how compliance is calculated. A baseline has been generated and reported in the Q1 preterm report: - For last financial year **65%** of women booked at SaTH who were in one of the above preterm criteria, gave birth in a unit with a same site NICU.
   The Trust are working with the Midlands Preterm Network. Cases delivered at a level 2 unit are peer reviewed. No trends identified but the geographical position of the Trust acknowledged as a barrier.

   Timeframe – 1 year within the optimisation pathway.

9. Other optimisation (current and new with a set ambition) combined

   a. Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth.
      Ambition already set min 40% - stretch 55%.
      Current position **47%**

   b. Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth.
      Ambition already set min 80% - stretch 90%.
      Current position **100%**

   c. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth

New standard
Ambition already set min 50% - stretch 75%.
Current position **58.6%**

d. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth.
New standard
Ambition already set min 65% - stretch 80%.
Current position **83.5%**

Requires – locally agreed timeframe
Advise - Timeframe – 1 year within the optimisation pathway.

10. Other optimisation (current and new without set ambition) combined

a. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection

Requires – locally agreed ambition and improvement trajectory based on the current system performance.
Advise – New standard requires a compliance ambition. Baseline Q1 **90%**
Ambition min 80% - stretch 90%.
Timeframe – 1 year within the optimisation pathway. No improvement trajectory required.

b. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth.

Requires – locally agreed ambition and improvement trajectory based on the current system performance.
Advise – New standard requires a compliance ambition. Baseline Q1 **57.1%**
Ambition min 50% - stretch 75%. (same as national ambition for cord clamping).
Timeframe – 1 year within the optimisation pathway.

11. Volume-Targeted Ventilation For babies born below 34 weeks' gestation who need invasive ventilation, use volume-targeted ventilation (VTV) in combination with synchronised ventilation as the primary mode of respiratory support. This reduces the chance of death or bronchopulmonary dysplasia by 27% and intraventricular haemorrhage (grades 3–4) by 47% compared with pressure-limited ventilation modes.
Num: Babies born at less than 34 weeks who receive volume-targeted ventilation in combination with synchronised ventilation as the primary mode of respiratory support, if invasive ventilation is required
Den: Babies born at less than 34 weeks

Requires – locally agreed ambition and improvement trajectory based on the current system performance.
Advise – New standard – awaiting Neonatal advice

12. Caffeine For babies born below 30 weeks' gestation, caffeine reduces the chance of death or disability. Caffeine should be started within 24 hours of birth

Requires – locally agreed ambition and improvement trajectory based on the current system performance.
Advise – New standard. Compliance for Q1 **100%** (source Neonatal dashboard) Ambition min 85% - stretch 90%. No improvement trajectory required

Element 6: Management of Pre-existing Diabetes in Pregnancy

NB. The Implementation tool suggests 'LMNS required compliance over an agreed compliance timeframe'. Suggested ambitions are documented as a guide, as the Trust already has an established service. Trust advice would be to use the suggested ambitions but set a timeframe.

1. Women with type 1 diabetes should be offered real time continuous glucose monitoring (CGM) and be provided with appropriate education and support to use this.
   a. Num: number of pregnant women who have T1 diabetes that use CGM during pregnancy
   Den: number of pregnant women who have T1 diabetes
   Ambition already set min 80% - stretch 95%.
   Current position **New** – Pregnant T1 in the Trust are provided with a Dexicom continuous monitor. Funding in place.

   Requires – locally agreed timeframe
   Advise - Timeframe – 1 year to review entire element

   c. Annual staff training (MDT only)
   Ambition already set min 80% - stretch 90%.
   Current position **New** – CGM training mandatory within the Trust (no compliance data for the MDT available at time of writing this document)

   Requires – locally agreed timeframe
   Advise - Timeframe – 1 year to review entire element

2. Women with diabetes should have an HbA1c measured at the start of the third trimester and those with an HbA1c above 48mmol/mmol should be offered increased surveillance including additional diabetes nurse/dietetic support, more frequent face to face review and input from their named, specialist Consultant to plan ongoing care and timing of birth decisions.

   Num: Number of pregnant women with T1 and T2 diabetes that have had a HbA1c measured at the start of the 3rd trimester (between 28+0 and 28+6 weeks)
   Den: Number of pregnant women with T1 and T2 diabetes

   Ambition already set min 80% - stretch 95%.
   Current position **–** All pregnant diabetic women are offered HBA1C's monthly throughout pregnancy.

Requires – locally agreed timeframe

Advise – The specific timing set may potentially cause reduced compliance as it will depend on the women's clinic schedule i.e. clinic at 27+5 and then 31+5 gestation. Monitoring will allow the Trust to understand if there will be a compliance issue.

Timeframe – 1 year to review entire element

SBL Appendix 2a

Perinatal Optimisation Pathway Passport

British Association of Perinatal Medicine

This passport must be completed for all women at risk of birth before 34 weeks' gestation and should accompany the baby on admission to neonatal care.

Time of birth: _ _ : _ _ Gestation: /40

Type of birth: Birth weight: g

Time of admission to NNU: _ _ : _ _

Apgars: @1 @5 @10

Booking Hospital:

Name:
DOB:
Hosp No:
NHS No:
Or patient sticker here

1. Place of Birth:

Aim: babies <27/40, EFW <800g or multiple pregnancy <28/40 should be born in maternity centre with a NICU

Born in a maternity centre with the appropriate designation of neonatal unit?

Y ☐ N ☐ N/A ☐

If not, why was intrauterine transfer not achieved?

2. Antenatal Steroids:

Aim: women giving birth before 34 weeks should receive a full course of steroids no longer than 7 days prior to birth

Full course of antenatal steroids (2 doses 12-24hrs apart)?

Y ☐ N ☐ N/A ☐

Last dose: Date: / / Time: :

If a full course of optimally timed steroids was not achieved, why?

3. Antenatal Magnesium

Aim: women giving birth before 30 weeks should receive a loading dose and ideally a 4-hour infusion in the 24 hours prior to birth

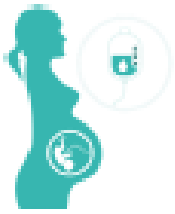
Loading dose given? Y ☐ N ☐ N/A ☐

Was a 4-hour infusion given within 24 hours prior to birth?

Y ☐ N ☐

If optimally-timed Magnesium was not achieved, why?

4. Antibiotic Prophylaxis



Aim: women in established preterm labour should receive intrapartum antibiotic prophylaxis to prevent early onset GBS infection

Required? Y ☐ N ☐

Given > 4hrs before birth? Y ☐ N ☐

If no antibiotic prophylaxis given or antibiotic given within 4h, why?

5a. Early Breast Milk (antenatal info)

Aim: women at risk of preterm birth should receive information about the importance of breast milk

Antenatal counselling and advice for mother re benefits of MBM and early & frequent expressing?

Y ☐ N ☐ N/A ☐

Supplemental information given eg. Written / digital

Y ☐ N ☐ N/A ☐

If not given, why?

6. Optimal Cord Management (OCM)

Aim: the umbilical cord should be clamped at or after one minute following birth

Was the umbilical cord clamped at or after one minute?

Y ☐ N ☐ N/A ☐

Time of OCM: __ minutes __ seconds

If no OCM, why?

7. Thermal Care

Aim: babies should have an admission temperature taken within one hour and this should be between 36.5-37.5C

Admission Temp between 36.5°C to 37.5°C ?

Y ☐ N ☐ N/A ☐

Admission Temp: °C

If normothermia was not achieved, why?

5b. Early Breast Milk

Aim: all mothers should be supported to express within 2 hours of birth

All babies should receive their own mother's milk within 24 hours of birth and ideally within 6 hours

Mother helped to express within 2h of birth?

Y ☐ N ☐ N/A ☐

Date: / / **Time:** :

Colostrum first available: **Date:** / / **Time:** :

Colostrum given to baby: **Date:** / / **Time:** :

If not achieved within first 24h, why?

www.bapm.org/pop www.weahsn.net/periprem

This passport has been modified with kind permission from PERIPrem.

SBL Appendix 2b

Perinatal Optimisation Passport

British Association of Perinatal Medicine

Right Place of Birth

(babies born before 27 weeks' gestation - 28 weeks for multiple births - or who may weigh less than 800 grammes)

I am at the right hospital in case my baby(ies) needs to be born early.

In Progress ○ Complete ○

Antenatal Steroids

(babies born before 34 weeks' gestation)

I have received a full course of steroids to help prepare my baby(ies) for being born early.

In Progress ○ Complete ○

Antenatal Magnesium Sulphate

(babies born before 30 weeks' gestation)

I have received magnesium sulphate to support the brain development of my baby(ies).

In Progress ○ Complete ○

Early Breast Milk

(babies born before 34 weeks' gestation)

I have received information about the benefits of early breast milk and have been shown hand expressing/breast pump techniques to help me try to make early breast milk for my baby(ies) before or within an hour of them being born.

In Progress ○ Complete ○

Antibiotics

(babies born before 34 weeks' gestation where mum was in established labour)

I have received antibiotics to reduce the chance of my baby developing an infection due to Group B Streptococcus.

In Progress ○ Complete ○

Optimal Cord Management

(babies born before 34 weeks' gestation)

After my baby(ies) is born, whenever possible, the perinatal team will support them to receive extra blood from the placenta for at least a minute before the umbilical cord is clamped.

In Progress ○ Complete ○

Thermal Care

(all babies)

After my baby(ies) is born, the perinatal team will aim to maintain their temperature between 36.5 and 37.5oC. They will also help me to hold my baby skin-to-skin as soon as it is safe to do so.

In Progress ○ Complete ○

www.bapm.org/pop www.weahsn.net/periprem

This resource has been modified with kind permission from PERIPrem.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14th December 2023

Agenda item		162/23 Paper 1 within CNST INFORMATION PACK **Appendix 8**		
Report Title		Black Maternal Health – Gap Analysis		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Helena Hermelin, Continuity of Carer Midwife		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Maternity Governance Committee, October 2023 W&C Divisional Committee Meeting, October 2023 Quality and Safety Assurance Committee, October 2023 LMNS/PNQSG, November 2023		
Executive summary:		The UK has the lowest maternal mortality ratios in the World. There are however persistent disparities in outcome for women depending on their ethnicity. MBRRACE-UK's most recent report was published in November 2022 (using data from 2018-2020) and found that: • Black women were 3.7 times more likely to die than White woman. • 1 in 9 of the women who died during or up to a year after pregnancy in the UK were at severe and multiple disadvantages. • Women living in the most deprived areas continue to have the highest mortality rates. • Cardiac disease remains the largest single cause of indirect deaths. Thrombosis and thromboembolism (DVT) remain the leading cause of direct maternal deaths during or up to six weeks after the end of pregnancy. • Improvements in care may have made a difference to the outcome of 38% of women who died. The recommendations from the report have been reviewed and a GAP analysis produced to support service improvements.		

Recommendations for the Board:	The Board is asked to: Receive this report in line with CNST Safety Action 7.
Appendices:	None

Introduction

The Women and Equalities Select Committee Report on Black Maternal Health was published on the 18th of April 2023.

The work was undertaken to scrutinise progress to date. To review what was already known about the causes for maternal health disparities and critically assess the various solutions which have been proposed. Ethnicity data has regularly appeared in the confidential enquires reports from at least 2000 onwards. All reports have shown a greater risk for mothers from ethnic minority backgrounds, compared to White mothers.

Although the report is titled 'Black maternal Health', to acknowledge and address the particular stark disparity between Black and White women. The recommendations were intended to address the ethnic disparities more broadly, as well as the overlapping disparity for women suffering socio-economic deprivation.

The aim of this paper is to review the recommendations from the report and the current provision of maternity care to the Black, Asian and multiethnic communities as well as women suffering socio-economic deprivation.

The Key conclusion and recommendation of the Report:

1. The maternity workforce must be properly equipped to understand and recognise the significant disparities that exist, and to use that knowledge to deliver personalised, effective and respectful care*. Health Education England must lead a co-ordinated review involving the National Midwifery Council, General Medical Council, Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, to ensure that both the training curricula and continuing professional development requirements for all maternity staff include evidence-based learning on maternal health disparities, its possible causes, and how to deliver culturally competent, personalised, and evidence-led care.*

2. A fully staffed, properly funded maternity service workforce is fundamental to delivering safe, personalised care to pregnant women and new mothers, and a prerequisite to rolling out any measures to combat inequalities (Midwifery Continuity of Carer) *The Government should commit to increasing the annual budget for maternity services to £200–350 million from the next financial year.*

3. *The Government should publish measures for gauging the success of the Maternity Disparities Taskforce. It should commit to publishing the dates of meetings in advance, and the minutes of the meetings soon after. The Taskforce should update this Committee on a six-monthly basis on the progress the Taskforce has made to tackling maternal health disparities.*

Box 1: **Maternity Disparities Taskforce: summarised terms of reference**

- The Taskforce will particularly focus on improving pre-conception care and access to maternity care for women from ethnic minorities and those living in most deprived areas and "will look to explore and consider evidence-based interventions for the following areas":
- reduce rates of smoking, drinking and drug use in pregnancy
- improve education and awareness of pre-conception health with a focus on planning for pregnancy such as taking folic acid supplement before pregnancy and maintaining a healthy weight.
- improve personalised care and support plans and focus on addressing wider social determinants of health.
- improve access to maternity care for all women and develop interventions for women from the most vulnerable groups.
- improve access and support for informed decision-making during childbirth for all women

4. *NHS England should set out their approach for assessing and monitoring the strategies of local maternity services. The Government should also provide clear timescales for the roll-out of the maternal morbidity indicator.*

5. *The Office for National Statistics, NHS England, hospital trusts and all relevant stakeholders should work with the National Perinatal Epidemiology Unit (NPEU) to minimise delays in the delivery of data. The NPEU should provide us with a progress update on this work within 12 months of the date of publication of this report.*

6. *NHS England and NHS Improvement (NHSEI) and NHS Digital must prioritise the accurate and complete capture of ethnicity data and ensure their new system for ethnicity data captures granular level data on ethnicity. NHSEI should provide us with a progress update on the implementation of this system within 12 months of the date of publication of this report.*

7. *The Maternity Disparities Taskforce must ensure a minimum number of seats or spaces at each meeting is reserved for representatives of organisations run by and for Black women. Part of the Taskforce's focus over the next 12 months should be on working with stakeholders to ensure Black women can be better represented in maternal health research; both as participants and researchers*.

Themes	Recommendation	Current status	Desired Status	GAP	Confidence RAG	Action Owner	Target Completion Date
1.Causes of Maternal Health Disparities	1.The maternity workforce must be properly equipped to understand and recognise the significant disparities that exist, and to use that knowledge to deliver personalised, effective, and respectful care.	All maternity staff undertake mandatory Equality and Diversity training.	All staff to have undertaken Cultural competence training as recommended by the NHS Equity& Equality Guidance.	Not currently being undertaken		EDI Midwife – TBC Consultant Midwife Trust EDI Midwife Educational Lead Midwife	September 2024
			Employment of an EDI Midwife (Recruitment in progress)	EDI Midwife not currently in Post		Consultant Midwife	September 2023
		Staff receive Personalised care training on Mandatory training days.		GAP not identified		EDI Midwife – TBC Consultant Midwife	August 2023
		A number of Staff have undertaken external	All Staff to have receive Personalised care training.	Gap not identified as now incorporated		Consultant Midwife	August 2023

		Personalised Care On-line training.		on Mandatory Training		Educational Lead Midwife	
		Personalised care plans within Digital system (Badgernet)		GAP not identified		Digital Midwife	Completed
		Mandatory Training Day to include Equity and Equality training (due to commence August 2023).	PROMT training to include an awareness of the differing clinical signs in Black or Brown skinned women and babies (E.g., Wound Infection, jaundice)			Consultant Midwife Trust EDI Midwife Educational Lead Midwife	Completed August 2023
			Guidelines to include recognition of differing signs and symptoms with Black and mixed ethnicity.	Not all guidelines include signs and symptoms pertaining to Black and Brown skinned women.		Guideline Midwife. EDI Midwife – TBC	September 2023

		Trust has an Equality, Diversity, and Inclusion Team.		EDI Midwife not in post Recruitment in progress		Consultant Midwife	September 2023
			Engagement work to commence when EDI midwife is in role (currently out to recruitment) Ensure culture is considered when designing resources.	EDI Midwife not currently in Post		Consultant Midwife Trust EDI Midwife	September 2023
		Employment of International Midwives to increase diversity within the Maternity workforce.	Employment of 10 International Midwives.	5 International Midwives currently undergoing OSCE Preparation		EDI Midwife – TBC Consultant Midwife	September 2023
		National Reports Shared widely with safe via safety huddles, staff Facebook page.		GAP not identified – Regular updates are shared with MDT		Consultant Midwife Trust EDI Midwife DOM	September 2023

	2. Due to broader taboos and stigma around discussing mental health and/or pregnancy, patients may not have talked about their experiences or received support around previous birth trauma or trauma from baby loss.	Current provision of PNMH service including Lighthouse Service and Improving women's Health Midwife (IWH)	PNMH training to include training on service users from Black and Asian communities.	Not currently in place		EDI Lead Midwife Improving Women's Health Midwife Lighthouse Specialist midwife	September 2024
			Ensure resources pertaining to mental Health are provided via Badgernet and maternity Internet pages are available in multiple languages such as (https://perinatalpositivity.org/)	No current resources in multiple languages available		EDI Lead Midwife Improving Women's Health Midwife Lighthouse Specialist midwife Digital Lead Midwife Communications Team	September 2024
		Lighthouse service has Psychologist who is champion for	Engagement work to commence and Ensure culture is considered when designing resources.	No current specific service targeted at Black, Asian		Improving Women's Health Midwife	September 2024

		service users from High areas of deprivation and attends community engagement		communities, women within areas of high deprivation.		Lighthouse Specialist midwife Consultant Midwife Trust EDI Midwife	
		Bereavement Midwives currently in post who work closely with the Chaplin service in relation to specific cultural practices.	Ensure resources produced by Trust are available in multi languages	No specific service for Black and Asian service users.		Bereavement Midwives Trust EDI Midwife	September 2024
		Sensitive bereavement care provided by the Bereavement Midwives and the National bereavement Care pathway for Pregnancy and Baby Loss.					

		Bereavement Midwives provide Ibrahims Gift to our Muslim families. QR codes are provided to which direct the family to the SANDS Support Booklet in a different language e.g. Urdu.					
	3.The Government should publish measures for gauging the success of the Maternity Disparities Taskforce.	The Government Task force is currently focusing on pre-pregnancy care and is working in collaboration with the membership to produce pre-pregnancy guidance targeted for ethnic minority women and those living in most deprived areas.	Guidance under development- no update received to LMNS/Trusts	Not within SATH scope currently			

2. Tackling the Disparities	1.A fully staffed, properly funded maternity service workforce is fundamental to delivering safe, personalised care to pregnant women and new mothers, and a prerequisite to rolling out any measures to combat inequalities (Midwifery Continuity of Carer).	MCoC Teams suspended, and new roll out suspended in line with Ockendon recommendations of safe staffing and national letter received to all trust in September 2022. National target date to deliver MCoC have been removed (21/09/2022)	Roll out of enhanced MCoC teams in areas of high deprivation once staffing levels allow.	Work is ongoing on building blocks. Risk of Staff not wanting to work within MCoC Teams. MCoC model not yet decided.		Continuity of Carer Specialist Midwife EDI Midwife Consultant Midwife	September 2024
		Working on building blocks for MCoC focusing on enhanced MCoC.	Continue staff engagement regarding MCoC.	Risk of Staff not wanting to work within MCoC Teams.		Continuity of Carer Specialist Midwife Consultant Midwife	September 2024

		MCoC staff survey has recently been completed (9/8/23).	Continue staff engagement regarding MCoC. Work with MNVP to conduct Service users specific MCoC survey	No recent Service users Survey specifically for continuity of carer needs. Risk of Staff not wanting to work within MCoC Teams.		Continuity of Carer Specialist Midwife MNVP	September 2024
		An updated BR+ was undertaken in November 2022. Maternity workforce plan has been developed and ratified.		Gap not identified		HOM	September 2023
		WF Plan includes 24 % uplift and an additional 10wte to mitigate for unavailability and attrition within the current workforce.	Ongoing monthly workforce reviews. Ensure sustained staffing levels prior to roll out of MCoC.	Gap not identified		HOM CoC specialist Midwife	September 2023

		Currently Staffing is up to template but with unavailability.	Undertake CoC workforce planning Tool	Not yet undertaken		CoC specialist Midwife Consultant Midwife	September 2023
		Ongoing monthly workforce reviews	Continue with Monthly workforce reviews.	Gap not identified		HOM Matrons	Ongoing
		MCoC Midwife has undertaken review of ethnicity breakdown of bookings, areas of deprivation within the LMNS area and LSOA areas of Deprivation.	Engagement with local communities	No current engagement with local communities		Continuity of Carer Specialist Midwife EDI Midwife Consultant Midwife MNVP	September 2024
		MNVP have recruited Engagement Champion.	For MNVP and Trust to work collaboratively to ensure representation from Black and Asian service users	No current MNVP representation from black or Asian service users		EDI Midwife Consultant Midwife MNVP	September 2024

		CoC Midwife commenced undertaken engagement with staff (focus group).	Continue staff engagement in regard to MCOC.	Risk of Staff not wanting to work within MCoC Teams.		Continuity of Carer Specialist Midwife Consultant Midwife	September 2024
		Retention Midwife involved in stay conversation.	Continue with offering stay conversations. Ward managers inform retention Midwife of potential Leavers.	Gap not identified		Retention Midwife PMAs	September 2024
		PMA's involved in stay conversation.		Gap not identified			
		Preceptor package with 100% retention of preceptors in last two years.	Continue to offer robust preceptor package in line with national agenda.	Gap not identified		PEFs Retention Midwives	September 202.
		Recruitment of 10 WTE international Midwives and ensure support and pastoral care to ensure retention.	On going support for International recruited Midwives	Risk of International Midwives not being retained.		EDI Midwife Retention Midwife.	September 2024

	2.NHS England should set out their approach for assessing and monitoring the strategies of local maternity services. All LMNS will publish their Equity and Equality action plan by 31st March 2024	Trust has work collaboratively with LMNS to develop an Equity and Equality action plan (currently in draft form) The interventions within the plan are designed to reduce health inequalities and ensure equity is part of how care is provided (e.g., perinatal mental health). Maternity Strategy includes Shared Decision making.	Recently published, Trust will work with LMNS to support the E&E strategy.			EDI Midwife Consultant Midwife CoC specialist Midwife LMNS	September 2024
			Increase/launch services within areas of higher deprivation communities (e.g sonography services)	Minimal hubs with local communities		EDI Midwife Consultant Midwife Community Matron	September 2024
			Engagement with local communities and build Trust with community members through direct engagement.	No current Engagement with Local Community		EDI Midwife Consultant Midwife Community Matron MNVP	September 2024
			Engagement with community leaders to increase knowledge and traditions which can complement and enhance knowledge of healthcare professionals.	No current Engagement with Local Community		EDI Midwife Consultant Midwife Community Matron MNVP	September 2024

			Work with MNVP to ensure those seldom heard voices are represented. Increase demographic reach through MVP.	No current representation from Black and Asian service users within MNVP. No specific surveys targeted at Asian and Black services users in relation to their experiences.		EDI Midwife Consultant Midwife MNVP	September 2024
			Ensure Information Leaflets and information is provided in multiple languages.	Service users' information videos (e.g. IOL) currently not available in other languages. Badgernet not currently able to have multiple languages available.		EDI Midwife Consultant Midwife MNVP Digital Midwife Coms Team	September 2024
			Ensure Interpreting services are used for all contacts	No current Video interpreting			September 2024

			where women do not speak English.	service – additional to current service			
	4.NHS England Have developed 14 Maternal medicine Networks	SATH work in collaboration with Birmingham Women's which is the nearest Maternal Medicine Network. All women with chronic and acute medical problems around pregnancy, have access to specialist management. SATH have Diabetes specialist Midwife/ clinics	Continue to work closely with Maternal Medicine Network. Ensure Information provided is culturally sensitive and available in multiple languages.	Risk of Service users from areas of high deprivation unable to travel to other units due to financial concerns (cost of living). Large geographical areas within LMNS and poor transport links.		MDT	September 2024
3.Research and Data	1.The Office for National Statistics, NHS England, hospital trusts and all relevant stakeholders should work with	SATH met all 10 safety actions MIS year 4. Safety action 2 pertains to Ethnic coding data – SATH	Continue to work towards meeting all safety actions MIS year 5.		AMBER		September 2024

	the National Perinatal Epidemiology Unit (NPEU) to minimise delays in the delivery of data.	stands currently at over 90%. SATH are meeting the final submission deadlines and have passed CNST metrics for April 2023. Working towards MIS year 5					
	2.NHS England and NHS Improvement (NHSEI) and NHS Digital must prioritise the accurate and complete capture of ethnicity data and ensure their new system for ethnicity data captures granular level data on ethnicity	SATH Maternity Ethnicity Data currently above 90% complying with MIS Safety Action 2. All service users are asked their ethnicity at point of referral via Badgernet- single point of access.	New PAS system- Careflow will strengthen process and accuracy through mandatory fields. Careflow will also align with Ethnic categories set by NHS England. Ensure Ethnicity is recorded at Booking and compliance monitored by Digital Team.	Currently Historical DATA has discrepancies. Digital Team currently having to ensure Data is entered. No further Gaps identified	AMBER	Digital Lead Midwife Data Analyst	September 2024

		Booking coordinators add ethnic category to PAS Ethnicity data is being monitored on a weekly basis by Digital Midwife Team SATH Met all of 10 CNST					
	3.The Maternity Disparities Taskforce must ensure a minimum number of seats or spaces at each meeting is reserved for representatives of organisations run by and for Black women.	Research team is working with OBS-UK on Equality and diversity.	Research team to consider using the Race equality framework Self-assessment tool to improve racial equity in health and care research	Currently no research being undertaken specifically Targeted Black African, Asian and Caribbean-heritage communities. Research team aware of Race equality Framework but no formal work around this currently		Research Midwife EDI Lead Midwife Consultant Midwife	September 2024

		Launch of REACH study which is looking at using 'Pregnancy circles. This is being trailed with One community team within an area of highest Deprivation in Telford and Wrekin. Will also capture Black and Brown women within the study.				Research Midwife EDI Lead Midwife Consultant Midwife Community Matron	September 2024
	Part of the Taskforce's focus over the next 12 months should be on working with stakeholders to ensure Black women can be better represented in maternal health research; both as participants and researchers.	DOM regularly shares Clinical Research and leadership opportunities for those healthcare professionals from Ethnic Minorities to all Maternity staff	Ensure Staff from Ethnic Minorities continue to be made are aware Leadership opportunities.			DOM HOM SLT	September 2024

References

Black Maternal Health Third Report April 2023 https://committees.parliament.uk/publications/38989/documents/191706/default/

Black Maternal Health: Government Response to the Committee's Third Report - Women and Equalities Committee (parliament.uk)

Helena Hermelin – September 2023

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14th December 2023

Agenda item		162/23 Paper 1 within CNST INFORMATION PACK **Appendix 9**		
Report Title		Maternity Training Needs Analysis, CCFv2 for Safety Action 8 Year 5 MIS		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Karen Henderson, Clinical Education Midwife		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Maternity Governance Committee, October 2023 W&C Divisional Committee Meeting, October 2023 Quality and Safety Assurance Committee, October 2023 LMNS/PNQSG, November 2023		
Executive summary:		The Maternity Specific Training Guideline and TNA implementing CCF version 2 MIS Year 5 is presented to evidence the 4 key principles from the "How to" Guide for the second version of the core competency framework developed by NHS England. The training plan is presented to seek approval from the Quadrumvirate, LMNS/ICB and Trust Board. The following documents are attached for approval as required for Safety Action 8 of the Year 5 MIS. • TNA planning document • Maternity Training Needs Analysis • 5 Day programmes • Human Factors Lecture		
Recommendations for the Board:		The Board is asked to: Receive this report in line with CNST Safety Action 8.		
Appendices:		Appendix 1: TNA planning document Appendix 2: Maternity Training Needs Analysis Appendix 3: 5 Day programmes Appendix 4: Human Factors Lecture		

The training plan has been developed with service user involvement and is based on learning from local findings from incidents, audit, service user feedback and investigation reports. Learning is shared with the LMNS and multidisciplinary team promoting MDT learning.

The local training plans evidence how the 3 elements (Fetal Monitoring and Surveillance in the Antenatal and Intrapartum period, Maternity Emergencies and Multi-professional Training and Neonatal Basic Life Support) will be facilitated and achieved.

Fetal monitoring and surveillance in the antenatal and intrapartum period compliance for >90% of
obstetric consultants, obstetric doctors contributing to the obstetric rota, midwives (including managers and matrons), bank and agency midwives and maternity theatre midwives.
Training is monitored maintaining compliance for maternity emergencies and multi-professional training >90% for obstetric consultants, all obstetric doctors including staff grade doctors, obstetric trainees, sub speciality trainees, clinical fellows and foundation year doctors contributing to the obstetric rota. Midwives (including managers and matrons), community midwives, bank and agency midwives, maternity support workers, healthcare assistants and obstetric anaesthetist consultants, staff grades and anaesthetic trainees.

Training schedule planning includes an emergency scenario conducted in a clinical area or at point of care achieving compliance of 90% for all team members.

Neonatal basic life support compliance >90% for neonatal consultants or paediatric consultants covering neonatal units, neonatal junior doctors and neonatal nurses Band 5 and above who attend births. Compliance >90% for Neonatal Nurse Practitioners, midwives (including midwifery managers and matrons, community midwives, birth centre midwives and bank and agency midwives). With plans to deliver the in-house neonatal life support annual updates and local NLS courses.

Maternity TNA Appendix 1: TNA Planning Document

The Shrewsbury and Telford Hospital NHS
NHS Trust

Maternity Specific Training Guideline (Including Training Needs Analysis)

VERSION 5

Lead Person(s)	:	Clinical Education Midwife
Care Group	:	Women and Children's
First implemented	:	March 2016
This version implemented	:	21st August 2023
Planned Review	:	August 2026 (Appendix TNA reviewed annually)
Keywords	:	Training, Training Needs Analysis, TNA
Written by	:	Clinical Education Midwife
Consultation	:	Care Group Director, Head of Midwifery, Maternity Governance Group, Maternity Medical, Midwifery and Nursing Educational leads and specialists providing training
Comments	:	References to SaTH Guidelines in the text pertain to the latest version of the Guideline on the intranet. Printed copies may not be the most up to date version.

For triennial review

Version	Implementation Date	History	Ratified By	Review Date
1	3rd March 2016	New guideline Revamp of previous	MGG Maternity Governance	March 2019
1.2	2nd November 2016	Guideline and training monitoring processes under review: Removal of Neonatal, Paediatric and Anaesthetic training needs as these groups are to monitor own training compliance. Updated against Trust Training Guidelines, references added and TNA updated with 2016/17 training needs.	MGG Maternity Governance	
2	12th September 2018	Full version review Revision to include priority training definitions in line with Trust Policy	MGG Maternity Governance	
3	5th August 2019	Full Review to include requirements for K2 Training, Safeguarding training compliance and process when staff are non-compliant. Update to TNA.	MGG Maternity Governance	
4	April 2020	Full Review and update to TNA	MGG Maternity Governance	
4.1	September 2021	Partial review of TNA pending MTP restructure of Maternity training and introduction of Trust Learning Management System.	MGG Maternity Governance	
5	21st August 2023	Full review.	Maternity Governance	August 2026

Contents.....2

1.0 Introduction

1.1 This Training Guideline provides an overview of the education and training provision for Medical, Midwifery and support staff working within the Maternity Services of the Shrewsbury & Telford NHS Hospitals Trust.

This guideline has been aligned with the training requirements of the Core Competency Framework Version 2 *(NHSE 2023)* which reflects the ethos and priorities of the Maternity Transformation Programme, focussing on ensuring maternity care is personal and safe and that the service user voice is fundamental to the training provided to staff.

The CCFv2 *(NHSE 2023)* sets out clear expectations for all Trusts, aiming to address known variation in training and competency assessment across England and is designed to facilitate maternity services in achieving other requirements such as the Maternity Incentive Scheme (MIS), the essential actions from the Ockenden Review *(2022)* and enhance the value of multidisciplinary team training as recommended in the Kirkup Report *(2022)*.

1.2 The Core Competency framework has 6 Core Modules which will be delivered as part of a 3-year Training Plan within SATH.

Module no.	Module name	Frequency of training
1	Saving Babies Lives Care Bundle v3	Yearly
2	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	Yearly
3	Maternity emergencies and multiprofessional training	Yearly with 3-year programme of scenarios
4	Equality, equity, and personalised care	3-year programme
5	Care during labour and the immediate postnatal period	3-year programme
6	Neonatal life support	Yearly

1.3 **Learning from results of audits, incidents, complaints and claims**
The CCF V2 training requirements have also been informed by themes from national reports such as HSIB *(2020)*, MBRRACE-UK *(2022)* and the Early Notification Scheme *(2022)*, as well as programmes for improvement such as the Saving Babies Lives Care Bundle v2 *(2019)* and the NHS Long Term Plan *(2019)***.**

The Maternity Specific Training provision is based on the 4 principles of the Core Competency Framework Version 2 (NHSE 2023) and includes learning from incidents, audit, service user feedback and investigation reports. Training also reinforces positive learning from examples of good practice and learning from excellence.

1.4 **Multiprofessional training**
Multiprofessional training within SATH is a standard part of professional's development both in routine and emergency situations. However, striving for more opportunities to develop team-based learning will help shared purpose and improved team working.

The implementation of the CCFv2 will be supported and regulated in accordance with Safety Action 8 of the Maternity Incentive Scheme (MIS) Year 5 within the Clinical Negligence Scheme for Trusts.

1.5 **The Guideline should be read in conjunction with the following Trust Policies**

Development and Training Policy – W11
Statutory and Mandatory Training Guideline - W32
Corporate and Local Induction – W36
Employee Performance Management Policy – W10
Disciplinary Policy -W7
Nursing and Midwifery Preceptorship Policy
SATH Education – Intranet home page
Learning Made Simple – Intranet home page

2.0 Aim

To maintain and optimise the safety of women and babies under the care of the Maternity services through on-going education and training for medical, midwifery and support staff

3.0 Objectives

3.1 To describe the Maternity Specific Mandatory Training requirements of all clinical staff groups within Maternity Services at Shrewsbury & Telford Hospitals NHS Trust.

3.2 To describe the roles and responsibilities of Managers and all employees in ensuring how this training will be systematically managed, monitored and reported.

3.3 To ensure the results of audit, learning from incidents, complaints, service user experience and national drivers from safety improvement strategies are incorporated into the training needs analysis (TNA)

3.4 To ensure that other training opportunities are only accessed by staff when they are able to demonstrate compliance with statutory, mandatory and maternity specific mandatory training

3.5 To ensure that Maternity Specific Training meets the National Training requirements of the CNST Maternity Incentive Scheme and NHSR Core Competency Framework

3.6 To provide a framework around training to support staff and address poor performance or attendance

4.0 Definitions

4.1 **Annual Training –** To demonstrate compliance**,** staff must have attended annual training within the last 12 months

4.2 **LMS -** Learning Made Simple (SATH Education Electronic Platform)

4.3 **PROMPT Faculty** - PROMPT training is facilitated by a multidisciplinary team of staff who have attended the PROMPT Train the Trainers workshop and have cascaded the training to other faculty members.

5.0 Process

5.1 Achievement of training and education- roles and responsibilities

Group	Responsibilities
Individuals	• Complete all required Trust Statutory and Mandatory risk management training and Maternity Specific Mandatory training as identified in the Maternity Specific TNA (Appendix 1) and LMS • Keep records to be able to provide evidence of training completed for monitoring purposes • Ensure that their induction requirements are signed off by their Line Manager/Educational Supervisor
Line Managers	• Identify individual staff training needs and competence at induction and annual appraisal. • Enable staff to attend required training • Monitor training compliance and follow up non-attendance • Book Staff training via the LMS and record on eroster
Staff that deliver or facilitate training	• Ensure that all attendance and non-attendance is recorded on a register for each training session and that the register is sent to the Education and Guidelines Coordinator to record on the LMS • Ensure that the content of the training session is recorded and that any deviation from this standard content is recorded and is available for audit purposes.
Obstetric Staff	• The Care Group Medical Director supported by Clinical Directors is responsible for all Permanent Obstetric Consultants, Associate Specialists and Staff Grades • The Royal College of Obstetricians (RCOG) Tutor is responsible for ensuring that Obstetric medical staff in training comply with local training requirements • The Care Group Medical Director supported by Clinical Directors has the overall responsibility for monitoring attendance for Medical staff and liaises with the Clinical Education Midwife regarding training requirements and attendance
Midwifery staff	The Director of Midwifery is accountable for all midwifery staff including: - Midwives - Women's Services Assistants - Maternity Support Workers - Health Care Assistants
Education Team	
Clinical Education Midwife	• Coordinates the provision and delivery of maternity mandatory training days and internal training events in liaison with educational leads from the other professional groups. • The CEM will monitor and report compliance with Safety 8 of the Maternity Incentive Scheme.
Practice Education Facilitators	• To oversee and facilitate the completion of mandatory training for midwives on the preceptorship programme and those completing the in-house bridging programme to become Maternity Support Worker's, (MSW's). • To oversee and facilitate International Recruitment within Maternity services at SATH.
Guidelines and Education Administration Coordinator	Provides administrative support to the Education and Guidelines team

5.1.2 **Maternity Training Faculty**

The Maternity Training Faculty is a working party made up of representatives from all the professional groups involved in maternity training to support planning, implementation, delivery and evaluation of all Maternity Education and training activity and meets a minimum of quarterly.

5.2 Trust Mandatory Training and Maternity Specific Mandatory Training

5.2.1 Statutory and Mandatory training needs for Medical, Midwifery and WSAs/MSWs/HCAs working within Maternity services are identified in the:

- Maternity Specific TNA (Appendix 1).
- Statutory and Mandatory Training Guideline - W32
- Corporate and Local Induction – W36
- Nursing and Midwifery Preceptorship Policy
- SATH Education - Learning Made Simple

5.2.2 As part of the requirements of the Maternity Incentive Scheme other staff groups working in Maternity will be required to attend Maternity Specific Training:

- Anaesthetists – PROMPT Training and Simulation of obstetric emergencies in clinical areas. 90% compliance is required, and compliance will be reported as part of the Maternity Incentive Scheme assessment.
- Theatre staff are part of the Multiprofessional team and will be encouraged to attend PROMPT Training where possible however attendance is not part of the Maternity Incentive Scheme assessment. Theatre staff will be included in simulation of obstetric emergencies in Clinical areas.
- Neonatal Unit Staff and Neonatologists will be required to attend an annual NLS update as part of the Maternity Incentive scheme assessment and 90% compliance for each staff group is required. Neonatal staff will also attend simulation of obstetric and neonatal emergencies as part of Multiprofessional team working.

5.3 Corporate Induction of Newly Appointed Clinical Staff working within Maternity Service

All new employees are required to undertake a Corporate Induction programme within 3 months of commencing employment in SATH (HR02). Compliance will be recorded on the LMS.

5.4 Local Induction and Preceptorship (Midwifery, Nursing Staff and Maternity Support Workers)

5.4.1 Newly appointed Midwives and WSA / MSWs/ HCAs working within Maternity (new registrant and experienced) will complete a Local Induction check list and orientation and training needs assessment with their Line Manager, following which an individualised induction programme is agreed.

5.4.2 Newly appointed midwives have supernumerary status for up to 72 hours; however, this is flexible to ensure the needs of the individual midwives are met.

5.4.3 All newly registrant midwives entering employment for the first time since qualifying will complete a 12-month Preceptorship programme, as outlined in the Nursing and Midwifery Preceptorship Policy and Preceptorship Programme Handbook.

5.5 Induction and Supervision of Medical staff – Obstetric

5.5.1 **Doctors in Training, General Practitioner Vocational Trainees (GPTS) and FY Doctors**

All medical staff in training will receive a local induction coordinated by the RCOG/RCPCH tutor RCOG education weblink

5.5.2 **Permanent Doctors: Consultant and Specialty Doctors**

All permanent Doctors will receive a local induction as outlined in the Corporate and Local Induction Policy (W36)

5.5.3 **External Locum Doctors (Agency or temporary NHS employees)**

A one-to-one personal induction is organised by the Consultant Obstetrician on call scheduled to the first shift but may be facilitated by the Tier 2 doctor on duty.

5.5.4 **Specialist Trainee Doctors**

Doctors in training will maintain a record of all their training within their logbooks (e portfolio) and it is the responsibility of the Consultants, acting as Educational Supervisors, to ensure they are adequately taught and supervised

All Doctors in training are required to provide evidence of formal assessment and competence via the OSATs (Objective Structured Assessment of Technical Skills) process before undertaking clinical procedures without direct supervision.

5.5.5 **Consultant and Speciality Doctors**

Medical staff will access training via the LMS and Training compliance should be reviewed as part of the annual appraisal process

5.6 System for ensuring staff attendance at training

5.6.1 Training compliance should be reviewed as part of the annual appraisal process for all professional staff groups.

5.6.2 Ward Managers will ensure that staff are booked on to Statutory and Mandatory Training days including Maternity Specific training. Study days for mandatory training will be recorded on Health Roster. All training days will be booked via Learning Made Simple on the SATH Education page on the intranet

Where annual compliance is required, training should be booked to attend prior to the expiry date.

Bank staff must be compliant with Trust Mandatory, Statutory and Mandatory Maternity Specific training prior to undertaking a bank shift.

5.6.3 Ward Managers should review staff attendance on a monthly basis by accessing Trust and Maternity Training compliance data on the LMS.

Ward Managers will report training compliance and action plans for non-compliance at the Performance review meeting with the Senior Leadership Team.

5.6.4 The Clinical Education Midwife will review training compliance monthly and provide a quarterly report to Maternity Governance highlighting any training that has fallen below 90%.

5.6.5 Compliance with the training requirements of the Core Competency Framework will be monitored monthly by the Clinical Education Midwife. Where training falls below the

required standard of 90% the Clinical Education Midwife will escalate to the Senior Leadership team.

5.7 System for follow up of those who fail to attend booked training days or are non-compliant with training requirements (Refer to appendix 3).

When staff fail to attend Mandatory training days the Education team or training facilitator will notify the Manager of the Day. The Care Group Medical Director will be notified by email when medical staff fail to attend booked training days.

An action plan will be agreed between the individual staff member and Ward Manager or Educational Lead and CEM. This action plan is recorded in the staff member's personal file and will be monitored by the Ward Manager or Educational Lead. Action may include immediate on-the-job training/awareness raising/coaching to reduce short term risk. Where a risk assessment demonstrates that there is a significant risk through the non-compliance the Line Manager/Educational lead will be required to take immediate action to reduce the risk which will include temporary change in duties whilst retraining is facilitated.

If a member of staff has not attended mandatory, statutory or maternity specific mandatory training within the last 12 months the Trust will prevent the member or staff from undertaking any non-mandatory training until all the required elements of mandatory training has been completed.

5.8 Standards for attendance and maintaining competence

5.8.1 The standard required for attendance at all Statutory and Mandatory Training is 100% for all staff groups, however, there will be occasions when an individual's compliance lapses because they are unable to undertake a required update in the time period required. These circumstances include: absence from work through sickness, maternity, or when new training is introduced and where completion will have a progressive standard to match the roll out programme.

5.8.2 **Demonstrating level of competence**

Where the TNA requires demonstration of a level of competence through an assessment process, please refer to specific training in appendix 4. Where that pass rate is not achieved, the Midwife or Doctor will be responsible for notifying their Line Manager of their failure to achieve the required level of competency and arrange a Mitigation Meeting with the Line Manager.

The aim of the Mitigation meeting will be to facilitate achievement of required competencies to include identification of additional training needs and consideration to adjustments within clinical practice.

5.8.3 **Safeguarding Training Compliance Monitoring**

In addition to SATH Statutory Safeguarding Training Midwives, WSAs / MSWs and Obstetricians working within Maternity are required to have **Level 3 Specialist Knowledge and Skills** as defined in the Intercollegiate document **Safeguarding Children and Young People Roles and Competencies of Health Care Staff January 2019.**

Where a member of staff has not completed the required safeguarding hours the Line Manager will arrange a Mitigation meeting to facilitate adherence to the Maternity Training Guideline and Safeguarding Training requirements within the Intercollegiate Document

5.9 'Live' Skills drills / Simulations

5.9.1 'Live' skills drills in the immediate management of obstetric and neonatal emergencies in clinical practice will be undertaken within all clinical areas providing staff levels and activity is at an acceptable level to conduct a live drill without compromise to clinical care.

5.9.2 Facilitation of Live Drills will be undertaken by relevant clinical specialists in conjunction with Educational Leads, Education Team and Ward Managers.

5.9.3 Live drills encourage multi professional team working with obstetricians, neonatologists, obstetric anaesthetists, Theatre staff, Midwives and support workers, test local processes and ensure staff are familiar with equipment and procedures in the local area (multi-professional team will be dependent on the location of the live drill and available staff).

5.9.4 The Live drills should be carried out on a minimum of a monthly basis. A record of Live drills undertaken in the Clinical areas will be maintained by the Education team. Feedback from the Live drill will be sent to the Matron and Manager of the Clinical area highlighting any good practice or any shared learning. As part of the Maternity Incentive Scheme all staff are required to attend at least one Emergency scenario in the clinical area every 12 months. This may be part of PROMPT training when training occurs within the clinical setting or as a Live drill conducted in the clinical area.

5.10 Coordinating Training records and archiving

5.10.1 Trust Risk Management Statutory and Mandatory Training attendance is maintained by the Corporate Education Team and compliance for Maternity is monitored by the ward managers and the Clinical Education Midwife. All e-learning certificates and evidence of self-directed booklet completion to be forwarded to the Education and Guidelines Coordinator

5.11 Continuing Professional Development

5.11.1 CPD is an essential requirement for all Registered Healthcare Professionals. It is the process by which individuals continue to increase their clinical and personal knowledge and skills for their role and keep up to date with developments in their discipline. It's an opportunity to reflect on the knowledge and skills they need to improve their clinical practice.

5.11.2 More information can be found on the trust intranet;
http://intranet.sath.nhs.uk/learning/CPD.asp

5.11.3 Individual members of staff can apply for funding via the link below;
http://intranet.sath.nhs.uk/Library_Intranet/documents/learning/Documents_and_Resources/Application%20for%20CPD%20Funding%202021.docx

5.12 Maternity Development Programme

5.12.1 Development opportunities for all staff exist within SATH. Please contact Line Manager for specific details around the Band 6 and 7 development programme and MSW development opportunities

5.12.2 **Enhanced Maternal Care Training**
Midwives who are part of the core team providing EMC (Enhanced Maternal Care) on Delivery Suite will complete an EMC Course at a designated University and undertake a

supernumerary placement in the Shrewsbury and Telford Hospital Critical Care department during which time they will complete the competencies as laid out in the SATH EMC Handbook.

Midwives who are deemed as competent in EMC will be required to continuously update and reflect on the enhanced skills they practice in line with the NMC (Nursing and Midwifery Council) Standards for Proficiency for Midwives (2019) and the NMC Code (2018). Core Team Midwives will attend an annual supernumerary placement in Critical Care to update and maintain skills.

6.0 Training

The Maternity Specific Training which is the subject of this guideline is identified in appendix 1. There is no training for staff or managers to implement this guideline.

7.0 Monitoring/audit

Compliance with this guideline / SOP will be audited as part of the Shrewsbury and Telford Hospital NHS Trust's five-year rolling programme of NICE and local guideline audits, unless circumstances require an earlier or more frequent audit. The audit will be carried out using the auditable standards and the results will be reported and acted on in accordance with the Trust Clinical Audit Policy (CG25).

8.0 References

Better Births: improving outcomes of maternity services in England – A Five Year Forward View for maternity care. (February 2016) Julia Cumberlege online www.england.nhs.uk/ourwork/futurenhs/mat-review

Knight M, Bunch K, Patel R, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2022.

Maternity Workforce Strategy – Transforming the Maternity Workforce March 2019

NHS National Bereavement Care Pathway (2020)

NHS England May (2023) Core Competency Framework Version 2: Minimum standards and stretch targets.

NHS England May (2023) How to Guide. A resource pack to support implementing the Core Competency Framework Version 2.

NHS England June (2023) Saving Babies Lives Version 3.

NHS England Avoiding Term Admissions into Neonatal Units Programme (2018)

NHS England May (2023) Three Year Delivery Plan for Maternity and Neonatal Care. Technical Guidance v1.0

NHS England NHS improvement. NHS patient safety strategy 2019 NHS England » The NHS Patient Safety Strategy

NHS Patient Safety Strategy: 2021 update Published February 2021

NHS Resolution May (2023) Maternity Incentive Scheme – Year 5

Final Report of the Ockenden Review (May 2022)

Royal College Of Nursing. Safeguarding Children and Young People: Roles and Competencies for HealthCare Staff. Intercollegiate Document. Fourth Edition : January 2019

Appendix 1: Training Needs Analysis Matrix

Training Requirements			Staff groups				
Training Topic Relevant to Role	Update Frequency	Mandatory	Midwives	WSA/ MSW	Consultant Obstetricians	Medical staff in training	GPTS
Day 1 PROMPT Maternity Obstetric Emergencies Training Day	12 months	Y	√	√	√	√	√
Day 2 Saving Babies Lives & Care during Labour and Immediate Postnatal period	12 months	Y	√	√	√	√	√ (optional)
Day 3 NLS and ABLS	12 months	Y	√	√			
Day 4 Fetal monitoring	12 months	Y	√		√	√	√ (optional)
Day 5 Equality, Equity and Personalised care	12 months	Y	√	√	√	√	√ (optional)
Safeguarding Children Training Level 3 Safeguarding Children and Young People: Roles and Competencies for HealthCare Staff. Intercollegiate Document.	4 Hours every 12 months	Y	√	√	√	√	As part of training programme

Training Topic Relevant to Role	Update Frequency	Mandatory	Midwives	WSA/ MSW	Consultant Obstetricians	Medical staff in training	GPTS
Area specific training							
MIST	4 yearly	Y	√ Community	√ Community			
Resuscitation Council Newborn Life Support (NLS)	4 yearly	Y	√ Community & Delivery Suite Coordinators	√ Community			
Enhanced Maternal Care Combined Training	3 yearly	N	√ Delivery Suite				
Pool Evacuation	2 yearly	Y	√	√			
Management of Epidural (Video and Assessment via LMS)	3 Yearly	Y	√ Delivery Suite				
Remifentanil PCA for analgesia in labour (Video and Assessment via LMS)	3 yearly		√ Delivery Suite				

Training Topic Relevant to Role	Update Frequency	Mandatory	Midwives	WSA/ MSW	Consultant Obstetricians	Medical staff in training	GPTS
eLearning							
Saving Babies Lives	3 yearly	Y	√		√	√	
Cultural Competency	3 yearly	Y	√	√	√	√	
Antenatal screening	12 months	Y	√				
ATAIN (Avoiding Term admissions into the Neonatal unit)	3 yearly	Y	√	√			
FGM	3 yearly	Y	√		√	√	
MIST eLearning	2 Yearly	Y	√ Community				
NBCP	Once	Y	√	√	√		

Training Topic Relevant to Role	Update Frequency	Mandatory	Midwives	WSA/ MSW	Consultant Obstetricians	Medical staff in training	GPTS
Place of Birth	Once	Y	√		√	√	
Perinatal Mental Health	Once	Y	√		√		
GAP eLearning	12 months	Y	√		√	√	
GROW Assessments	3 yearly	Y	√		√	√	
Miscellaneous							
ROBuST/ PROBust - Operative Birth Simulation Training	Once	Y			√	√	
UNICEF Baby Friendly Initiative	Once	Y	√	√			
Post Mortem Consent Training	Once	N			√	√	

Appendix 2

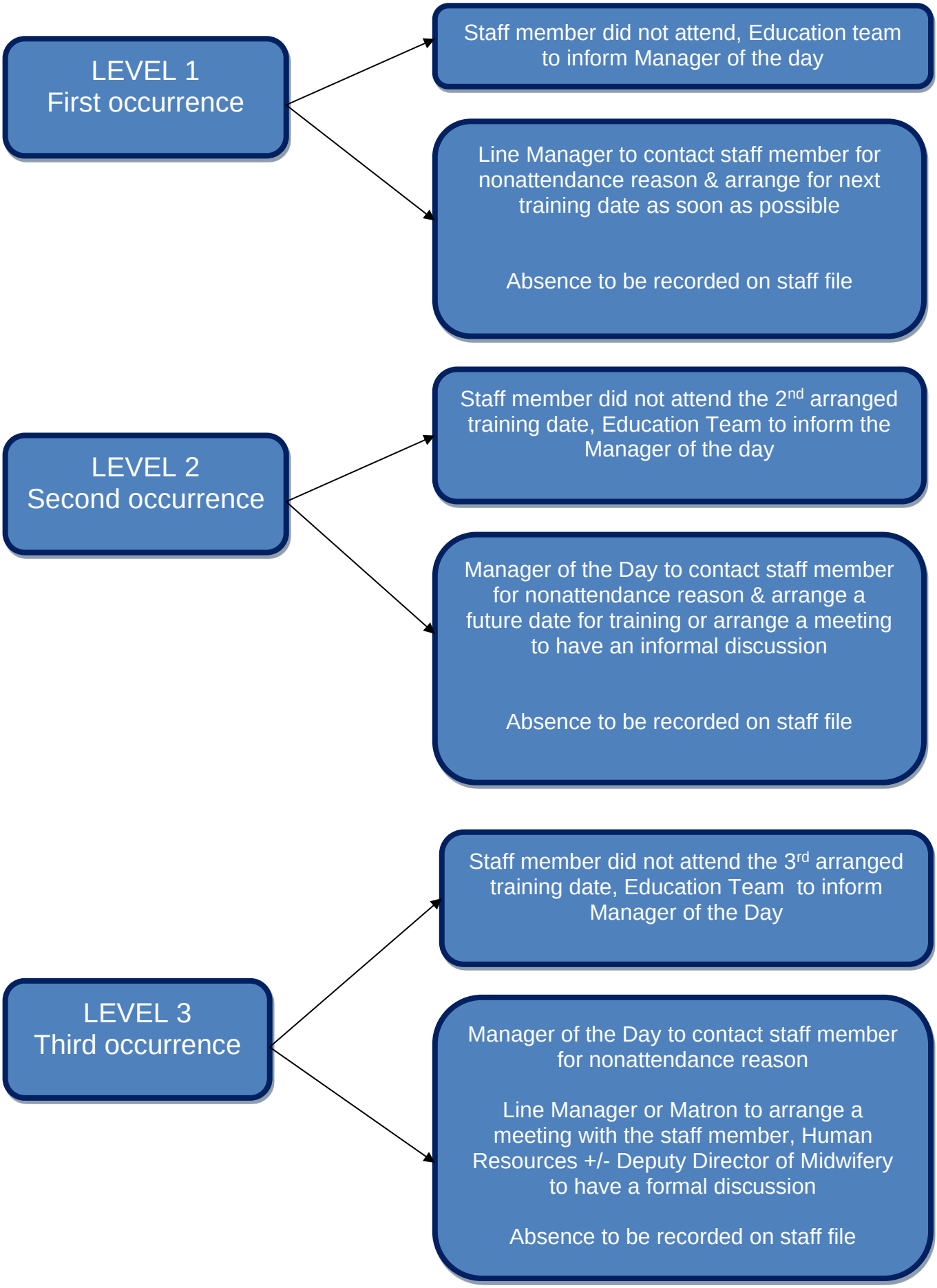
Additional Training for Specialised Roles

Specialist Roles Specific Training		
Specialist Role	Frequency	Additional Information
NIPE Practitioners		
Newborn Examination Course (NIPE)	Once	
Newborn Examination (NIPE) update	Annual	
Newborn Examination (NIPE) Competency assessment	Annual	
NIPE Smart Training	Once	
Named Midwives for Safeguarding		
Safeguarding Children Level 4	Once	Level 4 Training
Bereavement Midwife		
Awareness and Bereavement Foundation Course (CRUSE)	Once	
Perinatal Mortality Reviewer Training (West Midlands Clinical Network)	Once	
Post-mortem Consent	Once	
Professional Midwifery Advocate		
Trauma Resilience in Management (TRiM) training	Once	

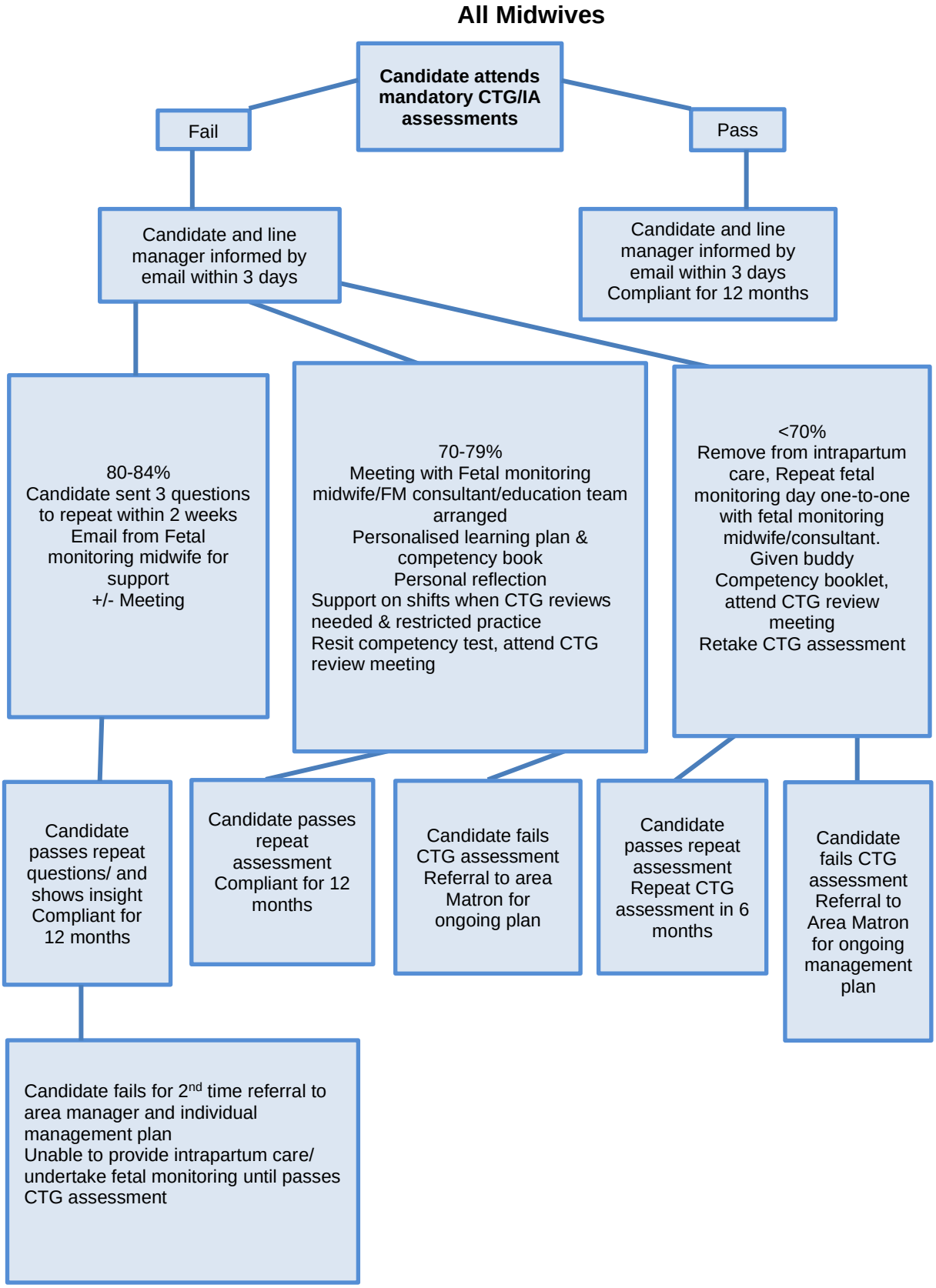
Professional Midwifery Advocate postgraduate course		Professional Midwifery Advocate to have completed bridging programme or full course
Infant feeding Specialist Midwife		
Ankyloglossia Management Course Advanced Clinical Skills		University module course –LBR Funded * Midwives who are nominated to complete frenulotomy training
International Board Certified Lactation Consultant (IBCLC)		75 hours of CPD over a 5 year period To include - Baby friendly Initiative (BFI) Maternity and Neonatal conferences which meet this requirement to include exam every 5 years.
Sonographers		
FASP Cardiac Training	2 yearly	4 Hours training
FASP Screening Training	Annually	4 Hours training
Doppler Training	Annually	All sonographers need to do a one-off 7.5 hours training and then an annual 1 hour update
PAC's Training/ Updates	Annually	2 hours training
View point Training	Annually	
EPAS Training	Annually	3.5 hours
Screening issues Training	Annually	3.5 hours
Ultrasound updates Training	Annually	3.5 hours
Newborn Hearing Screeners		
NHSP E-learning and competency assessment	Annual	

Diploma Health Screener	Once	For all new screeners training is staged e-learning, supervised screening and OSCE, Diploma to be completed within 1 year of commencing training
Newborn Life Support (NLS) in house	Annual	
Healthy Pregnancy Support Service		
National Centre for Smoking Cessation and Training (NCSCT) – certified practitioner course	Once	Mandatory for staff who provide Public Health Smoking Cessation Services
UNICEF Baby Friendly Initiative	Once	
Weight Management training eLearning	Annual	
Smoking cessation practitioner training (NCSCT-online qualification) and 2 day behavioural change training programme (face to face) *	Annual	**Annual update training after initial 2-day programme*
Immunisations in pregnancy training programme	Once	(*Band 5 HPSS co-ordinators only)*
Motivational interviewing	Once	

Appendix 3: **Failure to attend allocated Mandatory Training Days Guide**

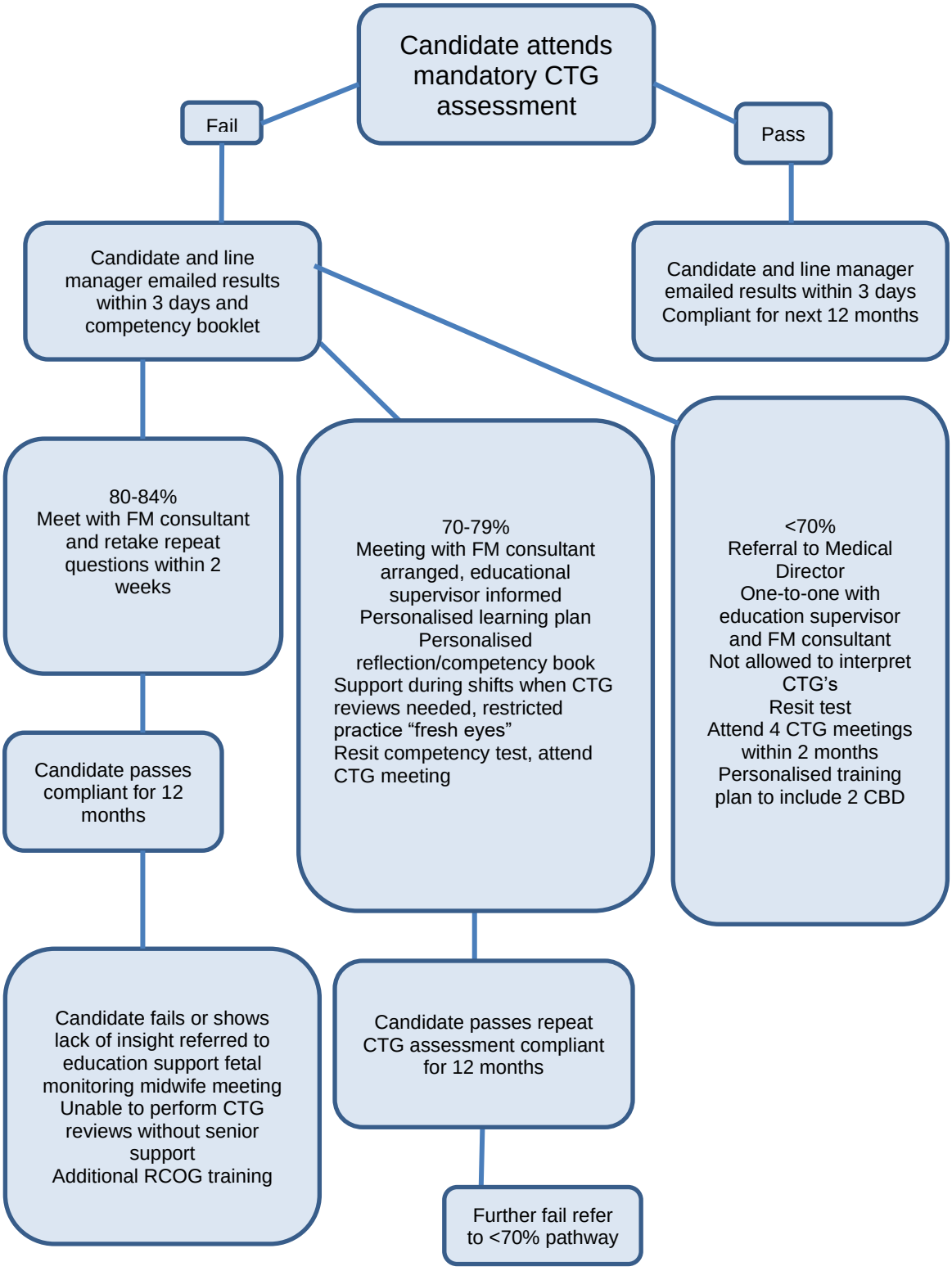


Appendix 4a - EFM Competency Assessment Pathways Fail pathways (2 pathways)



Appendix 4b EFM Competency Assessment Pathways

Obstetric Consultants and all other obstetric doctors



Core Competency Framwework Version 2 Training Needs Analysis

Core Competency 3 Year Plan

Core Competency Framework TNA	Link to CCF will be inserted here when the publication is finalised		Save new TNA each year, or as per any changes to show any developments																	
Date of agreement by LMNS each year:			**Training Faculty Meeting 26th April 2023. Maternity specific guideline and TNA ratified 21/8/23 Maternity Governance. 4/9/23 Guidelines Meeting - confirmed ratification. Training Faculty 5/9/23. LMNS / QSAC/ICB Gudienes sent 26/9/23**	**Content to be inputted. Plan for discussion at Training Faculty meeting in April 2024.**	**INSERT DATE** (Can attach meeting minutes here)															
			Year 1 August 2023	**Year 2 August 2024**	**Year 3 August 2025**											**Predicted staff expenditure perinatal team (WTE/Annum)**				
Core Competency Module	**Minimum standard**	**Stretch Target - Ambition/Aspiration**	**Training details**			**Monitoring system**	**Trust Compliance %**	**Mitigation/ Action Plan**	**Attend (Y/N)**	**Midwives**	**Attend (Y/N)**	**Maternity Care Assistants**	**Attend (Y/N)**	**Obstetricians**	**Attend (Y/N)**	**Anaesthetists**	**Attend (Y/N)**	**Theatre Staff**		
			Year 1	**Year 2**	**Year 3**															
										Total cost/year										
										WTE										
1. Saving babies Lives care bundle	90% attendance – annually for each element with eLfH module every 3 years Training must include learning from incidents, service user feedback and local learning Training must include local guidelines and care pathways E-learning can be appropriate for some elements. Learning must be responsive to local clinical incidents and service user feedback	≥95% attendance Shared learning from incidents across LMS and Buddy LMNS relating to morbidity & mortality. Benchmarking against other organisations with similar clinical profile and national programmes Staff evaluation on quality of training in place with evidence of improvement Service users share their experiences as part of training day Training to be tailored to role and place of work for each element.	SBL eLFH module if not completed within the last 3 years. MDT Day 2 - Lindsey and Guy Day 2 programme and presentation.Overview of SBL - Lindsey (CCF M4)	eLFH module if not completed within the last 3 years. MDT Day 2 - Lindsey and Guy Day 2 programme and presentation. Overview of SBL - Lindsey (CCF M4)	eLFH module if not completed within the last 3 years. MDT Day 2 - Lindsey and Guy Day 2 programme and presentation. Overview of SBL - Lindsey (CCF M4)	Compliance data will be recorded on the Trust LMS - Learning Made Simple and reported quarterly to Maternity Governance		Trusts to document mitigation/action plan if not compliant	**Please record data against module elements**									
			Lindsey case study	Lindsey case study	Lindsey case study															
Smoking in Pregnancy	Training must include:- All multidisciplinary staff trained to deliver Very Brief Advice to pregnant people and their partners NCSCT e-learning Local opt-out pathways/protocols, advice to give to pregnant people and actions to be taken. CO monitoring & discussion of result. Individuals delivering tobacco dependence treatment interventions should be fully trained to NCSCT standards	Smoke-free advisors have evidence-based behavioural training (i.e. CBT/Risk perception) Use of service user case study Every Contact Counts training Evidence of Specialist smoke-free advisors sharing briefings and national publications i.e. Maternal and Neonatal Health Safety Collaborative. Action on Smoking and Health (ASH) briefings for Integrated Care Systems	Day 2 Training day - 1 hour. Include training plan and programmme	Day 2 Training day - 1 hour. Include training plan and programmme	Day 2 Training day - 1 hour. Include training plan and programmme	Compliance data will be recorded on the Trust LMS - Learning Made Simple and reported quarterly to Maternity Governance		Trusts to document mitigation/action plan if not compliant	**Y**	£6,872	**Y**	£1,762	**Y**	£2,497	**N**	£0	**N**	£0
			Case Study	Case Study	Case Study					0.15		0.06		0.03		0.00		0.00		
Fetal Growth Restriction	Training must include:- local referral pathways, identification of risk factors and actions to be taken. Evidence of learning from local Trust detection rates and actions implemented Include symphysis fundal height measuring, plotting & interpreting results practical training and assessment, and case reviews from examples of missed cases locally	Use of service user case study Review of Trust's detection rates, compared to other similar organisations and national data Audit of compliance against training action plan developed as a result of incidents related to fetal growth restriction	GAP eLearning & case study Day 2	GAP eLearning & case study Day 2	GAP eLearning & case study Day 2	Compliance data will be recorded on the Trust LMS - Learning Made Simple and reported quarterly to Maternity Governance		Trusts to document mitigation/action plan if not compliant	**Y**	£13,745	**N**	£0	**Y**	£4,994	**N**	£0	**N**	£0
			Case Study Day 2	Case Study Day 2	Case Study Day 2					0.31		0.00		0.03		0.00		0.00		
Reduced fetal movements	Training must include:- Local pathways/protocols, and advice to give to pregnant people and actions to be taken. Evidence of learning from case histories, service user feedback, complaints and local audits	Use of service user case study Audit of compliance against training action plan developed as a result of incidents related to fetal movements	0.5 hours Fetal monitoring training day 0.5 hours SBL Day 2	0.5 hours Fetal monitoring training day 0.5 hours SBL Day 2	0.5 hours Fetal monitoring training day 0.5 hours SBL Day 2	Compliance data will be recorded on the Trust LMS - Learning Made Simple and reported quarterly to Maternity Governance		Trusts to document mitigation/action plan if not compliant	**Y**	£6,872	**N**	£0	**Y**	£2,497	**N**	£0	**N**	£0
			Fetal monitoring training Day - case study	Fetal monitoring training Day - case study	Fetal monitoring training Day - case study					0.15		0.00		0.03		0.00		0.00		
Fetal monitoring in labour	See Module 2	See Module 2	Refer to module 2	Refer to module 2	Refer to module 2	Refer to module 2		Trusts to document mitigation/action plan if not compliant	**Please record data in Module 2. Fetal Surveillance in labour (Below)**									
			Refer to module 2	Refer to module 2	Refer to module 2															

Preterm birth	Training must include:- Identification of risk factors, local referral pathways, All elements in alignment with the BAPM/MatNeoSIP optimisation and stabilisation of the preterm infant pathway of care A team-based shared approach to implementation as per local unit policy Risk assessment and management in multiple pregnancy	Evidence of impact using the improvement strategies to optimise preterm birth outcomes Use of clinical simulations Review of outcomes in relation to multiple births & identified improvement(s) Use of service user case study	0.5 hours Day 2 SBL update	0.5 hours Day 2 SBL update	PROMPT simulation 0.5 hour Day 2 SBL update	Compliance data will be recorded on the Trust LMS - Learning Made Simple and reported quarterly to Maternity Governance		Trusts to document mitigation/action plan if not compliant	Y	£6,872	Y	£1,762	Y	£2,497	Y	£847	Y	£317
			Case Study Day 2	Case Study Day 2	Case Study Day 2					0.15		0.06		0.03		0.01		0.01
Diabetes in pregnancy	Training must include:- identification of risk factors and actions to be taken referral through local multidisciplinary pathways including Maternal Medicine Networks and escalation to endocrinology teams Intensified focus on glucose management in line with NHS Long Term Plan & NICE guidance, including Continuous Glucose Monitoring Care in labour	Learning from local and national case reviews are disseminated Use of service user case study with diabetes in pregnancy	Day 2 Training day - 1 hour. DKA workshop PROMPT	2 yearly training	Day 2 Training day - 1 hour.	Compliance data will be recorded on the Trust LMS - Learning Made Simple and reported quarterly to Maternity Governance		Trusts to document mitigation/action plan if not compliant	Y	£10,309	Y	£1,762	Y	£3,745	N	£847	N	£0
			Case Study MVP Day 2 training	2 yearly training	Case Study MVP					0.23		0.06		0.04		0.01		0.00
2. Fetal monitoring and surveillance (in the antenatal and intrapartum period)	90% attendance Annual Update. All staff will have to pass an annual competency assessment that has been agreed by the local commissioner (CCG) based on the advice of the Clinical Network. Trusts should agree a procedure with their CCG for how to manage staff who fail this assessment. (Pass mark of 85%) 1 full day training in addition to the local emergencies training day Fetal monitoring lead trainers must attend annual specialist training updates outside of their unit Training must:- Be responsive to local clinical incidents, service user feedback and local learning, utilising local case histories. Include use of risk assessment at start of and throughout labour complying with fetal monitoring guidelines. Include antenatal fetal monitoring, intermittent auscultation and electronic fetal monitoring. Be tailored for specific staff groups e.g. Homebirth or birth centre teams Be multi-disciplinary & scenario-based. Include information about using the equipment that is available Include the fetal surveillance of multiple pregnancies Include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMNS.	≥95% attendance ≥95% pass mark/evaluation Use of positive case examples to learn from Shared learning across LMNS & Buddy LMNS. Benchmarking against other organisations with similar clinical profile and national programmes. Evidence of MDT case scenario discussions & shared with wider team to increase accessibility Evidence of improvement following staff evaluation on training when ≤95% feedback is evaluated as good or excellent Lead specialists are in collaboration with the national network of fetal monitoring specialists to support own learning, practice developments & evidence based care Wider training i.e. on neonatal HIE & nervous system physiology Intrapartum midwives attend additional high level training to support fetal monitoring knowledge on the ABC programme when available Independent external evaluation of local training	Fetal Monitoring Training day 7.5 hours	Fetal Monitoring Training day 7.5 hours	Fetal Monitoring Training day 7.5 hours	Compliance data will be recorded on the Trust LMS - Learning Made Simple and reported quarterly to Maternity Governance		Trusts to document mitigation/action plan if not compliant	Y	£72,161	N	£0.00	Y	£26,216.04	N	£0.00	N	£0
			Birth reflections Case study (MVP)	MVP case study	MVP case Study					1.62		0.00		0.29		0.00		0.00
3. Maternity Emergencies and multiprofessional training	90% of each relevant maternity unit staff group has attended an "in-house" MDT training day & include a minimum of 4 maternity emergencies with all scenarios covered over a 3-year period and priorities based on locally identified training needs Antepartum and postpartum haemorrhage Shoulder dystocia Cord prolapse Maternal collapse, escalation and resuscitation Pre-eclampsia/eclampsia severe hypertension Impacted fetal head Uterine rupture Vaginal breech birth Care of the critically ill patient Annual update Training should be face to face (unless in exceptional circumstances such as the Covid Pandemic) Training must:- Include the identification of deteriorating mother/baby and use of MEWS/MEOWS/NEWTT charts as locally relevant Include communication, escalation of care & use of tools such as SBARD Be sensitive and responsive to local safety insights, near misses or HSIB cases. Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan Use service user comments or feedback from investigations Maternal & Neonatal outcomes using exemplars from national programmes (i.e. NMPA/GIRFT/HSIB) Include at least one scenario from a learning from excellence case study. Be tailored for specific staff groups e.g. Homebirth or birth centre teams/ MSW. Include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. Include human factors training. Include at least one of the emergency scenarios to be conducted in the clinical area, ensuring full attendance from the relevant wider multi-professional team. This will enable local system and environmental factors within the clinical setting to be considered, any risks and issues identified and an action plan developed to address these.	≥95% attendance Shared learning across LMNS or network Programme of clinical simulations at point of care in variety of settings including community and evidence of learning, actions, feedback & debrief Staff evaluation on quality of training in place with evidence of improvement if ≤95% feedback is evaluated as good or excellent	PROMPT APH / PPH//PET //Maternal Resuscitation - Anaesthetic Emergency //Breech //shoulder dystocia// cord prolapse/// Human factors - Escalation & Civility (Theme for civility to be Psychological Safety) //// local cases (Feedback slides - HSIB cases / SI / Case study / Local Outcomes- NMPA/HSIB/GIRFT/ Learning from excellence case (Positive case study SU feedback) MSW workshop - communication / HOME BIRTH // DKA	PROMPT - APH/PPH// PET // Maternal resuscitation /Anaesthetic Emergency //Breech/Shoulder dystocia//Twins	PROMPT APH/PPH// IFH// PET// Uterine rupture// Maternal resuscitation// shoulder dystocia// Pre term birth	Compliance data will be recorded on the Trust LMS - Learning Made Simple and reported quarterly to Maternity Governance		Trusts to document mitigation/action plan if not compliant	Y	£41,235	Y	£10,570	Y	£14,981	Y	£6,779	Y	£3,808
			Learning from Risk / audit / local cases	Learning from Risk / audit / local cases	Learning from Risk / audit / local cases					0.92		0.37		0.17		0.07		0.09

4. Equality, Equity and Personalised Care	90% attendance (3 yearly programme of all topics) Training should cover local pathways and key contacts when supporting women, pregnant people & families. Training must include learning from incidents, service user feedback and local learning Must include local guidance, referral procedures and 'red flags' One topic from each list must be covered as a minimum, identified from unit priorities, audit report findings and locally identified learning, involving aspects of care which require reinforcing and national guidance:- List A Ongoing antenatal and intrapartum risk assessment and risk communication Maternal mental health Bereavement Care List B Personalised Care and Support Planning (including plans when in use locally) Informed decision making, enabling choice, consent & human rights Equality & Diversity with cultural competence	≥95% attendance Involving MNVPs/Service Users in coproducing and/or delivering training based on lived experiences. Service user feedback gained from PCSP audits are embedded into training Benchmarking against other organisations with similar clinical profile and national programmes Training on learning disabilities & Autism that is maternity specific is embedded in personalised care training Equality & diversity training includes unconscious bias; LGBTQ Risk assessment & risk communication includes genetic risk Staff evaluation on quality of training in place with evidence of improvement where ≤95% feedback is evaluated as good or excellent Yearly training on any subject Stakeholder support i.e. SANDS involved in supporting delivery of training	**Maternity Specific Training Day 5 List A.** Maternal Mental Health **List A.** Bereavement **List B** Equality and Diversity with cultural competence **List B** PROMPT - Informed choice / Consent/ Human rights **Stretch** - Learning disabilities / autism//// Day 2 - Ante natal screening -genetic risk	**Maternity Specific Training Day 5 List A.** Ongoing Ante natal and intrapartum risk assessement and risk communication (PROMPT) - Bereavement - Maternal Mental Health	**Maternity Specific Training Day 5 List A** Bereavement and Maternal Mental Health **List B** Personalised Care and support planning	Compliance data will be recorded on the Trust LMS - Learning Made Simple and reported quarterly to Maternity Governance		Trusts to document mitigation/action plan if not compliant	**Y**	£58,416	**Y**	£11,451	**Y**	£21,223	**Y**	£1,695	**Y**	£635
			Case Studies from MVP	Case Studies from MVP	Case Studies from MVP					1.31		0.37		0.24		0.02		0.02
5. Care during Labour and Immediate Postnatal Period	90% attendance (3 yearly programme of all topics) Training must:- Include learning from incidents, audit reviews and investigations, service user feedback and local learning Learning from themes identified in national investigations e.g. HSIB Have a focus on deviation from the norm and escalating concerns Include national training resources within local training e.g. OASI, ROBUST, Prevention & Optimisation of premature birth etc. Be tailored for specific staff groups depending on their work location and role e.g. Homebirth or birth centre teams/ MSW Subjects must include:- Management of labour including latent phase VBAC and uterine rupture GBS in labour Management of epidural analgesia and recovery care after general anaesthetic Operative vaginal birth Pelvic Health & Perineal Trauma – prevention of & OASI pathway and PFMT Multiple Pregnancy Infant Feeding ATAIN	>95% attendance of relevant staff group Shared learning across LMNS Benchmarking against other organisations with similar clinical profile and national programmes Staff evaluation on quality of training in place with evidence of improvement where ≤95% feedback is evaluated as good or excellent Use of service user case studies & service users to share their experiences	**Subject 1.** Infant feeding (I. 75 hour) Day 5 **Subject 2**. ATAIN (0.5 Day 2) **Subject 3**. Epidural workbook LMS videos **Subject 4** PFHS (Day 2)	**Subject 1**. Multiple pregnancy (1.0 PROMPT) **Subject 2.** Management in labour latent phase (PROMPT 1.0 or PCC) **Subject 3** - Infant feeding update (Day 2)	**Subject 1.** VBAC uterine Rupture **(1.0 PROMPT)** **Subject 2**. Operative Delivery **(1.0 PROMPT)** **Subject 3.** GBS (0.5 PROMPT) **Extra** - Infant feeding update (Day 2) Pre term birth **(PROMPT)**	Compliance data will be recorded on the Trust LMS - Learning Made Simple and reported quarterly to Maternity Governance		Trusts to document mitigation/action plan if not compliant	**Y**	£27,490	**Y**	£3,523	**Y**	£9,987	**Y**	£1,695	**N**	£0
			MVP Case studies	MVP Case studies	MVP Case studies					0.62		0.12		0.11		0.02		0.00
6. Neonatal Basic Life Support	90% attendance at a neonatal basic life support annual update either as an in-house neonatal basic life support training or Newborn Life Support (NLS) Only registered RC trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates Training must:- Be 'hands-on' and scenario based and tailored to learning from incidents, service user feedback and local learning priorities. Include knowledge and understanding of NLS algorithm. Include recognition of the deterioration of black and brown babies Include recognition of deteriorating newborn, action to be taken and local escalation procedures, and the use of SBARD handovers (or local equivalent). Include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. Include human factors. Be tailored for specific staff groups depending on their work location and role, e.g. Homebirth or birth centre teams/ MSW. Cover scenarios in different environments and must include training on use of the equipment available in those environments to ensure staff are familiar.	≥95% attendance Attendance on separate certified NLS training for maternity staff should be locally decided but this would be the gold standard with updates every 4 years. Evidence of MDT point of care simulation programme, attendance records and learning from them with innovative practices to ensure wide attendance from all staff groups/unsocial shifts/community staff Learning from national investigations & programmes e.g. HSIB & ATAIN Benchmarking against other organisations with similar clinical profile and national programmes Staff evaluation on quality of training in place with evidence of improvement plans where ≤95% feedback is evaluated as good or excellent Use of service user case studies and parents sharing their experiences	Resus Day 3 - NLS 2 hours PROMPT - Sim Community / MLU Midwives and Delivery Suite Coordinators will attend Resuscitation Council course NLS every 4 years MIST Training 4 yearly for Community and MLU staff	Resus Day 3 - NLS 2 hours PROMPT - Sim Community / MLU Midwives and Delivery Suite Coordinators will attend Resuscitation Council course NLS every 4 years MIST Training 4 yearly for Community and MLU staff	Resus Day 3 - NLS 2 hours PROMPT - Sim Community / MLU Midwives and Delivery Suite Coordinators will attend Resuscitation Council course NLS every 4 years MIST Training 4 yearly for Community and MLU staff	Compliance data will be recorded on the Trust LMS - Learning Made Simple and reported quarterly to Maternity Governance		Trusts to document mitigation/ action plan if not compliant	**Y**	£17,181	**Y**	£4,404	**Y**	£1,248	**Y**	£847	**Y**	£317
			Content - NLS Algorithm. Escalation / SBAR. Deteriorating newborn Pschological safety - civility. Assessment of Black and Asian babies / Practical stations - Community and Consultant Unit	Feedback from MVP	Feedback from MVP					0.38		0.15		0.01		0.01		0.01

Expenditure Input Data

Department inputs (table 1)		
	Annual Head Count	Annual Mid Point Salary
Midwives	300	£44,671.00
Maternity Care Assistants	120	£28,628.00
Obstetricians	54	£90,161.00
Anaesthetists	32	£103,269.00
Theatre staff	30	£41,257.00

Department Outputs (table 2)			
	Total AnnualCost	Total Annual WTE	Total hours training
Midwives	£261,154	6	38
Maternity Care Assistants	£35,234	1	20
Obstetricians	£89,884	1	36
Anaesthetists	£12,710	0	8
Theatre staff	£5,078	0	8
Total	£404,059		

Additional cost for Community Midwives MIST £5,735

MSWs / WSAs £1,607

NLS £5735 plus £4162.5 (£185 pp over 4 years)

Overall adjusted total annual cost 421,298.50 Maternity £403510.5

Table 3

Training Module	Groups	Input Data: Training Hour(s) per staff member per year(all blended learning to be added as a total)	Outputs: Total Annual Cost	Outputs: Annual WTE
1. Saving babies Lives				
Smoking in Pregnancy	Midwives	1	£6,872	0.15
	Maternity Care Assistants	1	£1,762	0.06
	Obstetricians	1	£2,497	0.03
	Anaesthetists	0	£0	0.00
	Theatre staff	0	£0	0.00
Fetal Growth Restriction	Midwives	2	£13,745	0.31
	Maternity Care Assistants	0	£0	0.00
	Obstetricians	2	£4,994	0.06
	Anaesthetists	0	£0	0.00
	Theatre staff	0	£0	0.00
Reduced fetal movements	Midwives	1	£6,872	0.15
	Maternity Care Assistants	0	£0	0.00
	Obstetricians	1	£2,497	0.03
	Anaesthetists	0	£0	0.00
	Theatre staff	0	£0	0.00
Fetal monitoring in labour (this will be the same as below)	Please record data in Module 2. Fetal Surveillance in labour (Below)			
Pre-term birth.	Midwives	1	£6,872	0.15
	Maternity Care Assistants	1	£1,762	0.06
	Obstetricians	1	£2,497	0.03
	Anaesthetists	0.5	£847	0.01
	Theatre staff	0.5	£317	0.01
Diabetes in pregnancy	Midwives	1.5	£10,309	0.23
	Maternity Care Assistants	1	£1,762	0.06
	Obstetricians	1.5	£3,745	0.04
	Anaesthetists	0.5	£847	0.01
	Theatre staff	0	£0	0.00
2. Fetal surveillance in labour	Midwives	10.5	£72,161	1.62
	Maternity Care Assistants	0	£0	0.00
	Obstetricians	10.5	£26,216	0.29
	Anaesthetists	0	£0	0.00
	Theatre staff	0	£0	0.00
3. Maternity emergencies	Midwives	6	£41,235	0.92
	Maternity Care Assistants	6	£10,570	0.37
	Obstetricians	6	£14,981	0.17
	Anaesthetists	4	£6,779	0.07
	Theatre staff	6	£3,808	0.09
4. Personalised Care	Midwives	8.5	£58,416	1.31
	Maternity Care Assistants	6.5	£11,451	0.40
	Obstetricians	8.5	£21,223	0.24
	Anaesthetists	1	£1,695	0.02
	Theatre staff	1	£635	0.02
5. Care during Labour and Immediate PN Period	Midwives	4	£27,490	0.62
	Maternity Care Assistants	2	£3,523	0.12
	Obstetricians	4	£9,987	0.11
	Anaesthetists	1	£1,695	0.02
	Theatre staff		£0	0.00
6. Neonatal life support	Midwives	2.5	£17,181	0.38
	Maternity Care Assistants	2.5	£4,404	0.15
	Obstetricians	0.5	£1,248	0.01
	Anaesthetists	0.5	£847	0.01
	Theatre staff	0.5	£317	0.01

Neonatal Input Data

Department inputs (table 1)		
	Annual Head Count	Annual Mid Point Salary
Neonatologists		£44,671.00
Neonatal Nurses		£28,628.00

Department Outputs (table 2)			
	Total AnnualCost	Total Annual WTE	Total hours training
Neonatologists	£0	0.00	2
Neonatal Nurses	£0	0.00	2
Total	£0		

Table 3				
		Input Data	Outputs	
Training Module	Groups	Training Hour(s) per staff member per year (all blended learning to be added as a total)	Total Annual Cost	Annual WTE
3. Maternity emergencies	Neonatologists		£0	0.00
	Neonatal Nurses		£0	0.00
6. Neonatal life support	Neonatologists	2	£0	0.00
	Neonatal Nurses	2	£0	0.00

Maternity TNA Appendix 3: 5 Day Programmes

Maternity Specific Mandatory Training Day 1 PROMPT (8.5 hours)						
Session time	Sessions			Training req. Year 1	Suggested staff groups for session	Trainer
08:05 - 08:15	Registration					
08:15 - 08:30	Introduction: What do you want out of the day? (Slido)					*Faculty*
08:30 – 08:45 08:45 – 09:30 09:30 – 10:00	Team of the shift (15 mins) Paper Chains Human Factors Escalation / Civility (Psychological safety) (45 mins) Personalised Care – group work (30 mins)			CCF M3 HF content to be agreed with LMNS CCF M4	MW, WSA / MSW, Anaesthetist, Obstetrician, Theatre	*Faculty*
	Simulations / Case studies					
09:45– 10:30	APH / PPH (Community transfer)	Eclampsia/Pre-Eclampsia Workshop	Anaesthetic Emergencies – high block	CCF M3	MW, WSA / MSW, Anaesthetist, Obstetrician, Theatre	*Faculty*
10:30 – 11:15	Eclampsia/Pre-Eclampsia Workshop	Anaesthetic Emergencies – high block	APH / PPH (Community Transfer)	CCF M3	MW, WSA / MSW, Anaesthetist, Obstetrician, Theatre	*Faculty*
11:15- 11:30	**Coffee Break**					
11:30– 12:15	Anaesthetic Emergencies – high block	APH / PPH (Community Transfer)	Eclampsia/Pre-Eclampsia Workshop	CCF M3	MW, WSA / MSW, Anaesthetist, Obstetrician, Theatre	*Faculty*
12:15 – 12:45	Feedback Session - Learning from Excellence – Case study to be agreed			CCF M3	MW, WSA / MSW, Anaesthetist, Obstetrician, Theatre	
12:45 – 13:15	**Lunch**					
13:15- 13:45	Risk / Governance / Quality / Local learning from Incidents/ Audit			CCF M3	MW, WSA / MSW, Anaesthetist, Obstetrician, Theatre	*Risk team*
13:45 – 14:15	Workshop 1. DKA Maternal Critical Care Midwives /Obstetricians		Workshop 2 WSAs- Content tbc	CCF M3	MW, WSA / MSW, Anaesthetist, Obstetrician	*Anaesthetist PEF*
	Workshops					
14:15 – 14:55	Shoulder Dystocia	Vaginal Breech Birth	Cord Prolapse escalation / communication	CCF M3	MW, WSA / MSW, Obstetrician	*Faculty*
14:55 – 15:10	Coffee Break					
15:10 – 15:50	Vaginal Breech Birth	Cord Prolapse escalation / communication	Shoulder Dystocia	CCF M3	MW, WSA / MSW, Obstetrician	*Faculty*
15:50 – 16:30	Cord Prolapse escalation / communication	Shoulder Dystocia	Vaginal Breech Birth	CCF M3	MW, WSA / MSW, Obstetrician	*Faculty*
16:30 – 17:00	Feedback session – SD audit / Breech/ Cord			CCF M3	MW, WSA / MSW, Obstetrician	*Faculty*
17:00	Key learning points & Evaluation feedback sheet – Finish					

Maternity Specific Mandatory Training Day 2 (7.5 hours)				
Session Time	Sessions	Training requirement	Suggested staff group	Trainers
08:30 – 08:45	Registration and Introduction			Education Team
08:45 - 09:15	Student Supervision and Assessment		Midwives	CPF
09:15 -09:45	Antenatal Screening update Includes Genetic screening	CCF M4	Midwives and Medical Staff	Jan Baker
09:45 – 10:00	Break			
10:00- 11:00	Saving Babies Lives update Pre-term birth case study GROW case study	CCF M1 SBL V3	All staff	Vicki Birch
11:00 – 12:00	Smoking in Pregnancy includes case study	CCF M1 SBL V3	All staff	Lindsey Reid & Lead Obstetrician
12:00 – 12:30	Lunch			
12:30 – 13:30	Diabetes includes case study	CCF M1 SBL V3	All staff	Sarah Davies & Lead Obstetrician
13:30 – 14:00	ATAIN update	CCF M5	All staff	ATAIN Lead
14:00 – 14:30	Pelvic health & perineal trauma – prevention of & Oasi pathway and PFMT	CCF M5	Midwives and Obstetricians	PFMT Team
14:30 – 16:00	Maternity Specific eLearning			
1.5 hours	Ante Natal Screening	KPI	Midwives	*Annual*
1.5 hours	ATAIN	CCF M5	Midwives	*3 yearly*
1 hour	FGM	CCF M4	Midwives & Medical staff	*3 yearly*
1 hour	Saving Babies Lives	CCF M1	Midwives & Medical staff	*3 yearly*
1 hour	Cultural Competency	CCF M4	Midwives & Medical staff	*3 yearly*
1.5 hours	MIST eLearning		Community MLU & Midwives	*4 yearly*
1 hour	NBCP Bereavement	Existing training	New starters	*Once*
1 hour	Place of Birth	Existing training	New starters	*Once*
1 hour	Perinatal Mental Health	Existing training	New starters	*Once*

Maternity Specific Mandatory Training Day 3 (7.5)				
Session Time	Sessions	Training requirement	Suggested staff group	Trainers
09:30- 11:15	ABLS	CSTF	Midwives & WSAs/MSWs	Resuscitation Officers
11:15 – 11:30	Break			
11:30 – 13:30	Newborn Life Support	CCF M6	Midwives & WSAs/MSWs	NLS Instructors
14:00 – 14:30	Lunch			
14:30 – 17:00	GROW assessments OASI bundle / Perineal suturing workshop / Medical devices eLearning	SBL v3 CCF M5 CSTF	Midwives	PEF

Maternity Specific Mandatory Training Day 4 (7.5 hours) Fetal Monitoring Training Day DRAFT Version 1.0				
Session time	**Sessions**	**Training requirement**	**Suggested staff groups for session**	**Trainer's name (Role)**
08.30-09.00	Introduction & setting the scene. The Race		Midwives and Medical Staff	
09.00-10.00	Fetal Physiology and Types of Hypoxia	CCF M2	Midwives and Medical Staff	
10.00-10.30	Intermittent Auscultation	CCF M2	Midwives and Medical Staff	
10.30-11.00	Break			
11.00-12.00	Group work – IA for community or Wrekin Midwives Cord gases for Delivery Suite/AN/Triage and Drs (other staff to decide which group they want to join)		Midwives and Medical Staff	
12.00-13.00	Antenatal Fetal monitoring and reduced Fetal Movements.		Midwives and Medical Staff	
13:00 – 13:30	***Lunch***			
13.30-14.30	A little goes along way- starfish story. Case Studies to include meconium, chorioamnionitis & Multiple pregnancies.	CCF M2	Midwives and Medical Staff	
14.30-15.00	Video with lighthouse women, discussing appropriate word use and Human factors	HF content to be agreed with LMNS – CCF M2	Midwives and Medical Staff	
15:00– 15:15	Coffee Break			
15.15-15.45	Assessment		Midwives and Medical Staff	
15.45-16.30	Feedback			

Maternity Specific Mandatory Training Day 5 (8.5 hours)				
Session time	**Sessions**	**Training requirement**	**Suggested staff groups for session**	**Trainer's name (Role)**
08:30 – 08:40	Registration			
08:40 – 08:45	Introduction Personalised care activity			
08:45 – 10:15	Infant Feeding BFI	CCF M5	Midwives / WSAs/ MSWs	*Infant feeding Specialist*
10:15 – 10:30	Break (Infant feeding update Medical staff)			
10:30 – 11:30	Equality and Diversity Cultural competency	CCF M4	MW, WSA / MSW, Obstetrician	*EDI Lead Midwife*
11:30 – 13:15	Bereavement	CCF M4	MW, WSA / MSW, Obstetrician	*Specialist Midwife*
13:15 – 13:45	***Lunch***			
13:45 – 15:45	Maternal Mental Health	CCF M4	MW, WSA / MSW, Obstetrician	*MDT Team*
15:45– 16:00	Coffee Break			
16:00 – 17:00	Learning Disabilities & Autism *Pre requisite : Oliver McGowan training – National requirement eLearning 2 hours*	CCF M4	MW, WSA / MSW, Obstetrician	*Community Lead* *MPFT Lead for LD and Autism*
17:00	Key learning points & feedback sheet – Finish			

MIST – DRAFT				
Session time	**Sessions**	**Training requirement**	**Suggested staff groups for session**	**Trainer's name (Role)**
09:00	Registration	CCF M3	*Community MW/MSW/WSA/ Paramedics*	
09:15 – 09:45	Introduction/ Ice Breaker activity		*Community MW/MSW/WSA/ Paramedics*	
09:45	Midwife Lecture – Managing birth complications in the home Personalised care Calling for help – contact numbers for support Stabilisation and Transfer Roles and Responsibilities Familiarisation with kit	CCF M3 M4	*Community MW/MSW/WSA/ Paramedics*	
	Coffee Break			
TBC	Simulation 1 Obstetric Emergency – APH / PPH	CCF M3	*Community MW/MSW/WSA/ Paramedics*	
TBC	Paramedic Lecture - Ambulance transfer Roles and responsibilities Use of ACR	CCF M3	*Community MW/MSW/WSA/ Paramedics*	
	Lunch			
TBC	Simulation 2 Cord Prolapse and transfer into ambulance	CCF M3	*Community MW/MSW/WSA/ Paramedics*	
TBC	Case Study- MVP	CCF M3	*Community MW/MSW/WSA/ Paramedics*	
	Coffee Break			
TBC	Simulation 3 Management of Shoulder Dystocia in the home	CCF M3	*Community MW/MSW/WSA/ Paramedics*	
TBC	Simulation 4 NLS and transfer to Hospital using ACR	CCF M3	*Community MW/MSW/WSA/ Paramedics*	
TBC	Waterbirth in the home	CCF M3	*Community MW/MSW/WSA/ Paramedics*	
TBC	Additional content TBC		*Community MW/MSW/WSA/ Paramedics*	

Maternity TNA Appendix 4: Human Factors Lecture

Teamworking , Communication Leadership Situational Awareness Escalation Toolkit RCOG Psychological safety

PROMPT Aug 23 – July 24

Sue Rutter

ANNUAL UPDATE 2022/23
PROMPT
PRactical Obstetric Multi-Professional Training®

each baby counts
learn & support

IDENTIFY COMMUNICATE ACT

TEAM OF THE SHIFT

TEAM WORK, CIVILITY, PSYCHOLOGICAL SAFETY

Team of the shift: Promoting excellence in teamwork. At the start of each shift, ask yourself...

Do I know everyone on shift today?
Do I know who I'm going to escalate concerns to?
Have I said thank you to a colleague?
Have we celebrated our successes together?
Have I checked if my colleagues are okay at the beginning and end of each shift?

ADVICE * INFORM * DO

COMMUNICATE

Make clinical escalation precise and concise using safety critical language to communicate concerns

Begin conversations with:

“I need Advice”
“I need to Inform”
“I need you to Do”

TEACH OR TREAT

ACT

Promoting respectful learning conversations between colleagues. Respond kindly, quickly and appropriately using

TEACH “Tell me what you think and why, I’ll do the same so we can discuss”
or
TREAT “Let’s take action to the clinical escalation”

each baby counts + learn & support

Positive Changes Seen in Units Who Have Implemented these Interventions

Teach or Treat

- Staff feel more empowered, confident and psychologically safe to ask questions
- Promoted learning environments
- Rationales behind decision-making explained
- Women find it reassuring and respectful
- Framework for concise communication

AID

- Escalation made more precise and direct
- Standardized conversations
- Better than SBAR
- Especially helpful for night shift calls
- Staff more confident when escalating to consultants
- Most improvement in communication between Band 7 coordinators and consultants

TOS

- Similar to sign in and sign out of the surgical checklist
- Great to identify who was there/skill mix for shift
- Supportive of staff's individual needs
- Helped students, junior and new staff
- Staff feel appreciated

Practical exercise 5 mins – TOS

- Identify all the staff on shift that day, including job role and length of shift
- Identify the team leaders, including those who will be escalated to
- Flatten hierarchies by giving everyone a voice and encouraging first name introductions
- Support staff by creating psychological safety, encouraging them to raise concerns and speak up
- Identify anyone in the team who may need additional support that day
- Identify learning needs for trainees and students
- Create a positive workplace culture by thanking staff and celebrating successes
- Foster a culture of kindness and civility
- Eliminate cultures of criticism, including “toxic handovers”
- Foster a sense of teamwork, mutual respect, and create a shared mental model of the team’s workload, priorities, and potential challenges that shift

Introduction to Fatigue Tool RCoA

FATIGUE TOOL

Make sure your colleagues get home safely

S L E P T

Do they feel **SLEEPY?**

Has it been a **LONG** shift?*

Are they relying on caffeine or **ENERGY** drinks to stay awake?

Do they need a **POWER nap?**

Do they look **TIRED?** Are they finding it hard to concentrate?

If the answer to any of these is "YES" Take Action! Don't let them NOD off!

N O D

NAP before driving home; miss rush hour & feel more alert.

Are there **OTHER ways to get home** than driving? Train, taxi, bus, tram, walk, get a lift?

DRIVING when tired is DANGEROUS!

***Remember to EXCEPTION REPORT in England, if the work schedule has been breached.**

Produced by the Association of Anaesthetists Trainee Committee and the Fatigue Working Group 2017

Association of Anaesthetists

The Faculty of Intensive Care Medicine

RCOA Royal College of Anaesthetists

Association of Anaesthetists is the brand name used to refer to both the Associaion of Anaesthetists of Great Britain & Ireland and its related charity, AAGBI Foundation (England & Wales no. 293575 and in Scotland no. SC040697).

www.anaesthetists.org/fatigue

Check on the individuals you get handover from
Consider where you could rest in PRH prior to home

ANNUAL UPDATE 2022/23 PROMPT PRactical Obstetric Multi-Professional Training

PROMPT Faculty – Team of the shift

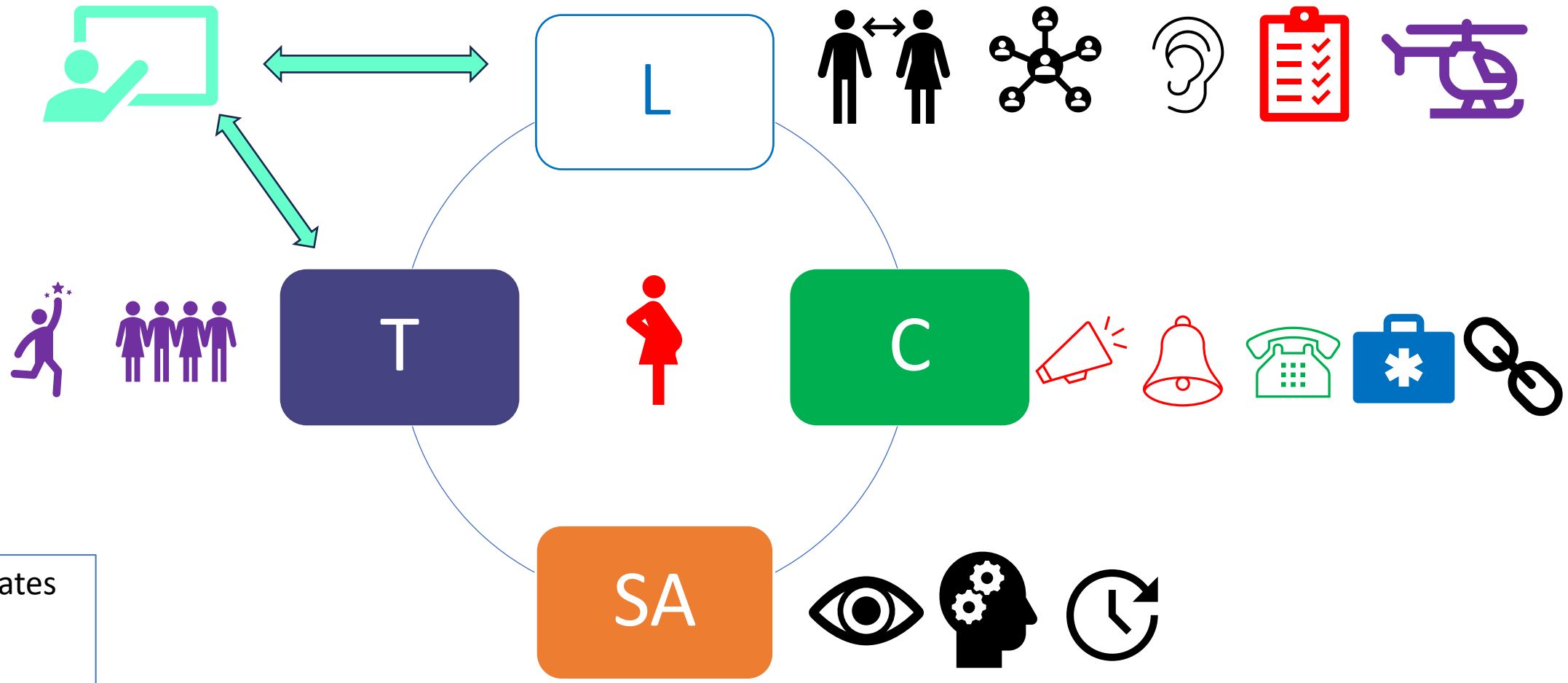
- We know all the team and roles
- Thanks to Chris +++ and the Team +++
- Celebrate success - that we have a new programme ++
- Apprehensive esp without Chris – support needed from anaesthetic colleagues on day
- Support needed from all of you
- Learning Needs – feedback

Ice breaker – 3 mins

SLIDO.com

Code on flipchart

Safe Teams



SBARR – formulates
AID, TOT , TOS
QUIET , RESET
CHECKLISTS
MEWS

2222

<u>MOH (urgent bloods)</u> **Obs cons** **Tier 2,** **Tier 1** **Porters** **Path lab** **Anaes cons ODP , Scrub , Recovery . Coordinator**	**<u>Arrest</u>** **Porters x2** **Resus officer** **Med reg** **Anaes reg** **Security** **Outreach**
<u>Neonatal</u> ANNP Neonatal reg Cons neonates Coordinator	<u>Obs emergency team</u> Obs cons , Tier 2 , Tier 1 Anaesthetist, ODP, Scrub , Recovery LW Coordinator

HOW TO DO IT

State team you need

State situation eg SD ,

Location eg rm 4 delivery suite

If MOH put phone down and call blood bank back, if need more than 1 team eg obs and neonates – repeat

Ice breaker – 3 mins

Civility and Workplace Behaviour

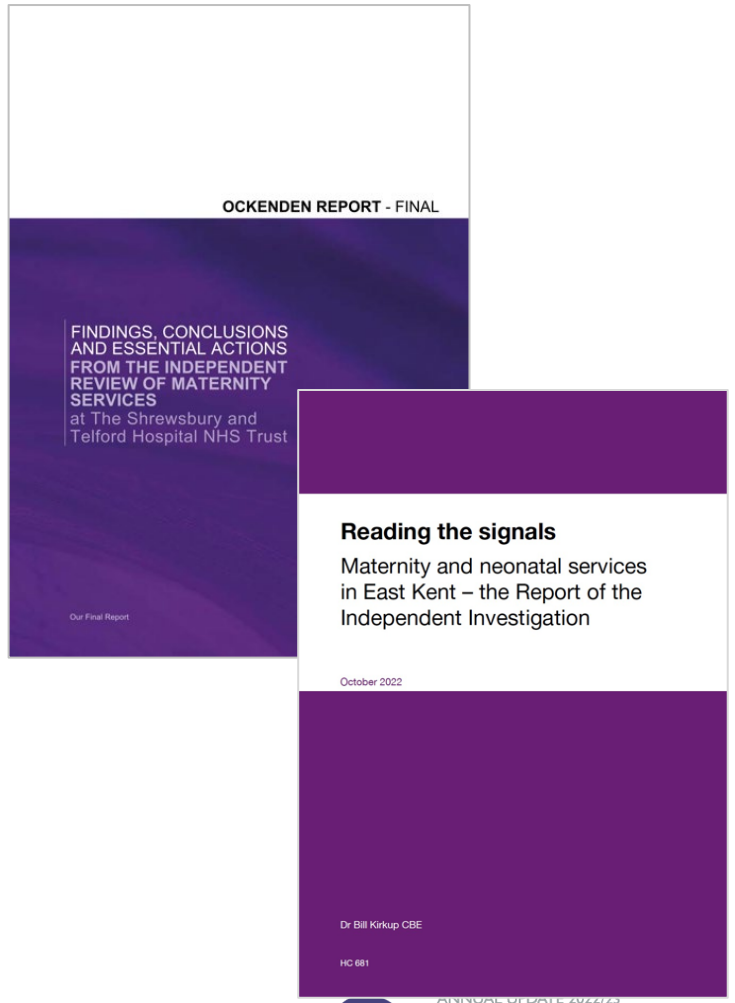
ANNUAL UPDATE 2022/23

PROMPT

PRactical Obstetric Multi-Professional Training®

Introduction

- Emerging evidence that workplace behaviour and incivility can significantly impact individuals, the team and the quality of care provided
- Staff shortages
  - Anxiety, stress, depression account for over 20% of sickness absence
- Ockenden
  - Lack of psychological safety
  - Members of the multi-professional team did not feel able to call out incivility and negative workplace culture
  - Mandated regular training in all units
- Kirkup 2022
  - *"dysfunctional working"*
  - Multiple reports of bullying and harassment, undermining behaviour



Seven features of safety in maternity units

ORIGINAL RESEARCH

OPEN ACCESS

Seven features of safety in maternity units: a framework based on multisite ethnography and stakeholder consultation

Elisa Giulia Liberati ,[1] Carolyn Tarrant,[2] Janet Willars,[2] Tim Draycott,[3,4] Cathy Winter,[4] Karolina Kuberska,[1] Alexis Paton,[5] Sonja Marjanovic,[1,6] Brandi Leach,[6] Catherine Lichten,[6] Lucy Hocking,[6] Sarah Ball,[6] Mary Dixon-Woods,[1] The SCALING Authorship Group

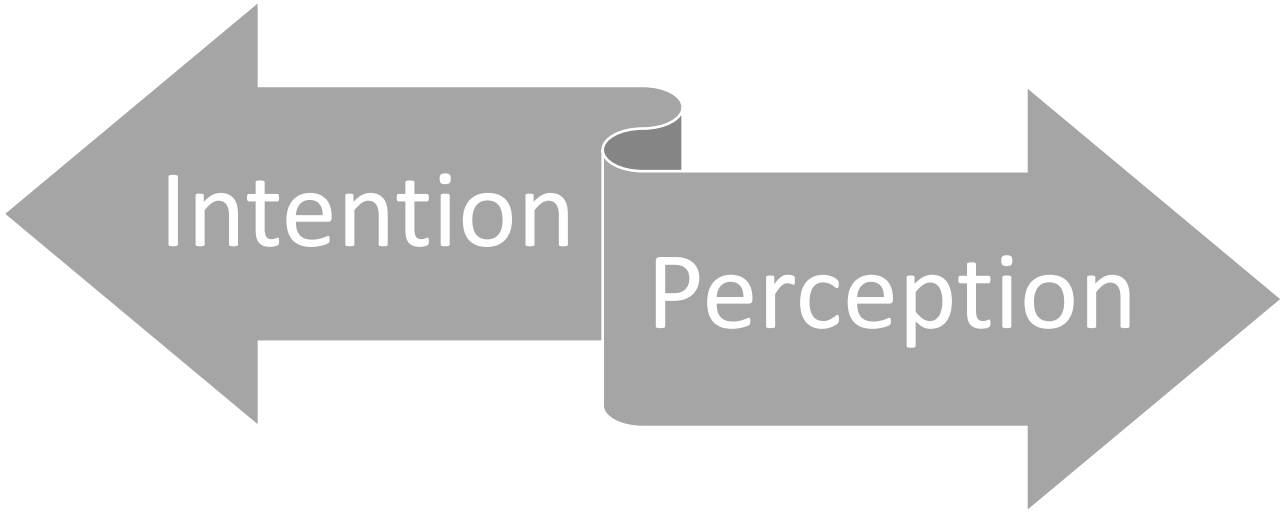
- Teamwork, cooperation and positive working relationships
- Constant reinforcing of safe, ethical and respectful behaviours

Civility Saves Lives

Perception of incivility

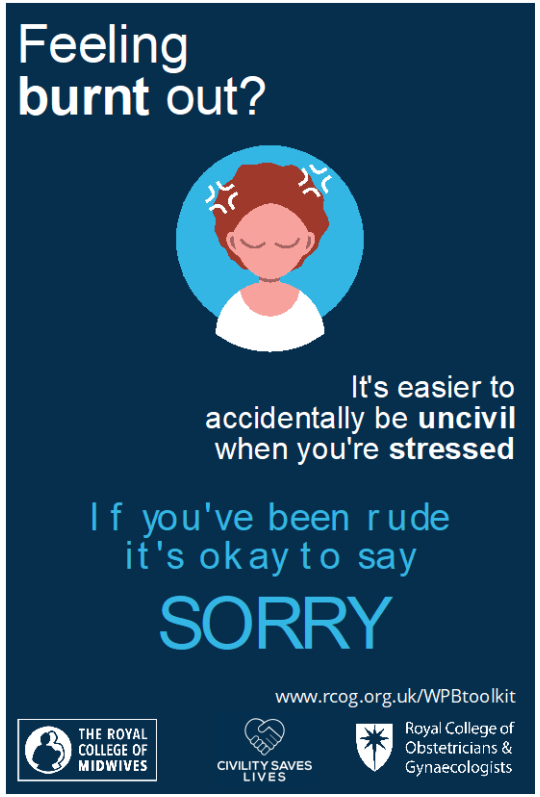
- Harmful and hurtful comments are often:
  - consequences of lack of thought
  - Unintentional

- However, the impact is dependent on how they are perceived by the receiver



- Reflection
  - Why bad, sad, mad ?
  - Vice versa

Solutions to Incivility – RCOG/RCM workplace behaviour toolkit



RCOG workplace behaviours toolkit – module 8 – practical approaches to calling it out

ANNUAL UPDATE 2022/23
PROMPT
PRactical Obstetric Multi-Professional Training

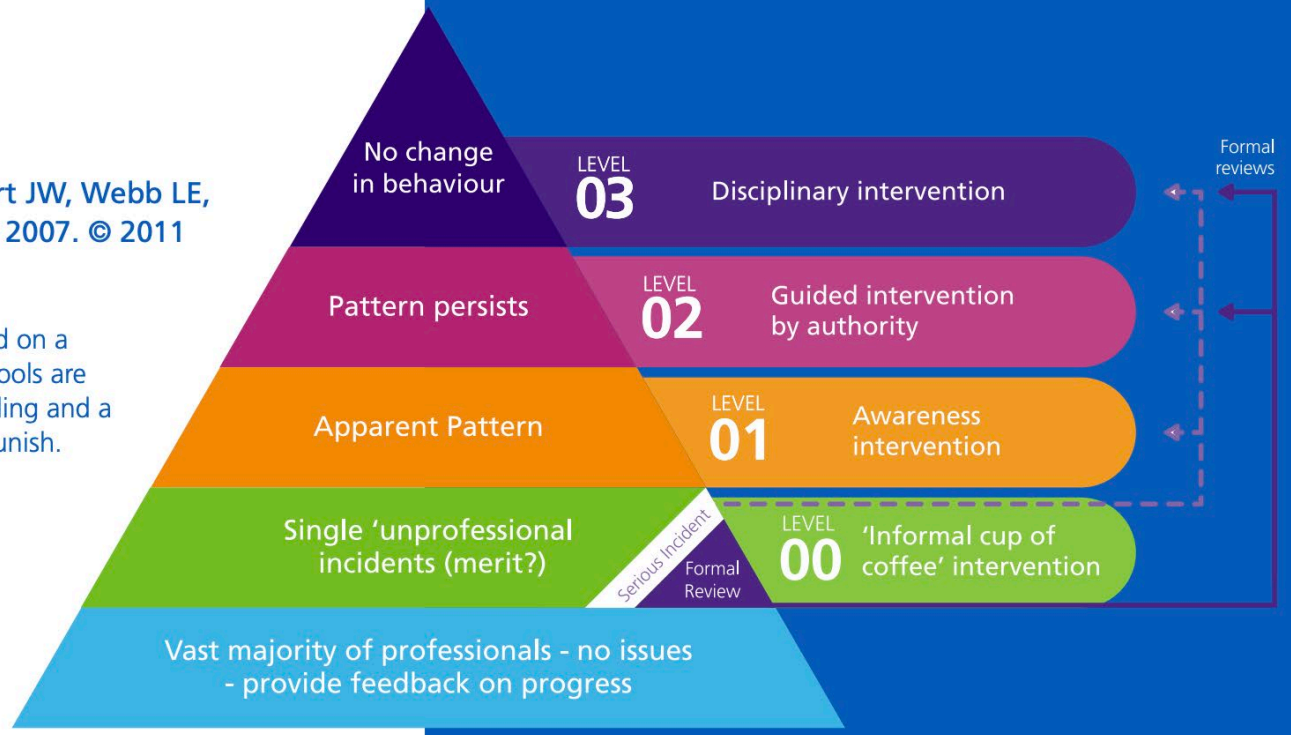
Professionalism Pyramid

Figure 1:

Promoting professionalism pyramid

Adapted from Hickson GB, Pichert JW, Webb LE, Gabbe, SG. Acad Med November 2007. © 2011 Vanderbilt University

The approaches in this toolkit are based on a supportive and corrective stance. The tools are intended to bring about an understanding and a change behaviour, not to blame and punish.



Psychological safety

What is it ? What are the 4 components ??

ANNUAL UPDATE 2022/23

PROMPT

PRactical Obstetric Multi-Professional Training®

Psychological safety – its not just being “nice”
Commitment to excellence and innovation

parabol

Psychological safety [is] a **shared belief** held by members of a team **that the team is safe for interpersonal risk taking**

Amy Edmondson
Harvard Business School

The 4 Key Stages of Psychological Safety in the Workplace

Understanding ModernGov

1. Inclusion Safety

Whether you're in a team of 5 or 25, all members must feel included and welcomed without discrimination of any sort.

2. Learner Safety

Now you feel included and welcomed, it's time to get comfortable being present in situations and start asking questions, looking for feedback and even experimenting in the environment.

3. Contributor Safety

Let's participate! You should feel open to contributing ideas and thoughts without fear of penalisation.

4. Challenger Safety

Now you're fully submerged into the team, you can now challenge the way the team works, brainstorms ideas or even senior members.

Psychological Safety

Organisational:

- Safety Culture
- Continuous improvement culture
- Organisational Support
- Familiarity across teams

Team:

- Leader behavioural integrity
- Status, hierarchy and inclusiveness
- Change oriented leadership
- Leader support
- Peer Support
- Familiarity leader
- Familiarity team members

Individual:

- Professional responsibility
- Individual differences

Cultural Change

Finally

Within organisations, resilience doesn't lie *within* the individual but lies *between* individuals and therefore, the more the bonds *between* individuals are supported, the better their mental health will be.

Key Learning Points

- National reports have highlighted the impact of negative workplace culture on maternity care
- Incivility directly reduces not just the clinical performance of the victim; incivility also negatively impacts the wider team, all of which impairs care provision
- Well functioning maternity units are characterized by positive working relationships and constant reinforcing of respectful behaviours
- Small steps in calling out incivility and negative behaviours in the workplace can lead to positive changes in the wider culture

Board of Directors' Meeting: 14th December 2023

Agenda item		162/23 Paper 1 within CNST INFORMATION PACK **Appendix 10**		
Report Title		Safety Action 8 Training Compliance Report		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Karen Henderson, Clinical Education Midwife		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Maternity Governance Committee, October 2023 W&C Divisional Committee Meeting, October 2023 Quality and Safety Assurance Committee, October 2023 LMNS/PNQSG, November 2023		
Executive summary:		This report provides an update on the requirements and training plans for Safety Action 8 following the release of the Maternity Incentive Scheme Year 5 on 31st May 2023. The report includes training compliance figures as of 6th October 2023 • Maternity Incentive scheme : Prompt, Fetal Monitoring and Newborn Life Support • Trust Statutory and Mandatory Training highlighting where training compliance does not meet the minimum requirement of 90% The Preceptorship programme and MSW development packages are now well established within Maternity Services and the report includes updates on progress. International Recruitment is now in place to support the current workforce and 10 Internationally Educated Midwives have been recruited and are currently undertaking OSCE preparation.		
Recommendations for the Board:		The Board is asked to: Receive this report in line with CNST Safety Action 8.		
Appendices:		None		

1.0 Introduction

1.1.1 CNST Maternity Incentive Scheme Safety Action 8

The NHSR Maternity Incentive Scheme Year 5 was published on 31st May 2023 and set out the requirements for Safety Action 8. Further guidance was issued in July 2023 *(NHSR Maternity Incentive Scheme V1.1 July 2023)*

The standard for Year 5 requires:

1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.
2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.
3. The plan is developed based on the "How to" Guide developed by NHS England.

The relevant timeframe and compliance requirements have been amended in the revised document and is described as:

- *12 consecutive months should be considered from 1st December 2022 until 1st December 2023 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for Trust boards to review.*
- *It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv1 (NHSR)*

1.1.2 Core Competency Framework V2

The new training programme commenced in August 2023 with the additional training days being introduced between August and September due to staffing capacity.

2.0 Maternity Specific Training Compliance figures as of 6th October 2023

A minimum of 90% compliance is currently required for the following training as part of the Maternity Incentive Scheme reporting for Year 5.

- PROMPT Maternity Obstetric Emergencies (2.1.1)
- Newborn Life Support (2.1.2)
- Fetal Monitoring Training (2.1.3)

2.1.1 PROMPT MDT Training Compliance as of 6th October 2023

PROMPT MDT	July 2023	August 2023	September 2023
Midwives	96.6%	96.8%	97.49%
Obstetric Consultants	100%	100%	100%
Other Drs	100%	88%	96.15%
WSA /MSW	89%	89%	96.05%
Anaesthetists	84%	79%	88.57%

2.1.2 Newborn Life Support Training compliance as of 6th October 2023

NLS	July 2023	August 2023	September 2023
Midwives	95.1%	95.18%	92.05%

2.1.3 Fetal Monitoring Training compliance as of 6th October 2023

Designation	July 2023	August 2023	September 2023
Midwives	95.1%	95.58%	96.82%
Consultants	95%	94.7%	100%
Other Doctors	100%	96%	100%

2.1.4 Saving Babies Lives : GROW Competency Assessment compliance as of 6th October 2023

Designation	Compliance
Bridgnorth Community / Ludlow Community	100%
Oswestry Community Team	100%
Maternity Outpatients RSH PRH	 100% 88.89%
Ward 21 /22	94.87%
Consultant Obstetricians	87.50%
Other Drs (Excludes GPVTS and Fy1)	54.54%

The 3 Year Training plan for the CCF version 2 also includes:

- Mandatory Day 2 - Saving Babies Lives (2.1.5)
- Mandatory Day 5 - Equality, Equity and Personalised Care * new training
- eLearning (2.1.6)

Compliance data is currently broken down into skills such as Infant feeding and Smoking in pregnancy on the LMS. A request has been made to report as attendance by staff groups at each training day and this work is ongoing.

Day 2 Compliance can only be reported as a skill and in order to provide a progress update the skill relating to Smoking in Pregnancy has been used as this training has been delivered on Day 2 for a number of years.

2.1.5 Mandatory Training Day 2 Compliance by Department as of 6th October 2023

Day 2 Training	Quarter 2 September 2023
Bridgnorth Maternity Unit	100%
Ludlow Maternity Services	100%
Maternity Scanning Department (PRH)	95%
Midwifery Management	100%
Oswestry Maternity Unit	87.5%
Shrewsbury Maternity Outpatients	100%
Shrewsbury Midwifery Team	100%
Specialist Midwives	100%
Telford Maternity Outpatients	100%
Ward 24 - Delivery Suite (PRH)	95/74%
Wrekin Midwife Led Unit	97.87%
Ward 21/22 - Postnatal/Antenatal (PRH)	91.80
Maternity Services	96.12%

2. 1 .6 Maternity Specific eLearning - overall compliance for Maternity Services

Training	Quarter 1 June 2023	Quarter 2 September 2023
Ante natal Screening eLearning	54.05%	62.75%
ATAIN eLearning (Midwives) (WSA / MSW)	75.92% 42.68%	79.92 53.95%
Bereavement eLearning (Midwives) (WSA / MSW)	70.71% 42.68%	73.59% 56.58%
GAP eLearning	55%	62.66%
MIST eLearning	29.41%	38.71%
Perinatal Mental Health eLearning Midwives WSA/MSWs	59.11% 57.32%	62.66 67.11
Place of Birth eLearning	73.33%	78.54%
Saving Babies eLearning	56.76%	56.94%
Management of Epidural	Not recorded **New training on LMS*	60%

3.0 Trust Mandatory and Role Specific Training

Trust Mandatory and Role Specific Training is reported monthly as part of the Trust SSU Compliance Report. A minimum of 90% compliance is required.

3.1.1 Trust Statutory / Mandatory Training (CSTF) compliance by department as of 6th October 2023

Department	Quarter 1 June 2023	Quarter 2 September 2023
Bridgnorth Maternity Services	↓93.33%	↑94.67
Ludlow Maternity Services	↓98.25%	↑99.22
Maternity Scanning Department	↑92.42%	↓90.00
Screening Department	↑100%	↓98.96
Oswestry Maternity Services	↑81.82%	↑85.42
Midwifery Management	↑97.44%	↓93.44
Shrewsbury Outpatients	↑93.33%	↓85.33
Shrewsbury Midwifery Team	↑86.79%	↑89.77
Specialist Midwives	↑97.24%	↓95.95
Telford Outpatients	↑90.99%	↓83.33
Ward 21 Postnatal Ward 22 Antenatal	↑97.27%	↓94.98
Ward 24 Delivery Suite	↑94.83%	↓94.70
W&C Assurance Team	↑100.00%	↓88.89
Wrekin MLU and Community	↑88.02%	↓84.96
W&C Management	↓78.82%	↑86.00
Medical Staff Obs and Gynae	↓73.05%	↑88.39
Medical Staff Obs and Gynae Senior	↓90.06%	↑90.26
Maternity Services Total	↑93.35%	↓92.14%

3.1.2
Role specific and Trust CSTF below 90%

The following has been reported as below 90% compliance in Quarter 2. Although compliance is showing an upward trajectory 90% has not been achieved in some of the key areas. Data from the last quarter highlighted improvement needed with compliance for MCA / DOLS , ABLS and Preventing Radicalisation.

- MCA / DOLS- overall compliance has increased very slightly but still below the required 90% (3.1.3)
- Preventing Radicalisation – overall compliance is now over 90% but some areas are still below 90% and this should be addressed in PRM meetings with Ward Managers
- ABLS – overall compliance has dropped below 90% at the end of this quarter. Availability of places has been confirmed and a reminder being sent to Ward Managers (3.1.4)

The focus for the next quarter is on all areas highlighted within Table 1.0

Table 1.0

Training below 90%	**Quarter 1 June 2023**	**Quarter 2 September 2023**
ABLS	↑90.21%	↓89.51
MCA / DOLS	↓77.51%	↑78.68%
Patient Moving and Handling	↑83.77%	↓81.59
Information Governance and Data Security Awareness	↓86.70%	↓85.60
Infection, Prevention and Control Level 2	↑85.67%	↓74.77
Food Safety	↑90.70%	↓89.01
Donning and Doffing	↑75.22%	↑75.45
Learning Disabilities	↑80.35%	↑82.62%
Blood Transfusion Admin Theory	↑71.79 / 57.99%	↑79.31% / 63.41%

3.1.3 ***MCA / DOLS Training compliance by department as of 6th October 2023***

Department	**Quarter 1 June 2023**	**Quarter 2 September 2**
Bridgnorth Maternity Services	100.00%	100%
Ludlow Maternity services	↑100.00%	100%
Maternity Scanning Department	↓77.27%	↑80%
Oswestry Maternity Services	↑77.78%	↑88.89%
Midwifery Management	100.00%	↓50.00%
Shrewsbury Outpatients	↓60.00%	↑80.00%
Shrewsbury Midwifery Team	↑85.00%	↑94.74%
Specialist Midwives	↓90.00%	↓68%
Telford Outpatients	↓73.33%	73.33%
Ward 21 Postnatal Ward 22 Antenatal	↓75.41%	↑90.32%
Ward 24 Delivery Suite	↓75.47%	↓71.58%
W&C Assurrance Team	No data available	No data available
Wrekin MLU and Community	↓75.93%	↑77.08%
W&C Management	No data available	No data available
Medical Staff Obs and Gynae	↓58.33%	↑62.50%
Medical Staff Obs and Gynae Senior	↓78.26%	↑86.36%
Maternity Services Total	↓**77.51%**	↑**78.68%**

3.1.4 Adult Basic Life Support compliance by department as of 6th October 2023

Department	Quarter 1 June 2023	Quarter 2 September 2023
Bridgnorth Maternity Services	100%	100%
Ludlow Maternity services	100%	100%
Maternity Scanning Department	↓77.27%	↓65%
Oswestry Maternity Services	↑100.00%	100%
Midwifery Management	↑100.00%	100%
Shrewsbury Outpatients	↓80.00%	↓60%
Shrewsbury Midwifery Team	↑100.00%	↓94.74%
Specialist Midwives	↑85.71%	↑92%
Telford Outpatients	↓93.33%	↑100%
Ward 21 Postnatal Ward 22 Antenatal	↓93.44%	↑93.55%
Ward 24 Delivery Suite	↑92.45%	↓87.37%
W&C Assurrance Team	No data available	No data available
Wrekin MLU and Community	↑83.33%	↑91.67%
W&C Management	↓66.67%	↑75%
Medical Staff Obs and Gynae	↑66.67%	↑75%
Medical Staff Obs and Gynae Senior	↑95.65%	↓90.91%
Maternity Services Total	↑90.21%	↓89.51%

4.0 Risks and actions

4.1 Data Recording and Reporting of Maternity Training Compliance

4.1.1 **Compliance monitoring:**

Maternity Specific Training compliance is now accessed via the SSU compliance report on the Corporate X Drive. However issues around access to compliance data for Bank Staff and Medical staff remains ongoing.

The requirements for Fetal Monitoring training for all medical staff has still not been set on the LMS due to technical issues within the system. The Education Team continue to ensure that all Medical staff are booked to attend Fetal Monitoring Training and where compliance does not meet the requirements a process for escalation to the Medical Director is in place.

The Maternity Training Monitors will continue to be used to provide figures for the following staff groups :

- Obstetric Medical staff on rotation programme (Other Drs) – PROMPT / Fetal Monitoring / GROW assessments
- Anaesthetists working in Maternity– PROMPT

Bank Staff Compliance is not reported on the SSU report and Ward Managers are responsible for ensuring that all staff working within their clinical areas are compliant with training prior to booking Bank shifts. This has been escalated to the Senior Leadership Team and Managers have been asked to provide names of any Bank staff working in their clinical areas, for compliance reporting.

4.1.2 **Pool Evacuation Training**

Compliance figures are being recorded on the LMS for pool evacuation training however there appears to be a discrepancy in figures and is pending further review by the LMS team.
Some training sessions have also been cancelled due to availability of facilitators within the Manual Handling Team. Additional sessions are being made available with a training proposal being considered within the team. An additional member of staff to the team has recently been recruited. Training places are available for booking via the LMS.

4.1.3 **Medicines Management – Records of Compliance**

The Prescribing and Administration eLearning is now accessible via the LMS. The audiences are currently being applied and compliance data will be available via the LMS once the work around audiences has been completed. This work remains ongoing.

4.1.4 **Live Drills in Clinical Areas**

The CCF version 2 requirement for reporting of attendance at insitu simulation has been updated in the July 2023 guidance document.

'At least one emergency scenario needs to be conducted in the clinical area or at point of care. You need to ensure that 90% of your staff attend a minimum of one emergency scenario that is held in the clinical area, but not all of the scenarios have to be based in a clinical area'

At least one simulation during PROMPT has been delivered in the clinical area once training was moved back to the the Walker Training Suite in May 2023.

Live drills are also delivered where staffing and acuity allows. Discussions with Theatre Education Facilitators and Lead for Simulation in the Trust are taking place and plans to ensure regular MDT simulation with Theatre staff being developed.

4.1.5 **Epidural and Remifentanil Works Books**

An Management of Epidural teaching video developed by the Anaesthetic Lead for Maternity Training has now been uploaded on the to LMS where staff will complete a self verification once this training has been completed.

4.2 Action Plan for for non compliance with training

4.2.1 Ward Managers are required to review the LMS for training compliance for their clinical areas on a regular basis and report to the Head of Midwifery as part of Performance Review Meetings.

Where staff are non compliant with training the Ward Manager will meet with the individual to discuss how training compliance can be improved.

4.2.2 Ward Managers and Matrons are notified of any non attendance at training days by the Education Team and will rebook the training following discussion with the individual staff member.

The Manager of the Day is now notified of any non attendance at training days once the register has been taken and is responsible for following up the reason for non attendance with the individual.

4.3 Availability of Training Rooms

PROMPT continues to take place within the Walker Training Suite and Clinical areas and all bookings have been secured. Day 5 commenced in September at SECC and rooms have been booked for the rest of the training year.

The Copthorne Training Suite has now been moved to the site of the Staffordshire University School of Health now that the premises has been vacated. Rooms are available and have been booked for ABLS and NLS training.

5.0 Development and Training – PEF update

5.1.1 **Preceptorship Programmme for Band 5 Midwives**

9 Band 5 Midwives will be starting in the 2023 cohort - the first of which started on the 25th September.

The 2022 cohort are coming to the end of their first year and of the 23 starters, 12 have achieved a Band 6 and 11 are still working towards this.

5.1.2 **Maternity Support Worker Development**

There are 2 WSA's on the MSW apprenticeship at Birmingham City University who started their course in September 2023.

An additional 3 MSW's have been employed who will be completing the Bridging programme once they have an agreed start date.

5.1.3 **Midwifery Degree Apprenticeship**

3 support workers have started their Midwifery Degree Apprenticeship programme at Wolverhampton University in September.

5.1.4 **International Recruitment**

All 10 of the Internationally Educated Midwives have now joined the Trust with 2 cohorts of 5. One midwife in cohort 1 has successfully passed her OSCE and others are pending resits. The 2nd cohort have arrived very recently in the UK and will shortly be starting their OSCE training in Derby. Cohort 1 will be having some time in observational clinical practice in the coming weeks.

5.1.5 **Induction**

The production of the Welcome Booklet for the Consultant Unit has been paused pending streamlining of the Management structure.

5.1.6 **Rotation**

The rotation is planned to commence in October and additional training and upskilling is available from the Education team .

5.1.7 **Band 7 Development Programme**

A number of training days focusing on Human Factors, Leadership, Communication and Situational awareness have been delivered from January 2023.

A Band 7 Competency workbook has been developed and is currently being completed by Band 7 Midwives on Delivery Suite. Further opportunities are now available for Band 6 Midwives as part of the development programme.

5.1.9 **Enhanced Maternal Care Training**

A second cohort of Midwives have started the EMC Training earlier this year and continue to have supernumerary time on Critical Care to achieve the required competency.

The combined Critical Care and Maternity Training days resumed in March and subsequent training days have been orgainsed throughout the year. The training has been very well received with good attendance by both staff groups. Further dates for 2023 – 24 have been agreed.

5.2 Conclusion

Training Guideline update

The Maternity Specific Training guideline has been updated to align with the Core Competency Framework version 2 (NHSE 2023) and has been approved through the relevant Governance processes. It is now available on the SATH intranet. A further review will take place in preparation for the next training year commencing August 2024.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14th December 2023

Agenda item		162/23 Paper 1 within CNST INFORMATION PACK **Appendix 11**		
Report Title		Maternity & Neonatal Safety Champions Locally Agreed Dashboard		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Kim Williams, Head of Midwifery		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Maternity Governance Committee, October 2023 W&C Divisional Committee Meeting, October 2023 Quality and Safety Assurance Committee, October 2023 LMNS/PNQSG, November 2023		
Executive summary:		This report presents a quarterly update on key clinical performance incidcators for the Maternity and Neonatal Services. The quarter 1 report does not highlight any significant issues.		
Recommendations for the Board:		The Board is asked to: Receive the report in line with Safety Action 9.		
Appendices:		None		

Maternity Neonatal Safety Champions Locally Agreed Dashboard Q1

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

Maternity Safety Support Programme	Yes	

		QUARTER 1 - 2023/2024			April	May	June	Comment
1.	**PMRT**	Findings of review of all perinatal deaths using the real time data monitoring tool	Stillbirths		2	2	0	100% compliance for reporting to MBRRACE within 7 working days and informing families that a PMRT review will take place and letters sent regarding the review
			Late fetal losses >22 wks		0	0	1	
			Neonatal Deaths		1	0	0	
2.	**HSIB**	Findings of review of all cases eligible for referral to HSIB			0	0	0	No cases fitted the criteria for referral in Q1. 3 active cases for this quarter are 2 x stillbirths and 1 x HIE/Cooling
	Serious Incidents	Findings of all Sis			0	0	1	1 SI June, historic case, impacted head with skull fracture.
3a.	**INCIDENTS**	The number of incidents logged and graded as Moderate Harm or above and what actions are being taken			5	6	3	All cases reported as moderate harm are reviewed in an MDT meeting where level of harm is agreed, escalated or ammended. In April out of 5 reported as moderate harm, one was moved to be reviewed by Estates as it was not related to W&C, 2 were ammended to low harm after MDT review and 2 were ammended to no harm after MDT review. In May out of 6 reported as moderate harm, all were ammended to low harm. In June out of 3 reported as moderate harm 1 was ammended to low harm and 2 to no harm.
3b.	**TRAINING**	Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Obstetricians	PROMPT	95%	94%	100.00%	A minimum of 90% compliance is required for PROMPT, NLS and Fetal Monitoring training as part of the Maternity Incentive Scheme reporting. The Education team continue to ensure that all medical staff are booked to attend FMT and where compliance does not meet the requirements, a process for escalation to the Medical Director is in place. A full review of the training guideline is in progress along with the 3 yr local training plan to meet the requirements of the CNST MIS Safety Action 8 Plan is in place for NLS neo nursing staff to complete training during June/July.
				Fetal Monitoring	95%	95%	95%	
			Midwives	PROMPT	97%	96.4%	96.7%	
				NLS	90%	94%	94.29%	
				Fetal Monitoring	96%	98%	97.33%	
			Other Drs	PROMPT	100%	96%	96%	
				Fetal Monitoring	96%	96%	100%	
			Neonatal Nurses	NLS	71%	71%	71%	
			Anaesthetists	PROMPT	52%	57%	80%	
			WSAs	PROMPT	81%	89.00%	88.00%	
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	Maty Del Suite acuity		81%	86%	84%	Obs Unit for Drs - Minimum safety staffing level always available on Delivery Suite. Fill rates for delivery suite templates are being adjusted. AN data includes Triage staffing – there are changes underway to review and adjust the templates were necessary.
			Maty 1:1 care in labour		100%	100%	100%	
			Fill rates Delivery Suite RM		am 107% pm 102%	am 103%	am 100% pm 102%	
			Fill rates Postnatal RM		am 47% pm 49%	am 96% pm 92%	am 93%	
			Fill rates Antenatal RM		am 47% pm 47%	am 96% pm 92%	am 93%	
			Obstetric Cover on D Suite		100%	100%	100%	
4.	**SERVICE USER FEEDBACK**	Service User Voice Feedback from MVP and UX system achievements			MVP now incorporates MNVP which includes neonatal representation.Current Co-Production projects: - Fetal monitoring service leaflet - Community team promotion to combat no-show appointments - Mental Health team promotion to combat no-show appointments - Psychology interview support for Neonatal Unit - Head of Midwifery interviews supported - Sourced data in infographic form for Maternity statistics are shared monthly at SaTH and more widely through the MVP Team			
5.	**STAFF FEEDBACK**	Staff feedback from Bi-monthly frontline champion and walkabouts *(CNST requirement quarterly)*			Wrekin MLU	No walkabout (Bi-monthly)	Shrewsbury MLU	'Our Staff Said, We Listened' feedback posters with April/May updates for staff have been distributed widely via email and on display
6.	**EXTERNAL**	Requests from an external body (HSIB/NHSR/CQC or other organisation) with a concern or request for immediate safety actions made directly with Trust			No safety recommendations received from HSIB			The last safety recommendation reported by HSIB was in 2022 and this is related to an aspect of escalation for medical review.
7.	**Coroner Reg 28**	Coroner Regulation 28 made directly to Trust			0	0	0	None made directly to the Trust
8.	**SA 10 CNST**	Progress in achievement of CNST Safety Action 10			-	-	-	There have been no cases referred to HSIB in Q1 therefore nil to report
9.	**ECLAMPSIA**	Number of women who developed eclampsia			0	0	0	Zero cases reported for Q1 – no change from data reported in Q4
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment								44.3% for Maternity Services published 2023
Proportion of specialty trainees in Obs & Gynae responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours								Reported annually - 87% *(source GMC National Trainees Survey 2022)*

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14th December 2023

Agenda item		162/23 Paper 1 within CNST INFORMATION PACK **Appendix 12**		
Report Title		Maternity & Neonatal Safety Champions Meeting Minutes		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Marie Harris, Governance Administrator		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Maternity Governance Committee, October 2023 W&C Divisional Committee Meeting, October 2023 Quality and Safety Assurance Committee, October 2023 LMNS/PNQSG, November 2023		
Executive summary:		This paper presents the meeting minutes from the Maternity and Neonatal Safety Champions meeting. Actions arising from the meeting have been summarised in the enclosed table.		
Recommendations for the Board:		The Board is asked to: Receive this report in line with Safety Action 9.		
Appendices:		None		

MATERNITY AND NEONATAL SAFETY CHAMPIONS GROUP

MEETING MINUTES

MEETING DETAILS	
WORKSTREAM	Maternity and Neonatal Safety Champions
DATE	03/10/2023
TOPIC	Monthly meeting
MINUTE TAKER	Marie Harris (retrospectively by recording)

ATTENDEES		
Dr John Jones	[JJ]	Medical Director / Board Level Safety Champion
Dr Tim Lyttle (Chair)	[TL]	Associate Non-Executive Director, Board level Safety Champion
Dr Jennifer Brindley	[JB]	Consultant Neonatologist, Women & Children's Division
Louise Duce	[LD]	Deputy Director of Nursing, Women & Children's Division
Rachel North	[RN]	Quality Governance Officer, Women & Children's Division
Lauren Taylor	[LT]	Intrapartum Matron, Women & Children's Division
Sarah Ellement	[SE]	Inpatient & Antenatal Care Matron, Women & Children's Division
Sue Brown	[SB]	Neonatal Nurse, Women & Children's Division
Angela Loughlin	[AL]	Maternity & Neonatal Voices Partnership
Emma Biggs	[EB]	Quality Midwife, NHS Shrop T&W ICS
Mae Hughes	[MH]	Quality Governance Administrator, Women & Children's Division

APOLOGIES		
Mr Will Parry-Smith	[WPS]	Obstetrician Gynaecologist, Women & Children's Division
Dr Dorreh Charlesworth	[DC]	Consultant Obstetrician, Women & Children's Division
Dr Patricia Cowley	[PC]	Consultant Neonatologist, Women & Children's Division
Kim Williams	[KW]	Head of Midwifery, Women & Children's Division
Rebecca Gwilt	[RG]	Midwife, Women & Children's Division
Sharon Fletcher	[SF]	Perinatal Snr Quality Lead & Patient Safety Specialist NHS Shrop T&W ICS

AGENDA ITEMS AND DISCUSSIONS	
1.0	**Introduction, Apologies, Quoracy and any conflicts of interest** 1.1 JJ opened the meeting and welcomed Lauren Taylor who will replace Sarah Ellement as a maternity frontline safety champion. 1.2 Apologies were recorded. 1.3 No conflicts of interest were noted.
2.0	**Walkabout and Feedback Session** 2.1 There was no walkabout scheduled for October – walkabouts are bi-monthly and the neonatal unit was visited during the month of September.
3.0	**Minutes of Last meeting & AAAA approval** 3.1 There was some confusion around the minutes from the last meeting. It was noted that the incorrect minutes had been circulated with the papers and July's minutes are still outstanding. 3.2 MH to address and provide both September and October's minutes for the next meeting in November.

	3.3 It was noted that due to lack of admin cover, July's minutes are still outstanding and will be circulated in due course. 3.4 The Safety Champions AAAA from the last meeting was circulated and no amendments or additions requested. TL added that this had been shared and discussed at QSAC. **Matters Arising** 3.5 EB will liaise with KW regarding increased midwifery attendance at the safety champions meetings.
4.0	**Maternity Dashboard & AAA** 4.1 LT shared August's data and shared the following 7 alerts. 4.2 Smoking rate at delivery has shown a slight increase in August to 12% (11.9% July, 7.4% June). LT reported that the Health Pregnancy Support Service continue to work closely with families towards the target rate of 5%. Cost pressures remain around Saving Babies Lives V3 stipulating the provision of nicotine replacement therapy is being explored within the Division. 4.3 Induction of labour (IOL) rates remain stable 38.6% in August (compared to 38.1% in July and 40.8% in June). Noted that this remains above target of 29.2% but aligned to Saving Babies Lives Care Bundle V3 which offers IOL for reduced fetal movements and fetal growth restriction. This is in line with the National Ambition reducing stillbirths, neonatal deaths and intrapartum brain injury. 4.4 Term admission rates for August were reported as 7.2% in August (compared to 6% in July and shows an increase from previous at 5.4% for June). The national target is below 6%. This month there were 3 admissions that were identified as avoidable, one admitted due to postnatal collapse, one admitted following induction of labour at 38 weeks and one baby was admitted and transferred for colling; this case has been referred to HSIB. On further review by a multidisciplinary team using the ATAIN tool, the overall primary reason for admission was again this month found to be for respiratory conditions and all were reviewed and agreed as unavoidable. LT assured the group that there is no concern. 4.5 Baby less than 27 weeks and 6 days – there was one baby born and sadly RIP within 2 hrs of birth due to known complications. 4.6 Transferred for cooling – in August there were 2 babies transferred for cooling (6.5%) and has been declined by HSIB following referral. The second baby has been referred to HSIB and and a decision to investigate is awaited.

	4.7 Baby deaths – there were 2 babies sadly RIP less than 8 days post birth in August. No immediate learning was identified that would have had an impact on the outcome. Both cases will receive robust scrutiny following the PMRT process. 4.8 Delivery suite positive acuity – this was reported as 75% in August, 82% in July, 84% in June and 86% in May which is inconsistent with the target of 85%. The care required during preterm birth has an impact on acuity due to the additional optimisation required during labour. One to one care would be required similar to a term baby however, additional drugs and preparation is necessary thus explaining the drop in acuity to 75% in the month of August due to the additional care needs required to provide intrapartum care to preterm babies. LT assured the group that this should improve and figures reflect unexpected long-term sickness. 4.9 The Safety Champions were assured that other metrics offer assurance of safety including coordinator supernumerary status and one to one care in labour which demonstrates 100% compliance. The midwifery workforce lead continues to maintain oversight with proactive monitoring and robust recruitment and retention processes in place. 4.10 EB added that when the actual dashboard is shared as a document here and at LMNS, the summary is shared without upper or lower process metrics or SPC charts showing and wondered if there if there is another format available to view to for quality and oversight purposes. JJ agreed this would be helpful. 4.11 Decision to delivery - the Obstetric Lead for Maternity Governance has oversight of the 'decision to delivery' timescales where category 2 caesarean section exceed <75 minutes and a thematic review was undertaken highlighting the rationale behind delays. Plans are underway to implement improvements. LT added that 11 delays with valid and appropriate reasons. Total within the 75 minutes is approximately 10% in terms of national data. JJ noted that it would be useful to see national averages in comparison percentage-wise. 4.12 TL highlighted that this area was discussed at length in September's safety champions where cases that would be categorised as Category 3 sections with less urgency, have to be included in Category 2 data therefore increasing the numbers. TL added that DC Consultant Obstetrician is working on providing figures from a monthly review to demonstrate numbers but this is not reflected in the paper. LT added that discussions had taken place with DC with a view to considering a review of our categories and aligning them with national NICE guidance.
5.0	**Trust's Claims Scorecard – Trisha McSkeane – CNST requirement for Safety Action 9**

	5.1 KW was not in attendance at today's meeting, but had requested that the claims scorecard and paper from Trisha McSkeane was made available to the safety champions meeting. 5.2 Trisha McSkeane was unable to present in person, but papers were available for the group to view.
6.0	**Maternity CQIM MSDS Report** Clinical Quality Improvement Metrics – Maternity Services Dataset – CNST requirement Safety Action 2 6.1 LT presented and it was noted that due to the data being retrieved from the Data Warehouse, it has been necessary to report July data in September. Moving forward, data will be reported in the manner to allow data validation which is in line with data submission to NHSE. 6.3 The group learnt that the new indicators for CNST Year 5 no longer include BMI or Complex Social Factors. Measures now included the following which passed in all areas: • Apgar, Breastfeeding, PPH, Preterm, Tears, VBAC, Robson 1,2 and 5, Smoking at booking Smoking at delivery, Ethnicity and Continuity of Care. 6.4 It was noted that the Continuity of Carer (CofC) metric is not reported on, due to this remaining a suspended service. 6.6 Ethnicity at Booking a 90% and Personalised Care Planning at 99% met the CNST safety action data requirements.
7.0	**Maternity Clinical Governance AAA from September meeting** 7.1 LT presented update. VTE compliance across maternity services continues to not demonstrate 100% compliance - training has been identified as a major issue due to transfers from clinical areas and has been escalated to Ward Managers for resolution. 7.2 The Safety Champions learned that the guidelines continue to be monitored and measures in place to achieve compliance. 7.3 Data has been analysed to review waiting times within the maternity triage department and variations in data entries noted. Staff have been reminded of the importance of competing documentation within Badgernet and accurately capturing the arrival time. This is being monitored. Serious Incidents and Divisional Investigations were noted.

	7.4	Incident reporting continues to be monitored by Ward Managers and the Governance team providing weekly oversight of Datix incidents and complaints.
	7.5	One new SI was reported in August relating to a neonatal death which was mentioned earlier and has been referred to HSIB. Four DIs remain outstanding which are being monitored for completion by the Quality Governance Lead.
	7.6	JJ went on to explain the Trust's revised serious investigation (SI) process with the imminent arrival of the Patient Safety Incident Response Framework (PSIRF). If RALIG (Review Actions and Learning from Incidents Group) decide that an incident clearly meets the SI criteria, this will progress as usual. If an incident meets HSIB referral criteria, but the Trust does not think it is an SI level of investigation, we will now follow HSIB's lead and wait to see if they decline a case for further investigation. If they decline, we won't progress, if they accept the case, the Division will then report the case as an SI and progress down the normal SI process.
	7.7	RN explained that the national investigations Healthcare Safety Investigation Branch (HSIB) has handed over its maternity and healthcare investigations programmes and transitioned to the Maternity and Newborn Safety Investigation Body (MNSI) and HSSIB (Health Services Safety Investigations Body).
	7.8	LT highlighted that another focus at Maternity Clinical Governance is around patients being triaged within 15 minutes – currently at 86% and data capture is being monitored to ensure correct recording of figures, which is continuing to transition from paper-based to Badgernet. National average is 95% and an action plan is in place to look at time of arrival to time to triage.
8.0	**Neonatal Dashboard**	
	8.1	JB reported that Term Admissions for the month of August were 7.2% (compared to 5.7% July, 5.4% in June and 6.3% in May 2023).
	8.2	JB explained that although figures for BAPM standards for staffing are included on the dashboard, QIS nursing figures per shift have not been included to date. Consideration has been given to including this data and will be reportable on the dashboard.
	8.3	JB assured the group that now the Data Validation member of staff is now in post, a retrospective data cleanse exercise in underway and improved figures are now showing.
	8.4	A significant improvement is showing in the 'babies receiving breastmilk at 14 days of age' metric is now 100% (66.7% July, 50% June).

	8.5 The percentage recorded for temperature on admission of babies born less than 34wks within one hour of admission has also improved to 100% (66.7% July, 50% June). 8.6 It was noted that delayed cord clamping (DCC) for more than 60 seconds for babies born less than 34 weeks is 75% (July 50%). 8.7 JB assured the group that there is a dedicated ANNP who monitors the metric whether parents have been seen by a senior member of staff within 24 hours of admission. The data reported for August is 100%. JB will highlight the disparity to the Data Validation clerk. 8.8 It was noted that the ROP screening number of eligible babies figure of 0% shows that the data is unavailable at the time of reporting due to the babies still being admitted to the unit and is captured once discharged. 8.9 TL suggested that for assurance purposes, the neonatal dashboard might benefit from the support of a AAA alike maternity, which explains performance and breaks down the data identifying themes. TL highlighted the areas of staffing issues in particular which would help understand the comparisons to previous months/years and what the expectations or targets are. 8.10 **ACTION** - JB assured the group that a AAA accompanies the dashboard to Neonatal Clinical Governance, which will be shared with Safety Champions in future. 8.11 JB explained that staffing figures are documented against BAPM standards and it is recognised that data capture around escalation levels, refusal of admissions and bed usage needs improvement and it would be useful to document how long the unit sits at 'red' or 'amber' during any one month. 8.12 **ACTION** - LD added that this data is reported and should be available for analysis on the sitrep. JJ agreed would be useful and to share each month at safety champions. 8.13 More narrative around the 'clinical events and number of reported Datixes' was also requested and JB assured the group that the governance AAA should support this.
9.0	**VTE Update** 9.1 Since the introduction of Badgernet, it has been highlighted that the documentation of VTE assessments has declined. 9.2 LT explained that VTE assessments for patients is still being monitored as this is still not 100% compliant.

	9.3 The group were assured that training is still ongoing with VTE assessments audited daily by the midwifery Manager of Day. The aim is to consistently improve compliance. 9.4 Discussions are ongoing with the network to see if a mandatory field for VTE can be made available on Badgernet to help improve data capture. 9.5 LT highlighted that there are VTE assessments at 6hrs and 24hrs which monitor and report differently on the system. 9.6 Work is underway to identify any themes for non-compliance. It was discussed that in Triage, a patient does not always require a VTE assessment. JJ added that that there may be an option to look at different cohort data for low risk/high risk patients and suggested analysing data for those patients that did not have an assessment. 9.7 **ACTION -** LT assured the group that data is being monitored for patients who have been admitted and transferred to Antenatal and then to Delivery Suite – it is the Delivery Suite assessments that are being looked as it should be repeated due to different risk factors. However, LT added that a more in-depth analysis would be beneficial. JJ agreed and acknowledged the work being done around this. JJ asked for an update on any progress on data analysis could be included on December's safety champions agenda.
10.0	**Maternity and Obstetric Incident Trends** 10.1 125 incidents were reported for Maternity in August compared with 114 incidents in July. 10.2 Intrapartum incidents remain the highest reported category, with Post Partum Haemorrhage being the highest subcategory followed by the delay of more than 8 hours for ARM/augmentation. 10.3 Overdue incidents are being monitored and support provided weekly by the Quality Governance team to review and close these in a timely manner. 10.4 ATAIN has already been discussed, but incidents are being contemporaneously reviewed. August rates are 7.2%J with July rates at 5.7%. The National target being 6.0%. Learning from these reviews will be shared with staff.
11.0	**Safety Intelligence Locally Agreed Dashboard** 11.1 The dashboard was shared to include Q2 data and is a CNST requirement for Safety Action 9.

	11.2 September's data to complete Q2 is unavailable at the time of reporting (3/10) and will be presented at November's following the reporting of figures at Maternity Clinical Governance. 11.3 **ACTION** - It was noted that there is a variation in August data reported for positive acuity (80%) on the maternity dashboard, to that reported on the locally agreed dashboard (75%). LT explained that this is due to the dashboard figure including 13 wk rolling average Birthrate Plus data – this is 80%. For the month of August which would report a 4 wk average, the positive green acuity data is 75%. For consistent data reporting, JJ suggested we use the same monthly acuity data that feeds into the maternity dashboard. 11.4 It was noted that the rest of the fill rate data is not entirely accurate due to the staff rotations that have recently commenced. LT assured the group that these will be correct and amended. 11.5 **ACTION** – amend MVP to MNVP. 11.6 The staff score survey was discussed and the group would decide whether to bring the data to the safety champions meeting once published.
12.0	**Maternity Staffing Report** 12.1 LT shared the report. The 13wk positive green acuity data for Delivery Suite has slightly declined with 80% reported (compared to this time last year August 2022 50%). Further analysis showed this is due to peak annual leave and increase in sickness, with an increase in bank staff requirements. 12.2 August reported green acuity at 75% with 23% amber and 2% red. 12.3 During August we have reported green acuity at **75%** with 23% Amber and 2% Red. 12.4 Confidence factor in the data entry has continued to be maintained above 85% - August confidence factor is continuing to increase and reported at 95% this provided accurate data when reviewing acuity and red flags. 12.5 45 Red Flags reported in August with 93% being reported due to delay in ARM. 12.6 The Delivery Suite co-ordinator was supernumerary on all occasions in August. 12.7 One to one care in labour is reported as 100%

	12.8 LT added that fill rate data is being looked at due to Triage and Delivery Suite being treated as one area, the same applying to Antenatal and Postnatal. 12.9 Rotations have now commenced to improve midwifery skillsets, the international midwives have commenced and three MSWs have been recruited to start next year. In addition, three Midwifery Apprentices have started during the month of September.
13.0	**Mortality and Morbidity Report** 13.1 LT presented the quarterly maternity perinatal report to include Perinatal loss data (criteria & figures), cases reported to MBRRACE/PHE/HAS4, next steps to improve the service and continuing delays in Post-mortem and Placental Histology Reports from Regional Pathology Centre 13.2 The report monitors performance and reports any actions for areas where performance is declining. It also provides an opportunity to review those areas where performance is improving and provide assurance of the sustainability of actions implemented. 13.3 The group noted Perinatal loss figures for Quarter 2 (April- June 2023) noting MBRRACE reporting is (Jan- December) reporting not financial year reporting (April-March).
14.0	**CNST MIS Y5 Progress Report** **(Clinical Negligence Scheme for Trusts, Maternity Incentive Scheme Year 5)** 14.1 LT presented the report. The Trust is largely on track, however some risk to delivery remain around failure of Safety Action 6 and the new additions for diabetes in element 6, Saving Babies Lives (SBL) V3. Training compliance Safety Action 8 is also at risk of failure due to compliance that must be achieved in October 2023. 14.2 Safety champions heard that the teams are working hard to mitigate these risks wherever possible. 14.3 **ACTION -** AL discussed point 9.3 in the report and proposed that a report containing feedback and actions from the 15 steps walkabouts is fed into a number of forums where the action plans are monitored and shared at Safety Champions, MNVP and Maternity Governance meetings. AL to propose a plan to Director of Midwifery, Annemarie Lawrence and feedback to Safety Champions.
15.0	**Wrekin MLU Update** 15.1 Midwifery led care is available either at Wrekin MLU or at home. 15.2 There were 21 Births at Wrekin and 1 homebirth in August. This demonstrates a positive increase in numbers of births in midwifery led and

	home settings and is testament to the work being undertaken to maintain the service. 15.3 There was a total of 45 women who commenced labour care on the MLU with a total of 24 transfers as a result of: meconium-stained liquor, delay in the second stage of labour, anomalies identified in the fetal heart rate, requesting epidural analgesia and postnatal concerns. 15.4 All transfers have been reviewed and were appropriate.
15.0	**Confirm Walkabout for November** 15.1 The group agreed that the next walkabout for November would be for 1pm at the PRH Scanning and Outpatients departments. 15.2 JJ mentioned that it would be useful to meet a midwife who is early on in their career.
16.0	**Our Staff Said… We Listened** 16.1 Agreed to revisit next month. 16.2 Uplift for neonatal staff shifts was discussed, but agreed this is not a safety concern.
17.0	**Key Issues to include in AAA report** 17.1 JJ will draft.

18.0	**Any Other Business** **Neonatal Staffing update** 18.1 Neonatal Staffing Update – LD gave verbal update for August. Unavailability high for Augst at just over 40% with 14% of that largely due to sickness absence and training. Annual leave within parameters. 18.2 3 B5 vacancies and recruited to 3. Ward Manager is back out to advert due to lack of interest. 24 mth plan was presented at Divisional Cttee. QIS compliance is 55%. 18.3 New frontline nursing champion will be joining the meetings will go forward. **Neonatal Mortality** 18.4 JJ alerted the group to a review of the Trust's PMRT process that is underway and neonatal mortality will be looked at over 2021-2022. It will be run by the Royal College of Physicians, but experts from the Royal College of Paediatric Health will be used. Standardised stillbirth rates have been falling, so this data will not be included. JJ added that he has confidence in our teams and PMRT process and is hoping for an outcome in the coming months. JJ acknowledged the difficulty sometimes in for staff in times of tragedy looking after baby and mother and it is important that our staff are fully supported. **Administration for Safety Champions** 18.5 The ongoing issue for administrative cover was discussed. 18.6 RN explained that this work formed part of a dedicated Band 6 CNST Governance Officer role (12 mth secondment) but this role ended in Jan 2023 and no longer exists. 18.7 Due to the need for admin cover still required, the previous Band 6 individual has inherited this work and asked to caretake the admin role alongside her current Band 4 role she has returned to and is performing these outside of her job description. It was noted that admin cover is provided for safety champions at times, but not to the same standard. 18.7 JJ acknowledged the difficulties, however, the situation will have to remain for the time being and sit in the Governance team due to the safety champions meetings having to be administered to meet CNST requirements.
NEXT MEETING	Tuesday 7th November 2023, 2.30pm – 5pm, Room A, Education Centre, PRH Walkabout, 1pm PRH Scanning and Outpatient Areas

MATERNITY AND NEONATAL SAFETY CHAMPIONS GROUP

MEETING MINUTES

OPEN ACTIONS

Date Action Raised	Owner	Subject	Description	Due	Status
2023-10-06	AL	15 Steps report and action monitoring (9.3 SA9)	Liaise with Director of Midwifery AML regarding MNVP proposal and feedback to safety champions	Nov-23	
2023-10-05	KW/MH	Amend locally agreed dashboard	Change MVP to MNVP and change HSIB to MNSI	Nov-23	
2023-10-04	KW/MH	Update acuity data for locally agreed dashboard	Amend the locally agreed dashboard positive acuity data using the monthly figure that feeds into the maternity dashboard (and not the 13wk Birthrate Pus rolling average figure).	Nov-23	
2023-10-03	LT	VTE Assessments	Share update on any progress of further analysis of data to December's safety champions	Dec-23	
2023-10-03	LD	Sitrep	Bring to each safety champions meeting starting November to support understanding of neo staffing figures	Nov-23	
2023-10-02	JB	Neonatal Dashboard AAA	Bring to each safety champions meeting starting November	Nov-23	
2023-10-01	DC	Category 3 and Category 2 Caesarean Section data monthly review	Cases categorised as Category 3 sections with less urgency, have to be included in Category 2 data therefore increasing the numbers. DC working on providing figures from a monthly review to demonstrate numbers with safety champions	Nov-23	In progress
2023-07-01	LT	VTE mandatory field on Badgernet	Remains the case not a mandatory field. Addition of VTE field is being explored by Digital Midwife – LT to give status update at November's meeting	Oct-23	In progress
2023-04-2	KW	HSIB Report – Assessment of Risk During the Maternity Pathway	KW to bring to Safety Champions once complete – c/f	Oct-23	In progress

2023-02-1	JJ DC	MRI availability for obstetric issues	Out of hours MRI is a wider issue to maternity – JJ to update Safety Champions once paper presented at QOC – carry forward  FW_ OOH Mri .msg	Oct-23	In progress

CLOSED ACTIONS

Ref No	Owner	Action		Due	Status
2023-07-02	KW	VTE Report	Agreed as an additional agenda item for forthcoming monthly meetings – KW to provide No Maternity Governance meeting in August, c/f to October's agenda. On October's agenda. Close	Oct-23	Closed 3/10/23
2023-06-06	KW	**Wrekin MLU Bradycardia Drill** Review proforma	Proformas to be made available in theatre. Proformas for acute hypoxia to be rescoped for Wrekin MLU/community settings – adjustments are being made to align with theatre proformas. KW to bring revised version to S Champs Aug. Complete – close from action plan.	Aug-23	Closed 3/10/23
2023-07-03	JJ All	Safety Champions poster	Changes to be agreed in October's meeting with change of frontline S Champions members c/f Oct Agreed EB as a 'hybrid' ICB/Quality Midwife should be included on the safety champions poster. Close from action plan	Oct-23	Closed 3/10/23

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14 December 2023

Agenda item		162/23 Paper 1 within CNST information pack **Appendix 13**		
Report Title		Saving Babies Lives Care Bundle version 3(SBLCBv3) – Preterm Team TOR and Element 6 divergence document		
Executive Lead		Hayley Flavell, Director of Nursing		
Report Author		Lindsey Reid, Lead Midwife for Saving Babies' Lives,		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF 1, BAF 2 BAF 3, BAF 4 BAF 7, BAF 8
Effective	√	Our people		
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance		CRR 15
Well Led		Our partners	√	
Consultation Communication		Maternity Governance Meeting October 2023 W & C Divisional Committee October 2023 QSAC October 2023 LMNS November 2023		
Executive summary:		SBLCBv3 implementation has required: • Establishment of a Preterm Oversight Team within Element 5 • A divergence request for 1 standard in Element 6. Both attached documents require acknowledgment and sign off by the Trust Board before the next SBLCBv3 review meeting (LMNS/ICB/Trust representatives).		
Recommendations for the Board:		The Board is asked to: Receive this report in line with Safety Action 6.		
Appendices:		Appendix 1 – Reducing preterm births and optimising perinatal care group Terms of reference Appendix 2 – Divergence panel report for Element 6 – HbA1C pathway		

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 and year of CNST.

1.3 SaTH is now part-way through delivery of CNST year 5(2023-24), which includes implementation of SBL version 3. The purpose of this brief paper is to:

- 1.3.1 Approve the Reducing preterm births and optimising perinatal care group Terms of reference.
- 1.3.2 Provide background to the attached divergence document.
- 1.3.3 Request that both documents gain oversight and sign off by the Trust Board

2.0 Background

2.1 The 3rd version of the care bundle (SBLCBv3)[1] was released in June of this year. Building on the achievements of the previous versions, Version 3 includes a refresh of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit.

2.2 There are now 6 elements of care:

- 2.2.1 Element 1 Reducing smoking in pregnancy
- 2.2.2 Element 2 Fetal Growth: Risk assessment, surveillance, and management
- 2.2.3 Element 3 Raising awareness of reduced fetal movement (RFM)
- 2.2.4 Element 4 Effective fetal monitoring during labour
- 2.2.5 Element 5 Reducing preterm birth
- 2.2.6 Element 6 Management of pre-existing diabetes in pregnancy

3.0 Progress update on Element 5: Reducing preterm birth.

3.1 SBLCBv3 new standard in Element 5.

Each provider trust should have a Preterm Birth Lead Team:

a) An Obstetric Consultant lead for preterm birth, delivering care through a specific preterm birth clinic, or within an existing fetal medicine service.
b) An identified local preterm birth/perinatal optimisation Midwife Lead
c) A Neonatal Consultant lead for preterm perinatal optimisation
d) An identified Neonatal Nursing lead for preterm perinatal optimisation

3.1.1 The Team will provide leadership, review Trust preterm data and have oversight of the preterm optimisation pathway.

3.1.2 The Team has been established within the current workforce. It was agreed that the Neonatal MNVP representative should also be invited to join the Team. This

[1] https://www.england.nhs.uk/publication/saving-babies-lives-version-three/

offer has been accepted

3.1.3 Terms of Reference (appendix 1, page 5) have been agreed by the Preterm Team.

3.1.4 The Trust board should specifically confirm to the system that within their organisation they have appointed and have in post the leads specified (CNST yr5)

Preterm Leads

Obstetric Consultant lead for preterm birth – Mr Guy Calcott
Preterm birth/perinatal optimisation Midwife Lead – Lindsey Reid
Neonatal Consultant lead for preterm perinatal optimisation – Dr Sagarika Ray
Neonatal Nursing lead for preterm perinatal optimization – ANNP Stacey Dixon

The Trust board are asked to acknowledge that the Trust has established a Preterm Team in line with the SBLCBv3

4.0 **Progress update on Element 6: Management of Pre-existing Diabetes in Pregnancy (new Element in version 3)**

4.1 SBLCBv3 new standard in Element 6

Women with diabetes should have an HbA1c measured at the start of the third trimester.

(The hemoglobin A1c (HbA1c) test measures the amount of blood sugar (glucose) attached to your hemoglobin. Hemoglobin is the part of your red blood cells that carries oxygen from your lungs to the rest of your body. It is an important blood test that gives a good indication of how well your diabetes is being controlled (Diabetes UK)).

4.1.1 CNST year 5 stipulates a timeframe of 28+0 -28+6 weeks.

4.1.2 A baseline review demonstrated only 20% of cases had a HbA1c taken in this narrow timeframe. However, it did demonstrate after 79% had it taken between 24 and 29+6 weeks. Overall, the review demonstrated very good compliance to NICE guidance 90-95% per trimester.

The Trust submitted a divergence request to the Midlands Perinatal Team. Following a panel review where the Trust's representatives presented the review findings, the panel accepted the Trusts current pathway as safe and an acceptable variation (appendix 2, page 8).

4.1.3 LMNS/ICB representatives have agreed and accepted the panel's findings.

4.1.4 The Trust board is requested to acknowledge LMNS/ICB agreement and accept the divergence panel's recommendations on behalf of the Trust

5.0 **Actions requested of the committee**

5.1 The Trust board are asked to declare that the Trust has established a Preterm Team in line with the SBLCBv3

5.2 The Trust board is requested to acknowledge LMNS/ICB agreement and accept the divergence panel's recommendations on behalf of the Trust

SBL Appendix 1-

NHS England Midlands

Reviewing local guidance which diverges from Saving Babies' Lives Care Bundle version 3 (SBLCBv3) recommended practice.

Appendix 2: Midlands Perinatal Team and Expert Panel Recommendations Template:

Trust:	Shrewsbury and Telford NHS Trust
LMNS:	Shropshire, Telford, and Wrekin
Trust Lead:	Louise Barnett
Commissioning Lead :	Nick White
Panel Review Date:	05/10/2023
Panel Review Members: **Name, job role and trust**	
1	Susanna Al-Samarrai, Regional Lead Obstetrician, Midlands Perinatal Team and Consultant Obstetrician Sherwood Forest Hospital NHS Trust.
2	Helena Maybury, Regional Lead for Diabetes, Midlands Perinatal Team and Consultant Obstetrician University Hospitals Leicester
3	Aisha Janjua, Consultant Obstetrician, Birmingham Women's Hospital NHS Trust
4	Ceinwyn Hogarth, Lead midwife for diabetes, Nottingham University Hospital
Recommendations from panel members:	Shrewsbury and Telford Hospital NHS Trust current pathway presented by • Lindsey Reid, Saving Babies' Lives Lead Midwife • Guy Calcott, Consultant Obstetrician • Laura Bangs, Consultant Obstetrician The panel heard that Shrewsbury and Telford NHS Trust have a current pathway in place for women with pre-existing diabetes where an HbA1c is taken between 24-29+6 weeks.

	The trust has recently reviewed this pathway and found 79% of women with diabetes had an HbA1c taken within this gestational window and have a plan in place to improve this locally. The panel agreed that Saving Babies' Lives Care Bundle version 3, element 6 is not prescriptive in relation to the gestation at which an HbA1c is taken and states, "women with diabetes should have an HbA1c measured at the third trimester and those with an HbA1c above 48 mmol/mmol should be offered increased surveillance including additional diabetes nurse/diabetic support, more frequent face to face review and input from their named specialist consultant to plan ongoing care and timing of birth decisions". The panel were all in agreement that the current pathway as outlined by the representatives from Shrewsbury and Telford NHS Trust meets this SBLCB intervention and that this is a safe pathway. The panel discussed the requirement in the SBLCB implementation tool for HbA1C to be carried out between 28-28+6 weeks gestational age and agreed this did not align to the intervention in the SBLCBv3 national document. This has been escalated at national level. In conclusion the panel recommend that Shrewsbury and Telford NHS Trust continue with their current care pathway for women with pre-existing diabetes to have an HbA1C between 24-29+6weeks

Risks identified:	No risks identified
Please notify the MPT of the outcome and local agreement within 28 days of receipt to england.midlandsperinatal@nhs.net	
1. **What has been agreed locally with commissioners & LMNS?**	The ICB/LMNS representatives agree with continuing the current pathway as pre Trust request and panel recommendation. The System has agreed a minimum ambition of 75% and a stretch of 85%.
2. **What is the process for review?**	The review presented to the panel has formed a baseline review. The results have met the minimum ambition. Action plan -the compliance will be monitored over Q3/4 (financial year) 2023. The stretch ambition will then be reviewed
3. **Has this variation been signed off by the trust board which acknowledges sign off from local commissioners and the Midlands Perinatal Team recommendations?**	The variation agreement will be presented at the next Maternity Governance meeting with a request to escalate for Trust Board sign off.

SBL Appendix 2

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Reducing preterm births and optimising perinatal care group
TERMS OF REFERENCE

Constitution

Saving Babies Lives Care Bundle Version 3 (SBLCB V3) sets out that each provider Trust should have
a) An Obstetric Consultant lead for preterm birth, delivering care through a specific preterm birth clinic, or within an existing fetal medicine service.
b) An identified local preterm birth/perinatal optimisation Midwife Lead
c) A Neonatal Consultant lead for preterm perinatal optimisation
d) An identified Neonatal Nursing lead for preterm perinatal optimization

Each Preterm Birth Lead team should have clear audit and QI pathways for preterm birth prevention, prediction and perinatal optimisation, and should engage in shared learning and QI with local preterm birth clinical networks, LMNSs and neonatal ODNs.

Its constitution and terms of reference shall be as set out below. As a committee of the Trust, the Standing Orders of the Trust shall apply to the conduct of the working of the reducing preterm births and optimising perinatal care group.

Membership

The membership of the Reducing preterm births and optimising perinatal care group will be:

Obstetric consultant (Pre-term Lead)
Neonatal consultant
SBLCB Lead Midwife
Maternity Transformation Matron
Neonatal Nursing/ANNP Lead
Neonatal MNVP representative

Responsibilities of Members

- Obstetric and Neonatal Consultants – Oversight of Preterm and Optimisation pathway and guidelines
- SBLCB Lead Midwife – Implementation and oversight of optimisation by monitoring, recording, presenting reports
- Transformation Matron – Oversight of implementation pathway and link between midwifery and neonatal
- Neonatal Nursing/ANNP Lead - Oversight of implementation pathway and link between neonatal and midwifery
- Neonatal MNVP representative – Support the group with user experience, co-design feedback surveys and feedback results to the group

Attendance

Quarterly

Quorum

The group will be deemed quorate to the extent that the following members are present:
Obstetric consultant (Pre-term Lead)
Neonatal consultant

Quorum
The group will be deemed quorate to the extent that the following members are present: Obstetric consultant (Pre-term Lead) Neonatal consultant SBLCB Lead Midwife
Frequency of meetings
• *Quarterly*
Reporting
• Monitoring/audits/reviews required to demonstrate compliance will be presented through Maternity Governance in the SBLCB quarterly preterm report
Administrative arrangements
• *Administration will be the responsibility of the team*
Review
The terms of reference will normally be reviewed annually, with recommendation on changes submitted to the Maternity Governance Committee for ratification.

Approved:	Lindsey Reid (on behalf of the MDT)
To be reviewed:	12/10/2024

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14th December 2023

Agenda item		162/23 Paper 2 within CNST INFORMATION PACK		
Report Title		CNST MIS Year 5 Progress Update - November 2023		
Executive Lead		Hayley Flavell, Director of Nursing		
Report Author		Annemarie Lawrence, Director of Midwifery		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF4,
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	782, 739
Well Led	√	Our partners		
Consultation Communication		Maternity Governance Committee, November 2023 W&C Divisional Committee Meeting, November 2023 Quality and Safety Assurance Committee, November 2023 LMNS/PNQSG TBC		
Executive summary:		SaTH is a participant in year 5 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), which is operated by NHS Resolution (NHSR) and supports the delivery of safer maternity care. The self-declaration deadline is 1 February 2024. This paper sets out SaTH's progress to date and includes information to evidence the risks to delivery of the Safety Actions, which the committee is asked to receive on behalf of the Trust's Board of Directors.		
Recommendations for the Board:		The Board is asked to review and discuss this paper, noting the content and the risks to delivery for the scheme. The Board is asked to note the declarations required in sections: 4.2, 4.3, 6.4, 6.7, 7.4, 10.5 The Board is requested to acknowledge that they agree the local training plan which is based upon the core competency framework.		
Appendices:		Appendix 1: Obstetric workforce paper Appendix 2: Anaesthetic rota Appendix 3: Neonatal workforce position against BAPM Standards (previously presented with CNST Update October) Appendix 4: Neonatal nursing workforce action plan/strategy Appendix 5: TNA (previously presented with CNST Update October) Appendix 6: Safety intelligence dashboard Appendix 7: Our staff said, we listened Appendix 8: Minutes of quad/safety champs meeting		

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 Year 5 guidance was published on 31 May 2023, with version 1.1 and references a relevant time period of 30 May 2023 until 7 December 2023 for delivery of the scheme. This also includes a self-declaration deadline of **noon on 1 February 2024.**

1.4 The purpose of this paper is to provide the Committee with:

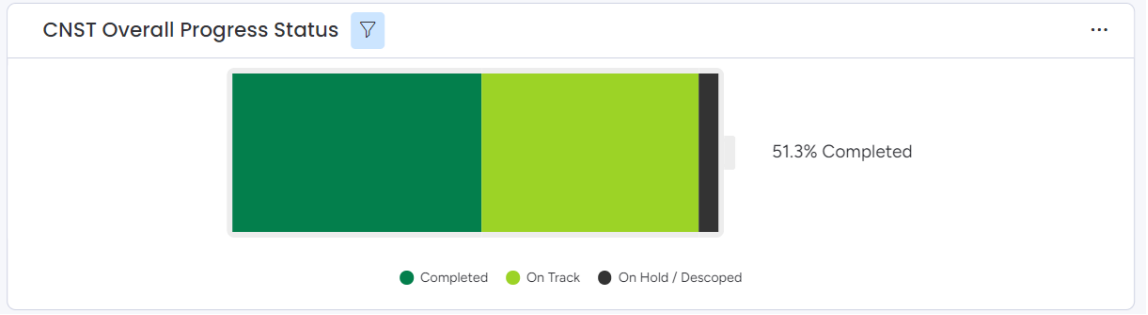
1.4.1 Details of the standards within year 5 of the scheme that must be evidenced between now and the reporting deadline.

1.4.2 An update on progress.

2.0 Overall Progress Status

2.1 The below batteries show an overall CNST progress status and delivery status as of November 2023 (including compliance with the standards and accrual of supporting evidence), with the current position reporting as 48.7% 'Evidenced and Assured', 25.6% 'Delivered Not Yet Evidenced', and 20.5% 'Not Yet Delivered'.

2.2 The above battery should be viewed in conjunction with the below progress battery which evidences the overall status of progress which is predominantly on track.



2.2 While there are elements in the above progress batteries that are N/A/on-hold/descoped, these relate to Midwifery Continuity of Carer (MCOC) which is currently paused in line with the National letter published in September 2022.

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.

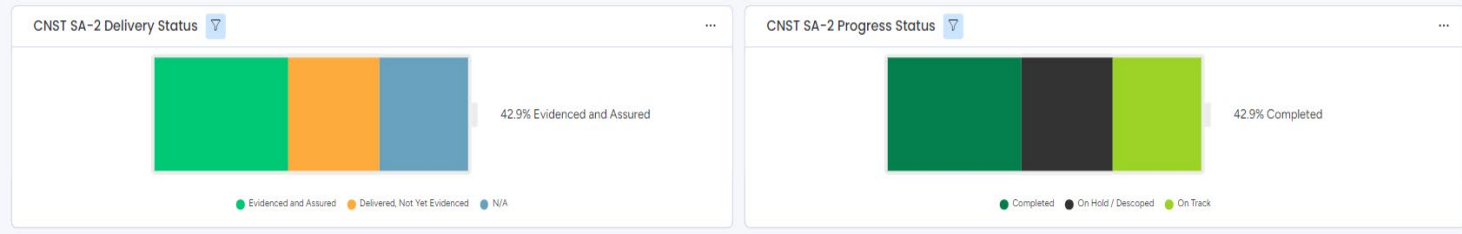
3.2 The Board of Directors (BoD) via the delegated authority of QSAC has received a report each quarter since August 2021 that includes details of the deaths reviewed and the consequent action plans.

3.3 Compliance with standard b) is ongoing, with all parents being informed 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 The team are on track to achieve the remaining standards of safety action 1.

3.5 **Progress Status: On Track**

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



4.1 NHS Digital have confirmed that the Trust has passed the associated data quality for the July data submission, which was published in October 2023, see appendix 1.

4.2 The Board are asked to be assured that SaTH have passed the minimum associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for all metrics.

4.3 ***Once assurance is confirmed as received by the Board***, NHS Resolution will be informed which is the final act of delivery required for this safety action.

4.4 Following this, this safety action will move to complete.

4.5 **Progress status: On Track**

5.0 Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

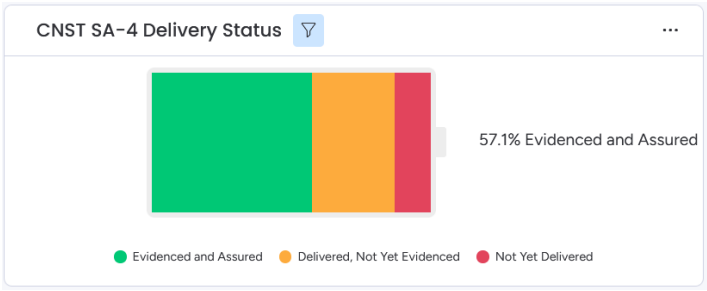
5.1 The Trust operates a Transitional Care service and associated pathway that continues to meet the national target of Avoiding Term Admission into the Neonatal Unit (ATAIN). These pathways have been agreed between maternity and neonatal teams with a focus on minimizing separation of mothers and babies. This element is therefore complete.

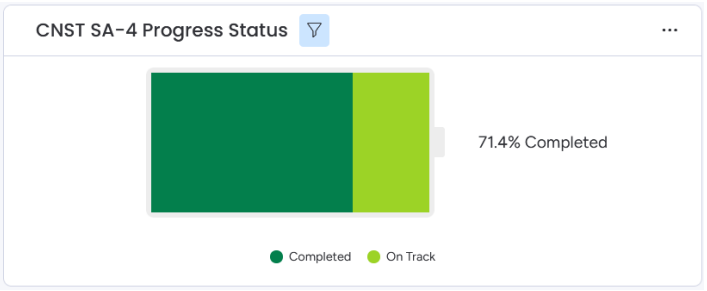
5.2 The BoD via the delegated authority of QSAC has continued to receive a report each quarter since August 2021 that includes details of all term admissions, including avoidable admissions and any associated action plans evidencing the required standards for b). This element is therefore complete.

5.3 The BoD via the delegated authority of QSAC has continued to receive a report each quarter on transitional care activity and any associated actions evidencing the requirements for standard c). This element is therefore complete.

5.4 Progress Status: Complete

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





6.1 Standard a) relates to the Obstetrics medical workforce and comprises of 4 sub actions which must be met.

6.2 Of these sub actions, 3 have been met, with the final sub action not possible to report on until after the scheme ends as the relevant time period is 30 May – 7 December 2023 inclusive. This is presented within a workforce paper which is included at **appendix 1**.

6.3 Standard b) relates to the Anaesthetic workforce and a duty anaesthetist being immediately available for the obstetric unit 24 hours a day. A copy of the rota is included at **appendix 2** evidencing this standard is met.

6.4 Standard c) relates to the Neonatal medical workforce and the requirement for the unit to meet the British Association of Perinatal Medicine (BAPM) national standards for medical staffing. ***This has previously been evidenced and is included again at appendix 3 but the Board are required to formally record this in the Trust Board minutes for this to move to completed.***

6.5 Finally, standard d) relates to Neonatal nursing workforce and the requirement to meet BAPM standards for nursing staff.

6.6 The Trust does not currently meet this standard as evidenced within Year 4 of the scheme however there is progress on the previously agreed action plan, and this is reflected within the recent neonatal nursing workforce strategy.

6.7 ***The Board are required to evidence within the Trust Board minutes that this standard is not met, but that there is evidence of progress against the previously agreed plan and also include new relevant actions to address deficiencies*** *(**appendix 4**).*

6.8 The plan must be evidenced as being shared with the LNNS and the Neonatal Operational Delivery Network (ODN) to achieve this safety action.

6.9 Progress Status: On Track

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

7.1 The BoD has continued to receive the bi-annual midwifery staffing paper since the year 4 scheme ended, with the last report being present to the Board in June 2023.

7.2 Additionally, the service submits a monthly midwifery staffing paper to the Trusts workforce meeting which captures standards c) and d) of safety action 5; this meeting is chaired by the Director of Nursing (DoN).

7.3 The bi-annual staffing paper for Q1/2 was previously received at QSAC in October 2023 and includes evidence of coordinator supernumerary status and 1:1 care in labour for all women. See appendix 2.

7.4 The Trust Board must evidence within the minutes that the midwifery staffing budget reflects the requirements set out within the BR+ recommended establishment of clinical midwives.

7.5 Progress status: Complete

8.0 Safety Action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

8.0 This is one of the largest and most complex of all the safety actions because it comprises the six elements of SBL care bundle.

- 8.0.1 Reducing smoking in pregnancy
- 8.0.2 risk assessment, prevention and surveillance or pregnancies at risk of fetal growth restriction (FGR)
- 8.0.3 Raising awareness of reduced fetal movements (RFM)
- 8.0.4 Effective fetal monitoring during labour
- 8.0.5 Reducing preterm birth
- 8.0.6 Management of pre-existing diabetes (New for version 3)

8.1 Trusts are asked to hold quarterly improvement discussions with the ICB using the new national implementation tool and there must be 2 meetings held before March 2024. The initial discussion meeting was held in August 2023, and the first formal meeting took place in September 2023, with the second and final meeting due to take place on 27 November 2023.

8.2 To achieve CNST year 5, each element within this safety action must have achieved a minimum of 50% compliance and have an overall compliance of 70% for all elements.

8.3 The percentages are generated from within the tool and are evidenced in the below table. This position is currently unvalidated, until the ICB quarterly improvement meeting later this month and therefore maybe subject to change.

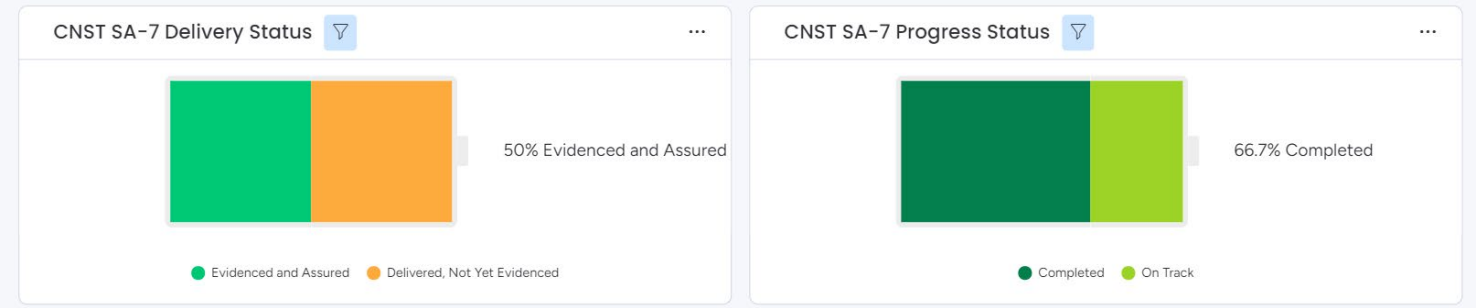
Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)
Element 1	Smoking in pregnancy	Partially implemented	70%
Element 2	Fetal growth restriction	Partially implemented	90%
Element 3	Reduced fetal movements	Fully implemented	100%
Element 4	Fetal monitoring in labour	Partially implemented	80%
Element 5	Preterm birth	Partially implemented	78%
Element 6	Diabetes	Partially implemented	50%
All Elements	TOTAL	Partially implemented	79%

8.4 If the position is unchanged following the ICB validation session, this safety action will be complete.

8.5 **Progress Status: On Track**

9.0 Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.



9.1 The productive partnership between SaTH and the Maternity and Neonatal Voices Partnership continues to yield important outcomes for service users and staff alike; the MNVP have recently recruited to a number of new, key roles that will enhance the current offer and afford the capacity to extend the reach to the wider community. Community engagement events including an Open Day hosted by SaTH and the MNVP, facilitated open access to the community to ask questions and offer a tour of the Maternity Unit. Tours of Maternity services commenced in September 2023 following the Open Day, to invite parents and families to view services with the opportunity to raise questions, concerns, or suggestions.

9.2 The CQC maternity survey has a coproduced action plan which was presented at maternity governance meeting in July 2023; this was fed into the safety champions and LMNS board meeting that took place in August 2023, and progress is being monitored at the Perinatal Quality Surveillance Group (PNQSG) meeting moving forward.

9.3 The maternity and neonatal safety champions regularly seek feedback from staff in local areas as part of the scheduled walkabouts which are undertaken bi-monthly. These walkabouts are managed in conjunction with the 15 Steps walkabouts and subsequent action plans are monitored via safety champions, MNVP Hub meetings, and maternity governance meetings.

9.4 The team are in the process of acquiring the relevant documents from the MNVP following which this action will move to complete and become evidenced and assured.

9.5 Progress Status: On Track

10.0 Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

10.0 The Trust has been fortunate to participate in the NHSE Pilot of version 2 of the Core Competency Framework (CCF) therefore our local training plan reflects the ask within the technical guidance.

10.1 The updated plan has been agreed by the quadrumvirate in June 2023 and presented to QSAC and LMNS in August 2023, as part of the evidence requirements for this safety action.

10.2 There is a risk to delivery in that all staff groups require 90% attendance over a 12-month consecutive period which is calculated from the end date used to inform percentage compliance to meet Safety Action 8 in the Year 4 scheme.

10.3 Figures at present are being affected by the junior doctor rotation in August, and the new midwifery cohort in September, both of which have contributed to lowering of our overall compliance rates.

10.4 The education team are working collaboratively with the management team to ensure all remaining staff are released to attend planned sessions, but this is dependent on any industrial action and staff unavailability therefore delivery of this action overall will remain at risk until the scheme ends.

10.5 ***The Board are asked to acknowledge within the minutes that they agree the content of the local training plan mentioned within 10.1,*** **see appendix 5.**

10.6 Progress Status: At Risk

11. 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?

11.1 The Trust has a robust maternity and neonatal safety champions process in place which evidences ward to board escalation of any quality issues evidencing completion of standard a).

11.2 The locally agreed safety intelligence dashboard **(see appendix 6)** captures a minimum dataset which is reviewed monthly, and any issues escalated via the safety champions AAAA which is reported to Divisional Committee, QSAC and MTAC.

11.3 There is a requirement that this dataset is agreed by the LMNS lead and the regional chief midwife however a previously scheduled meeting to undertake this was unable to go ahead on the day due to unplanned sickness on the part of the regional chief midwife. A further meeting is planned for this month and the deputy regional chief midwife will have delegated authority in the absence of the regional chief midwife due to no current return to work date. The Board can take reassurance from the knowledge that this dataset was previously agreed during Year 4 of the scheme, with the Year 5

agreement being undertaken as a belt and braces approach.

11.4 Standard b) refers to the Trusts claims Scorecard data which should be reviewed alongside incident and complaints data and used to agree targeted interventions aimed at improving patient safety which are then reflected in the Trusts Patient Safety Incident Response Plan. This should be undertaken at least twice in the MIS reporting year and was discussed at Divisional Committee during the months of July and October 2023, and then additionally at safety champions in August and October 2023. Minutes pertaining to both meetings are available on request.

11.5 Safety champions are required to evidence that concerns expressed by staff are made visible to all and this is evidenced within the 'Our staff said, we listened' posters which can be seen at **appendix 7**.

11.6 Standard c) requires that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources. ***This has been completed***.

11.7 Additionally, the Board Safety Champions are required to meet with the Perinatal 'Quad' Leadership team on a quarterly basis, with at least 2 meetings before the end of the reporting period. These meetings took place in August and November 2023, with the minutes from the most recent meeting available at **appendix 8.**

11.8 Progress Status: On Track.

12. Safety Action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?

12.1 This safety action relates principally to the work of the divisional governance team, supported by the legal team.

12.2 As with Safety Action 1, the need to report appropriately to the Maternity and Newborn Safety Investigations (MNSI) programme (previously HSIB) and the NHS Resolution Early Notification Scheme (ENS) is ongoing, hence this action will not be evidenced as delivered/complete until after the reporting deadline of 7 December 2023.

12.3 Family information on the role of MNSI and the ENS is given at the time consent is obtained for referral and is monitored alongside our statutory Duty of Candour; a report will be produced to evidence compliance following the reporting deadline which is in keeping with Year 4 of the scheme.

12.4 Progress Status: On Track.

13.0 Risks to Delivery

There is a risk that…	The risk is caused by…	The potential impact of the risk is…	The mitigation in place is…
The Trust may miss the 90% target for training for midwives, Drs, and support staff	The 12 months consecutive date range begins from the date used to inform compliance for the year 4 scheme therefore compliance must be achieved by October 2023.	Failure of safety action 8	There are several sessions planned to try and capture as many staff as possible however this is intrinsically linked with a high unavailability rate/planned industrial action therefore it is likely that our position will not be known until the qualifying period ends.

14.0 Summary

14.1 SaTH is on track to achieve CNST MIS Year 5, although there remains a very real risk to delivery for Safety Action 8 for the reasons specified above. The team are working hard to mitigate the risk by arranging multiple training days in month in an attempt to capture all eligible staff however this will not be confirmed until after the scheme ends.

15.0 Summary of safety action statuses

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

16.0 Actions requested of QSAC

16.1 Review and discuss this paper and advise the Director of Midwifery of any further detail required.

16.2 Note the content for upwards reporting to the Board of Directors via QSAC which must be done to ensure the Board oversees the quality of perinatal services at every meeting.

16.3 Note the ongoing risk to delivery of the scheme for safety actions 8 which may result in non-compliance for this year of the scheme.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14 December 2023

Agenda item		162/23 Paper 2 within CNST INFORMATION PACK **Appendix 1**		
Report Title		Obstetric clinical workforce plan		
Executive Lead		John Jones, Medical Director		
Report Author		Mei-see Hon, Obstetrics Clinical Director		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Maternity Governance Meetings October 2023 W & C Divisional Committee October 2023 QSAC October 2023 LMNS November 2023		
Executive summary:		We are required for CNST Safety Action 4 to demonstrate an affective Obstetric Clinical Workforce Plan. This report demonstrates compliance with RCOG requirements at all tiers of the medical workforce.		
Recommendations for the Board:		The Board is asked to: Receive the report in line with CNST Safety Action 4.		
Appendices:		Appendix 1 – Roles and responsibilities for Consultant on call in Obstetrics & Gynaecology		

CNST safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

For the Obstetric medical workforce there are 4 sub actions:

1. NHS Trusts / organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetric and gynaecology on tier 2 or 3 (middle grade) rotas:
   a. Currently work in their unit on the tier 2 or 3 rota or
   b. Have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory ARCP or
   c. Hold a RCOG certificate of eligibility to undertake short-term locums

   Minimum evidence requirement:

   Audit compliance via medical HR.

   If standards not met report to Trust Board, Trust board level safety champion and LMNS meetings that process and actions have been put in place to prevent deviation.

   Compliance demonstrated by completion of audit and action plan to address lapses.

   Relevant time period is six months after February 2023.

   Evidence: An audit was conducted of shifts that required Tier 2 locums between February 1st – July 31st 2023. In this time period there were there were 46 shifts that needed covering. All shifts were covered by doctors currently in post and no external locums were used. Therefore this standard was met.

2. Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level Safety champions and LMNS meetings.

   Minimum evidence requirement:

   Use the monitoring / effectiveness tool contained within guidance (p8) to audit compliance and have a plan to address any shortfalls in compliance. Action plan should be signed off by Trust Board, Trust Board level safety champions and LMNS

   Relevant time period is 6 months after Feb 2023

   Evidence: The RCOG document ‘Guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland & Wales’ refers to the employment of long-term locums who are working on the middle grade rota.

In this time period we did not employ any long-term middle grade locums therefore the standard has been met.

For completeness and transparency, we have applied the same standard to the employment of long-term locums on the Consultant rota. In this time period there have been 3 locums employed to work within Maternity. One is an NHS locum who was appointed through a competitive interview process with references. Two were agency locums. All three undertook a documented induction process within the Trust and the RCOG monitoring of compliance and effectiveness tool was completed. All three have received positive feedback and had their contracts extended / returned for another period of employment.

Therefore this standard has been met.

3. Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level Safety champions and LMNS meetings

   Minimum evidence requirements:

   Provide evidence of SOP and their implementation to assure Boards that those undertaking non-resident on calls OOH are not undertaking clinical duties following busy nigh on calls without adequate rests. Evidence of compliance could also be demonstrated by obtaining feedback.

   SOP in place by October 2023

   Relevant time period is 30 May – 7 Dec 2023

   Evidence: This action is not relevant as we do not have any non-resident Obstetric doctors. This SOP details the Roles and Responsibilities of the on call Obstetric consultant:

Roles and
responsibilities for Co

4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document ‘Roles and Responsibilities of the consultant providing acute care in obstetrics and gynaecology’ into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be

reviewed at unit level as an opportunity for departmental level with agreed strategies and action plans implemented to prevent further non-attendance.

Minimum evidence requirement:
Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS

Audit clinical situations / scenarios mandating presence in guidance.
Monitor adherence via incident reporting
Feedback / surveys may triangulate compliance.
Episodes where attendance has not been possible should be reviewed as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

Relevant time period is 30 May – 7 Dec 2023

This will be reported on in January 2024 after completion of the reporting period.

The Shrewsbury and Telford Hospital NHS
NHS Trust

Standard Operating Procedure (SOP)

SOP Title	**Roles and responsibilities for Consultant on call in Obstetrics & Gynaecology**		
SOP Number	3263		
Care Group	Women's & Children's Centre		
Version Number	2		
Effective Date	6/1/2022	Review Date	6/1/2027
Author	Mr Nibedan Biswas, Consultant Obstetrician/Gynaecologist Dr Mei-See Hon, Consultant Obstetrician		
Approved by	Agreed at the Consultant Meeting on the 27th September 2021 Ratified at Clinical Governance 9/11/2021 Present version agreed by W&C Divisional Committee Meeting on 30/11/21		
Approval date	30/11/2021		
Distribution	O & G consultants Switch board Ward 14, GATU, delivery suite, antenatal & postnatal wards		
Location	Shrewsbury & Telford NHS Trust		

Document Control				
Version	Date	Author	Status	Comments
1	30th Aug 2021	NB		Formatted following discussion at the strategy meeting on 25th June 2021 Updated based on feedback from MSH & MU 14/9/2021
2	30/11/2021	NB & MSH		Updated with NHS 7day working standards 30/11/2021

SOP Objectives	To provide clear responsibility for the different on call roles for the Consultant
Scope	This standard operating procedure aims to ensure that all the patients are seen in a timely manner.

Background

In June 2021 the RCOG published an updated Roles & Responsibilities of the consultant providing acute care in obstetrics and gynaecology.

https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/roles-and-responsibilities-of-the-consultant-workforce-report-june-2021.pdf

In the summary it states:

"The roles and responsibilities of the obstetrics and gynaecology consultant are diverse and wideranging. They extend beyond those of an experienced clinician, competent in both technical skills and complex decision-making. O&G consultants are required to role-model collaborative, inclusive and compassionate leadership thereby establishing positive cultural norms for their teams. They should cultivate a range of leadership styles and skills which they can flex between, allowing them to work across different teams and adapt to the varying challenges of the clinical workload. Adopting shallow authority gradients helps foster trust within teams and is key to developing respectful team relationships and providing safe patient care. Consultants are also required to provide clinical supervision and mentorship. This helps develop technical proficiency amongst junior colleagues and the wider multi-professional team as well as create a sense of psychological safety. Furthermore, consultants play a key role in ensuring consistency in the quality of care experienced by women. Their situational awareness, prioritisation skills and ability to take a helicopter view are critical to ensuring individual patient safety as well as to developing services to improve patient outcomes and experience. Their role as patient advocate means they have a responsibility to actively participate in incident investigations and contribute towards organisational learning. This requires a willingness and an ability to adopt a reflective approach towards one's own practice and to continually strive towards improving patient care and outcomes."

In addition, the NHSE document 'Seven Day Services Clinical Standards' published in September 2017 https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf needs to be embedded into every day practice.

The key points relevant to obstetrics and gynaecology are as follows:

1. Patients and where appropriate families and carers must be actively involved in shared decision making and supported by cleat information from health and social care professional to make fully informed choices about investigation, treatments and on-going care that reflects what is important to them. This should happen consistently, seven days a week.
2. All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital. All patients admitted during the period of consultant presence on the acute ward (normally at least 08.00-20.00) should be seen and assessed by a doctor promptly, and seen and assessed by a consultant within six hours.
3. All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours

4. Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.
5. All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

(Please note that this is not a complete list of the standards set out in the Seven Day Services Clinical Standards)

It is also important to acknowledge that women admitted in labour are NOT emergency admissions. Their admission is planned but unscheduled.

It is intended that this SOP is read in conjunction with both the RCOG roles and responsibilities and the NHSE seven-day standards documents in order to understand the background and context.

Roles and responsibilities of O&G consultants at SaTH

In September 2021 the Obstetrics and Gynaecology Consultant on call rotas split. At any one time, 24 hours a day 7 days a week, there is a separate consultant on call for Obstetrics and another for Gynaecology. We no longer have a 'first on' and 'second on' on call O&G Consultant.

This document aims to clarify the roles and responsibilities of each doctor on call.

Resident consultants over night

- The consultants who work resident night shifts may be pure Obstetricians or may be a 'hybrid Consultant' (both an Obstetrician and Gynaecologist.)
- If carrying the 334 bleep they are the on-call consultant for Obstetrics only.
- If carrying the 331 bleep they will have the support of both a non-resident consultant Obstetrician and a separate Gynaecologist and are not expected to conduct Gynaecology beyond the level of expected of a Tier 2 doctor. Even if more than capable to do so there is not the capacity to do this when carrying the 331 bleep.

Obstetrics

0830h-2100h seven days a week

- Resident consultant Obstetrician. Carries bleep 334.
- Responsible for all women on the Delivery Suite, Antenatal ward, Postnatal ward, Triage, Day Unit and any other obstetric patients in ED / outliers on medical and surgical wards.
- Responsible for supervision of Tier 1 and Tier 2 doctors.
- Does NOT have any other planned DCC
- Conduct regular ward rounds

Ward round times:

0830h Huddle, board round and handover followed by face-to-face review of all women under consultant led care on the Delivery Suite, followed by review of all women on the Antenatal ward and those identified as requiring review on the Postnatal ward.

1300h Board round on Delivery Suite with co-ordinating midwife.

1700h Board round and handover to oncoming consultant

1730h Face to face review of women on the Delivery Suite admitted under consultant care / AN ward or readmissions to the PN ward not yet reviewed by a Consultant.

2030h Huddle, board round and handover to oncoming team.

2100h Face to face review of women on the Delivery Suite admitted under consultant care / AN ward or readmissions to the PN ward not yet reviewed by a Consultant.

2030h-0830h seven days a week

- The night shift will always have 3 doctors available and will be one of the following:
  a) Resident Tier 1, resident Tier 2 (carries bleep 331) and non-resident consultant
  b) Resident Tier 1, resident consultant (carries bleep 331) and non-resident consultant
  c) Resident Tier 1, resident Tier 2 (carries bleep 331) and resident consultant (carries bleep 334)

- A non-resident obstetric consultant will attend within 30mins if required as per escalation poster (see appendix 1) or if requested to attend by the Delivery Suite co-ordinator or resident doctors. This is particularly important when the resident team are dealing with a complex situation and may not be in a position to maintain a helicopter view.
- If there is no resident consultant then the non-resident consultant will hand over to the incoming day consultant by telephone at 0830h.

Gynaecology – Resident Consultant

0800h-1800h Monday to Friday

0800h-1200h then 1800h -2000h Saturday and Sunday

- Carry Gynae on-call phone – 07710115244
- Responsible for Gynae ward, GATU, EPAS and any other emergency activities including covering RSH
- Does NOT have any other planned DCC

Activities

- Ward round of all Gynae patients including any outliers daily at 08:00am and then at the end of day
- Undertaking or supervising NCEPOD list cases in a timely manner
- Board round with ward 14 nurse in charge and or patient review at 4pm.

Daily triage

- Triage of all 62/7 referrals including phoning those that need a telephone consultation.
- Completing all advice & guidance.
- Responding to GP correspondences.

Physically reviewing

- All in patients
- All patients attending GATU (unless seen by Tier 2)
- Any admission during resident hours.
- Reviewing anyone starting on methotrexate
- Reviewing anyone on 3rd or more BHCG or asked to see by EPAS
- Reviewing patients in A&E within the hour if referred by Tier 1 or 2 who can't see them due to emergencies.

Responsibilities

- Responding to other speciality in timely & professional manner and accepting cases with Gynae or early pregnancy problems (<16 weeks pregnant and or >10days following delivery).
- Supervising Tier 1 & 2.
- All emergency admissions need to be seen at the point of admission by the senior most clinician (either Tier 2 or the consultant on call).
- No patient should be seen and discharged by the Tier 1 unless seen by Tier 2 or the on-call Consultant.

- To attend delivery suite if called by the on call Obstetric consultant to help with any other emergencies or excessive workload including:
    - Return to theatre
    - Caesarean/postpartum hysterectomy
    - Is not expected to interpret CTGs, conduct instrumental deliveries, or make complex intrapartum decisions if they are a pure gynaecologist
    - Can conduct CS, repair a perineum, review patients in triage, assist the obstetric team with whatever is needed

Gynaecology – Non -resident Consultant

1800h-0800h Monday to Friday

1200h-1800h and 2000h-0800h Saturday and Sunday

Available for:

- Gynae advice and support where needed
- Be the primary consultant to attend RSH if necessary
- To discuss with the Obstetrics Consultant if anticipating T1 or T2 assistance in the emergency theatre

Available to attend within 45 min of the call for

- To undertake all Gynae surgery
- Whenever requested to do so
- To attend delivery suite if called by the on call Obstetric consultant to help with any other emergencies or excessive workload including:
    - Return to theatre
    - Caesarean/postpartum hysterectomy
    - Is not expected to interpret CTGs, conduct instrumental deliveries, or make complex intrapartum decisions if they are a pure gynaecologist
    - Can conduct CS, repair a perineum, review patients in triage, assist the obstetric team with whatever is needed

Gynaecology handover

- Weekdays 0800h to oncoming GOD by phone (not text or WhatsApp)
- Weekdays 1800h to oncoming GON and to the rest of the on-call team as appropriate.
- Weekend - Friday at 06:00pm to the weekend Gynae on call.

Appendix 1:

The Shrewsbury and Telford Hospital NHS Trust

All staff are empowered and encouraged to contact the consultant obstetrician if concerned about the safety of a mother or baby

A consultant MUST attend for:	
Vaginal twins delivery	Eclampsia
Vaginal breech delivery	Intrapartum still birth
Caesarean for • Placenta praevia • <28/40 singleton • <30/40 twins • Transverse lie • BMI >45	Sepsis - Escalation if there is: • Reduced or altered conscious level in a pregnant/postpartum woman • Lactate ≥4mmol/l • Respiratory rate >25 on 2 occasions • No improvement in the hypotension (systolic BP remains <90mmHg) and/or the serum lactate level following a fluid bolus
• Ongoing PPH of 1500ml or more or if the patient is unstable	• Any 4th degree tear
• Patients who decline blood products i.e. Jehovah witness and others, who are having a C/section, MROP or where high blood loss is anticipated.	• Whenever requestedto by any member of staff due to complexity of cases, workload or high levels of activity e.g. a second theatre being opened
• Any return to theatre (O or G) both consultants to attend	• Maternal collapse e.g. septic shock, massive abruption, eclampsia
• **The consultant should always be called at the start of second stage for vaginal twins or any vaginal breech births** • **All handovers and communication should useSBAR**	

Situations when the consultant MAY attend (dependent on the *assessed* competencies of the resident obstetrician)	
• Trial of instrumental delivery in theatre	• Confirmation of intrauterine death
• Any Caesarean section if • in 2nd stage • BMI >40 • <32 weeks gestation	

Version 1.3 19 th May 2021 Martyn Underwood & Mei -See Hon

See also https://intranet.sath.nhs.uk/document_library/ViewPDFDocument.asp?DocumentID=11154

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14 December 2023

Agenda item		162/23 Paper 2 within CNST INFORMATION PACK **Appendix 2**		
Report Title		Anaesthetic Rota		
Executive Lead		Hayley Flavell, Director of Nursing		
Report Author		Zain Siddiqui, Deputy Director of Operations		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Maternity and Neonatal Governance Meetings November 2023 W & C Divisional Committee November 2023 QSAC November 2023 LMNS		
Executive summary:		This report summarises the rota showing anaesthetic cover for Theatre, Labour Ward, Consultant on-call and Obstetric on-call over a 4-week period. This is covered by Consultant and Specialist Grade.		
Recommendations for the Board:		The Board is asked to: Receive this report in line with CNST Safety Action 4.		
Appendices:				

	Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun
		09-Oct	10-Oct	11-Oct	12-Oct	13-Oct	14-Oct	15-Oct
PRH Consultant on call 031	Am	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Pm	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Eve	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Night	Covered	Covered	Covered	Covered	Covered	Covered	Covered
PRH Theatre 9 Obstetric Theatre	Am	Consultant cover	Specialist grade	Consultant cover	Consultant cover	Consultant cover		
	Pm							
Labour ward	Am	Specialist grade	Consultant cover	Specialist grade	Specialist grade	Consultant cover		
	Pm	Consultant cover	Consultant cover	Specialist grade	Specialist grade	Consultant cover		
PRH Obstetrics on call Bleep 349	Am	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade
	Pm	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade
	Eve	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade
	Night	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade

	Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun
		16-Oct	17-Oct	18-Oct	19-Oct	20-Oct	21-Oct	22-Oct
PRH Consultant on call 031	Am	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Pm	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Eve	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Night	Covered	Covered	Covered	Covered	Covered	Covered	Covered
PRH Theatre 9 Obstetric Theatre	Am	Consultant cover	Consultant cover	Consultant cover	Consultant cover	Consultant cover		
	Pm							
Labour ward	Am	Specialist grade	Specialist grade	Consultant cover	Consultant cover	Consultant cover		
	Pm	Specialist grade	Consultant cover	Consultant cover	Consultant cover	Consultant cover		
PRH Obstetrics on call Bleep 349	Am	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade
	Pm	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade
	Eve	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade
	Night	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade

	Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun
		23-Oct	24-Oct	25-Oct	26-Oct	27-Oct	28-Oct	29-Oct
PRH Consultant on call 031	Am	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Pm	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Eve	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Night	Covered	Covered	Covered	Covered	Covered	Covered	Covered
PRH Theatre 9 Obstetric Theatre	Am	consultant cover	consultant cover	consultant cover	consultant cover	consultant cover		
	Pm							
Labour ward	Am	Not covered	Not covered	specialist cover	consultant cover	consultant cover		
	Pm	consultant cover	Not covered	consultant cover	consultant cover	Specialist grade		
PRH Obstetrics on call Bleep 349	Am	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade
	Pm	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade
	Eve	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade
	Night	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade

	Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun
		30-Oct	31-Oct	01-Nov	02-Nov	03-Nov	04-Nov	05-Nov
PRH Consultant on call 031	Am	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Pm	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Eve	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Night	Covered	Covered	Covered	Covered	Covered	Covered	Covered
PRH Theatre 9 Obstetric Theatre	Am		consultant cover	consultant cover	consultant cover	consultant cover		
	Pm	consultant cover						
Labour ward	Am	consultant cover	consultant cover	Specialist grade	Specialist grade	Specialist grade		
	Pm	Specialist grade	consultant cover	consultant cover	consultant cover	consultant cover		
PRH Obstetrics on call Bleep 349	Am	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade
	Pm	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade
	Eve	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade
	Night	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade	Specialist grade

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14th December 2023

Agenda item		162/23 Paper 2 within CNST INFORMATION PACK **Appendix 3**		
Report Title		Neonatal Nursing Workforce Action Plan/Strategy		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Tina Kirby, Centre Manager Maternity Neonatal, Louise Duce, Divisional Deputy Director of Nursing, Dr Patricia Cowley, Clinical Director for Neonatal Services		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community		
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners		
Consultation Communication		Maternity Governance Committee, November 2023 W&C Divisional Committee Meeting, November 2023 Quality and Safety Assurance Committee, November 2023 LMNS/PNQSG, TBC		
Executive summary:		Key workforce planning priorities arising from this strategy are identified below :- • Assess nursing staffing levels at least twice annually using the workforce tool. • Measure diverted activity to understand any impact on cot numbers. • Pursue implementation of the Ockenden final report business case with a view to securing additional funding to address BAPM standard and Ockenden recommendation staffing gaps. - Quality roles - Shift coordinators - Transitional care nursing - Psychology support • Enhance recruitment through IR, recruitment of paediatric or maternity trained staff and skill mix with band 4 nursing associates. • Over-recruit at band 5 to support unavailability and later recruitment to band and 7 posts. • Achieve trajectory for 70% of clinical nursing as QIS including uplift of QIS staff to band 6 post training. (cost £31,943)		

	• Continue internal ANNP trainee programme once funding secured. • Further develop lead roles for ANNPs including team management role and rotation to level 3 units. (cost £14,867) • Address reduction in Deanery medical trainees through increasing numbers of ANNPs or recruitment of Trust Speciality doctors. • Review ward nursing template in light of HTP layout.
Recommendations for the Board:	The Board is asked to: Approve the strategy Note the costs of implementation that are not currently contained within the Ockenden Business case. • Uplift of QIS nursing staff to band 6 £31.943 • 1 day/ week management role for ANNPs £14,867
Appendices:	None

The Shrewsbury and Telford Hospital NHS Trust

Workforce Plan
Neonatal Unit
October 2023

Contents

Step 1 Define the Plan

Goal: Determine the Parameters, Scope, and Objectives of the Plan

1.1 Purpose

- To define the current workforce
- To inform future service development
- To identify gaps to achievement of National workforce standards.

1.2 Scope

- This workforce plan covers all clinical staff within the Neonatal service.

1.3 Ownership

- This plan is owned by the Neonatal Service with support from the wider Women and Children's Division.

Step 2 Map the Service Change

Goal: Determine the Model and Shape of Services Within the Next Year

2.1 Goals and Benefits

- Achieve BAPM standards for Neonatal Nursing staffing including required level of training (70% QIS nursing)
- Maintain BAPM standards for medical staffing
- Achieve BAPM standards for the provision of transitional care.
- Achieve BAPM standards for the provision of quality and coordination functions
- Achieve Ockenden report staffing recommendations for nursing and medical staffing.
- Reduce complaints and datix related to poor staffing levels and lack of quality lead roles
- Reduce staff stress and improve staff morale.
- Reduce staff turnover and ensure that succession planning is in place.
- Improve performance against quality measures.
- Improve recruitment and reduce vacancies
- Reduce unavailability.

2.2 Current Baseline Summary

Nursing and Medical staffing wte plan, actuals and cost are presented in Appendix 1.

In summary the budgeted workforce consists of:

- 5.8 Consultants
- 8.8 Other Medical Staff
- 53.16 Nursing Staff

- 10.03 ANNPs
- 2.33 Support Staff

Agency Hours equate to:

- Consultant 0.32 wte
- Nursing 1.41 wte

Bank hours equate to:

- Nursing 2.62 wte
- Support staff 0.22 wte

2.3 Drivers and Constraints

National Drivers:

National staffing standards are described in BAPM guidance and in recommendations of the Ockenden Report.

These cover:

- Nursing staffing
- Medical staffing
- Allied health professionals

2.3.1 Nursing staffing standards

a) BAPM Core Clinical Nursing requirements – workforce tool (Appendix1)

BAPM publish core requirements for the level of nursing staffing required against activity. This is assessed through the use of a workforce toolkit which looks to ensure that:

- There are sufficient overall clinical nursing numbers
- There are sufficient nurses Qualified in Speciality (QIS) This latter should be 70% of the total qualified nurses.

The tool complete in August 2023 demonstrates that the overall nursing staffing budget is sufficient to meet BAPM nursing standards.

However, there are issues with recruitment to senior posts, with 4.99wte vacancies for clinical nurses. Moreover, the tool calculations are based on recorded activity. There have been historic issues with under-reporting of activity.

There are also issues with numbers of clinical nurses qualified in speciality. We currently have 55% of clinical nurses qualified in speciality against a standard of 70%.

This workforce tool does not include quality, management or transitional care staffing elements. These are covered by the separate BAPM guidance outlined below.

b) BAPM Quality standards

The British Association of Perinatal Medicine published Service and quality standards for Neonatal Care in the UK in November 2022. These standards include detailed staffing recommendations.

The service undertook benchmarking of the SATH service against these standards in February 2023.

A number of gaps in nursing staffing were identified particularly around, dedicated time for nursing quality roles and shift coordinators.

Quality Roles:

Nurses should act as champions for the quality of practice within the unit and should have protected time and responsibility for lead roles. Gaps in quality roles can significantly impact on patient care, increase stress levels for staff and subsequently reduce staff morale.

The chance of survival of the smallest and most preterm babies relates not only to nurse staffing ratios but also to the specialist levels of education and experience of nurses delivering care. Hence the need for the essential quality roles.

Specific gaps in quality roles are identified in section 3.2 below.

Shift Coordinators:

The BAPM quality standards identify that there should be a super-numerary shift coordinator on the ward 24/7 at a band 7. The unit does not currently achieve this standard.

c) Transitional Care neonatal nursing support

BAPM also published a Framework for Neonatal Transitional care in 2017 that included staffing requirements for this area of service. The service undertook benchmarking of the SATH service against these standards in February 2023.

Transitional care should be staffed by a combination of midwifery and Neonatal nursing staff. The ratio of staff to patients should be 1:4.

To meet this standard, we would require investment in one neonatal nurse available 24/7. The guidance recommends that one of these nurses is funded at band 7 to act as a lead for the service. This service lead could also provide leadership for the neonatal outreach team.

d) Ockenden requirements

Many of these themes are also highlighted in the Ockenden report recommendations as below:

IEA 14.8

Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 medical staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.

LAFL 14.59

The number of nurses at the Trust who are "qualified-in-speciality" must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review.

2.3.2 Medical Staffing and ANNPs

Standards for medical staffing are outlined by BAPM and within the Ockenden report. The unit's medical teams are able to meet all these standards.

a) Required BAPM standard for medical staffing:

British Association of Perinatal Medicine (BAPM) published revised standards for medical staffing for LNUs in November 2022. The neonatal unit meets these updated BAPM national standards of medical staffing. The BAPM national standard is articulated in the following document:

The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK November 2022

The requirements are:

Tier 1 staffing: Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general paediatrics in addition.

- The unit meets this standard and have done so for >10 years. This can be evidenced by our Tier 1 rotas.

Tier 2 staffing: Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff.

- The Tier 2 is currently 1 in 8 with some shared cover with paediatrics between 23.00 and 08.30.

- From September 2023, the rotas are fully separated with a rota of 8 WTE staff purely for neonates at Tier 2.

Tier 3 staffing: A minimum of 7 WTE neonatal paediatricians/neonatal consultants on the on-call rota. Minimum of 1 consultant with a designated lead interest in neonatology. At least one LNU Tier 3 consultant should have either a CCT in neonatal medicine or neonatal SPIN module.

- The Tier 3 rota moved from 6 WTE to 7 WTE template in April 2023. We currently have one vacancy, but the rota remains 1 in 7.
- All consultants only have on call commitment to Neonates.
- We have two consultants with CCT in Neonatal Medicine.

b) Ockenden recommendations for medical and ANNP staffing

The Ockenden report includes the recommendations below around medical staffing.

LAFL 14.58

The Trust must ensure that sufficient resources are available to provide safe neonatal medical or ANNP cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU.

IEA 14.47

As the Trust has benefitted from the presence of Advanced Nurse Practitioners (ANNPs) the Trust must have a strategy for continuing recruitment, retention and training of ANNPs.

The number of Deanery trainees has been steadily reducing putting pressure on the ANNP workforce. There is also a need for succession planning amongst ANNPs as a significant percentage are expected to retire within the next 3-5 years. We currently have 10 ANNPs with one vacancy. Of these 3 staff have already retired and returned on reduced hours. There is therefore an urgent need for a rolling programme of training of ANNPs. See section 4.3.

2.3.3 Allied Health Professionals

The British Association of Perinatal Medicine published Service and quality standards for Neonatal Care in the UK in November 2022. These standards include detailed staffing recommendations.

The service undertook benchmarking of the SATH service against these standards in February 2023.

There has been significant investment in AHP support in 2022/23 through the neonatal network, including hours for Dietetics, Speech and Language therapy, Occupational therapy and Physiotherapy. Once recruitment is complete, these disciplines will fully meet National staffing guidelines for NNUs.

There remains a gap in permanent funding for psychology support as funding currently available is only for 0.5 wte band 8a for 12 months.

The standard for this provision would require 1 wte to be permanently funded.

Step 3 Defining the Required Workforce

3.1 Activity Analysis

The level of activity within the Neonatal unit is not forecast to change substantially over the next few years. Nursing staffing levels are determined by the activity at different care level.

Activity by care level (HRG) is presented below. It is acknowledged that there have been some issues with ensuring complete activity recording in the last couple of years. This may particularly effect recorded transitional care days. Full validation of activity data is now in place which should improve this issue going forward. Bay B is currently closed with possible diversion of some activity to other units.

	Care Days by Level			
Year	**Intensive Care**	**High Dependency**	**Special Care**	**Transitional Care**
2018	731	937	4233	2935
2019	553	761	3865	1919
2020	691	927	3674	1670
2021	735	872	3705	1561
2022	582	831	3653	1087
2023 (up to 31/07)	342	387	2216	499

3.2 Types and Numbers of Staff Required

Further enhancement of the neonatal nursing workforce is required to meet BAPM nursing standards and Ockenden recommendations. This will require recruitment across all levels of qualified staff (band 5 upwards). Levels of internal promotion are likely to require significant backfill at band 5.

There will also be a need for recruitment to address attrition and forecast retirement levels.

To address the National drivers, we require the additional staff outlined below. These requirements have been included in the Ockenden final report business case that is currently being considered for funding by the Trust.

3.2.1 Shift Coordinators

The BAPM quality standards identify that there should be a super-numerary shift coordinator on the ward 24/7 at a band 7.

This would require 5.6 wte band 7 nurses. Current templates only include 3.5 clinical band 7 coordinator posts. We therefore require a further 2.1 wte band 7 coordinators to cover all shifts.

post	wtwte	banding	Costing
Shift coordinator	2.1	7 7	£116,190
Total			**£116,190**

3.2.2 Quality Roles

The British Association of Perinatal Medicine Services produced "Quality Standards for Provision of Neonatal Care in the UK "(November 2022). This guidance identified that 'nurses should act as champions for the quality of practice within the unit' and should have protected time and responsibility for very specific lead roles for neonatal units. These roles are outlined below:

Essential Lead Roles	wte	band	cost
Education and practice development	1.0	7	**£55,329**
Infant feeding lead	1.0	7	£55,329
Family integrated care	0.6	7	£33,197
Developmental care	0.5	6	£22,336
Discharge planning	0.6	7	£33,197
Safeguarding children	0.6	6	£26,803
Risk and governance and patient safety lead	0.6	6	£26,803
Infection control	0.6	6	£26,803
Bereavement support and palliative care	0.4	6	£17,869
Total			**£297,664**

3.2.3 Support Services – Allied Health Professional

The standards also stipulate that psychology support for parents needs to be available consistently. A quote for the provision of this service via the local mental health service is outlined below. To note, this quote includes the cost for supervision of the psychologist for the service which is a required professional standard.

Role	Wte	Band	Cost
Psychology support through MPFT, with supervision	1.0	8a	£117,396
Total			**£117,396**

3.2.4 Transitional Care Neonatal Nursing Support

To meet this standard, we would require investment in one neonatal nurse 24/7. Guidance in A Framework for Neonatal Transitional Care 2017 recommends that one of these nurses is funded at band 7 to act as a lead for the service.

Role	wte	Band	Cost
Transitional care service lead	1	7	£55,329
Transitional care nurse	5.0	5	£181,991
Named lead consultant	0.25 PA/ Week	Consultant	£3,146
Total			**£240,465**

3.3 Productivity and New Ways of Working

Transfer of Staff

As part of the Trust's Hospital Transformation Programme, the service is due to relocate to Shrewsbury in 2026. This will be a reprovision of the existing service. This move of service may affect recruitment and retention of some existing nursing and medical staff living in the East of the County. It may also reduce the attractiveness of the unit as a student training site.

Once the layout of the new unit is finalised a review of current staffing templates will be required to ensure that all areas are adequately staffed.

Step 4 Workforce Supply and Retention

Goal: Identify Current and Future Staff Availability Based on Current Profile and Deployment (Workforce Supply)

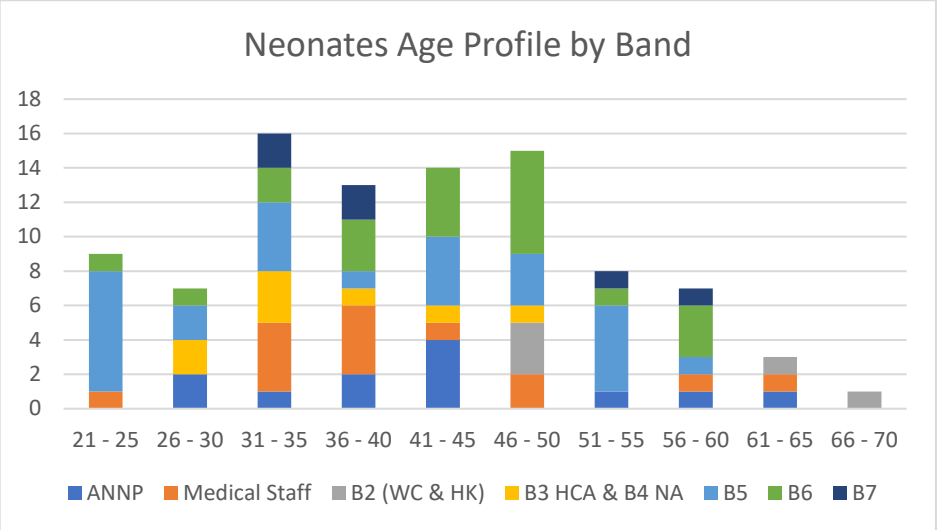
4.1 Current Workforce

Gender profile

Gender	
Female	86
Male	7
Not Specified	0

Age Profile

The age profile of staff by band is outlined below:



Staff in Post by Role & Age											
	21 - 25	***26 - 30***	***31 - 35***	***36 - 40***	***41 - 45***	***46 - 50***	***51 - 55***	***56 - 60***	***61 - 65***	***66 - 70***	***Total***
ANNP		2	1	2	4		1	1	1		12
Medical Staff	1		4	4	1	2		1	1		14
B2 (WC & HK)						3			1	1	5
B3 HCA & B4 NA		2	3	1	1	1					8
B5	7	2	4	1	4	3	5	1			27
B6	1	1	2	3	4	6	1	3			21
B7			2	2			1	1			6
Total	**9**	**7**	**16**	**13**	**14**	**15**	**8**	**7**	**3**	**1**	**93**
							Retirement Pipeline				

20% of the current workforce are aged over 50 years with 12% over age 55.

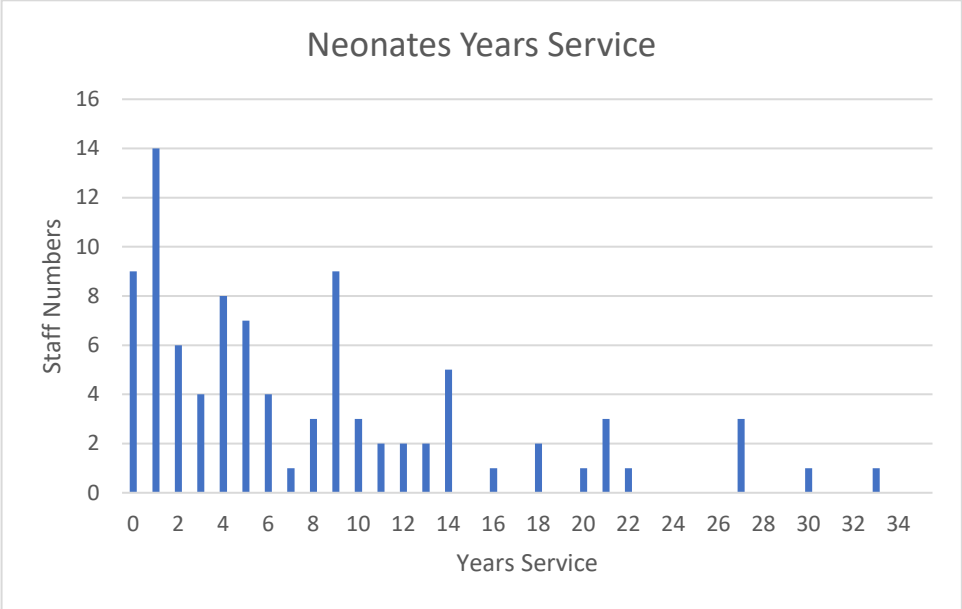
Gender profile

Gender	
Female	86
Male	7
Not Specified	0

Ethnicity Profile

Ethnicity	
Asian or Asian British	8
Black or Black British	7
Mixed	1
Not Stated	1
Other Ethnic Group	1
White	75

Years of Service



Unavailability

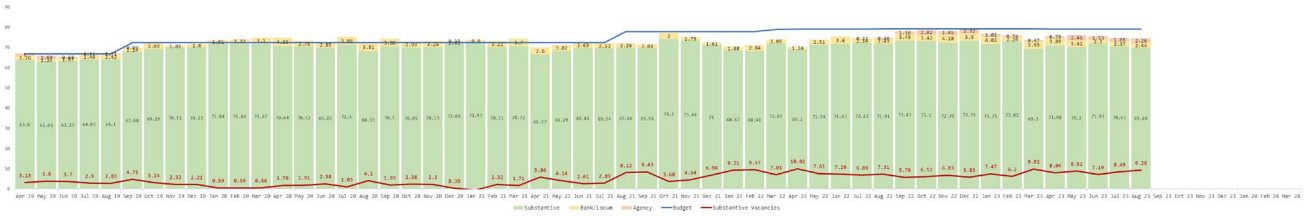
Period	6	5	4	3	2	1	
Dates	**03.09 - 30.09.23**	**06.08 - 02.09.23**	**09.07 - 05.08.23**	**11.06 - 08.07.23**	**14.05 - 10.06.23**	**16.04 - 13.05.23**	**Average**
Total	40.00%	42.00%	37.00%	38.00%	37.00%	34.00%	**38.00%**
Annual Leave	16.00%	17.00%	14.00%	13.00%	12.00%	13.00%	**14.20%**
Sick Leave	12.00%	16.00%	13.00%	11.00%	12.00%	11.00%	**12.50%**
Study	3.00%	2.00%	2.00%	3.00%	1.00%	20.00%	**5.20%**

Nursing unavailability has been particularly high in 2023 at an average of 38%.

Sick leave has been an issue at 12.5% overall. The main reason for sickness absence is mental health issues.

Vacancies

Numbers of vacancies have risen from an average of 2.29 wte/ month in 2019/20 to an average of 7 wte/ month in 2022/23. However, budgeted wte has also risen over this period from 69.19 wte to 83.68 wte. The vacancy rate has risen from 3.3% to 8% over this period. Reasons for leaving over the last 12 months include career progression (2), personal reasons (3) ill health retirement (1).



4.2 Workforce Forecasting

National workforce standards and review recommendations have been responsible for a significant increase in the size of the Neonatal workforce and this is likely to continue over the next few years. Going forward this expansion is likely to offer increased options for band 6 and 7 nursing staff.

In addition, the existing workforce has a relatively high age profile particularly among medical and ANNP staff groups. There is therefore an urgent need for:

- Strong recruitment to nursing staff at all bands 5-7.
- In house training of ANNPs to support succession planning.

- Ongoing training for QIS nursing to support succession planning.

4.3 Options for Changing Supply

4.3.1 Recruitment strategy

To achieve BAPM standards and Ockenden recommendations we require significant increases in quality and coordination staff at a band 6 and 7. As these are National drivers there is likely to be a significant shortfall in suitable neonatally trained staff for these posts Nationally.

Internal recruitment to such posts could dangerously reduce the numbers of clinical staff on the ward.

It is therefore recommended that the service over-recruit initially at a band 5 to support high unavailability and later recruitment at band 6 and 7 which is likely to include internal promotion.
To help address the National shortage of Neonatally qualified nursing staff, the service is also exploring:

- Employment within the service of International recruits to SATH who have neonatal experience.
- Broadening skill requirements for posts to support applications from Paediatric of midwifery trained staff.
- Skill mix to develop band 4 nursing associate roles.

4.3.2 QIS training trajectory and band 6 uplift

In order to achieve the required standard of 70% QIS clinical nurses we would need to train a further 9 staff (we currently achieve 55% QIS). This requires 2 days per week training over 6 months.

A trajectory to achieve this has been provided over the next 24 months. To address attrition, an ongoing programme of 3 staff commencing training every 6 months is planned.

Staff requiring training	Complete training June 2023	Complete training January 2024	Complete training June 2024	Complete training January 2025
9	3	3	3	3

Funding to support this training programme has been included in the Ockenden Final report business case.

1 wte band 5 backfill £41,257
Course fees £81,648 (£13,608 / nurse)
Total £ 122,90

To aid retention is it recommended that staff achieving this level of training are uplifted to a band 6. The total uplift cost to increase QIS by 9 (band 5 to band 6) £31,943.

4.3.3 ANNP training and development

The number of Deanery trainees has been steadily reducing putting pressure on the ANNP workforce. There is also a need for succession planning amongst ANNPs as a significant percentage are expected to retire within the next 3-5 years. We currently have 9 ANNPs with one vacancy. Of these 3 staff have already retired and returned on reduced

hours. There is therefore a need for a rolling programme of training of ANNPs.

Funding for this has been included in the final Ockenden Business case to allow for two training posts as an ongoing training programme.

Backfill costs (2 x band 7) £110,657

Course and training fees £20,000 per ANNP

Further development opportunities for ANNPs are being developed including lead roles and rotation to level 3 units.

A management lead role is recommended to allow 1 day per week team management to be included. Cost £14,867/year.

4.3.4 Tier 2 rota staffing

Two challenges to maintaining Tier 2 staffing have been identified.

1. The reduction in Deanery trainees within the region.
2. The RCPCH Progress Plus plan for Paediatric training has removed the requirement for paediatric trainees to complete a Tier 2 neonatal placement. This is likely to have a further impact on the number of trainees allocated to us.

To address this, two options are possible:

1. Increase the number of Tier 2 ANNPs within the department. This has a cost implication as ANNPs work fewer hours per week than junior doctors. The advantages of this model are the stability of having permanent members of staff and provision of career progression opportunities for ANNPs within the department.
2. Implement a rolling programme of recruitment of Trust Speciality doctors. These will usually be overseas doctors looking to move to the UK and join the training programme. They will therefore be with us for a limited period of time and require regular recruitment for replacements. The advantage of this option is that these costs are already within the neonatal budget.

Step 5 Action Planning

Goal: Plan to Deliver the Required Workforce with the Right Skills, In the Right Place (New Skills in New Locations) with Milestones and Timescales to Manage the Change

5.1 Gap Analysis

Workforce gaps have been identified in the Ockenden final report business case that is currently with the Trust senior team for consideration against development funding.

5.2 Priority Planning

Key workforce planning priorities arising from this strategy are identified below:

- Assess nursing staffing levels at least twice annually using the workforce tool.
- Measure diverted activity to understand any impact on cot numbers.
- Pursue implementation of the Ockenden final report business case with a view to securing additional funding to address BAPM standard and Ockenden recommendation staffing gaps.
    - Quality roles
    - Shift coordinators
    - Transitional care nursing
    - Psychology support
- Enhance recruitment through IR, recruitment of paediatric or maternity trained staff and skill mix with band 4 nursing associates.
- Over-recruit at band 5 to support unavailability and later recruitment to band and 7 posts.
- Achieve trajectory for 70% of clinical nursing as QIS including uplift of QIS staff to band 6 post training. (cost £31,943)
- Continue internal ANNP trainee programme once funding secured.
- Further develop lead roles for ANNPs including team management role and rotation to level 3 units. (cost £14,867)
- Address reduction in Deanery medical trainees through increasing numbers of ANNPs or recruitment of Trust Speciality doctors.
- Review ward nursing template in light of HTP layout.

5.3 Action Planning

Priority	Action	Lead	Timescale	Update	Risks/issues	Mitigations
Assess nursing staffing levels at least annually using the workforce tool.	Complete and report to Division Committee	Tina Kirby Centre Manager/ Louise Duce Deputy Director of Nursing	August annually			
Measure diverted activity to understand any impact on cot numbers.	Establish system of monitoring	Triumvirate	Dec 2023			
Pursue implementation of the Ockenden final report business	Take to IIC and ICB investment panel	Carol McInnes Director of Operations	Dec 2023			

case with a view to securing additional funding to address BAPM standard and Ockenden recommendation staffing gaps.						
Enhance recruitment through IR and recruitment of paediatric or maternity trained staff. Develop band 4 nursing associate roles	Liaise with Trust IR team to review applications. Review JDs and job adverts.	Louise Duce Deputy Director of Nursing	November 2023			
Over-recruit at band 5 to support later recruitment to band and 7 posts	Recruitment of transitional care posts	Louise Duce Deputy Director of Nursing	November 2023			
Achieve trajectory for 70% of clinical nursing as QIS including uplift of QIS staff to band 6 post training	train 6 staff per year Request Division support for band 6 uplift	Louise Duce Deputy Director of Nursing/ Shirley Teece ward manager Tina Kirby Centre Manager	June 2025 November 2023			
Continue internal ANNP trainee programme once funding secured		Louise Duce Deputy Director of Nursing/ Dr Cowley CD	Ongoing			
Further develop lead roles for ANNPs including team management role and rotation to level 3 units	Request Division support for management day Assign lead roles Implement rotation to level 3 units	Tina Kirby Centre Manager Dr Cowley CD Louise Duce Deputy Director of Nursing	November 2023 Dec 2023 June 2024			
Address reduction in Deanery medical trainees through increasing numbers of ANNPs or recruitment of Trust Speciality doctors.	Agree approach with Division Committee once outcome of Ockenden Business Case is known.	Dr Cowley CD/ Tina Kirby Centre manager	April 2024			
Review ward nursing template in light of HTP layout.		Louise Duce Deputy Director of Nursing				

5.4 Managing Change

Women and Children's Division Committee are asked to approve and support this strategy.

Step 6 Implement, Monitor and Refresh

Goal: Implementation of the Plan, Processes to Measure Progress and Refresh the Plan as Determined

6.1 Implementation and progress monitoring

The strategy action plan will be reviewed quarterly through the Neonatal Business Meeting.

6.2 Refreshing Your Plan and Actions

This strategy will be refreshed annual by the Neonatal Triumvirate

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14th December 2023

Agenda item		162/23 Paper 2 within CNST INFORMATION PACK **Appendix 4**		
Report Title		Maternity & Neonatal Safety Champions Locally Agreed Dashboard		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Kim Williams, Head of Midwifery		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Maternity Governance Committee, November 2023 W&C Divisional Committee Meeting, November 2023 Quality and Safety Assurance Committee, November 2023 LMNS/PNQSG TBC		
Executive summary:		This report presents a quarterly update on key clinical performance incidcators for the Maternity and Neonatal Services. The quarter 2 report does not highlight any significant issues.		
Recommendations for the Board:		The Board is asked to: To receive the report in line with CNST Safety Action 9.		
Appendices:		None		

Maternity Neonatal Safety Champions Locally Agreed Dashboard Q2

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

Maternity Safety Support Programme	Yes

		QUARTER 2 - 2023/2024			July	August	September	Comment
1.	**PMRT**	Findings of review of all perinatal deaths using the real time data monitoring tool	Stillbirths		1	0		100% compliance for reporting to MBRRACE within 7 working days and informing families that a PMRT review will take place and letters sent regarding the review
			Late fetal losses >22 wks		0	1		
			Neonatal Deaths		1	1		
2.	**HSIB**	Findings of review of all cases eligible for referral to HSIB			1	2		Referral in July rejected by HSIB due to normal MRI result Referrals for August - 1 rejected due to normal MRI result and at the time of writing still waiting on decision for 2nd referral
	Serious Incidents	Findings of all SIs			1	1		1 in July but later declined by HSIB. 1 SI reported in August relating to a neonatal death
3a.	**INCIDENTS**	The number of incidents logged and graded as Moderate Harm or above and what actions are being taken			4	3		All moderate harm or above incidents reviewed at weekly IRM (Incident Review Meeting). Following MDT review, 4 incidents from July remain Moderate harm: - HSIB referral awaiting decision from ICB and Trust Corporate Governance to close. - Neonatal Divisional Governance investigation - Requiring further input from PMHT - Closed but remains Moderate not requiring further investigation 3 incidents from August remain Moderate harm: - Two incidents relate to recently referred HSIB case, also declared as an SI - HSIB referral declined due to normal MRI, awaiting decision for closure as case above
3b.	**TRAINING**	Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Obstetricians	PROMPT	100%	100%		A minimum of 90% compliance is required for PROMPT, NLS and Fetal Monitoring training as part of the Maternity Incentive Scheme reporting. The Education team continue to ensure that all medical staff are booked to attend FMT and where compliance does not meet the requirements, a process for escalation to the Medical Director is in place. A full review of the training guideline is in progress along with the 3 yr local training plan to meet the requirements of the CNST MIS Safety Action 8
				Fetal	95%	95%		
			Midwives	PROMPT	97%	97%		
				NLS	95%	95%		
				Fetal	96%	96%		
			Other Drs	PROMPT	100%	88%		
				Fetal	100%	96%		
			Neonatal	NLS	97%	97%		
			Anaesthetists	PROMPT	84%	79%		
			WSAs/MSW	PROMPT	89%	89%		
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	Maty Del Suite positive acuity		82%	80%		Obs Unit for Drs - Minimum safety staffing level always available on Delivery Suite. The Delivery Suite co-ordinator was supernumerary on all occasions in August
			Maty 1:1 care in labour		100%	100%		
			Fill rates Delivery Suite RM		87% day 89% night	tbc		
			Fill rates Postnatal RM		103% day 77% night	tbc		
			Fill rates Antenatal RM		100% day 88% night	tbc		
			Obstetric Cover on D Suite		100%	100%		
4.	**SERVICE USER FEEDBACK**	Service User Voice Feedback from MVP and UX system achievements			Achievements in Q2: •1Selected to present Birth preferences card at baby lifeline National Maternity safety conference conference •1UX workshop held on the topic of Healthy Pregnancy Services •1coordinated a communications campaign on social media to promote baby buddy •1started work on improvements for service users with high BMI and suffering with diabetes			
5.	**STAFF FEEDBACK**	Staff feedback from Bi-monthly frontline champion and walkabouts *(CNST requirement quarterly)*			Shrewsbury MLU and Outpatients	No walkabout (Bi-monthly)	Neonatal Unit	'Our Staff Said, We Listened' feedback posters with updates for staff are distributed widely via email and on display
6.	**EXTERNAL**	Requests from an external body (HSIB/NHSR/CQC or other organisation) with a concern or request for immediate safety actions made directly with Trust			None to report			The last safety recommendation reported by HSIB was in 2022 and this is related to an aspect of escalation for medical review.
7.	**Coroner Reg 28**	Coroner Regulation 28 made directly to Trust			0	0		None made directly to the Trust
8.	**SA 10 CNST**	Progress in achievement of CNST Safety Action 10			100%	100%		3 investigations have been published in July and August with no safety recommendations. There have been no safety recommendations in any reports published in the last year. The last was made in April 2022. 50% of SaTH investigations to date have had no safety recommendations from HSIB compared to national figure of 15%
9.	**ECLAMPSIA**	Number of women who developed eclampsia			0	0		Zero cases reported for Q4 and Q1 2023
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment								44.3% for Maternity Services published 2023
Proportion of specialty trainees in Obs & Gynae responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours								Reported annually - 87% *(source GMC National Trainees Survey 2022)*

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14th December 2023

Agenda item		162/23 Paper 2 within CNST INFORMATION PACK **Appendix 5**		
Report Title		Our Staff said, We Listened March-April 2023		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Marie Harris, Governance Administrator		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community		
Effective	√	Our people	√	
Caring	√	Our service delivery		**Trust Risk Register id:**
Responsive	√	Our governance		
Well Led	√	Our partners		
Consultation Communication		Maternity Governance Committee, November 2023 W&C Divisional Committee Meeting, November 2023 Quality and Safety Assurance Committee, November 2023 LMNS/PNQSG TBC		
Executive summary:		This report summarises key issues raised by staff in Ludlow Community during the Safety Champions Walk Abouts and actions taken as a result. There were 10 issues raised in March.		
Recommendations for the Board:		The Board is asked to: Receive the report in line with CNST safety action 9.		
Appendices:		None		

Maternity & Neonatal Safety Champions

The Shrewsbury and Telford Hospital NHS Trust

Our staff said...

March April Update 2023

...We listened

March 2023
Ludlow MLU Walkabout
Laptop connectivity to GP Practices is poor preventing simultaneous Badgernet updates

April 2023
Badgernet functionality allows working offline and updating records contemporaneously. Data will auto upload when connected – be sure to download records before leaving the unit

March 2023
Ludlow MLU Walkabout
IT - Problems around info transfer for babies born in Hereford

April 2023
Downloading caseloads and working off-line will allow you to read documentation from Hereford

March 2023
Ludlow MLU Walkabout
IT – not set-up for Microsoft Teams meetings microphone/camera

April 2023
This can be ordered! Please raise this with your area Manager for authorisation of equipment needed

PACT Partnering · Ambitious Caring · Trusted

1 of 4

Maternity & Neonatal Safety Champions

The Shrewsbury and Telford Hospital NHS Trust

Our staff said...

March April Update 2023

...We listened

March 2023
Ludlow MLU Walkabout
Patient information leaflets not visible on 'staff view'

April 2023
Work is underway to address this and will be made available on the SaTH internet page for service users and staff

March 2023
Ludlow MLU Walkabout
Service User travel from Ludlow areas to PRH/RSH for scans since Covid

April 2023
Sonography services are now centralised and arranged simultaneously during Consultant appointments to reduce impact of travel. Monitoring will take place in collaboration with the MVP (Maternity Voices Partnership) team

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Maternity & Neonatal Safety Champions

The Shrewsbury and Telford Hospital NHS Trust

Our staff said...

March
April
Update 2023

...We listened

March 2023
Ludlow MLU Walkabout
Midwives facing difficulties booking appropriate training to support assisting Delivery Suite at time of escalation

April 2023
All midwives are pre-booked on to all mandatory training by the Ward Manager. This is monitored during monthly PRM with the senior management team and Human Resources

March 2023
Ludlow MLU Walkabout
Wide area covered for homebirths – new process welcomed for initially calling Wrekin MLU means that the equipment & 1st midwife response has improved

April 2023
A new SOP is in place and training is underway!

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Maternity & Neonatal Safety Champions

The Shrewsbury and Telford Hospital NHS Trust

Our staff said...

March
April
Update 2023

...We listened

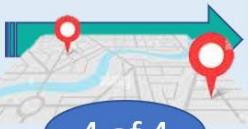
March 2023
Ludlow MLU Walkabout
Delay to 4x4 vehicle being available at Bridgnorth

April 2023
The vehicle has been ordered – a replacement car is available to use

March 2023
Ludlow MLU Walkabout
Size of unit feels too large for the number of staff now in the building

April 2023
There is currently a community review taking place which will address community working, facilities and practices

March 2023
Ludlow MLU Walkabout
Unnecessary travel for short training sessions



April 2023
Work is underway with the Education team to look at allocation of training for all staff to undertake training in one block week

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The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14th December 2023

Agenda item		162/23 Paper 2 within CNST INFORMATION PACK **Appendix 6**		
Report Title		Minutes of the Second Quad/Safety Champions Quarterly Meeting		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Millie Gibson, PA to Director of Midwifery		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community	√	
Effective		Our people	√	
Caring		Our service delivery	√	**Trust Risk Register id:**
Responsive		Our governance	√	
Well Led	√	Our partners	√	
Consultation Communication		Maternity Governance Committee, November 2023 W&C Divisional Committee Meeting, November 2023 Quality and Safety Assurance Committee, November 2023 LMNS/PNQSG TBC		
Executive summary:		These are the minutes from the quarterly Safety Champions/W&C Quad meeting as per Safety Action 9.		
Recommendations for the Board:		The Board is asked to: Receive the report in line with CNST Safety Action 9.		
Appendices:		None		

The Shrewsbury and Telford Hospital NHS Trust

Perinatal Quad / Board Safety Champions Quarterly Meeting
Monday 6th November 13:30 – 15:00
MS Teams
MINUTES

In Attendance	Annemarie Lawrence	Director of Midwifery
	Carol McInnes	Divisional Director of Operations
	Mei-See Hon	Obstetric Clinical Director
	Julie Plant	Divisional Director of Nursing
	John Jones	Executive Medical Director
	Tim Lyttle	Non-Exec Director
Apologies	Andrew Sizer	Divisional Medical Director

2023/09	**Welcome and apologies**
	Welcome and apologies were noted as above. AL verbally ran through what was discussed in the August meeting and advised that the same agenda will be followed this quarter. This meeting has been set up to satisfy the ask of Safety Action 9.
2023/10	**Declarations of Conflicts of Interest**
	No declarations made.
2023/11	**Perinatal Culture and Leadership Development Programme (PCLDP)**
	AL explained that since the last meeting in August, the quad visited London for a PCLDP day to meet with other Trusts quads. The focus for the day was 'Having Courageous Conversations', however learning from the day was limited and this was fed back to the course providers. AL advised that the Korn Ferry programme has now commenced and is being facilitated by a team from NHS England for culture improvement work. The quad have had their initial 1:1 meetings with the coaches, however the coaches have admitted to feeling intimidated coming in to assist as it is not clear what they can bring to the team that we are not already doing. The quad took part in an exercise on 26th October to answer questions on the teams primary purpose and statement ideas. MSH explained that the quad advised the culture team during the session that it did not feel beneficial and that it did not add any value. AL agreed and explained that the regional culture programme had approached the division previously and when we explained what we have done regarding culture, they stepped away and didn't come to SaTH as we had already taken steps beyond what they were offering.

	It would therefore be beneficial if Korn Ferry had better understood the quad's current position before implementing a 'one size fits all' programme.
2023/12	**Understanding Local Culture**
	TL asked what culture work the quad would like to do next – CM explained that there are two things that have been discussed recently: 1. Bringing the division together as a whole, as pieces of work have been done at speciality level but there is not as much of an overarching divisional approach. 2. Building the trust between staff and the SLT further. Although there has been a lot of progress with this recently, more work is still required. JP explained that the Neonates culture has changed recently, particularly over the last 3-4 months following changes within the Senior Leadership Team (SLT). There is currently a fear factor amongst staff as it is not clear what will happen next within their SLT. Previously there was a lot of union inclusion and staff going directly to the executive team to escalate concerns, whereas this is changing, and staff are beginning to approach the current SLT and seem more comfortable doing so. AL added that previously, as part of investigations staff have backed out and withdrawn their statement in fear of the outcome, which meant the staff member comes back to work. This may be what is leading to the additional fear factor currently. JJ asked how we can support staff and Midwives to confidently write in patient notes that something happened in the room while they were caring for someone, without the possibility of it being misinterpreted as blame. AL explained that this has been covered significantly through meetings with the community Midwifery teams as they have raised that they are frightened of this happening following the recent Coroners' Inquest. There are also care planning meetings where women planning to birth outside of guidance are discussed and planned for. MSH added that it is important that staff are factual when documenting in the notes, as well as using respectful with the language they use in the documentation. AL advised that we should be going into escalation out in the community areas when certain circumstances occur requiring specific documentation, and having a 2:1 ratio for intrapartum in these circumstances so that one midwife can be working clinically, and the other midwife can be documenting everything in detail. AL advised that the civility training has been useful for staff. The MNVP have a teaching slot on the maternity Day 5 training programme which includes examples from service users around language used and ways in which this can be improved; the MNVP are members of the faculty as part of the NHSE Core Competency Framework.
2023/13	**Cultural Score Survey**
	CM advised that a piece of work is going to be done following the Culture Score Survey results, however the uptake for this survey has been light. From

	these results, cultural conversation will be designed followed by another team coming in to look at the intelligence of these conversations. JJ asked what results the team are expecting from the Culture Survey, CM explained that the hope is that staff say things are fairer and safer however this may be different across the workforces. MSH raised that as this has been completed by so few, it is likely to be those that are unhappy that would go to the efforts of completing the survey rather than those that are happy and have positive things to say.
2023/14	**Safety Champions Dashboard**
	The Maternity and Neonatal Locally Agreed Dashboard was shared during the meeting. AL explained that this dashboard gives us an opportunity to assure the Safety Champions and provides the overarching position of the division. This works well as it is an opportunity to escalate concerns and review quarterly. JJ suggested changing point 6 and link it more to point 7 so that there is an active trigger to raise something that does not fall into one of the other points. This would give an opportunity to report cases like the recent Coroners Inquest. Following on from the recent Coroners Inquest, meetings have been set up with staff members who were involved to find out any learning and feedback from the Midwives. AL explained that the team are looking at introducing a 'hold the line' process for staff when they are involved in a serious incident. This is being looked at as the team need a way of introducing a process that's restorative, gives staff time out and a period for the necessary process to be introduced without being received as punitive. The criteria for this will need discussing widely. A ToR is currently being produced for a working party and the aim is for this to be implemented wider in the other specialities. This will improve culture once in place and is an evidence-based approach to patient safety. JJ asked if we would like to be involved in the Royal College of Surgeons support programme. The aim is to have a toolkit on what to do when something when an incident happens and how to manage it while looking after those involved. All in agreement that they would like to be involved in this.
2023/15	**AOB**
	JJ asked the quad to find out the ongoing effects of the Coroners' Inquest and the Thirlwall Public Enquiry / Lucy Letby and the affect this may be having on Nursing staff. All Trusts with Neonatal units will be contacted for information. AL suggested that any requests coming in could be managed similarly to the CQC information requests – all into a portal to monitor and be signed off.

2023/16	Closing remarks
	Meeting closed.
2023/17	**Date of Next Meeting**
	Monday 5th February 2024 12:30 – 14:00