Oxford University Hospitals
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 10 July 2019

TB2019.75B

Title	**Maternity Incentive Scheme Compliance Report**

Status	For Information
History	Maternity Directorate Clinical Governance meeting 28th June 2019

Board Lead(s)	Sam Foster Chief Nurse			
Key purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

1. This paper provides an overview of compliance against the ten Safety Actions required for the NHS Resolution Maternity Incentive Scheme.

2. The paper outlines the evidence that has been supplied to the Trust's Assurance Team to demonstrate compliance with all of the Safety Actions. The Assurance Team have independently verified that there is sufficient evidence to demonstrate that the Trust will be compliant with all of the Safety Actions by the NHS Resolution deadline of 15th August 2019.

Recommendation

3. The Board is asked to:

   - Approve the action plans provided in appendices 1 and 3.
   - Agree, subject to the approval of the action plans as mentioned above, that sufficient evidence has been made available to the Trust Board (via Board Pad) to demonstrate compliance with the required standards.
   - Give permission for the Trust Chief Executive to sign the Board Declaration Form to be submitted to NHS Resolution by 12 noon on Thursday 15th August 2019 (provided as Appendix 6 for information).
   - Note that once the Board Declaration Form has been formally signed that the Director of Midwifery will discuss the contents of the form with the local commissioner of the Trust's maternity services

Maternity Incentive Scheme Compliance Report

1. Context / Background

1.1. NHS Resolution 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.

1.2. This paper provides an overview of compliance against the ten Safety Actions required for the NHS Resolution Maternity Incentive Scheme.

1.3. The paper outlines the evidence that has been supplied to the Trust's Assurance Team to demonstrate compliance with all of the Safety Actions. The Assurance Team have independently verified that there is sufficient evidence to demonstrate that the Trust will be compliant with all of the Safety Actions by the NHS Resolution deadline of 15th August 2019.

2. Safety Action 1: Perinatal Mortality Review Tool

2.1. The Perinatal Mortality Review (PMR) group was formed in 2016, with the aim of providing a process for carrying out comprehensive reviews of all perinatal deaths within the following national MBRRACE criteria:

Included:	**Excluded:**
· All perinatal deaths between 22+0 weeks gestation and 28 days after birth. · Babies who die after 28 days but who have been cared for on the Neonatal Unit	· Cases below 22+0 weeks. · Terminations/Feticides · Babies with a birthweight below 500g where an accurate gestation is not known

2.2. The table below shows the Trust's progress towards the required standard for this Safety Action:

Required Standards	OUH FT Progress
a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death. b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death. c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.	**Compliant** with all required standards. Evidence shown in quarterly reports submitted to Private Trust Board in May 2019 and July 2019.

3. Safety Action 2: Maternity Services Data Set

3.1. In order to provide evidence of compliance against this safety action the Directorate is required to demonstrate the following:

- To report to the Board whether it has met the Maternity Services Data Set (MSDS) requirements in terms of the quality and completeness of data submitted.
- To have passed all mandatory criteria and 14 of the 19 other criteria.
- To show readiness for implementing the next version of the dataset (MSDSv2) by submitting a 'readiness questionnaire' to NHS Digital. MSDSv2 includes a third mandatory criterion.

3.2. The table below shows the progress of the Maternity EPR team against the Maternity Incentive Scheme standards set by NHS Resolution:

Required standard	Quality, completeness, readiness	OUHFT Progress
Minimum evidential requirement for Trust Board	**1.** NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. **2.** The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria have been met and whether the overall score is enough to pass the assessment. **3.** It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria	**1. Achieved:** Scorecards have been successfully submitted by reporting team each month **2. Achieved:** all accepted by NHS Digital **3. Ahead of schedule** - please see table below for details: • 2 of 3 mandatory criteria passed (3rd is successful final submission of April data on July 5) • 18 of 19 criteria met to date
Relevant time period	• The assessment will include data from the MSDS from January 2019. • This data needs to be submitted to MSDS for the deadline of 31 March 2019. • One MSDS criterion relates to data for six months, from October 2018 to March 2019, which needs to be submitted to MSDS for deadlines between 31 December 2018 and 31 May 2019. • One criterion relates to the submission of data for the first month of MSDSv2. This data relates to April 2019 and needs to be submitted to the (updated) deadline of 5 July 2019.	• **Submitted and accepted** • **Submitted and accepted** • **Submitted and accepted** • **Submitted**
Deadline for reporting to NHS Resolution	**Thursday 15 August 2019 at 12 noon**	**On target**

3.3. The Trust has been receiving NHS Digital Scorecards approximately 4-5 months after the data were submitted. At the time of writing this report the last scorecard received

(in May 2019) showed data for January 2019. This demonstrated that the Trust passed 2 out of 2 mandatory criteria and 18 of the 19 other criteria. Therefore providing evidence to support that the Trust is compliant with this Safety Action.

3.4. The last data submission, for the scorecard in April 2019, is due to be received in August as all the April 2019 data submitted showed that the Trust was compliant with the MSDSv2 data set it is expected that this will be confirmed as compliant.

4. Safety Action 3: Supporting the Avoiding Term Admissions into Neonatal Units Programme

4.1. The table below shows the Trust progress towards the required standard for this Safety Action:

Required Standard	OUH FT Progress
a) Pathways of care for admission into and out of 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.	a) **Compliant:** Local pathways are available
b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.	b) **Compliant:** Data available from the Neonatal Unit BadgerNet system
c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews.	c) **Compliant:** Action plan submitted to the Board, LMS and ODN.
d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN	d) **Compliant:** Progress with agreed action plan shared

4.2. For more information about the ATAIN programme see separate papers submitted to the Trust Board in March and May 2019.

4.3. Further evidence will be available on Board Pad to provide additional assurance of compliance, if required.

Standard Compliance

4.4. The evidence described in this section provides assurance that the Trust is meeting the required standards for Safety Action 3, supporting the Avoiding Term Admissions into Neonatal Units Programme.

5. Safety Action 4: medical work force planning

5.1. In order to provide evidence of compliance against this safety action the Directorate is required to demonstrate the following:

- To report to the Board whether it meets the Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6;
- Where trusts did not meet these standards, they must produce an action plan (ratified by the Board) stating how they are working to meet the standards;
- To formally report to the Board the proportion of obstetrics and gynaecology 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*.'

- An action plan produced by the Directorate to address lost educational opportunities due to rota gaps is presented for approval by the Board and a copy will be submitted to the RCOG.

Anaesthesia Clinical Services Accreditation (ACSA) standards

5.2. The Maternity Directorate has a dedicated consultant led Obstetric Anaesthetic service which complies with ACSA standards. These are summarised in the table below.

ACSA Standard	Description of Standard	Directorate Status	Standard met
1.2.4.6	Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff	There are currently 4 all day caesarean section lists. There is a dedicated team who are solely responsible for elective caesarean sections in the trust. This includes a named Consultant Obstetrician and Consultant Anaesthetist.	Yes
2.6.5.1	A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident	The obstetric unit provides a 24 hour epidural service and is covered by a dedicated resident anaesthetist 24 hours a day. A consultant obstetric anaesthetist provides back up at home out of hours.	Yes
2.6.5.2	A separate anaesthetist is allocated for elective obstetric work	There is a named consultant anaesthetist for elective obstetric work (elective caesarean list) who has no other responsibilities for that shift.	Yes
2.6.5.3	Where the duty anaesthetist has other responsibilities, an anaesthetist must be immediately available (within five minutes) to deal with obstetric emergencies	The delivery suite anaesthetist is on a separate rota from other areas of the trust and only has obstetric responsibilities.	Yes
2.6.5.4	Medically-led obstetric units have, as a minimum, consultant anaesthetist cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed)	The department have a minimum of 2 consultant obstetric anaesthetists to cover delivery suite during the day time, Monday to Friday. The elective caesareans are covered by a third consultant who has no responsibilities for emergency obstetrics.	Yes
2.6.5.5	There is a named consultant anaesthetist or intensivist responsible for all level two maternal critical care patients (where this level of care is provided on the maternity unit)	The level two maternal critical care patients are cared for in a clinical area adjacent to the delivery suite (Observation area). The delivery suite consultant anaesthetist is the named consultant anaesthetist for these patients 24 hours a day.	Yes
2.6.5.6	The duty anaesthetist for obstetrics should participate in labour ward rounds	The duty anaesthetist is expected to participate in the multidisciplinary labour ward rounds. As per ACSA standard guidance, evidence for this will be the anaesthetist rota showing availability during labour ward rounds.	Yes

5.3. The Directorate meets the Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 as set out above. As a result no formal action plan is required at this time.

General Medical Council National Training Survey 2018

5.4. The Safety Action requires the Directorate to:

- Formally report to the Board the proportion of obstetrics and gynaecology 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.'*
- An action plan produced by the Directorate to address lost educational opportunities due to rota gaps is presented for approval by the Board and a copy will be submitted to the RCOG.

5.5. The Board is asked to note that 68% of Trust Obstetrics and Gynaecology Trainees reported that they '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.'*

5.6. Following the Survey report, the college tutors in both the maternity and gynaecology directorates met with the trainees, the Obstetrics and Gynaecology Training Programme Director and the clinical directors to develop an action plan. This action plan was developed to address the training opportunities lost due to gaps in the rota.

5.7. The action plan that was developed to address the four main issues identified and is provided as Appendix 1 to this report. The Board is asked to approve the action plan developed by the Directorates to address lost educational opportunities due to rota gaps

Standard Compliance

5.8. The Directorate meets the Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 as set out in this Safety Action. As a result no formal action plan is required at this time as all of the Anaesthesia Clinical Services Accreditation (ACSA) standards are all met.

5.9. The evidence described in this section provides assurance that the Trust is meeting the required standards for Safety Action 4, with an effective system of medical workforce planning.

6. Safety Action 5: midwifery workforce planning

6.1. The required standards are as follows:

- A systematic, evidence-based process to calculate midwifery staffing establishment has been done;
- The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service;
- Women receive one-to-one care in labour (this is the minimum standard that Birthrate Plus® is based on);

6.2. The relevant time period for this Safety Action is listed as any consecutive three month period between January to July 2019. The minimum requirement for the Trust Board is a bi-annual paper that includes evidence on seven key areas. This report

includes an update on these seven evidence requirements, using data from the three month period of January to March 2019.

Evidence update

6.3. The following evidence is required to enable this standard to be met:

A clear breakdown of BirthRate Plus® or equivalent calculations to demonstrate how the required establishment has been calculated.

6.4. A systematic evidence based process to calculate midwifery staffing establishment has been undertaken using the BirthRate Plus® tool. Information on how BirthRate Plus® calculates the required establishment were included in the paper presented to the Trust Board Meeting 8th May 2019. There have been no changes to the midwifery staffing establishment calculations since that paper was submitted.

Details of planned versus actual midwifery staffing levels

6.5. Each week there are two staffing meetings to review planned midwifery staffing levels against the agreed establishment for each clinical area. Furthermore, twice a day the Safety Huddles (see Appendix 2) review the actual midwifery staffing levels and acuity levels, to ensure a fast response with mitigating actions to address any highlighted staffing shortfall.

6.6. The RAG rating agreed at the Safety Huddles is reported to the Trust staffing meeting once a day via dial-in, and is updated via email if it changes. There is a robust escalation policy with agreed action pathways to be taken for each rating.

6.7. The table below shows the RAG rating for red flags in actual midwifery staffing levels for January to March 2019. Green signifies that the maternity service has available beds and appropriate staffing levels for the workload on that particular day.

	RAG Rating			
	GREEN	AMBER	RED	Not Declared
January 2019	21	9	0	1
February 2019	15	9	3	1
March 2019	17	11	1	2

6.8. Actions were taken in line with the escalation policy to mitigate against RAG ratings of Amber and Red. This included delaying elective activity and addressing staff shortfall by using on-call staff and sourcing additional staff.

An action plan to address the findings from the full audit or table-top exercise of BirthRate Plus® or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls

6.9. The original action plan to address findings from BirthRate Plus® was included in paper presented to Trust Board Meeting on 8th May 2019. The findings identified a deficit in midwifery staffing levels; therefore an updated action plan can be seen in Appendix 3.

6.10. The Maternity Directorate continues to actively recruit new staff which includes recruitment of midwives, international obstetric nurses and promoting new career pathways for Maternity Support Workers to Maternity Assistant Practitioners. In February 2019, a member of the senior team joined the Trust team to recruit Obstetric Nurses in India. Over 30 offers were made to successful candidates.

The midwife: birth ratio

6.11. The agreed funding establishment for the midwife to birth ratio at the Trust is 1:29, and the red flag applies when the ratio is over 1:31. As highlighted by the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists' (RCOG) recommendation is for a midwife:birth ratio of 1:28.

6.12. In 2019, the Maternity Directorate has struggled to maintain the agreed midwife to birth ratio. The midwife to birth ratio for this period of time remains around 1:30. The midwife to birth ratio has improved in comparison to the previous 6 months when it was over 1:31. This is monitored monthly on the maternity dashboard. The table below shows the midwife: birth ratio in the period covered by this paper.

January	**1:31**
February	**1:30.6**
March	**1:30.3**

The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate Plus® accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives.

6.13. The BirthRate Plus® report (December 2018) recommended an increase in the midwifery establishment by approximately 16 W.T.E. In order to meet the 9% of the establishment who are not included in clinical numbers, the 16 W.T.E. should include 8 W.T.E management or specialist midwife roles.

6.14. In March 2019, a further Consultant Midwife was appointed and an additional governance post was approved, which addresses some of the recognised shortfall in specialist/management posts. A business case has been developed and is being submitted to Divisional Board in July 2019, in order to address the recommendations of BirthRate Plus®.

Evidence from an acuity tool (which may be locally developed) and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any shortfalls

6.15. The twice daily Safety Huddle monitors the supernumerary status of the delivery suite coordinator to ensure they have oversight of all birth activity in the service. If there is an occasion when the delivery suite coordinator does not have supernumerary status this is escalated to the Maternity Bleep Holder, mitigating action is taken to address the issue and red flagged on the electronic Health Roster System. In this data period there has been 100% compliance with supernumerary delivery suite coordinator status. This data is also review at the Maternity Clinical Governance monthly meeting.

Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising.

6.16. The number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months was detailed in the paper presented to the Trust Board on 8th May 2019. The agreed staffing red flags are listed in Appendix 4.

6.17. As an update to that paper, the red flag incidents for the three month time between January and March 2019 have been outlined in Appendix 5. The system for reporting red flags was changed in December 2018 so the data in Appendix 5 is from the new reporting system of Safe Care. It should be highlighted that the red flags for staffing includes 'Supernumerary workers within the numbers'; this includes staff who are supernumerary in one clinical area being moved to cover a staffing shortfall in another clinical area where they are able to be counted within the numbers. The data therefore shows a number of occasions where this has flagged, but does not indicate that the Delivery Suite Coordinator has stopped being supernumerary, as described above.

Standard Compliance

6.18. The evidence described in this section provides assurance that the Trust is meeting the required standards for Safety Action 5, with an effective system of midwifery workforce planning.

7. Safety Action 6: Saving Babies Lives Care Bundle

7.1. The Saving Babies Lives Care Bundle has been designed to help trusts reduce still births, early neonatal deaths and intrapartum brain injuries and achieve the national ambition to reduce the rate of these poor outcomes by 50% by 2030. Implementation of the four elements of the Saving Babies Lives Care Bundle is Safety Action 6 of the Maternity Incentive Scheme. these include

- Reducing smoking in pregnancy
- Risk assessment and surveillance for fetal growth
- Raising awareness of reduced fetal movements
- Effective fetal monitoring during labour

7.2. The Board should note that the still birth rate has remained low (4.0/1000 live births). The reduction in the number of moderate to severe Hypoxic-Ischemic Encephalopathy (HIE 2/3) has remained low at 0.4/1000 live births (nationally 2.0/1000 live births). The detection of growth restricted babies, 58% remains higher than the national average (30%).

7.3. All four elements of the care bundle have been implemented in the Trust. Further information and evidence to show compliance with the Safety Action should be reviewed in the separate paper presented to the Public Board in July and in the evidence on Board Pad.

7.4. There has been a successful additional pilot quality project associated with the risk assessment and surveillance for fetal growth element of the Saving Babies Lives care bundle which has been run in association with the AHSN.

Required Standard	OUH FT Progress
a) Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services. b) Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).	Compliant: separate paper 'Saving Babies Lives Report 2019' submitted to the July Public Board meeting. Compliant: all elements implemented

8. Safety Action 7: A patient feedback mechanism for maternity services

8.1. This Safety Action asks: "Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

8.2. The required standard is: "User involvement has an impact on the development and/or improvement of maternity services"

Minimum evidential requirement for Trust Board	OUH FT Progress
Evidence should include: a) Acting on feedback from, for example a Maternity Voices Partnership. b) User involvement in investigations, local and or Care Quality Commission (CQC) survey results. c) Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.	Compliant with the above standard. Evidence: a) Attendance of MVP representatives at Intrapartum Group and Antenatal/Postnatal Group shown in minutes and presentation by user representative. Actions taken following feedback and communications to report back shown in At a Glance. b) Parents' involvement in investigations into their care (Duty of Candour and Perinatal Mortality Review letter); evidence of discussion and feedback on CQC survey results at MVP meeting. c) Minutes of regular MVP meetings; stakeholder information from Health Overview Scrutiny Committee (HOSC) meeting; planning for an 'OxAnts' Oxford Antenatal Trainers meeting, requested by service users, for freelance antenatal education practitioners to have updates from Maternity and a chance to discuss current practice.

Standard Compliance

8.3. The evidence described in this section shows that user involvement has an impact on the development and improvement of maternity services. Therefore demonstrating the Trust is compliant with this Safety Action.

9. Safety Action 8: Multi-Professional Maternity Emergencies Training

9.1. Safety Action 8 of the Maternity Incentive Scheme, year two, asks for evidence to respond to the question "*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?"*

9.2. Since April 2018, the Maternity Directorate has provided training in maternity emergencies using the PROMPT (**PR**actical **O**bstetric **M**ulti-**P**rofessional **T**raining)

course. The courses are facilitated monthly by the Practice Development team and PROMPT faculty.

9.3. Annual attendance is mandatory for midwives, anaesthetic doctors, obstetric doctors, maternity support workers and obstetric theatre staff.

9.4. The Practice Development Team also runs regular multi-professional 'Emergency Skills and Drills' sessions on Delivery Suite and in the Spires (MLU) at the John Radcliffe site, and in the free-standing MLUs across Oxfordshire.

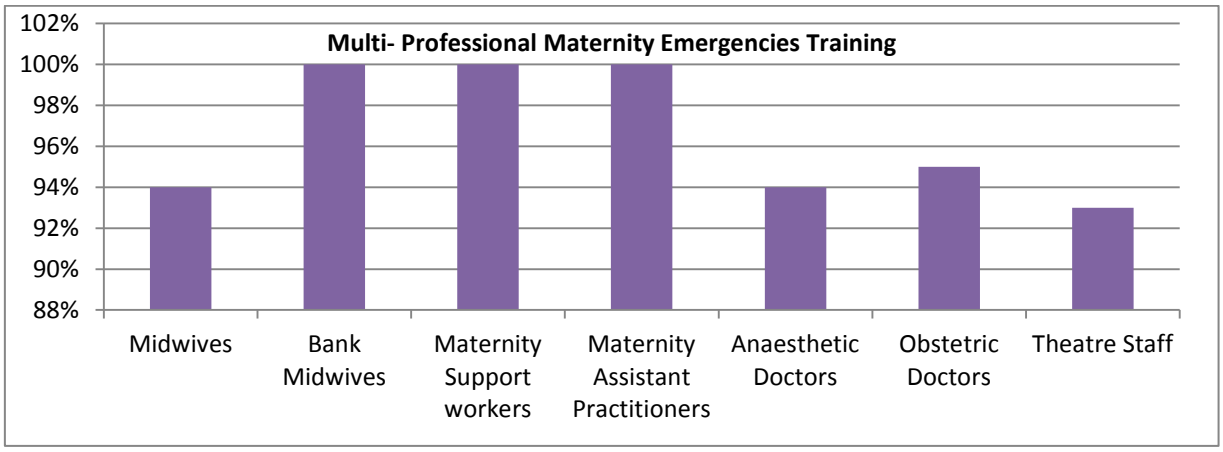
9.5. PROMPT is an evidence-based programme which was developed at Southmead hospital in Bristol to reduce adverse perinatal outcomes through local multi-professional training.

9.6. The syllabus focuses on both the technical and non-technical skills required to manage different types of maternity emergencies, emphasising the importance of effective communication, teamwork, and interdisciplinary work. Training is led by a local multi-professional faculty of clinicians from the Trust, and brings multi-professional clinical teams together to rehearse, reflect and improve on their collective practice. The syllabus is reviewed regularly by the PROMPT faculty and is amended in relation to relevant learning from Trust investigations, local maternal and neonatal outcomes, local audit findings, new evidence that is published and changes to local and national guidelines.

9.7. Since January 2018, Midwives and Obstetricians have been attending an annual multi-professional Fetal Monitoring assessment session which is mandatory. The first part of the session comprises case studies from previous investigations involving fetal monitoring, for group discussion of the outcomes and learning from each case. The second part of the session involves assessments in Continuous Electronic Fetal Monitoring and Intermittent Auscultation. Results are kept on the Practice Development training database.

9.8. In order to ensure that the Directorate is compliant with this Safety Action 8, a training database is kept by the Practice Development Team. This allows easy monitoring of when staff members have last attended training to ensure they keep their mandatory attendance up to date.

9.9. Graph 1 shows the proportion of the different staff groups in the Trust who have attended multi-professional training in maternity emergencies during the last training year (July 2018- June 2019.) and demonstrates that the Trust is fully compliant with this Safety Action.



Graph 1

9.10. The obstetric theatre staff group have been attending PROMPT courses since September 2018 and 90% of them have attended multi-professional training in maternity emergencies during the last training year. It is anticipated that during the next training year the percentage of obstetric theatre staff attendance will be significantly higher.

9.11. This demonstrates that the Trust is compliant with this Safety Action. The training database, examples of the training programme used and aspects of the syllabus taught have been included in the evidence for the Board to review.

Standard Compliance

9.12. The evidence described in this section gives assurance that OUH FT will remain compliant with this Safety Action as at least 90% of each maternity unit staff group will have attended an 'in-house' multi-professional maternity emergencies training session within the last training year. In addition the Directorate continue to maintain a focus on the compliance levels to ensure that the Trust remains compliant up to the date of final submission.

10. Safety Action 9: Trust safety champions are meeting bi-monthly with Board level champions to escalate locally identified issues

10.1. In November 2015 the Secretary of State for Health announced a national ambition to halve the rates of stillbirths, maternal and neonatal deaths and brain injuries that occur during or soon after birth by 2030; a timeframe subsequently revised to 2025.

10.2. OUH FT have identified and designated three individuals to champion maternity safety in their organisation: a board-level maternity champion as well as one obstetrician and one midwife to be jointly responsible at unit level. The board-level maternity safety champion will act as a conduit between the board and the obstetric and midwifery champions.

10.3. The role of the maternity provider safety champions is to support the regional and national maternity safety champions for delivering safer outcomes for pregnant women and babies

10.4. At OUH FT the Chief Nurse is the designated Board-Level Champion who works with the obstetric and midwifery champions to ensure maternity issues are communicated

and championed at board level. The local safety champions are the Clinical Director of Maternity and the Director of Midwifery.

10.5. The obstetric and midwifery champions also liaise with the Clinical Director of Neonatology who has been identified as an extra safety champion beyond what is required by the Maternity Incentive Scheme.

10.6. The Chief Nurse is also the executive sponsor for the maternal and neonatal health safety collaborative. As part of this role she actively engages with supporting quality and safety improvement activity within the Trust and Local Learning System.

Required Standards	OUH FT Progress
a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS)	a) Compliant: minutes of bi-monthly meetings with all safety champions, showing engagement of Executive Sponsor in quality and safety improvement activity.
b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues	b) Compliant: Evidence of monthly events demonstrating concerns raised by staff and progress against actions taken.
c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff	c) Compliant: steps taken to address safety concerns are outlined in a monthly newsletter that is sent to all Maternity Staff.

Standard compliance

10.7. The evidence presented in this section gives assurance that OUH FT is compliant with this Safety Action, with trust safety champions meeting bi-monthly with Board level champions to escalate locally identified issues.

11. Safety Action 10: Reporting 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification Scheme

11.1. Since April 2017, the NHS Resolution Early Notification Scheme (ENS) has required Trusts to report all maternity incidents of potentially severe neonatal brain injury diagnosed in the first seven days of life which meet the following criteria:

Term delivery (≥37+0 completed weeks of gestation)
Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) **[OR]**
Was therapeutically cooled (active cooling only) **[OR]**
Had decreased central tone **AND** was comatose **AND** had seizures of any kind.

11.2. In order to ensure 100% compliance the following processes are undertaken:

11.3. The Datix incident reporting system and BadgerNet Electronic Patient Hospital record (EPHR) are checked at least once per day for qualifying ENS incidents by the Maternity Governance Manager or Perinatal Risk Coordinator.

11.4. Qualifying incidents are reviewed by the governance team to see whether they were potentially avoidable.

11.5. Duty of Candour is undertaken as soon as possible by a member of the Maternity Governance team.

11.6. Since July 2018, ENS incidents have also been reported to and investigated by the Healthcare Safety Investigation Branch (HSIB).

11.7. As of April 2019, the Directorate has received two finalised HSIB reports.

11.8. There is weekly contact between the maternity governance team and Legal Services department to provide assurance that no cases are missed

Minimum evidential requirement for Trust Board	OUH FT Progress
Trust Board sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team.	Compliant: The Assurance Team have been provided with evidence which demonstrates that 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme have been reported as required. This evidence is available via the Trust Board Reading Room document repository.

12. Assurance

12.1. The Assurance Team have been provided with evidence to demonstrate compliance against each of the ten Safety Actions. The evidence provided has been checked by the Assurance Team and independently verified to support full compliance with the required standards.

12.2. This evidence is available via the Trust Board Reading Room document repository. The evidence described in this paper provides assurance that the Trust is meeting the required standards for NHSLA Maternity Incentive Scheme.

13. Recommendation

13.1. The Board is asked to:

- Approve the action plans provided in appendices 1 and 3.
- Agree, subject to the approval of the action plans as mentioned above, that sufficient evidence has been made available to the Trust Board (via Board Pad) to demonstrate compliance with the required standards.
- Give permission for the Trust Chief Executive to sign the Board Declaration Form to be submitted to NHS Resolution by 12 noon on Thursday 15th August 2019 (provided as Appendix 6 for information).
- Note that once the Board Declaration Form has been formally signed that the Director of Midwifery will discuss the contents of the form with the local commissioner of the Trust's maternity services.

Sam Foster
Chief Nursing Officer

Paper contributions from:

Naomi Manley, Maternity Clinical Governance Manager
Ms Veronica Miller, Clinical Director, Maternity
Rosalie Wright, Director of Midwifery
Annie Williams, Quality Assurance and Improvement Midwife

June 2019

Oxford University Hospitals NHS FT
Appendix 1 - Action plan in response to General Medical Council National Training Survey 2018 findings

Issue	Specific Action Required to achieve standard	Lead	Timescale	Evidence	Outcome
Due to gaps in working rotas the Trainees are required to cover the out of hours Rota which impacts on their clinical workload and availability to attend elective clinical sessions with training opportunities	To recruit additional Trust Grade Doctors: • 4 Trust Grade Doctors • 2 long-term locum appointments	Clinical Director for Maternity and Clinical Director for Gynaecology	December 2018	Appointment of Medical Staff. Working Rotas	Complete
Trainees reported lack of equity in accessing training opportunities	• To ensure equitable training opportunities are allocated to Trainees when creating the rota • Audit rotas and training opportunities from August 2018 to March 2019 to monitor compliance with equitable training opportunities being given to Trainees. To share audit findings with Trainees and implement further actions if required • To introduce a rolling audit of ST3 – ST5 rotas, with updated action plans as required. The first audit should start with the new Trainees, who start in August 2019, and cover the remainder of Q2 data.	The designated Rota Coordinator College Tutors College Tutors	Ongoing June 2019 November 2019	Rotas Audit presented at OXFOG in May 2019 POD Meeting in June 2019 Quarterly reports presented at Maternity, Gynaecology Directorates and Divisional Meetings.	Complete Complete Ongoing

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Theatre capacity has reduced on JR site which has led to reduction in Gynaecology training opportunities	To source training accreditation from Health Education England Thames Valley (HEETV) to provide additional training opportunities at the Churchill, Manor and Ramsay Theatres	Clinical Director for Gynaecology	December 2018	Letter of accreditation received from HEETV in December 2018	Complete
Reduction in training opportunities due to cancellation of theatre list due to lack of Surgical Assistants availability	To explore the roles of non-medical surgical assistants and identify 10 staff members that can be trained as First Surgical Assistants to facilitate training opportunities: ➢ 5 staff members to be trained by September 2018 ➢ A further 5 trained by October 2019	Clinical Director for Gynaecology Matron for Theatres	September 2018 October 2019	Names and evidence of training completion	Complete Ongoing

Safety Huddle

The Safety Huddle is a multidisciplinary meeting held twice a day, one at 09:30 and one at 16:00 hours. Members of the Maternity Safety Huddle include:

- Director of Midwifery
- Duty Consultant Obstetrician
- Clinical Midwifery Managers for each area (or deputy)
- Duty Consultant Anaesthetist
- 1570 Maternity Bleep Holder
- Midwifery Manager on-call (may represent via telephone)
  Delivery Suite Coordinator

Using the RAG rating system of Red, Amber or Green the safety huddle members will assess the unit's workload, staffing and acuity and declare Maternity's RAG status as follows:

- **Green** signifies that the maternity service has available beds and appropriate staffing levels for the workload
- **Amber** signifies the maternity service is at the upper limits of bed capacity, staffing or activity
- **Red** signifies that there are no available beds and all available staff are committed to labour care. The service cannot guarantee 1:1 midwifery care in labour or safe staffing in other areas of the service.

Issue	Specific Action Required to achieve standard	Lead	Timescale	Evidence	Outcome
To implement the Birthrate Plus Acuity Tool to monitor acuity and staffing levels throughout the 24 hour period	To purchase Birthrate Plus Acuity Tool for all Maternity clinical areas To cascade the tool to all inpatient areas, commencing with Delivery Suite, Observation Area and the Spires Alongside Midwifery Led Unit	 Delivery Suite Clinical Midwifery Manager	November 2018 October 2019	Tool purchased Acuity Reports	Complete Complete for Delivery Suite, Observation Area and Spires
To ensure that frontline staff are aware of the process for escalating staffing red flags	Email to all Maternity Operational Managers Area-specific training to match the red flags that would be associated with the specific clinical area To review current systems for frontline staff reporting any staffing red flags during their shift and identify any areas for improvement	 Clinical Midwifery Managers for Outpatients and Inpatients	March 2019 June 2019 June 2019	Email Training plan for individual clinical areas, and signed record of understanding Written report of recommendations to be submitted to Maternity Clinical Governance	Complete Ongoing Report of red flags submitted in May and now a standard agenda item at Clinical Governance.
Increase the midwifery establishment in line with Birthrate Plus Report	Submit a business case Continue with the recruitment and retention plan as outlined in TB2019.58B	Director of Midwifery Senior Midwifery Team	May 2019 Rolling programme	Business case to be submitted to Trust Board Minutes of Directorate Band 7 Meetings, with standard agenda item detailing recruitment and	Business case being submitted to Divisional Board on 3/7/19 for approval. Continuous – agenda item to be in place by June 2019. Completed.

Issue	Specific Action Required to achieve standard	Lead	Timescale	Evidence	Outcome
				retention updates	

'Safe Midwifery Staffing for Maternity Settings' (2015)

The agreed staffing red flags were approved and ratified in 2017

- (All Areas) Staff moved between specialty areas
- (All Areas) Supernumerary workers within the numbers
- (All Areas) Administrative or Support staff unavailable
- (All Areas) Staff unable to take recommended meal breaks or working over their scheduled finish time
- (All Areas) Delays in answering call bells
- (All Areas) Delay of more than 30 minutes in providing pain relief
- (All Areas) Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan
- (All areas) Beds not open to fully funded number - state number not staffed and reason
- (All areas) Elective activity or tertiary emergency referrals declined
- (Maternity Only) Delay of 30 minutes or more between presentation and triage
- (Maternity Only) Full clinical examination not carried out when presenting in labour
- (Maternity Only) Delay of 2 hours or more between admission for induction and beginning of process
- (Maternity Only) Any occasion when 1 midwife is not able to provide continuous one to one care and support to a woman during established labour.
- (Maternity Only) The Midwifery Labour Ward Coordinator has supernumerary status.

Maternity Staffing red flags results January – March 2019

RED FLAG All areas: 2019	January	February	March
Staff moved between specialty areas	30	24	8
Supernumerary workers within the numbers	0	0	0
Administrative or Support staff unavailable	5	2	0
Staff unable to take recommended meal breaks or working over their scheduled finish time	0	0	0
Delays in answering call bells	0	0	0
Delay of more than 30 minutes in providing pain relief	0	0	0
Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan	0	0	0
Beds not open to fully funded number - state number not staffed and reason	0	0	0
Elective activity or tertiary emergency referrals declined	0	0	0
RED FLAG Maternity only: 2019			
Delay of 30 minutes or more between presentation and triage	0	0	0
Full clinical examination not carried out when presenting in labour	0	0	0
Delay of 2 hours or more between admission for induction and beginning of process	9	8	7
Any occasion when 1 midwife is not able to provide continuous one to one care and support to a woman during established labour	0	0	0

Adjustments to the data have been made to reflect mitigating actions identified in the Staffing Safety Huddles.

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	
2	Are you submitting data to the Maternity Services Data Set to the required standard?	
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	
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?	
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	