

Maternity and Neonatal Safety Champions

CNST Maternity Incentive Scheme Webinar

05 February 2020, 14:30 – 16:00

*** This webinar is being recorded. The recording will be shared following the webinar.**

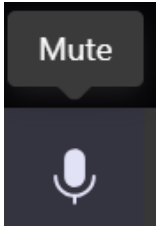
NHS England and NHS Improvement



Agenda

- **Welcome & Microsoft Teams Tips** – Jacquie Dunkley-Bent and Matthew Jolly
- **Overview of CNST Maternity Incentive Scheme Year 3** – Dee Davies, NHS Resolution
- **Safety Action 7: Service user feedback and MVPs** – Lisa Ramsay, NHS England & NHS Improvement
- **Safety Action 1: PMRT** – Dee Davies, NHS Resolution
- **Safety Action 2: MSDS** – Katharine Robbins, NHS Digital
- **Safety Action 3: ATAIN** – Michele Upton, NHS England & NHS Improvement
- **Safety Action 4: Clinical Workforce** – Dee Davies, NHS Resolution
- **Safety Action 5: Midwifery Workforce** – Zeenath Uddin, Royal College of Midwives
- **Safety Action 6: SBLCBv2** – Matthew Jolly, NHS England & NHS Improvement
- **Safety Action 8: Maternity staff training** – Dee Davies, NHS Resolution
- **Safety Action 9: Safety Champions** – Michele Upton, NHS England and NHS Improvement
- **Safety Action 10: Early Notification Scheme** – Dee Davies, NHS Resolution
- **Q&A session** – Jacquie Dunkley-Bent and Matthew Jolly

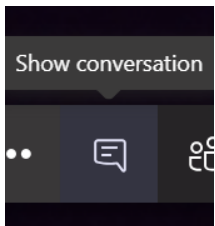
Tips for using Microsoft Teams



Please ensure that you are muted on your dial in device (phone or laptop) during the presentations; this helps reduce the background noise.



Please do not start sharing your screen during the webinar as this will interrupt the presenters.



This is an interactive session, please add your questions and comments into the chat box as we go through the presentations and we will address as many of these as we can in the Q&A session.

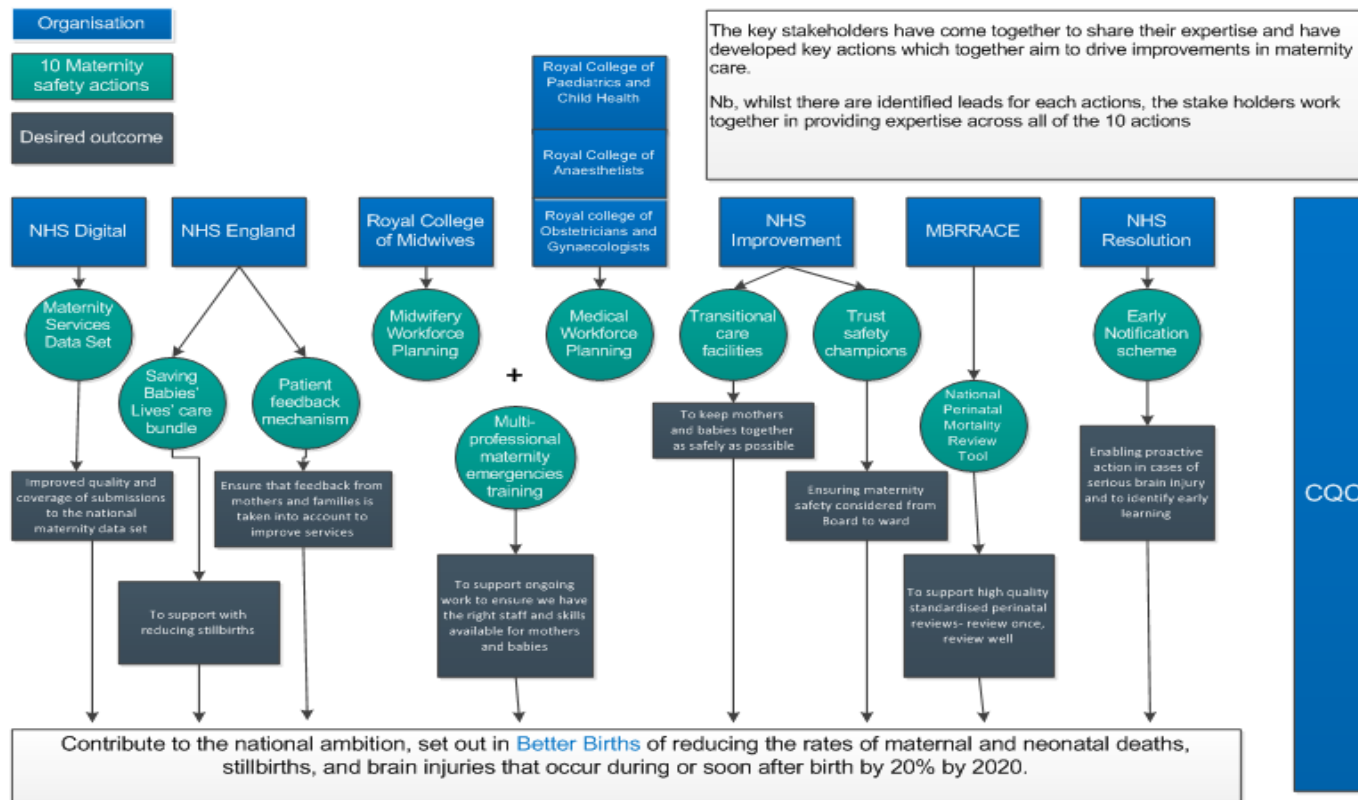
If you are experiencing any technical problems please send a message to Emily Clinton / Host via the chat panel and we will do our best to help.

Maternity Incentive Scheme Year 3

Dee Davies

Maternity Clinical Advisor

Maternity incentive scheme – Collaborative partnership



Key points: year 3

- Overarching standards are the same but stretched
- Preparation and planning
- Understand the technical guidance detail
- Ask questions MIS@resolution.nhs.uk
- Communication at Trust Board – how often?
- Contingency strategy – do you know what the plan will be if a key member leaves?

The process

- Trusts must achieve all 10 safety actions to be eligible for the 10% rebate of the contribution
- Cross reference results with external data sets from MBRRACE-UK, NHS Digital and the NNRD for the following actions: safety action 1, safety action 2 and safety action 10 respectively.
- Only submit the Board declaration form which has been signed off and not the evidence

Ten safety actions achieved? Yes

- Complete the Board declaration form (within excel document).
- Discuss form and contents with the trust's local commissioner.
- Request for Board to permit the chief executive to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
- **Chief executive signs the form.**

Ten safety actions achieved? No

- If full compliance cannot be demonstrated trust may be eligible for a small amount of funding to support progress providing that savings are used to take action towards meeting the safety action and a clear plan
- Complete the Board declaration form (within excel document).
- Complete action plan for the action(s) not completed in full (action plan contained within excel document).
- **Chief executive signs the form and plan.**

Key points year 3

- Return Board declaration form to MIS@resolution.nhs.uk by 12 noon on Thursday 17th September 2020
- Electronic acknowledgment will be provided within 48 hours
- Appeals by Monday 14th October 2020
- Notification of the outcome by end of October 2020

Safety Action 7:

Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voice Partnership to coproduce local maternity services?



Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Lisa Ramsey
Service User Voice Lead
Maternity Transformation Programme
lisa.ramsey1@nhs.net
@doula_lisa #MatVoices #BetterBirths



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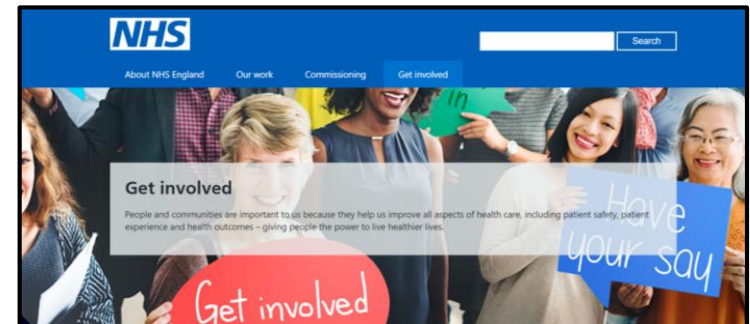
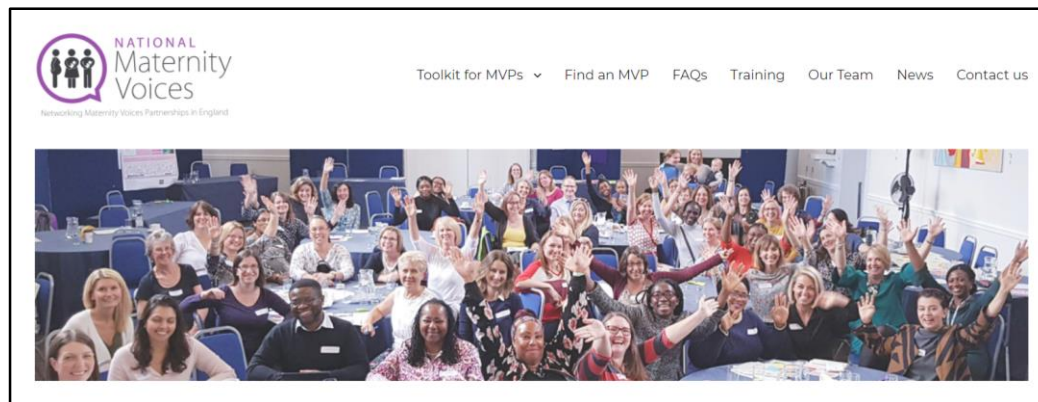
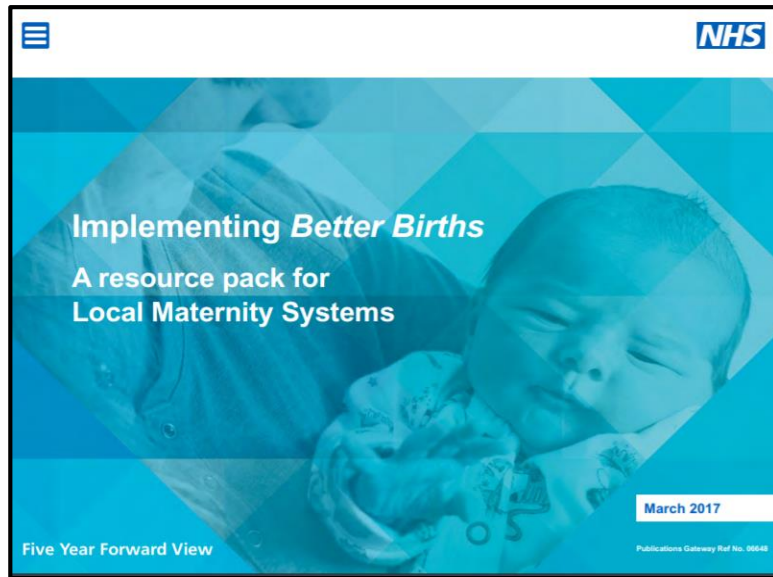


CNST Safety Action 7

Required standard:	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Minimum evidential requirement for trust Board:	<p>Evidence should include:</p> <ul style="list-style-type: none"> • Use of Care Quality Commission National Maternity Survey results • Terms of Reference for your Maternity Voices Partnership, • Minutes of regular Maternity Voices Partnership meetings demonstrating explicitly how a range of feedback is obtained and consistent involvement of trust staff in coproducing service developments based on this feedback. • Evidence of service developments resulting from coproduction with service users. • Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the MVP are able to claim out of pocket expenses
Validation process:	Self-certification to NHS Resolution using the Board declaration form



Resources to help you:



NHS England and NHS Improvement







People to help you:



Lisa Ramsey, Service User Voice Lead, Maternity Transformation lisa.ramsey1@nhs.net
Hannah Lynes, Chair, National Maternity Voices, info@nationalmaternityvoices.org.uk




**National Maternity Survey
- exploring the 2019 results**

Maternity Transformation Programme

1-2pm, Tuesday 25th February 2020

NHS England and NHS Improvement



NHS England and NHS Improvement



Safety Action 1:

Are you using the National Perinatal Mortality Tool to review perinatal deaths to the required standard?

Safety Action 1:(Perinatal Mortality Review Tool)

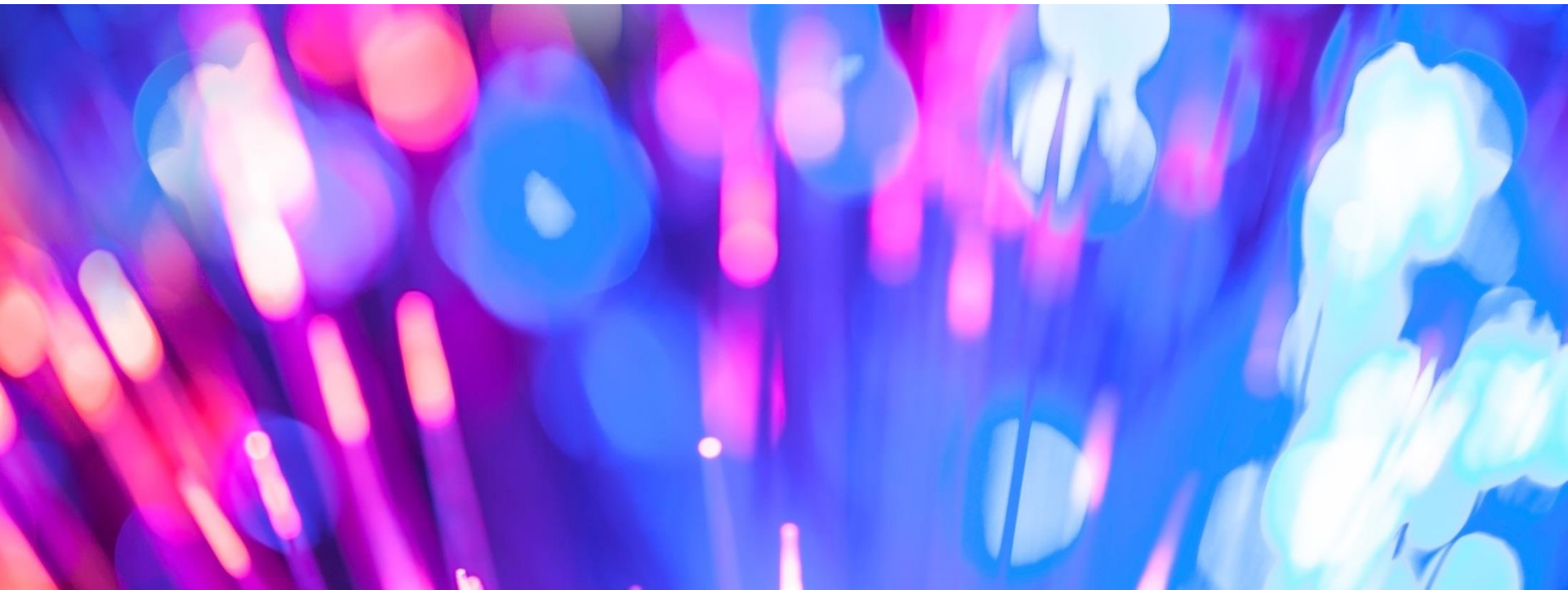
- No changes to the requirement
- a, b, c and d standards
- Includes clarity re home births and quarterly reports to be discussed with trust maternity safety champion
- Technical guidance is more detailed
- Greater emphasis on using the PMRT to produce reports and to monitor PMRT website for updates/messages.
- Quarterly board reports from 20/12/19 – 17/09/20

Safety Action 2:

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Safety Action 2: Maternity Services Data Set

Katharine Robbins

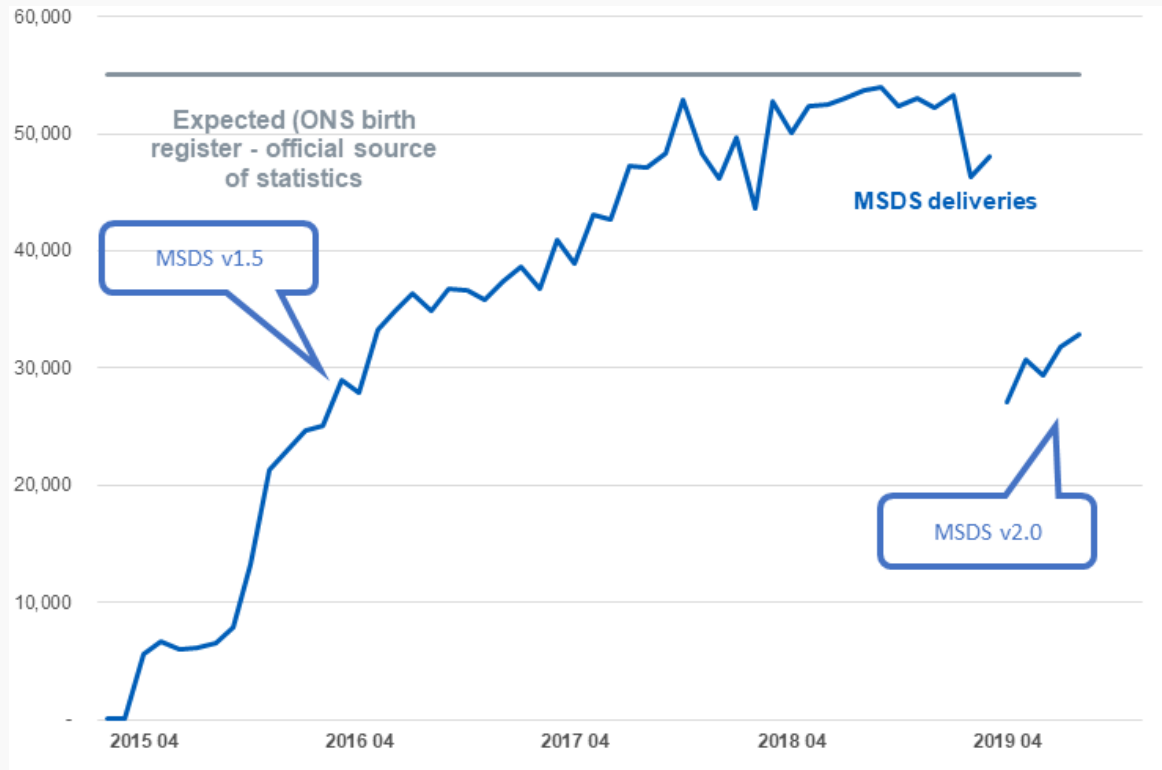


Information and technology
for better health and care

Progress update

- MSDS v2.0 ISN published September 2018
- All 130 trusts have made a submission from April 2019 onwards
- The submissions vary in scope, coverage and quality
- This means that we know less about maternity services than we did at March 2019

Progress update: Monthly deliveries



Challenges

- Not all trusts are sending all the key tables or data items
- Some are not sending any data on births, and some almost no data on bookings
- Some key data items such as EDD, postcode and ethnic category are poorly completed in some trusts
- A low level of submission of data for key policy areas such as continuity of carer and personalised care
- Also need to be rapidly working towards the data in the Saving Babies Lives Care Bundle v2

Maternity Incentive Scheme (CNST) 2020

- The 3rd Maternity Incentive Scheme is available at
 - <https://resolution.nhs.uk/wp-content/uploads/2019/12/Maternity-Incentive-Scheme-Year-three.pdf> & about to be updated
- **Safety action 2:** Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
 - All 14 criteria are mandatory. Criteria 1-13 will be assessed by NHS Digital and included in the scorecard, the final criterion 14, will be assessed by the trust and a declaration made to NHS Resolution.
- **Safety action 6:** Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
 - The relevant data items for these metrics should be recorded on the provider's Maternity Information System (MIS) and included in the April 2020 MSDS submission to NHS Digital. If there is a delay in the provider trust MIS's ability to record these data at the time of submission an in-house audit using locally available data or case records should have been undertaken to assess compliance with this metric.

CNST 2020 – Keeping in touch

New mailbox maternity.dq@nhs.net

1. At least two people registered to submit MSDS data to SDCS Cloud and still working in the trust on Friday 28 February 2020
2. MSDSv2 webinar attended by at least one colleague from each trust in January/February 2020
3. MSDSv2 post-implementation review questionnaire completed and returned to NHS Digital by 31 March 2020. This will be issued in late Feb 2020. It will include a question to ask trust Boards to confirm that they have a plan in place to fully conform with the MSDSv2 Information Standards Notice, DCB1513 Amd 10/2018, which was expected for April 2019 data, and ask whether there will be full conformance by Nov 2020
14. Trust Boards confirm to NHS Resolution that a plan is in place by 30 April 2020, to fully implement Information Standards Notice DCB3066 Amd 112/2018 by November 2020, which mandates compliance with the Digital Maternity Record Standard.

CNST 2020 – Submitting data

4. Made a submission in each of the last seven months Nov 2019 - May 2020 data, submitted to deadlines Jan 2020 - July 2020
5. April 2020 and May 2020 data included all following tables
 - MSD000 MSDS Header
 - MSD001 Mother's Demographics
 - MSD002 GP Practice Registration
 - MSD101 Pregnancy and Booking Details
 - MSD102 Maternity Care Plan
 - MSD201 Care Contact (Pregnancy)
 - MSD202 Care Activity (Pregnancy)
 - MSD301 Labour and Delivery
 - MSD302 Care Activity (Labour and Delivery)
 - MSD401 Baby's Demographics and Birth Details
 - MSD405 Care Activity (Baby)
 - MSD901 Staff Details

CNST 2020 – Submitting key data items

6. April 2020 and May 2020 data contained at least 90% of the deliveries recorded in Hospital Episode Statistics (unless reason understood). (MSD401)
7. April 2020 and May 2020 data contained at least as many women booked in the month as the number of deliveries submitted in the month (unless reason understood) (MSD101)
8. April 2020 and May 2020 data contained Estimated Date of Delivery for 95% of women booked in the month (MSD101)
9. April 2020 and May 2020 data contained valid postcode for mother at booking in 95% of women booked in the month (MSD001)
10. April 2020 and May 2020 data contained valid ethnic category (Mother) for at least 80% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)
11. April 2020 and May 2020 data contained antenatal continuity of carer plan fields completed for 90% of women booked in the month (MSD101/2)
12. April 2020 and May 2020 data contained antenatal personalised care plan fields completed for 90% of women booked in the month (MSD101/2)
13. April 2020 and May 2020 data contained valid presentation at onset of delivery codes for 90% of births where this is applicable (MSD401)

Progress so far

- Webinars with Euroking, HD Clinical, DXC, System C, Clevermed, Cerner, Intersystems and K2, plus a general session
- High attendance at the webinars
- All trusts have submitted data for Nov 19 by the 31 Jan deadline
- Only a dozen trusts only have one data submitter
- Draft scorecard issued for info/comment

Safety Action 3:

Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal Units programme?

Required standard for Safety Action 3

- Pathways of care 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.
- *The pathway of care into transitional care has been fully implemented and is audited monthly. Audit findings are shared with the neonatal safety champion.*
- 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.
- Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, *on request*, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.
- An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews has been agreed with the *neonatal safety champion and Board Level Safety Champion**.
- Progress with the agreed ATAIN action plan has been shared with the *Neonatal Safety Champion and the Board Level Safety Champion***

Changes from Year 2 to Year 3

Year 2

- 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.
- 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.
- 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.
- d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN

Intentions of Safety Action 3

- Avoid separation of mother and baby where safe to do so
- Promote maternal infant bonding
- TC services as standard across England – embed – more than a policy
- Adequately staffed
- Deliver a seamless perinatal service – mutual understanding by staff
- Data to inform future commissioning
- Transfer of leadership for Atain to neonatal and Board Level Safety Champions
- Then out to LMSs, ODNs on request

Safety Action 4:

Can you demonstrate an effective system of clinical* workforce planning to the required standard?

Safety action 4 : Clinical workforce planning

Anaesthetic medical workforce

- We have reproduced the wording of the standards in the guidance so there is no need to go to the ACSA website
- ACSA website has the Excel version of the standards which lists both the old and new numbering for the standards
- Six month period between Wednesday 1 January 2020 and Tues 30 June 2020
- If not met an action plan is in place and agreed at board level

Neonatal medical workforce

- Meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing
- Six month period between Wednesday 1 January 2020 and Tuesday 30 June 2020

If not met an action plan is in place and agreed at board level and also the Neonatal Operating Delivery Network (ODN)

Safety Action 4 : Clinical Workforce planning

- Neonatal nursing workforce

Service specification standards annually using the neonatal clinical reference group workforce calculator

- Six month period between Wednesday 1 January 2020 and Tuesday 30 June 2020

If not met an action plan is in place and agreed at board level.

Copy submitted to Fiona.Smith@rcn.org.uk and Neonatal Operational Delivery Network (ODN)

Safety Action 5:

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Zeenath Uddin
Head of Quality and Safety
Royal College of Midwives



Promoting • Supporting • Influencing

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

38

Required standard	<ul style="list-style-type: none"> a) A systematic, evidence-based process to calculate midwifery staffing establishment is complete. b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service c) All women in active labour receive one-to-one midwifery care d) Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board.
Minimum evidential requirement for trust Board	<p>The bi-annual report submitted will comprise evidence to support a, b and c progress or achievement.</p> <p>It should include:</p> <ul style="list-style-type: none"> • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. • Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing. • An action plan to address the findings from the full audit or table-top exercise of BirthRate+ 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. • The midwife: birth ratio. • The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	Any consecutive six month period between Friday 20 December 2019 until Thursday 17 September 2020.
What is the deadline for reporting to NHS Resolution?	Thursday 17 September 2020 at 12 noon

Technical guidance

What midwifery red flag events could be included (examples only)?

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of two hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637

What if we do not have 100% supernumerary status for the labour ward coordinator?

An action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board, and includes a timeline for when this will be achieved.

What do you mean by bi-annual?

Every six months

Safety Action 6:

Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2?

Saving Babies' Lives v2

a) Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives Care Bundle Version 2 (SBLCBv2), published in April 2019.

Note: Full implementation of the SBLCBv2 is included in the 2019/20 standard contract.

b) Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network

c) The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net.

- Five elements – a new element to reduce preterm birth
- Outcome measures kept to a minimum
- Focus on QI through a process of continuous learning
- Most of the required data collection can be achieved through monthly submissions to the MSDS or use of the PMRT.
- Required standard for Safety Action 6:

Implementing SBLCBv2 Element 1

Element 1:

- Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital.
- Percentage of women where CO measurement at booking is recorded.
- Percentage of women where CO measurement at 36 weeks is recorded.

Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submission to NHS

Digital. If there is a delay in the provider trust MIS's ability to record these data at the time of submission an in-house audit of 40 consecutive cases using locally available data or case records should have been undertaken to assess compliance with this indicator.

A threshold score of 80% compliance should be used to confirm successful implementation.

If the process metric scores are less than 95% Trusts must also have an action plan for achieving >95%.

- Procure CO monitors
- Ensure CO reading is recorded on MIS
- Provide training for very brief advice
- Ask LMS to help with smoking cessation services

Implementing SBLCBv2 Element 2

Element 2:

- Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking.

Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submission to NHS Digital. If there is a delay in the provider trust MIS's ability to record these data at the time of submission an in-house audit of 40 consecutive cases using locally available data or case records should have been undertaken to assess compliance with this indicator.

A threshold score of 80% compliance should be used to confirm successful implementation.

If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

In addition, the trust board should specifically confirm that within their organisation:

- 1) women with a BMI > 35 kg/m² are offered ultrasound assessment of growth from 32 weeks' gestation onwards
- 2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation
- 3) There is a quarterly audit of the percentage of babies born < 3rd centile > 37+6 weeks' gestation.

If this is not the case the trust board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice.

- Symphysis fundal height training programme
- Training needs assessment for sonographers
- SGA and FGR guideline update
- Consider a demand management tool, e.g. USS request form

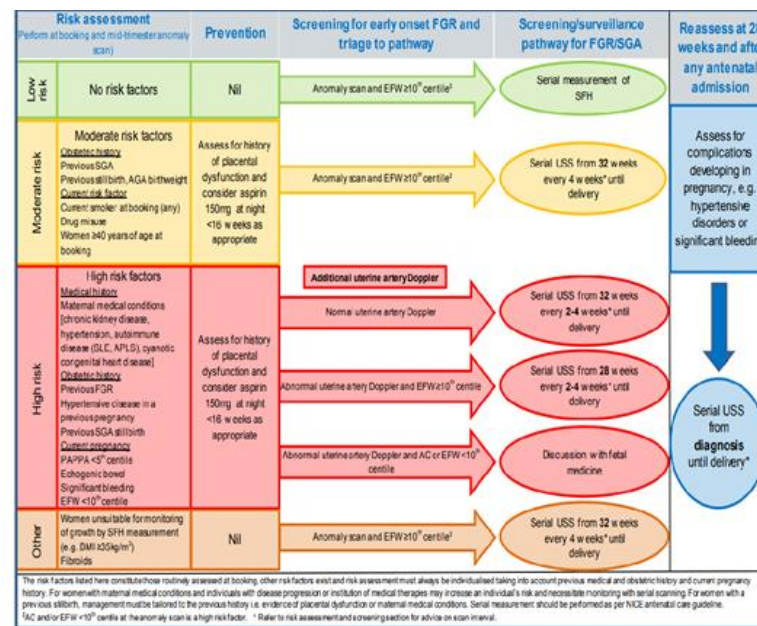
USS request form

ANTENATAL ULTRASOUND REQUEST FORM

Western Sussex Hospitals NHS Foundation Trust

Hospital number:	EDD (USS):
Surname:	Gestational age:
Forename(s):	Risk factor /Indication:
Date of Birth:	
For audit purposes only: <input type="checkbox"/> Request review of request	
Reason:	

<p>Serial Scan Requests</p> <p><input type="checkbox"/> Serial USS from 32 weeks every 4 weeks until delivery</p> <p>INDICATIONS</p> <p><input type="checkbox"/> Previous SGA</p> <p><input type="checkbox"/> Previous stillbirth, AGA birthweight</p> <p><input type="checkbox"/> Current smoker at booking (any)</p> <p><input type="checkbox"/> Drug misuse</p> <p><input type="checkbox"/> Women ≥40 years of age at booking</p> <p><input type="checkbox"/> BMI >35kg/m²</p> <p><input type="checkbox"/> Unsuitable for SFH measurement (fibroids)</p> <p><input type="checkbox"/> EFW < 10th Centile (discuss management with Consultant)</p> <p><input type="checkbox"/> High risk factor and Normal Ut Art Doppler (Document risk factor in box above)</p> <p><input type="checkbox"/> None of the above [Consultant only request] (Document indication in box above)</p> <p><input type="checkbox"/> Serial USS from 28 weeks every 4 weeks until delivery (See overleaf for indications and document in box above)</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Serial USS from 28 weeks every 2 weeks until delivery [Consultant only request] (See overleaf for indications and document above)</p> <p><input type="checkbox"/> Multiple Pregnancy</p> <p><input type="checkbox"/> DCDA Twins USS from 24 weeks every 4 weeks until delivery</p> <p><input type="checkbox"/> MCDA Twins USS from 16 weeks every 2 weeks until delivery</p>	<p>Single Scan Request</p> <p><input type="checkbox"/> Uterine artery Doppler at anomaly scan (See overleaf for indications and document above)</p> <p><input type="checkbox"/> Presentation scan (To be done in Antenatal Clinic or DAU if possible)</p> <p><input type="checkbox"/> Placental site scan (N.b. may be a TV scan)</p> <p><input type="checkbox"/> Fetal wellbeing scan [biometry, deepest vertical pool and umbilical art doppler]</p> <p>INDICATIONS</p> <p><input type="checkbox"/> Recurrent reduced fetal movements</p> <p><input type="checkbox"/> Poor growth on SFH chart</p> <p><input type="checkbox"/> Excessive growth on SFH chart</p> <p><input type="checkbox"/> Other (Document indication in box above)</p> <p><input type="checkbox"/> Other scan (e.g. MCA Doppler or Cx length)</p> <p>..... (Document indication in box above)</p> <p>Urgency of the request:</p> <p><input type="checkbox"/> next day, <input type="checkbox"/> 72 hours, <input type="checkbox"/> 1 week, <input type="checkbox"/> 2 weeks</p> <p><input type="checkbox"/> GA /40</p> <p>Date:</p> <p>Referrer's Name (GMC Number / Stamp):</p> <p>Referrer's Signature:</p>
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Guide to identifying abnormal growth:

1. Slow Growth on SFH

- Use the 90th and 10th centile lines on the SFH chart as the upper and lower limits to define 'normal growth', and visual assessment as to whether the plotted sequential measurements follow a curve, the slope of which is within the 90th and 10th centile line 'slope limits'.
- Avoid using the term 'crossing centiles' as this is often misinterpreted as crossing one of the three lines on the customised growth chart (90th, 50th and 10th). A drop from 45th to 15th centile can be significant yet crosses neither of these lines

2. Slow Growth on USS

- Increase in EFW less than 280g over 14 days (20g per day) from 34 weeks

3. Excessive Growth on SFH

- The clinical concerns about large for dates are very much less than small for dates. A large for dates pregnancy might be a first presentation of gestational diabetes, which can present with both a large baby and polyhydramnios
- The fundal height measurement is known to have considerable variability, often being above the 90th centile on the customised charts in the 24 – 30 week range.
- An initial measurement above the 90th centile does not prompt ultrasound referral but is repeated in 2-3 weeks and is only assessed by ultrasound examination if the plot increases steeply which might occur with polyhydramnios (see excessive growth).
- The emphasis is on using your clinical judgement.

Further guidance regarding Element 2

Compliance with the intervention for surveillance of low-risk women does not mandate participation in the Perinatal Institute's Growth Assessment Protocol (GAP) or the use of customised fundal charts. Providers should however ensure that for low risk women, fetal growth is assessed using antenatal symphysis fundal height charts by clinicians trained in their use. All staff must be competent in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated.

Implementing SBLCBv2 Element 3

Element 3:

- Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy.
- Percentage of women who attend with RFM who have a computerised CTG.
- Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of 2 weeks' worth of cases or 20 cases whichever is the smaller to assess compliance with the element 3 indicators.

A threshold score of 80% compliance should be used to confirm successful implementation.

If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

- RFM advice leaflet
- Update RFM guidance
- Consider procurement using end of year underspend

Suggested Checklist for the Management of Reduced Fetal Movements (RFM)	
1. Ask	
Confirm there is maternal perception of RFM? How long has there been RFM? Is this the first episode? When were movements last felt?	
2. Act	
Auscultate fetal heart (hand-held Doppler/Pinnard) to confirm fetal viability.	
Assess fetal growth by reviewing growth chart, perform SFH if not performed within last 2 weeks.	
Perform CTG to assess fetal heart rate in accordance with national guidelines (ideally computerised CTG should be used).	
<p>Ultrasound scan for fetal growth, liquor volume and umbilical artery Doppler needs only to be offered on first presentation of RFM if there is no computerised CTG or if there is another indication for scan (e.g. the baby is SGA on clinical assessment).</p> <p>Ultrasound scan for fetal growth, liquor volume and umbilical artery Doppler should be offered to women presenting with recurrent RFM after 28+0 weeks' gestation.</p> <p>Scans are not required if there has been a scan in the previous two weeks.</p>	
In cases of RFM after 38+6 weeks discuss induction of labour with all women and offer delivery to women with recurrent RFM after 38+6 weeks.	
3. Advise	
Convey results of investigations to the mother. Mother should be encouraged to re-attend if she has further concerns about RFM.	
IN THE EVENT OF BEING UNABLE TO AUSCULTATE THE FETAL HEART, ARRANGE IMMEDIATE ULTRASOUND ASSESSMENT	

Implementing SBLCBv2 Element 4

Element 4:

- Percentage of staff who have received training on fetal monitoring in labour, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.
- Percentage of staff who have successfully completed mandatory annual competency assessment.

Note: An in-house audit should have been undertaken to assess compliance with these indicators. The compliance required is the same as CNST action 8 i.e. 90% of maternity staff which includes 90% of each of the following groups:

- Obstetric consultants
- All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota
- Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres

- Annual training and competency assessment on CTG interpretation
- Risk at the onset of labour
- A fetal monitoring lead

Further guidance regarding Element 4

The Royal College of Midwives (RCM) and RCOG are introducing a national intrapartum fetal surveillance training package in 2020 that can be used locally and will comply with Element 4 of the SBLCBv2

If a local one-day fetal monitoring training programme has not yet been introduced, then two half days of training would be acceptable. Completion of an electronic training package such as Health Education England's [e-Learning for Healthcare Learning Paths on eFetal Monitoring](#) or [the Fetal monitoring modules of the K2 Perinatal Training Programme](#) would count as one half days' worth of training.

If a local one-day fetal monitoring training programme has not yet been introduced, there should be evidence of an action plan, with Trust board sign off, to release staff to attend this additional training programme in the future.

Implementing SBLCBv2 Element 5

Element 5:

- Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.
- Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.
- Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).

Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submission to NHS Digital. If there is a delay in the provider trust MIS's ability to record these data at the time of submission an in-house audit of a minimum of 4 weeks' worth of consecutive cases up to a maximum of 20 cases to assess compliance with the element 5 indicators.

Completion of the audits should be used to confirm successful implementation. If the process indicator scores are less than 85% Trusts must also have an action plan for achieving >85%.

In addition, the trust board should specifically confirm that within their organisation:

- women at high risk of pre-term birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice.
- An audit has been completed to measure the percentage of singleton live births (less than 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids.

- Identify two clinicians to run preterm birth service
- Referral form
- Pathway recorded on MIS

Further guidance regarding Element 5

The Board's assessment of the percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance) should be based on all deliveries from April, May and June 2020. This data is captured on BadgerNet.

Leadership and implementing SBLCBv2

- Identify a lead for each element and give them some well defined tasks to complete by a deadline.

Safety Action 8:

Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Safety Action 8 (In- house training)

There are now 3 requirements to this standard :

- Staff group has increased with the inclusion of neonatal staff (only include those who that contribute to obstetric rota)
- Addition of twice yearly in-situ training
- Neonatal resuscitation training
- Technical guidance and resource links

NB safety action 6 SBLCBv2 requires a separate local fetal monitoring training day

Safety Action 9:

Can you demonstrate that the Trust Safety Champions (obstetric and midwifery) are meeting bimonthly with Board Level Safety Champions to escalate locally identified issues?

Required Standard for Safety Action 9

- *A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and board safety champions, including the Executive Sponsor for the MatNeoSIP, share safety intelligence from floor to board and through the LMS and Local Learning System (LLS).*
- Board level safety champions are undertaking monthly feedback sessions for maternity and neonatal staff to raise concerns relating to safety issues and can demonstrate that progress with actioning named concerns are visible to staff.
- *Board level safety champions have agreed and maintain oversight of an action plan that describes how the maternity service is working towards a minimum of 51% women receiving continuity of carer pathway by March 2021.*
- The Executive Sponsor (and/or board level safety champion) for the MatNeoSIP is actively supporting capacity (and capability) building for all staff involved in the following areas:
 - Maternity and neonatal quality and safety improvement activity within the Trust
 - The LLS of which the Trust is a member
 - Specific national improvement work lead by the MatNeoSIP that the Trust is directly involved with
 - *The national Clinical Improvement Leaders Group (CILG) where Trust staff are members*

Changes from Year 2 to Year 3

Year 2

- a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement within
 - I. The Trust
 - II. The Local Learning System (LLS)
- 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
- c) The board level safety champions have taken steps to address names safety concerns and that progress with actioning these are visible to staff.

Intentions of Safety Action 9

- Develop the profile of safety champions in each Trust
- Increase the visibility of safety champions so that everyone knows who their safety champions are
- Develop strong relationships between maternity, neonatal and board safety champions locally
- Provide a forum for staff to raise safety concerns openly and allow for discussion
- Incentivise support for implementation of CoC to 51%
- Continue to embed QI locally with oversight for QI as part of wider safety intelligence at board level
- Ensure local insights, good practice and learning is shared with LMSs
- Develop strong working relationships between Trusts and the LMS

Safety Action 10:

Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification Scheme?

- ***Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?***
- No changes have been made to this standard

Safety Action 10

- Qualifying incidents are term deliveries ($\geq 37+0$ completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life.

These are any babies that fall into the following categories:

- 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.

- If the case meets ENS criteria and has been accepted by Each Baby Counts, it will be treated as a Qualifying Incident.
- Reporting of all qualifying incidents that occurred in the 2019/20 financial year: Monday 1 April 2019 to Tuesday 31 March 2020

Q&A Session:

Please send your questions through the chat box – if possible please include the specific safety action your question is in relation to.

Thank you very much for joining the webinar today!

The recording of the webinar will be disseminated as soon as possible and can be shared with colleagues who were not able to join today.

If you have any queries regarding the CNST Maternity Incentive Scheme Year 3 please contact:

MIS@resolution.nhs.uk

If you have any queries regarding Safety Champions please contact: nhsi.maternitysafetychampions@nhs.net



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Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive scheme year two

**Jo Mountfield RCOG Vice
President for Workforce and
Professionalism**



Safety standard action 4

Can you demonstrate an effective system of medical workforce planning to the required standard

2020 conditions:

1. All boards should formally record in their minutes the proportion of O&G trainees in their Trust who 'Disagreed/Strongly disagreed' with the 2019 GMC National Trainees Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'



Conditions continued...

2. Furthermore, there should be a plan produced by the Trust to address these lost educational opportunities due to rota gaps. The plan must also include an agreed strategy with dates, to address their rota gaps. The RCOG have examples of successful Trust level innovations that have successfully addressed rota gaps available to view at www.rcog.org.uk/workforce.
3. 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.



2019 Results

- In 2019 66 out of 132 Trusts (50%) complied with submitted the required information to the RCOG.
- Of the Trusts that responded, the percentage of Trainees who disagreed/strongly disagreed to the 2019 GMC National Trainees Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' are high:
 - The average across all trusts is 53% of trainees losing opportunities due to rota gaps

2019 Results Continued..



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- Less than 40% of training opportunities lost: 25% of CNST respondents
- Between 40-50% of training opportunities lost: 9% of CNST respondents
- Between 50-70% of training opportunities lost: 46% of CNST respondents
- Over 70% of training opportunities lost: 20% of CNST respondents

Key questions for Trusts:



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- How are you addressing the long term gaps in their rotas?
- What actions are you taking to address loss of training opportunities?

Feedback to date (rota gaps)



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Results are hugely varied across Trusts, the following are some of the most cited approaches Trusts are taking:

- Increased recruitment at Trainee and senior levels
- Ongoing reviews of rota design
- Greater flexibility in working patterns (on call, night rota etc.)
- Protected clinical training and development time
- Rules on using only Trust Doctors or Locums to fill rota gaps
- Review of senior medical support in maternity services
- Increased professional opportunities for SAS and LED's to reduce attrition

Feedback to date (rota gaps)



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- Proactively reduce clinical work on all deanery teaching days
- Establish a regular junior doctors forum
- Agency locums/bank locums used for service provision to allow trainees to attend national, regional and deanery meetings.
- Exception reports established and reviewed
- Using GP's, Physician Associates, MTI's, Clinical Fellows, locums and agency to support more (where appropriate)
- Recruitment to cover maternity leave rota gaps

Feedback to date (loss of training)



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- Training sessions to be incorporated into rota plans
- Training opportunities discussed at induction meetings and at monthly education supervisors meetings
- Increasing flexibility around mandatory training
- Development of exception reports for lost training opportunities
- Comprehensive development plans agreed with supervisors
- Study leaves to be booked in advance in order to ensure trainee attendance as well as cover for the Services
- Loss of training opportunities escalated to QOC

Feedback to date (loss of training)



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- Attendance records for training sessions
- Junior doctor rotas were redesigned at both SHO and Registrar levels
- SpR's to support postnatal ward rounds to free junior doctors time
- Trainee personal performance review (PPR) to be undertaken on regular basis
- Adjust clinical activity to facilitate teaching.



Next steps

- RCOG plan to develop standard action plan template for Trusts for 2020
- Review of 2019 CNST feedback and showcase best practice to our Members
- Increase CNST Trust engagement for 2020, built on the expertise shared from 2019
- Support the development of safety actions for 2021 through the advisory group work