Ashford and St. Peter's Hospitals NHS Foundation Trust

TRUST BOARD
25 JULY 2019

AGENDA ITEM	15.3	
TITLE OF PAPER	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme**	
Confidential	No	
Suitable for public access	Yes	
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED		
Quality of Care Committee 18 July 2019 Chair approved the paper to go directly to Board.		
STRATEGIC OBJECTIVE(S):		
Quality of Care	✓	CNST Maternity Standards support safer patient care, as well as enable the Trust to obtain a reduction in our annual clinical negligence premium for maternity.
People	✓	
Modern Health Care	✓	
Digital	✓	
Collaborate	✓	
EXECUTIVE SUMMARY		
	NHS Resolution (NHSR) is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. This paper summarises achievement against the 10 standards so far. 7 standards are fully met with no outstanding actions – Standards 1, 2, 4, 5, 6, 7 and 10. Standard 3 is also fully met, but has an ongoing action to update against the action plan status to the Chief Nurse (on behalf of Board) by early August. 2 standards (8 and 9) are not yet met, and these have clear ongoing actions planned to achieve compliance by the due date: • Standard 8 - Anaesthetists and Operating Department Practitioners were still being trained during July and this is being actioned with Divisional tracking. • Standard 9 – A staff feedback session is to be held on 22 July 2019 in response to raising of safety concerns in Maternity. Further actions, per CNST Scheme Terms, also needed before the scheme can be signed-off and submitted to NHS Resolution: • Board declaration (with draft NHSR submission including action plan template) contents to be shared discussed with NW Surrey CCG • Board to give Chief Executive Permission to sign form once above outstanding actions complete	

	Board can be assured that there are clear plans in place to ensure compliance with all 10 CNST standards by the due date of 15 August 2019.
RECOMMENDATION:	See Board action below.
AUTHOR	Dr Erica Heppleston, Associate Director of Quality & Konstantina Stavrakelli, Divisional Chief Nurse/Midwife
PRESENTED BY	Andrea Lewis, Deputy Chief Nurse, on behalf of Sue Tranka Chief Nurse
DATE	19 July 2019
BOARD ACTION	Board is asked to **note** and **approve** the paper contents and actions; and **approve** that the physical signing of the final NHSR declaration/submission may be made by the Chief Executive [or the Chief Nurse on behalf of the Chief Executive] under Board delegated authority, upon completion of the outstanding items as noted above.

Standard 1 - Using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard

1a) 95% Perinatal deaths since 12/12/2018 required a mortality review 'started' within 4 months of each baby's death. As of 17 July 2019 there have been 11 applicable cases. Performance is currently 100%.

1b) 50% Perinatal deaths since 12/12/2018 required a draft mortality review report prepared within 4 months of each baby's date of death. As of 17 July 2019 there have been 7 applicable cases (the last cohort being for end of March 2019) which had MDT draft reports issued by the end of May 2019. Performance is 100%.

1c) Duty of candour needed completion and parents given an opportunity to contribute to the mortality review scope. For the 11 cases to date, performance is 100% for this measure as at 17 July 2019.

1d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans. As of 17 July 2019 there have been 7 applicable cases and the Chief Nurse has received update reports on behalf of the Board for these cases under delegated authority.

Any new cases arising between now and the 15th August 2019 scheme deadline would not fall due in the reporting period.

Conclusion - This standard is fully met.

Standard 2 – Maternity Services Dataset Submission

This standard involved submitting maternity data to NHS Digital in line with specific requirements.

Conclusion - The Head of Information Assurance has validated this standard and confirmed it is met.

Standard 3 – Transitional Care Services to Support Avoiding Term Admissions into Neonatal Units

Assurance was reviewed by the Chief Nurse under delegated Board Authority on 18 May 2019 regarding:

- The development of the local policy in accordance with the principles of British Association of Perinatal Medicine (BAPM) transitional care.
- The Trust has an excellent service based on quarterly benchmarking with other units and we participate in the South East Neonatal Operating Delivery Network (ODN).
- The Neonatal team have agreed an improvement plan (the Plan) to move the service from good to outstanding. The scheme requires Plan agreement and updates with two system partners, the Local Maternity System (LMS) and the ODN.

The LMS approved the Plan which was then subsequently formally evidenced in the notes from the LMS Quality and Safety Forum on 2 April 2019. Progress on the plan was sent to the LMS on 9 May 2019.

The Plan was shared with the ODN on 6 March 2019. Owing to the South East Neonatal ODN not having a Network Manager in post, alternative arrangements for Plan submission to the ODN required putting in place. On 17 May 2019 the Trust sent the Plan, with a progress update, to the South West ODN Network Manager for review and approval. This situation was outside ASPH control.

Trust Board update on the Plan was reviewed by the Chief Nurse under delegated Board authority on 18 May 2019.

Conclusion – The standard is met. The Division will provide the Board, via Chief Nurse delegated authority, with a final update against the plan before the scheme is signed off in August.

Standard 4 – Effective System of Medical Workforce Planning

Evidence supporting achievement of CNST standard 4 was approved by the Chief Nurse under delegation on 24 May 2019.

Standard 4A relates to educational training opportunities being lost from rota gaps.

Standard 4A requires Trust Board to note that the proportion of Obstetrics and Gynaecology (O&G) trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota' was 50/100 (50%).

The O&G survey has seen good improvements since the last survey, losing 2 reds and 7 pink flags. The O&G General Practitioner (GP) Programme has seen a decline this year, losing a green flag and obtaining 3 pink flags and suffering from 3 red flags. This is the only programme that received a red flag for Rota Design and has resulted in gaps on the GP post due to sickness and maternity leave.

As a response to the above, the GMC action plan has been devised and completed by the Obstetrics and Gynaecology Project Team led by College Tutor, Specialty Lead, Head of Medical Education and Training and Rota Coordinator who agreed the action plan with the GP Trainees and Medical Workforce. This plan is to address lost educational opportunities due to rota gaps. The approved action Plan has been submitted to Royal College of Gynaecologists (RCOG) as required by the CNST.

Standard 4B pertains to meeting Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.

The standard requires a gap analysis against the ACSA standard and an action plan to be in place to achieve full compliance. A gap analysis from the Women's' Health and TASCC Division demonstrates that the Trust meets standard 2.6.5.1; however the Trust does not meet standards 1.2.4.6 and 2.6.5.6. The Board, through the Chief Nurse's delegated authority, have noted the gap analysis and the ratified plan of action to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.

The gap analysis found that of the 2 Maternity Unit theatres, only one theatre - Theatre 2, has dedicated staff to undertake both electives and emergency sections. The gap analysis has discovered that to meet the standard which states that all units with more than 250 elective sections should have a separate elective theatre with its own dedicated staff separate from emergency sections, and, as ASPH Maternity unit undertakes over 550 elective sections a year, the Trust is required to staff Theatre 1 with a dedicated elective theatre team. The plan of action is that a business case is being produced for approval to staff Theatre 1, and recruitment will commence.

Conclusion - This standard is fully met.

Standard 5 – Midwifery Workforce Planning

On 8 July 2019 the Chief Nurse received under Delegated Authority a paper assuring on CNST Standard 5, Midwifery Workforce Planning. The paper had previously been submitted to the Women's Health and Paediatrics Divisional Governance Meeting. The CNST standard was met owing to there being an effective system of Midwifery workforce planning to the required standard. A radical workforce re-design, to achieve a different way of working, is required to be able to achieve the continuity of carer element of Better Births and the Saving Babies Lives Care Bundle.

The recommendations have specified that maternity care must be reorganised to deliver:

- A team of midwives caring for all women in a small, defined area – and following these women through the maternity system.
- Midwives specialising in caring for specific cohorts of women, whether that be low risk, or those requiring more medically or socially complex care.
- Consideration should be given to the inclusion of specialist roles and Maternity Support Workers.

An action plan is underway with monitoring at Divisional Governance in response to the above review of midwifery staffing needs.

Conclusion - This standard is fully met.

Standard 6 – Saving Babies Lives Care Bundle

The Trust is compliant with implementation of all elements of Saving Babies Lives Care Bundle (SBLCB) version 1 and meets the requirement of Standard 6 of CNST Maternity Safety Standards for 2019/20. An evidence bundle has been collated which is held Divisionally.

The Saving Babies' Lives Care Bundle is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

Quarterly audit submissions to NHS England of implementation of the SBLCB have been taking place since 2017. The most recent audit submission – submission no. 12 in April 2019, demonstrates compliance with implementation of all aspects of the care bundle. Submission 12 is the latest national data request issued, as the quarterly national audit is under review whilst it is upgraded to SBLCB version 2.

Conclusion - This standard is fully met.

Standard 7 – Patient Feedback Mechanisms for Maternity Services

A paper evidencing the requirements of this standard was submitted to the Patient Experience Monitoring Group on 9 May 2019. The key items evidenced were acting on feedback, user involvement in investigations and survey results, and evidence of liaison through the Maternity Voices Partnership.

Conclusion - This standard is fully met.

Standard 8 – In-house Multi-professional Maternity Emergencies Training Sessions

The Trust is required to train 90% of maternity unit staff using an in-house multi-professional maternity emergencies training session. A programme to achieve this has been running throughout the scheme.

As at 1 July 2019, the Division had trained more than 90% of Midwives and 90% of Obstetricians. Anaesthetists and Operating Department Practitioners were still being trained in July and confirmation that the skills drills are completed is being sought.

Conclusion - This standard is still underway, with a plan in place to achieve compliance for remaining colleagues by the end of the scheme.

Standard 9 – Role of Safety Champions

Standard 9 involves engagement with staff and external programmes. The Trust has actively participated in the region's Local Learning System (LLS) and national forums such as the Maternal and Neonatal Health Safety Collaborative National Learning event. At this, maternity safety priorities and safety QI projects in the UK were explored collaboratively. The Trust is involved with the monthly Surrey Heartlands Local Maternity System's Quality and Safety Forum. The Board Champion has implemented monthly feedback sessions for maternity and neonatal

staff to raise concerns related to relevant safety issues. Staff feedback sessions are held on progress against the local improvement action plan in response to items raised.

Conclusion - This standard is on track, but has one remaining action. There is a further monthly feedback session for staff on actions taken regarding raising of concerns in maternity. This feedback session is scheduled for the 22 July 2019 and this will then complete the Standard.

Standard 10 – Reporting of qualifying incidents to NHS Resolution's Early Notification Scheme

This standard pertains to notifying applicable deaths to NHS Resolution's Early Notification Scheme. There are 3 cases which have been validated as meeting CNST Standard 10 reportable criteria for 2018/19 year and all those cases have been notified to NHSR.

Conclusion - This standard is met.