APPENDIX 2a

The Shrewsbury and Telford Hospital NHS Trust

Divisional Committee Meeting: April 2024

Agenda item				
Report Title		CNST MIS Year 6		
Executive Lead		Hayley Flavell		
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	√	
Well Led	√	Our partners		
Consultation Communication		N/a		
Executive summary:		The Committee's attention is drawn to safety actions 2,3,7 and 9 which have been updated for year six of the scheme. As it stands currently, there are no known risks to delivery of the scheme this year. In addition, safety action 6 is acheived at commencement of the scheme with all six elements having been delivered to 100% and the position assured following validation by the ICB.		
Recommendations for the Board:		The Committee is asked to: Review and discuss this paper and advise the Director of Midwifery of any further detail required. Make note of the changes to the scheme this year, including new additions that require the quality surveillance dashboard be presented by a member of the perinatal quadrumvirate to provide context on the quality and safety information under safety action 9. Note appendix 1 which contains the full scheme information including the technical guidance for all ten safety actions.		
Appendices:		Appendix 1: NHS Resolution Maternity (and perinatal) Incentive Scheme - Year Six		

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 6 guidance was published on 2 April 2024 and references a relevant time period (depending on the safety action) of either *8 December 2023 until 30 November 2024* or *2 April 2024 until 30 November 2024* for delivery of the scheme.

1.4 This also includes a self-declaration deadline of **12 noon on 3 March 2025.**

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

1.5.1 Details of the standards within Year 6 of the scheme that must be evidenced between now and the reporting deadline.

1.5.2 Any risks to the delivery of the scheme under the new safety actions technical guidance.

2.0 Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

Required Standard
a) **Notify all deaths:** All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. b) **Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards. c) **Review the death and complete the review:** For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 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 and published within six months. d) **Report to the Trust Executive:** Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.

2.1 This safety action is in keeping with the guidance from previous years.

2.2 Completion of the MBRRACE-UK surveillance information is undertaken as standard as part of divisional business as usual (BAU) processes and the tool is completed as soon as possible following notification of the event.

2.3 All parents are notified of the PMRT review, and their views sought for inclusion.

2.4 A quarterly report has been provided for this standard since the beginning of the Year 4 MIS which details all eligible cases and gradings of care.

2.5 In line with the technical guidance of the scheme, the reports include any themes identified and their consequent action plans and evidence that the required standards a), b) and c) have been met.

2.6 Progress status: on track

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

Required Standard
This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1 Trust Boards to assure themselves that at least 10 out of 11 MSDS-only (see technical guidance) Clinical Quality Improvement Metrics (CQIMs) have passed the 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 2024. Final data for July 2024 will be published during October 2024. 2 July 2024 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001).

3.1 The required standards detailed above are predominantly the same as the standards required for year 5 of the scheme, however the CQIMs in scope for this assessment differ in year 6.

3.2 The divisional data analyst is currently undertaking an assessment against the 'CNST: Scorecard' in the Maternity Services Monthly Statistics publication series to determine our position against these new CQIMs and will undertake a review of the 'Mata Data' file should this be required.

3.3 For the purposes of the CNST assessment, Trusts will only be assessed on July 2024 data for those CQIMs, with the final data being published in October 2024.

3.4 Trusts will be required to check whether they have passed the requisite data quality required for this safety action within the "CNST: Scorecard" in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts.

3.5 Progress status: awaiting verification

4.0 Safety Action 3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

Required Standard
a) Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the **BAPM Transitional Care Framework for Practice** **Or** Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards. b) Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS.

4.1 The Trust operates a Transitional Care service and associated pathway that continues to meet the national target of avoiding term admissions into the neonatal unit (ATAIN).
4.2 In year 6 of the scheme, Trusts are required to register a QI project with the local Trust quality improvement team to meet standard b).
4.3 Additionally, by the end of the reporting period, Trusts must present an update to the LMNS and safety champions regarding development and any progress.
4.4 Progress status: on track

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

Required Standard
a) Obstetric medical workforce
1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics 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 Annual Review of Competency Progressions (ARCP) or c. hold a certificate of eligibility (CEL) to undertake short-term locums

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings.

3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist 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. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.**

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 learning with agreed strategies and action plans implemented to prevent further non-attendance.

b) Anaesthetic medical workforce

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

c) Neonatal medical workforce

The neonatal unit meets the relevant BAPM national standards of medical staffing.
or
the standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.
or
The standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal ODN.

5.1 The above standards are predominantly the same as the previous year of the scheme and in-keeping with Year 5, there will need to be an action plan in place to evidence progress against the standard.
5.2 Given this was met in the previous year of the scheme, this safety action does not appear to be at risk based on the information known to date.
5.3 Progress Status: on track

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

Required Standard
a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift. d) All women in active labour receive one-to-one midwifery care. e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

6.1 The maternity service last undertook a Birthrate Plus workforce assessment in 2022, with the report shared with Trust Board in October 2022, therefore required standard a) is met.
6.2 The midwifery staffing budget exceeds the recommended establishment as it includes an additional 10wte which was agreed as part of the workforce plan to combat long-term unavailability seen in the number of midwives taking maternity leave. Midwifery is predominantly an all-female profession and the number of staff taking maternity leave often exceeds 17wte at any one time there the agreement to over establish by 10wte goes some ways to reducing that long-term unavailability; standard b) therefore is met.
6.3 Both the monthly staffing paper and the bi-annual staffing paper report on 1:1 care in labour and supernumerary status of the coordinator. Additionally, the maternity services escalation policy includes steps to take should no coordinator be available however this would be unlikely as the workforce plan supports a two-tier roster.
6.4 The Board have continued to receive the bi-annual staffing paper since Year 4 of the MIS as part of the standard cycle of business.
6.5 Progress Status: on track

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

Required Standard
Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.

7.1 The SBLCBv3 was published in May 2023 alongside Year 5 of the CNST MIS, and the Trust has held quarterly assurance meetings with the ICB since then.

7.2 In March 2024, the Trust received external confirmation that it had achieved 100% compliance across all 6 elements of the bundle as can be seen within the table below:

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)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Fully implemented	100%	Fully implemented	100%	CNST Met

7.3 The Trust will continue to hold quarterly assurance discussions with the ICB for ongoing assurance, but this safety action is currently met.

7.4 Progress Status: delivered

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

Required Standard
1. Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting: a) Engagement and listening to families. b) Strategic influence and decision-making. c) Infrastructure. **2.** Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of

free text data, and progress monitored regularly by safety champions and LMNS Board.

8.1 The productive partnership between SaTH and the Maternity and Neonatal Voices Partnership continues to yield important outcomes for service users and staff alike.
8.2 SaTH participate in the LMNS MNVP workstream as part of the core membership group for which the terms of reference include working through the MNVP guidance published in November 2023 to ensure an appropriate workplan is in place.
8.3 In order to meet standard 1b), the Trust must be able to demonstrate that the MNVP lead is a quorate member of the following:

- 8.3.1 Safety champion meetings
- 8.3.2 Maternity business and governance
- 8.3.3 Neonatal business and governance
- 8.3.4 PMRT review meeting
- 8.3.5 Patient safety meeting
- 8.3.6 Guideline committee

8.4 The MNVP are already included within the terms of reference for many of the meetings above however work is underway with the LMNS to ensure the remainder of the meetings are included within the MNVP workplan moving forward.
8.5 In line with the previous year, the maternity team are currently working towards a coproduced action plan to address the qualitative data within the free text boxes of the CQC maternity survey. Once completed, this will be monitored via safety champions and the LMNS Board.
8.6 Progress Status: on track

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

Required Standard
90% of attendance in each relevant staff group at: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal Life Support Training See technical guidance for full details of relevant staff groups. ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for MIS. It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.

9.1 The Trust has fully embedded all six core modules of the Core Competency Framework as evidenced within the delivery of Year 5 of the MIS.
9.2 The technical guidance for the above has relaxed somewhat this year for certain staff groups however this will have no bearing on SaTH as the training

components for safety action 8 is well embedded within our business-as-usual processes.
9.3 Based on previous years, the delivery of this action will not be determined until the end of the reporting period however as it stands currently, we are on track to achieve rather than at risk.
9.4 Progress Status: on track

10.0 Safety Action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Required Standard
a) All Trust requirements of the PQSM must be fully embedded. b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings. c) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.

10.1 This safety action is in keeping with the previous year of the scheme for elements a) and c) both of which are largely embedded into business-as-usual processes.
10.2 For element b), this will require a review of the safety intelligence dashboard for the new MIS year to ensure the ask is captured correctly within the information contained within the dashboard. This review will be carried out by the safety champions and an updated dashboard presented in due course.
10.3 The technical guidance advises that a review of the maternity and neonatal quality and safety must be undertaken at every Board meeting and, that the safety intelligence dashboard is presented by a member of the perinatal leadership team to provide context to the quality and safety information.
10.4 Progress Status: on track

11.0 Safety Action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Required Standard
a) Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.

b) Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 8 December 2023 until 30 November 2024.

c) For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that:

1. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and

2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

11.1 This safety action will only be confirmed as delivered after the scheme ends on 30 November 2024 when a report will be prepared for Board outlining the status of all three components.
11.2 The process of reporting is well embedded into business as usual and is monitored at divisional oversight assurance group (DOAG) on a weekly basis.
11.2 Progress Status: on track

12.0 Summary

12.1 At first publication of the Year 6 MIS, there are no obvious risks to delivery on any of the safety actions.

13.0 Actions requested of the Board/QSAC/Divisional Committee*

13.1. Review and accept this paper, advising the Director of Midwifery of any further detail required.
13.2 Note the excellent starting position against the MIS actions for this year of the scheme, including the delivery position of safety action 6.
13.3 Make note of the changes to the scheme this year, including new additions that require the quality surveillance dashboard be presented by a member of the perinatal quadrumvirate to provide context on the quality and safety information under safety action 9.
13.4 Note the content for onward reporting to the Board of Directors via the Integrated Maternity Report