The Shrewsbury and Telford Hospital NHS Trust

**LMNS: July 2024**

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<tr><td>Report Title</td><td colspan="4">CNST MIS Year 6 – Progress Report</td></tr>
<tr><td>Executive Lead</td><td colspan="4">Hayley Flavell, Director of Nursing</td></tr>
<tr><td>Report Author</td><td colspan="4">Kim Williams Interim Director of Midwifery</td></tr>
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<tr><td colspan="2">CQC Domain:</td><td colspan="2">Link to Strategic Goal:</td><td>Link to BAF / risk:</td></tr>
<tr><td>Safe</td><td>√</td><td>Our patients and community</td><td>√</td><td rowspan="2">BAF1, BAF4,</td></tr>
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<tr><td>Caring</td><td>√</td><td>Our service delivery</td><td>√</td><td>Trust Risk Register id:</td></tr>
<tr><td>Responsive</td><td>√</td><td>Our governance</td><td>√</td><td rowspan="2"></td></tr>
<tr><td>Well Led</td><td>√</td><td>Our partners</td><td></td></tr>
<tr><td colspan="2">Consultation Communication</td><td colspan="3">N/a</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="2">Executive summary:</td><td colspan="3">The Committee’s attention is drawn to Safety Action 2. Deadline for April’s provisional data was the 31 May 2024; the Trust had until 30 June 2024 to correct any anomalies discovered in the provisional data set. Issues have been identified with Robson Group criteria which was showing as zero despite submission to NHS England. Pre -set descriptions were not being used, free text was used by medical staff which has had an impact on the mapping. The Data Warehouse have made the correction so that this free text can be included. The April submission results will be known by 18/07/24. It is not known whether there will be issues with the data set that may impact delivery of this safety action (and subsequently delivery of the scheme).<br><br>As it stands currently, this is the only known risk to the scheme for this year.</td></tr>
<tr><td colspan="2">Recommendations for the Board:</td><td colspan="3">The Committee is asked to:<br><br>Review and discuss this paper and advise the Director of Midwifery of any further detail required.</td></tr>
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|---|---|
| **Appendices:** | Appendix 1. PMRT Q1 Report (SA 1)<br>Appendix 2. PMRT Board Report (SA 1)<br>Appendix 3. Transitional Care Q1 Report (SA 3)<br>Appendix 4. ATAIN Q1 Report (SA 3)<br>Appendix 5. ATAIN QI Project Registration (SA 3)<br>Appendix 6. Neonatal Medical Workforce Staffing paper (SA 4c)<br>Appendix 7. Anaesthetic Medical Workforce Paper (SA 4b)<br>Appendix 7b. SOP (SA 4b)<br>Appendix 8. Monthly Staffing Report (SA5)<br>Appendix 9. CQC Co-produced Maternity Survey (SA 7)<br>Appendix 10. Education and Training Compliance Report Q1 (SA 8)<br>Appendix 11. Safety Intelligence Dashboard Q1(SA 9)<br>Appendix 12. Perinatal Quad Minutes Meeting Q1 (SA 9) |

**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:

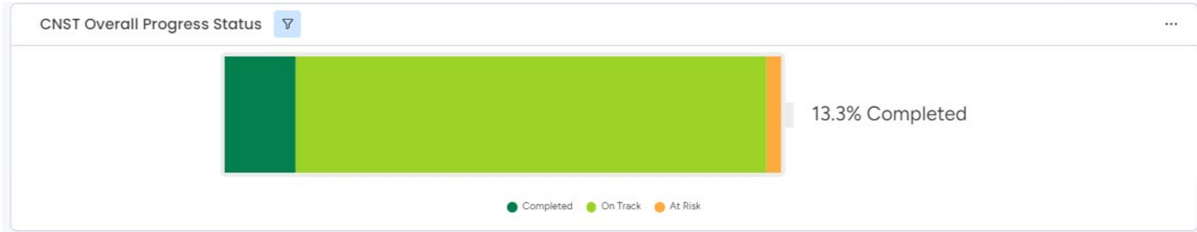
1.5.1 Details of the standards within Year 6 of the scheme that must be evidenced between now and the reporting deadline.

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

1.6 The overall delivery status of the scheme is presented in the battery below and shows that a healthy 16.7% has been delivered, evidenced, and assured, whilst 60% has been delivered, not yet evidenced.

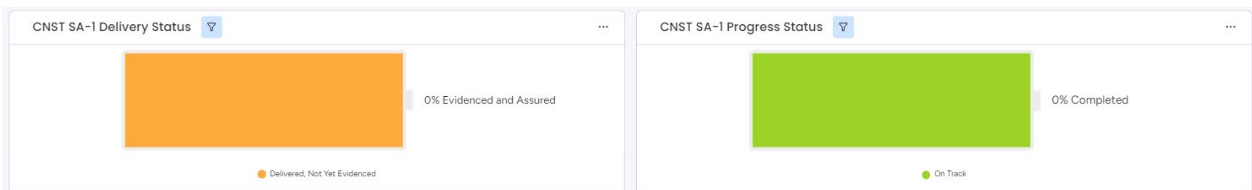
1.7 This does leave 23.3% which has not yet been delivered, however progress is being made as can be evidenced in the battery below, with 13.3% completed, 83.3% on track, and 3.3% at risk.

The Shrewsbury and Telford Hospital NHS Trust




1.8 Further information on the at-risk element is discussed under section 3.0

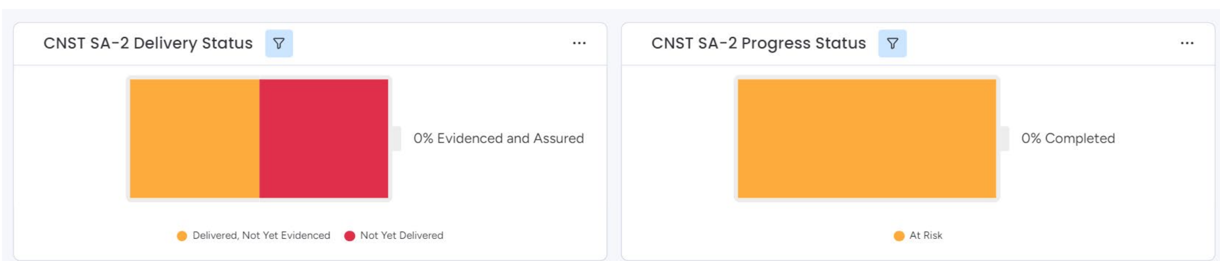
## 2.0 Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?




2.1 The service has continued to produce a quarterly report that presents the position against this safety action.
2.2 Q1 position for 2024/25, evidencing delivery against elements a), b) and c) is presented in Appendix 1/2.
2.3 Following receipt of each quarterly report by the Trust Board, element d) will also be delivered for each quarter.
2.4 A quarterly report will continue to be produced as standard in line with the technical guidance of the scheme to evidence that the required standards a), b) and c) have been met.

**2.5 Progress status: On Track**

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




3.1 Year six of the scheme has seen the introduction of three new Clinical Quality Improvement Metrics (CQIM) which are:
    3.1.1 Babies who were born preterm
    3.1.2 Babies with a first feed of breastmilk
    3.1.3 Women who were current smokers at booking
3.2 The divisional performance analyst is currently working with the Trusts senior data architect to ensure the meta data files are updated to include the new CQIMs.
3.3 The deadline for April's provisional data was the 31 May 2024; the Trust had until 30 June 2024 to correct any anomalies discovered in the provisional data

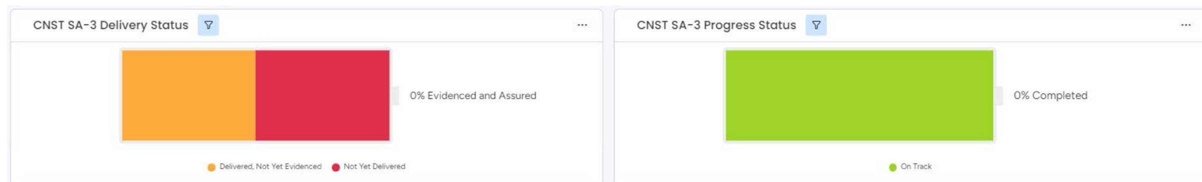
set. Issues have been identified with Robson Group criteria which was showing as zero despite submission to NHS England. Pre -set descriptions were not being used, free text was used by medical staff which has had an impact on the mapping. The Data Warehouse have made the correction so that this free text can be included. The April submission results will be known by 18/07/24. It is not known whether there will be issues with the data set that may impact delivery of this safety action (and subsequently delivery of the scheme).

3.4 The Trust will be formally assessed on the July 2024 MSDS data set, of which the results will not be published until October 2024.

3.5 Until the data set is released, this safety action is noted to be at risk for the reasons specified above.

**3.6 <u>Progress status: at risk</u>**

**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?**




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) which meets standard a).

4.2 In order to meet standard b) for year 6 of the scheme, the Trust is required to register a QI project (Appendix 4) with the local quality improvement team that will support the reduction of term admissions to the neonatal unit. **Registration of this QI project is to be documented in the Safety Champion minutes.**

4.3 A Quality Improvement (QI) project has been registered focussing on nasogastric tube feeding and early recognition of Chorioamnionitis. A presentation with updates on the QI project is required as evidence to the LMNS including; aim of QI project in a statement, measures, change actions and outcomes. This action is set to be delivered in September 2024. An update must be presented to Safety Champions and noted in the minutes before the end of the reporting period.

4.4 The service continues to undertake quarterly reports for Transitional Care (TC) (Appendix 3) and Avoiding Term Admissions into the Neonatal unit (ATAIN) (Appendix 4).

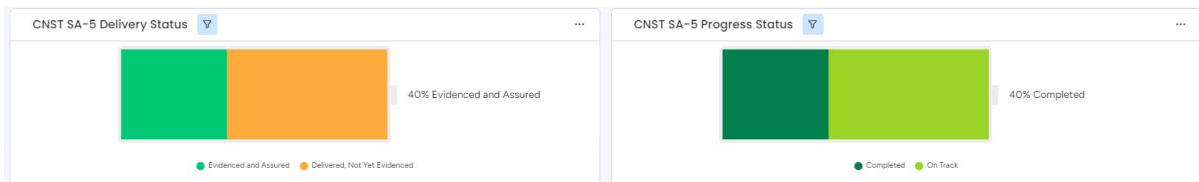
4.5 All cases are reviewed to ensure any learning is disseminated timely and good practice is shared widely. These reports are also shared onwards to the LMNS.

**<u>4.6 Progress status: on track</u>**

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

5.1 The above standards are predominantly the same as the previous year of the scheme which means standards a), b) and c) of the scheme have been delivered. For good governance, standard b) Anaesthetic Medical Workforce, evidence pertaining to 24 hours a day cover has been included (Appendix: 7, 7b), staffing Rotas are available upon request. Neonatal Medical Workforce (SA 4c) is included (Appendix 6) to evidence compliance with BAPM standards.
5.2 For standard d), the neonatal nursing workforce does not currently meet BAPM standards however therefore there is an action plan in place that the service are working towards this, which is in line with the previous year of the scheme. Evidence of progress against the previously agreed action plans will be provided during this reporting period.
5.3 The service will need to evidence the progress that has been made against the action plan and that this has been shared with both the LMNS and the Neonatal Operational Delivery Network (ODN).
**5.3 Progress Status: on track**

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




6.1 Standards a) and b) of this safety action have already been met as presented within the April 2024 CNST Progress Report.
6.2 The evidence for these stands can be found in the form of the 2022 BirthRate Plus (BR+) workforce assessment and the budgets versus BR+ report.
6.3 Standards c) and d) cannot be fully evidenced and assured until the scheme has ended however progress is reported monthly via the maternity staffing paper which is submitted to the workforce meeting (Appendix 8).
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. The latest paper previously submitted, presented the data from Q3/4 of 2023/24.
**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?**

7.1 This action has been delivered as can be evidenced within the table below and further evidenced within the SBLCB implementation tool (Appendix 11).

| 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 Trusts lead for SBL is currently designing a board within Monday.com for a workspace to demonstrate ongoing ambition compliance monitoring as the SBL implementation tool is not suitable to use once this has been fully implemented.
7.4 The Trust is required to provide a signed declaration from the Executive Medical Director declaring that the SBLCBv3 is fully in place as agreed with the ICB.

**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.**

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. The Trust has a fully funded, user-led Maternity and Neonatal Voices Partnership (MNVP) in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) which supports:

a) Engagement and listening to families.
b) Strategic influence and decision-making.
c) Infrastructure.

8.2 In order to meet standard 1b), the Trust must be able to demonstrate that the MNVP lead is a quorate member of the following:

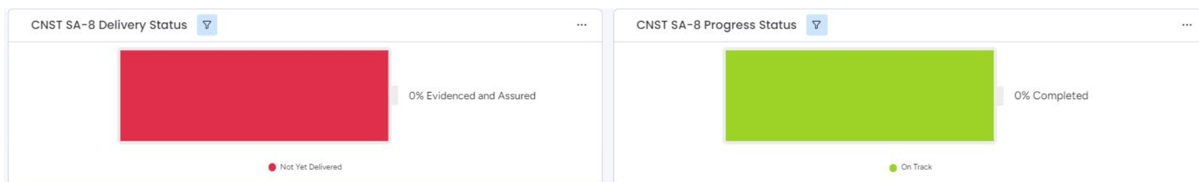
8.2.1 Safety champion meetings
8.2.2 Maternity business and governance
8.2.3 Neonatal business and governance
8.2.4 PMRT review meeting
8.2.5 Patient safety meeting
8.2.6 Guideline committee

8.3 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.

8.4 In line with the previous year, the maternity team have coproduced an action plan to address the quantitative and qualitative data within the CQC maternity survey (Appendix 9). This will be monitored via safety champions and the LMNS Board.

**<u>8.6 Progress Status: on track</u>**

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



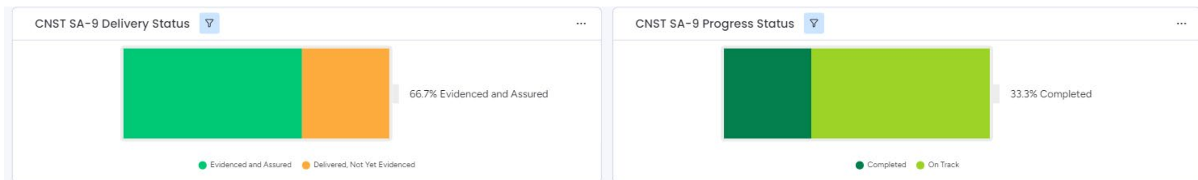

9.1 The Trust has fully embedded all six core modules of the Core Competency Framework as evidenced within the previous year of the scheme; the technical guidance for this safety action has relaxed this year for certain staff groups however this will have no bearing on SaTH as the training components for safety action 8 is well embedded within our business-as-usual processes.

9.2 In order to maintain safe staffing levels, it was necessary to stand down some scheduled training days (excluding Prompt) in April 2024 due to high levels of staff unavailability. As a one off, it is not anticipated that this cancellation will impact on the delivery of this safety action (Appendix 10).

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.

**<u>9.4 Progress Status: on track</u>**

**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?**




10.1 This safety action is in keeping with the previous year of the scheme for elements a) and c) both of which are embedded into business-as-usual processes and therefore evidenced and assured. The Trust have fully embedded the Perinatal Quality Surveillance Model (PQSM) and inline with the technical guidance, a non-executive director (NED) is working with the Board Safety Champion.
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 (Appendix 11). This review will be carried out by the safety champions and an updated dashboard presented for each quarter. The technical guidance advises that evidence is provided to assure collaboration with LMNS/ICB pertaining to shared learning and escalation of Trust-level intelligence to ensure early action in line with PQSM.
10.3 Evidence of ongoing staff engagement sessions and progress with action and progress made provided through publication of the ‘You said, we did’ posters will be shared in the next iteration of this progress report.
10.4 The Trusts Claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal Trust Board Level Safety Champion at Board meeting quarterly (twice per reporting period). This action will be delivered at the end of the reporting period.
10.5 Evidence in the Trust Board minutes that Board Safety Champions are meeting with the Perinatal Leadership Team bi-monthly and that any support required of the Trust Board has been identified (Appendix 12).
10.6 The technical guidance advises that a review of the maternity and neonatal quality and safety must be undertaken at every Board meeting (or sub-committee of Board with delegated responsibility) 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.
10.7 Evidence in the Trust Board (or appropriately delegated committee) that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support considered and implemented.
**<u>10.8 Progress Status: on track</u>**

**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?**

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.
**11.3 Progress Status: on track**

## 12.0 Summary

12.1 SaTH is mostly on track to achieve CNST MIS Year 6, although there is a risk to delivery associated with safety action 2 which our compliance is not known at this stage.

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

13.1. Review and accept this paper, advising the Director of Midwifery of any further detail required.
13.2 Note the risk to delivery identified for safety action two.
13.3 Make note that the quality surveillance dashboard, which is presented under safety action 9, is reviewed and this should be reflected within the minutes (Appendix 11).
13.4 A signed declaration is required from the Executive Medical Director declaring that the SBLCBv3 is fully in place as agreed with the ICB.
13.5 Note the content for onward reporting to the Board of Directors via the Integrated Maternity Report.