Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	10 June 2021
Paper number	Enc F4

Introduction/Background

The NHS Resolution Clinical Negligence Scheme for Trusts Maternity Incentive Scheme supports all acute Trusts to deliver safer maternity care. This scheme applies to all acute Trusts and incentivises ten safety actions that each Trust must provide evidence of achievement annually.

This quarterly update outlines progress to date and reports on the required evidence to demonstrate compliance against the ten safety actions to support the Board to confidently complete the Board declaration to NHS Resolution.

This year (year 3 of the scheme) was paused due to the recognised challenges of the coronavirus pandemic. The maternity incentive scheme has been revised to include additional elements that ensure key learning from important emerging Covid-19 themes have been considered and implemented by NHS maternity services.

The Scheme was relaunched in October 2020 and underwent a second revision in January and a further revision in March 2021.

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration fro to NHS Resolutions by **12 noon on Thursday 15th July 2021**.

This quarterly report details compliance, progress and actions required for all of the CNST safety standards for January – March 2021. The 10 required standards are discussed below.

Issues and options

Safety Action 1 - Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

Attached is the Trust quarterly PMRT report providing a summary of the cases during Q4 and subsequent actions. This demonstrates compliance with all aspects of this standard. These quarterly reports have been discussed with the Trust Maternity Safety Champion. (Appendices 1 and 2)

Attached is the 2nd Annual Baseline Summary report in response to the National MBRRACE report released in December 2020. This has been submitted through the internal Governance processes and shared wider with the LMNS. (Appendix 3)

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

Confirmation has since been received from NHS digital, that WAHT have achieved compliance with this standard during Q4, this was confirmed based on the submission made on 25.02.21 detailed below.

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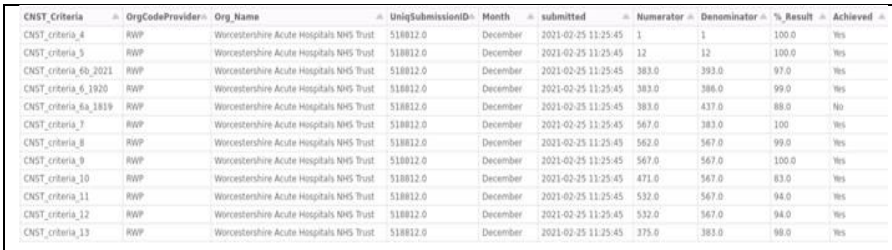

CNST_Criteria	OrgCodeProvider	Org_Name	UniqSubmissionID	Month	submitted	Numerator	Denominator	%_Result	Achieved
CNST_criteria_4	RWP	Worcestershire Acute Hospitals NHS Trust	518812.0	December	2021-02-25 11:25:45	1	1	100.0	Yes
CNST_criteria_5	RWP	Worcestershire Acute Hospitals NHS Trust	518812.0	December	2021-02-25 11:25:45	12	12	100.0	Yes
CNST_criteria_6b_2021	RWP	Worcestershire Acute Hospitals NHS Trust	518812.0	December	2021-02-25 11:25:45	383.0	393.0	97.0	Yes
CNST_criteria_6_1920	RWP	Worcestershire Acute Hospitals NHS Trust	518812.0	December	2021-02-25 11:25:45	383.0	386.0	99.0	Yes
CNST_criteria_6a_1819	RWP	Worcestershire Acute Hospitals NHS Trust	518812.0	December	2021-02-25 11:25:45	383.0	437.0	88.0	No
CNST_criteria_7	RWP	Worcestershire Acute Hospitals NHS Trust	518812.0	December	2021-02-25 11:25:45	567.0	383.0	100	Yes
CNST_criteria_8	RWP	Worcestershire Acute Hospitals NHS Trust	518812.0	December	2021-02-25 11:25:45	562.0	567.0	99.0	Yes
CNST_criteria_9	RWP	Worcestershire Acute Hospitals NHS Trust	518812.0	December	2021-02-25 11:25:45	567.0	567.0	100.0	Yes
CNST_criteria_10	RWP	Worcestershire Acute Hospitals NHS Trust	518812.0	December	2021-02-25 11:25:45	471.0	567.0	83.0	Yes
CNST_criteria_11	RWP	Worcestershire Acute Hospitals NHS Trust	518812.0	December	2021-02-25 11:25:45	532.0	567.0	94.0	Yes
CNST_criteria_12	RWP	Worcestershire Acute Hospitals NHS Trust	518812.0	December	2021-02-25 11:25:45	532.0	567.0	94.0	Yes
CNST_criteria_13	RWP	Worcestershire Acute Hospitals NHS Trust	518812.0	December	2021-02-25 11:25:45	375.0	383.0	98.0	Yes

<u>Safety Action 3</u> - Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into neonatal unit programme?

The revised standards have now removed the following requirements A-C.

A) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.
B) The pathway of care into transitional care has been fully implemented and is audited every other month. Audit findings are shared with the neonatal safety champion.
C) A data recording process for capturing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded.

Attached is the ATAIN report that has been submitted through the internal Governance processes and shared wider with the LMNS at the neonatal work stream & Maternity Sub group meeting. (Appendix 4)

D) We submit NCCMDS data monthly as part of the SUS process for submitting hospital episode data to NHSD for the commissioning data set (CDS). The ODN can and do have access to this through Badgernet Neonatal, as a Trust WAHT input all TC data on Badgernet. To date there have been no requests to submit information to the ODN - this has been confirmed by the ODN Director.

E) A review of term admissions to the NNU & TCU during the COVID-19 period was undertaken to identify:

a) Closures or reduced capacity of TC – No reduction in NNU or TCU were made during this time. Embedded is the risk assessment that was completed at the time (Appendix 5)
b) Changes to parental access – there were no changes made at WAHT
c) Staff redeployment – no staff redeployment during this time
d) Changes to postnatal visits leading to increase in admission including those for jaundice, weight loss and poor feeding. (Appendix 6)

An audit undertaken reviewing readmissions demonstrates that we did not see an increase in term admissions due to criteria d above.

The only COVID-19 related issue identified during this time was surrounding women not having steroids administration during the 1st wave, which may have impacted on a couple of admissions with respiratory issues. This was actioned and reinstated by the maternity service.

F) The ATAIN Action Plan is attached and has been submitted through the internal governance processes for oversight and discussed with the Maternity Safety Champion. (Appendix 7)

10% of admissions to TCU are audited each month to ensure the admissions are appropriate and the criteria are reached. These are detailed within the ATAIN quarterly report.

A Newsletter during Q4 was developed and circulated. (Appendix 8)

Safety Action 4 - Can you demonstrate an effective system of medical workforce planning to the required standard?

The following standards a - c related to the obstetric workforce have been removed. It is recommended that monitoring continues and escalation of concerns via the safety champions to the Trust Board.

Obstetric Medical Workforce

a) All boards should formally record in their minutes the proportion of obstetrics and gynaecology trainees in their Trust who responded 'Disagreed or /strongly disagreed' to the 2019 General Medical Council (GMC) National Trainees Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'
b) Furthermore, there should be an agreed strategy and an action plan with deadlines produced by the Trust to address these lost educational opportunities due to rota gaps. The Royal College of Obstetricians and Gynaecologists (RCOG) has examples of Trust level innovations that have successfully addressed rota gaps available to view at http://www.rcog.org.uk/workforce
c) The action plan should be signed off by the Trust Board and a copy (with evidence of Board approval) submitted to the RCOG at workforce@rcog.org.uk

4.2 Anaesthetic Medical Workforce: It has been confirmed that for this reporting period, WAHT has met all of the ACSA standards required 1.7.2.5, 1.7.2.1 and 1.7.2.6.

4.3 Neonatal Medical Workforce: The Neonatal Unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. A tier 1 doctor is available 24/7 in line with recommendations from BAPM.

4.4 Neonatal Nursing Workforce: previously a staffing paper submitted to NHSE/I in an attempt to secure funding for BAPM in 2019/2020. Furthermore a staffing paper submitted to NWAG in November 2020 was detailed in Q3 report.

Implementing the Recommendation of the Neonatal Critical Care Transformation review: Neonatal Implementation Plan 2020-2025. An Action Plan has been developed and is embedded within this report for reference. This has been through the Divisional Governance structure for oversight. (Appendix 9)

The action plan has been submitted through the ODN and the updated NCCR action plan will go to the LMNS once it has been through the Divisional Governance processes.

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

In the previous Q3 report, Midwifery staffing reports were submitted from January – June 2020 and July – December 2020 and included within the report.

During Q4 the following reports have been submitted. (Appendices 10 and 11)

Included is April 2021 report for reference. (Appendix 12)

Implementation of red flags on safer care has been implemented and this will demonstrate if the coordinator is not supernumerary and if 1 to 1 care is not provided to women in labour. Datix has been utilised as a mechanism for reporting by exception prior to this launch.

Safety Action 6 - Can you demonstrate compliance with all 5 elements of SBL bundle version 2?

In Q4 a gap analysis was undertaken against SBL V2, this was shared with the LMNS and is embedded within the report. Funding was secured to enable employment on secondment of 2 Midwives on 1 WTE Fetal Surveillance post. (Appendix 13)

Some slight changes have been made within the safety standard.

CO testing (Element 1)

If CO monitoring remains paused within the Trust due to COVID-19 the audit described above needs to be based on the percentage of women asked whether they smoke at booking and at 36 weeks. The Very Brief Advice and referral to smoking cessation services remain part of the pathway. This is in line with guidance issued by

NHS England and NHS Improvement (https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-covid-19-information/) when CO monitoring was initially paused. The timing of the audit is at the Trust's discretion but should include the dates when women booked, and reference to the national CO testing policy at that time.

Fetal Monitoring (Element 4)

The compliance required is the same as safety action eight i.e. 90% of maternity staff which includes 90% of each of the following groups.

The threshold of 90% has been removed. This applies to fetal monitoring requirement of safety action 6. We recommend that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible.

Trust Board should minute in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when this is permitted.

This has continued to be monitored throughout the challenges posed by the COVID pandemic and actions put into place to address any shortfalls. The compliance of 90% will be achieved as planned by September 2021 due to the additional session put in place.

Safety Action 7- Can you demonstrate that you have patient feedback mechanisms for maternity services and that you regularly act on feedback

7.1 Terms of reference have been agreed for the Maternity Voice Partnership (MVP). (Appendix 14)

7.2 Regular feedback sessions and Maternity Voice Partnership meetings are ongoing. Embedded are the minutes from March 2021. We have user representation in labour ward forum meetings and involvement in the changes to the induction of labour process/guideline and the reduced fetal movement's guidance along with other areas following surveys completed in those areas. (Appendix 15)

7.3 Remuneration for the chair & other services user members of the committee has been obtained to demonstrate compliance with this criterion.

The LMNS recently created a poster "Staying Healthy in Pregnancy", which has been circulated widely across the Trusts and social media. This covers the elements that women should focus on when pregnant and picks up on the specific messages for BAME women.

Safety Action 8 - Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within

the last training year? This has now been removed alongside the requirement related to system testing which has also been removed.

This has since been changed to the following **Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?**

a) COVID-19 specific e-learning training has been made available to the multi-professional team members?
b) Team required to being involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since the launch of MIS year three in December 2019?
c) There is a commitment by the Trust Board to facilitate multi-professional training sessions, including fetal monitoring training once when this is permitted.

Training compliance is monitored through the Divisional Governance structure, due to the 2nd wave of the pandemic compliance was affected. However training recommenced in October 2020. An action plan was developed to address the training shortfalls identified as a result of COVID. (Appendix 16)

Changes have been made in the standard to enable e learning training content to enable it to be delivered remotely or digitally and the 90% threshold as described above.

The threshold for compliance will be achieved in that all staff groups will be over 90% by 30th September due to an additional session that had been facilitated to address the small shortfall.

Safety Action 9 - Can you demonstrate that Trust safety champions (Obs, Midwifery & Neonatal) are meeting bimonthly with board level champions to escalate locally identified issues?

a) A pathway has been developed to formalise how safety intelligence from floor to board which is shared through LMNS & MatNeoSip. (Appendix 17)

b) Board level safety Champions undertaking feedback session every other month for maternity and neonatal staff to raise concerns relating to safety issues. Demonstrate progress with actioning named concerns that are visible to staff.

The maternity Safety Board level Champion undertakes monthly walkabouts. This is documented in a template developed to capture the detail of those events. (Appendix 18)

Safety Action 10 - Have you reported 100% of qualifying 2019/20 cases to HSIB (for 2019/20 births only) reported to NHSR Early Notification Scheme?

2 cases were reported to HSIB during Q4.

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MI-003263 – IP stillbirth
MI – 003346 – SUDIC 3 days

Reports should continue to HSIB which will in turn inform NHS Resolution of relevant incidents.

Conclusion

The maternity and neonatal services were able to demonstrate compliance with all 10 safety actions in 2019 a full rebate was received in 2019. In 2020 all Trusts received a full rebate as the scheme was suspended due to the pandemic. Compliance in 2021 has been extremely challenging as the information outlined within the scheme has undergone a number of revisions, the pandemic has interrupted some committees where the evidence would be reported and discussed, and staff have been deployed to critical areas of the wider hospital to deliver care which will impact on training compliance and the roll out of continuity of carer.

However regular updates have been provided to ensure that the Board are sighted on the going position and compliance with each safety action.

The report provides a good level of evidence for the majority (8) standards with 2 standards requiring additional small audits and the completion of an action plan.

The Board declaration is required for submission to NHSR on 15th July 2021; this coincides with the next available Board meeting and therefore it is recommended that any outstanding evidence is presented to Trust Management Executive Committee at the end of June so that a declaration can be made against all 10 standards.

Recommendations

The Trust Board are asked to note the content of this report, the current position and recommendation to submit further evidence to TME to provide the best opportunity to demonstrate compliance against all 10 standards and therefore receive the full rebate.

In order to be eligible for payment under the scheme, WAHT Trust must submit the completed Board declaration form to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 15 July 2021 and must comply with the conditions stated within the guidance.

Appendices – Available in the Reading Room

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
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Paper number	Enc F5

Audit and Assurance Committee Report

For approval:		For discussion:		For assurance:	X	To note:	

Accountable Director	Anita Day, Audit and Assurance Committee Chair		
Presented by	Anita Day, Committee Chair	**Author /s**	Rebecca O'Connor, Company Secretary

Alignment to the Trust's strategic objectives (x)							
Best services for local people	X	Best experience of care and outcomes for our patients		Best use of resources	X	Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Board is requested to: 1. Note the report for assurance

Executive summary	This report summarises the business of the Audit and Assurance Committee at its meeting held on 11 May 2021. The following key points are escalated to the Board's attention: **1. Data Quality** Committee received a presentation on the actions in pace to address improvements in relation to data quality. Issues were primarily centred around missing NHS numbers and data cleansing with regards to the waiting list logic. A reduced assurance level of 5 was agreed and a further update would be presented to Committee in September. **2. internal Audit Plan** Committee approved the internal audit plan, agreeing that following discussion with executive colleagues, internal audit scopes would be presented to Committee for approval. The outputs from the Away Day session, which enabled development of the plan are in the reading room. **3. Committee Effectiveness** Committee had completed its self assessment review of effectiveness anonymously using survey monkey with the support of internal audit. No red flags were identified with the feedback themes suggesting Committee was operating in an increasingly effective manner. The full report is appended within the reading room for Board members reference.

Risk

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Which key red risks does this report address?		**What BAF risk does this report address?**	*N/A – the Committee reviews all strategic risks*

Assurance Level (x)	0		1		2		3		4		5	X	6		7		N/A	
Financial Risk	*None directly arising as a result of this report*																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						