CNST Incentive Scheme

Author: Elaine Broughton Head of Midwifery Sponsor: Eleanor Meldrum Acting Chief Nurse **Trust Board paper F**

Executive Summary

Context

In March 2018 the Trust were informed, as providers of maternity services, of details of an incentive scheme, being delivered through the NHS Resolution, Clinical Negligence Scheme for Trusts (CNST).

The process requires trusts to self-certify (with Board sign-off) their progress against 10 actions and discuss this with their commissioners before submitting the completed template Board report to NHS Resolution by Friday 29 June 2018. NHS Resolution does not require the supporting evidence provided to the Board. The evidence should be retained locally and be made available on request.

The incentive scheme will assess compliance against the actions and award a reduction in premium if the Trust can prove compliance.

Questions

1. Which actions can we provide full compliance for
2. What are the challenges in compliance and why
3. What are the financial implications

Conclusion

1. Nine actions out of ten we can demonstrate and provide evidence of full compliance, some evidence as indicated in the support document, can be sought through national reporting such as the national maternity data set and National perinatal review tool. The Saving babies lives care bundle is reported regionally every quarter and this is submitted to NHS England. We provide transitional care in a post natal ward setting and have included text from the neonatologists in relation to this, it can also be evidenced in the coding of these babies. Two actions will be compliant by June, we have a Maternity Voice partnership launch, although we continued to have a very well attended Maternity Services Liaison committee and collect patient feedback in many other ways.

2. The main challenge is action 8 in the template "90% compliance with multidisciplinary attendance at skills drills training". Currently the maternity care assistants do not attend this, nor do the anaesthetic team unless they attend as trainers. There is currently not enough capacity on the training days or enough facilitators to provide any more training days. From June 2018 we have stopped student midwives attending the skills drills in favour of the maternity care assistants, theatre staff had already started to attend. Compliance for midwives and obstetricians currently is 87% and 92% respectively. Together with the education team a trajectory to achieve compliance with the Maternity care assistants and anaesthetists by May 2019, has been devised, this will be monitored mothly at CMG quality and safety Board
3. The financial implication is not totally clear, NHS Resolution will review the signed off Board paper and make a decision in relation to the percentage of discount, which will be 10% off the current premium for achieving all ten actions. What is unclear is if there is a robust plan to achieve compliance in the future, will a discount be awarded. The saving on the premium would amount to 500-600k

Input Sought

We would welcome the Trust Board's input regarding how to achieve compliance with anaesthetic attendance on maternity skills drills currently recorded at 0%.
Facilitators for training days are also in short supply, to enable an increase in training capacity, clinical staff are asked to be facilitators which means removing them from the clinical areas, it proves difficult if the area is busy. It will take some time to achieve 90% compliance for Maternity care assistants and anaesthetists as above we are aiming to be compliant The attached completed template with the evidence attached must be signed off by Trust Board on 7th June 2018

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes /No /Not applicable]
Effective, integrated emergency care	[Yes /No /Not applicable]
Consistently meeting national access standards	[Yes /No /Not applicable]
Integrated care in partnership with others	[Yes /No /Not applicable]
Enhanced delivery in research, innovation & ed'	[Yes /No /Not applicable]
A caring, professional, engaged workforce	[Yes /No /Not applicable]
Clinically sustainable services with excellent facilities	[Yes /No /Not applicable]
Financially sustainable NHS organisation	[Yes /No /Not applicable]
Enabled by excellent IM&T	[Yes /No /Not applicable]

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Yes /No /Not applicable]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
XXXX	There is a risk …			XX

If NO, why not? Eg. Current Risk Rating is LOW

b. Board Assurance Framework [Yes /No /Not applicable]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken: [Insert here]

4. Results of any **Equality Impact Assessment**, relating to this matter: [Insert here]

5. Scheduled date for the **next paper** on this topic: [TBC]

6. Executive Summaries should not exceed **4 sides** [My paper does comply]

7. Papers should not exceed **7 sides.** [My paper does not comply]

Board report on UHL NHS Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Date: 15th May 2018

SECTION A: Evidence of Trust's progress against 10 safety actions:

Leicester Royal Infirmary

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	The NPMRT was launched in January 2018, the maternity Service in UHL has been using it since that date and prior to that date piloted the tool. Evidence of compliance with this will be this will be shown in the future MBRRACE reports for UHL.	**YES**
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	UHL are currently submitting 8 out 10 of the required criteria to maternity data set and this meets the standard  Maternity Services Dataset.docx append (**Evidence Appendix 1)**	**YES**
3). Can you demonstrate that you have transitional care	We do not have a dedicated transitional care unit, we are able to provide care by trained healthcare professionals on the postnatal ward to late preterm	**YES**

facilities that are in place and operational to support the implementation of the ATAIN Programme?	infants and to infants requiring intravenous antibiotics. These babies are reviewed daily during dedicated rounds, where these babies are assessed and appropriate plans are made. There is an escalation policy for any babies which are unwell which is well known by the team and followed should the need arise. Although we are at present unable to provide complementary nasogastric tube feeding in the postnatal ward, we have recently developed outreach services which provide complementary nasogastric tube feeding at home to selected babies and families with the aim to help transition to bottle feeding. In the future models of care the service has developed, it is recognised a transitional care unit is of significant value and it has been included.	
4). Can you demonstrate an effective system of medical workforce planning?	Attached evidence, there have be no consultants acting down for some time and the template is included to show that for a 4 week period 19th March 2018-15th April 2018 **(Appendix 2, 3 & 4)** cnst-workforce-data-collection-tool-reporti cnst-workforce-data-collection-tool-reporti	**Yes**

	RCOG of cnst-workforce-data-	
5). Can you demonstrate an effective system of midwifery workforce planning?	Midwife and support worker staffing requirements are assessed using birth rate plus **(Appendix 5)** within the service we use the intrapartum acuity tool to monitor acuity levels and have establishment reviews with the electronic Rostering lead and Chief nurse every 6 months. UHL Final BR+ Report_31 10 16.doc	**YES**
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	The maternity service has implemented all four elements and reports compliance quarterly to the East Midlands clinical Network Copy of East Midlands RWE Survey **(Evidence Appendix 6)**	**YES**
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and	UHL have worked closely with our commissioners to maintain a well-attended MSLC, in line with national recommendations the development of Maternity Voice Partnership is underway with a launch planned at the beginning of June 2018, there is recruitment on going currently to encourage users to join this	

that you regularly act on feedback?	group. Within the Trust we collect maternity FFT with a response rate of 35-40% and a promotor score of 94-96%, there is written feedback and we review and respond on a local level. Within the service we collect “Message to matron” and provide response to feed back for the Trust quarterly report. We have allocated patient partners who help us collect feedback from the women. **(Evidence Appendix 7-10)**  Maternity Voice partnership.pdf  MSLC Agenda.pdf  Labour Ward - LRI Apr '18.pdf  Postnatal ward - LRI Ward 6 Apr '18.pdf	
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-	The service has been monitoring compliance with skills drills training on previous CNST standards which required 75% compliance with obstetricians and midwives. Previously we have not had the maternity care assistants at	**Partially**

<table>
<tr>
<td>house' multi-professional maternity emergencies training session within the last training year?</td>
<td>skills drills as we cover skills they would never do. They receive BLS training in a multidisciplinary group but no obstetric skills drills. Therefore we will have to accommodate them on the skills drills, from June 2018 we have made places available to them.

We do not collate figures for anaesthetic staff currently, anaesthetists do assist as faculty on the day and there are places available to attend. The education team are looking at extra capacity to ensure extra training places are available

<table>
<tr><th colspan="2">Obstetric Skills Drills</th></tr>
<tr><td>Midwives</td><td>Consultants</td></tr>
<tr><td>87%</td><td>92%</td></tr>
</table>
The figures above are not adjusted to exclude long term sick leave or maternity leave</td>
<td></td>
</tr>
<tr>
<td>9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board</td>
<td>Head of Midwifery and Clinical Director for Womens and Children’s (and obstetrician) are the Trust Maternity Safety Champions.

The Head of Midwifery reports directly to the Chief Nurse, evidence of</td>
<td>YES</td>
</tr>
</table>

level champions to escalate locally identified issues?	meetings in Head of Midwifery diary The Board level champions are the Chief Nurse and a Non-executive director and meeting requests are sent bi monthly	
10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	Data base of all qualifying incidents held locally and reported to the Trust deputy director (Head of legal Services), the evidence for this will be held corporately but contain sensitive patient information but can be confirmed by the Head of Legal services. Included as evidence is the blank reporting template that is used to submit cases from the Maternity service. In 2017 UHL reported 9 cases IN 2018 UHL have reported 7 cases so far **(Appendix 11)**  NHS Resolution Early Notification Blank.do	

SECTION B: Further action required:

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?

The service has been monitoring compliance with skills drills training on previous CNST standards which required 75% compliance with obstetricians and midwives. Previously we have not had the maternity care assistants at skills drills as we cover skills they would never do. They receive BLS training in a multidisciplinary group but no obstetric skills drills. Therefore we have to start trying to accommodate them on the skills drills, from June 2018 we have made room for them by stopping the student midwives attending, as this was the only way we can create capacity.

Also we do not collate figures for anaesthetic staff currently; anaesthetists assist as faculty on the day, but will now be allocated places on the skills drills afternoon from June 2018

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?

Head of Midwifery and Clinical Director for Womens and Children's (and obstetrician) are the Trust Maternity Safety Champions. The Head of Midwifery reported directly to the Chief Nurse who was the Board level champion once a month, however she is no longer in post and therefore following discussion with the Director of Quality and Risk we are selecting a non-executive director to be the Trust Board maternity champion and the meetings will commence within the next month.

SECTION C: Sign-off

……..

For and on behalf of the Board of UHL NHS Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Position: ……..

Date: ……..

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

……..

SECTION D: Appendices

Please list and attach copies of all relevant evidential appendices:

Appendix 1. Evidence from CMG Business analyst of compliance with submission of data set requirements

Appendix 2. Shift cover for LRI on reporting template

Appendix 3. Shift cover for LGH on reporting template

Appendix 4. Blank RCOG template with information to inform appendix 2&3

Appendix 5. Birth rate plus report

Appendix 6. Quarterly monitoring tool for Saving Babies lives care bundle

Appendix 7. Maternity Voice partnership poster

Appendix 8. MSLC agenda

Appendix 9 &10. Maternity FFTx2 examples

Appendix 11. Blank NHS Resolution notification scheme

APPENDIX 1

The table below shows UHL's current performance against the 10 criteria being measured for MSDS Data Quality as part of the CNST scheme.

UHL is currently meeting the requirement – see below for details.

UHL's Performance vs the Standard:
To qualify for the Data Standard (one of ten standards in the Incentive Scheme), Trusts must be able to demonstrate progress on **at least 8 out of the 10 criteria** being measured for the standard.
Although this most recently published data does not count towards the actual period to be measured for the incentive scheme, (Jan, Feb and Mar data will count, but are not yet published), **UHL is currently meeting the requirement for this standard i**.e. achieving 8 out of the ten criteria.

UHL's Anticipated Future Performance vs the Standard
The data validation which Farzin Karolia (Clinical Systems Coordinator) carries out should ensure that **for the data we do collect**, this performance level should continue.
The two criteria not being met have resulted from tables which require data items not currently collected at booking due to system and process limitations.
There are plans in place to address the coverage of UHL's MSDS submission, including the two sets of incomplete tables, through online access to E3 for Midwives, to be implemented during 2018/19.

Summary

Organisation Code	Org Name	October 2017	November 2017	December 2017	Notes
RWE	University Hospitals of Leicester NHS Trust	8	8	8	

Detail

Month	Organisation Code	Organisation Name	Submitted MSDS in all of the last three months	Latest submission contained booking appointments in the month	Latest submission contained method of delivery for at least 80% of births	Latest submission contained at least 80% of HES births expectation	Latest submission contained all of the tables 501, 502, 404, 409	Latest submission contained all of the tables 401, 406, 408, 508, 602	Latest submission contained valid* smoking at booking for at least 80% of bookings	Latest submission contained valid baby's first feed for at least 80% of births	Latest submission contained valid in days gestational age for at least 80% of births	Latest submission contained valid* presentation at onset for at least 80% of deliveries where onset of labour recorded	Number of criteria met
Oct	RWE	University Hospitals of Leicester NHS Trust	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	8
Nov	RWE	University Hospitals of Leicester NHS Trust	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	8
Dec	RWE	University Hospitals of Leicester NHS Trust	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	8

MIDDLE GRADE ROTA

FOR MATERNITY UNIT COVER ONLY wc 19 March LGH

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Planned Shift Cover							
Day - morning	C, ST	C, NTNC	C, NTNC	C, NTNC	C, ST	C, ST	C, ST
Day - afternoon	C, ST	C, NTNC	C, NTNC	C, NTNC	C, ST	C, ST	C, ST
Twilight	C, ST	C, NTNC	C, NTNC	C, NTNC	C, ST	C, ST	C, ST
Overnight	C, ST	C, NTNC	C, NTNC	C, NTNC	C, ST	C, ST	C, ST
Actual Shift Cover							
Day - morning	C, ST	C, NTNC	C,NTNC	C, NTNC	C, ST	C, ST	C, ST
Day - afternoon	C, ST	C, NTNC	C,NTNC	C, NTNC	C, ST	C, ST	C, ST
Twilight	C, ST	C, NTNC	C,NTNC	C, NTNC	C, ST	C, ST	C, ST
Overnight	C, ST	C, NTNC	C,NTNC	C, NTNC	C, ST	C, ST	C, NTNC

wc 26 March

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Planned Shift Cover							
Day - morning	C, NTNC	C, NTNC	C, NTNC	C, ST	C, NTNC	C, NTNC	C, NTNC
Day - afternoon	C, NTNC	C, NTNC	C, NTNC	C, ST	C, NTNC	C, NTNC	C, NTNC
Twilight	C, NTNC	C, NTNC	C, NTNC	C, ST	C, NTNC	C, NTNC	C, NTNC
Overnight	C, ST	C, ST	C, ST	C, ST	C, NTNC	C, NTNC	C, NTNC
Actual Shift Cover							
Day - morning	C, NTNC	C, ST x2	C, ST	C, ST	C, NTNC	C, NTNC	C, NTNC
Day - afternoon	C, NTNC	C, ST	C, St, NTNC	C, ST	C, NTNC	C, NTNC	C, NTNC
Twilight	C, NTNC	C, NTNC	C, NTNC	C, ST	C, NTNC	C, NTNC	C, NTNC
Overnight	C, ST	C, ST	C, ST	C, ST	C, NTNC	C, NTNC	C, NTNC

wc 2 April

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Planned Shift Cover							
Day - morning	C, ST	C, ST	C, ST	C, NTNC	C, NTNC	C, NTNC	C, NTNC
Day - afternoon	C, ST	C, ST	C, ST	C, NTNC	C, NTNC	C, NTNC	C, NTNC
Twilight	C, ST	C, ST	C, ST	C, NTNC	C, NTNC	C, NTNC	C, NTNC
Overnight	C, NTNC	C, NTNC	C, ST	C, ST	C, ST	C, ST	C, ST
Actual Shift Cover							
Day - morning	C, ST	C, ST	C, ST	C, ST, NTNC	C, NTNC, ST	C, NTNC	C, NTNC
Day - afternoon	C, ST	C, ST	C, ST x2	C, NTNC	C, NTNC, ST	C, NTNC	C, NTNC
Twilight	C, ST	C, ST	C, ST	C, NTNC	C, NTNC	C, NTNC	C, NTNC
Overnight	C, NTNC	C, NTNC	C, ST	C, ST	C, ST	C, L(S)	C, ST

wc 9 April

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Planned Shift Cover							
Day - morning	C, ST	C, ST	C, NTNC	C, NTNC	C, ST	C, ST	C, ST
Day - afternoon	C, ST	C, ST	C, NTNC	C, NTNC	C, ST	C, ST	C, ST
Twilight	C, ST	C, ST	C, NTNC	C, NTNC	C, ST	C, ST	C, ST
Overnight	C, NTNC	C, ST, NTNC	C, ST, NTNC	C, ST, NTNC	C, ST	C, ST	C, ST
Actual Shift Cover							
Day - morning	C, ST	C, ST	C, ST	C, ST	C, ST	C, ST	C, ST
Day - afternoon	C, ST	C, NTNC	C, NTNC	C, ST, NTNC	C, ST	C, ST	C, ST
Twilight	C, ST	C, ST	C, NTNC	C, NTNC	C, ST	C, ST	C, ST
Overnight	C, NTNC	C, ST, NTNC	C, ST, NTNC	C, ST, NTNC	C, ST	C, ST	C, ST

Key	**Planned Activities**
C	Consultant
ST	Trainee
NTNC	non-training, non-career
L(S)	Locum (who has been present in the unit for > 1 month)
G	Gap - no cover

Please use the abbreviations below to provide additional information	**Un-planned activity - Gap filled by**
CU	Con moved from another planned activity or programmed time off
STULe	Trainee at same level moved from another planned activity or programmed time off
STUUp	Trainee acting up moved from another planned activity or programmed time off
STUDo	Trainee acting down moved from another planned activity or programmed time off
NTNC U	NTNC moved from another planned activity or programmed time off
LU	Locum who has been in the unit < 1 month.

INSTRUCTIONS

Please complete the table above, as directed, which aims:

1. To capture the number of consultants acting down
2. To obtain information on how rota gaps are filled
3. Where there are 2 tiers of middle grade please include gaps either on the table or complete 2 forms

Please send a copy of the data sheets to:

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We will anonymise the information and use it only for information regarding middle grade rotas

MIDDLE GRADE ROTA

FOR MATERNITY UNIT COVER ONLY wc 19 March LRI wc 26 March wc 2 April wc 9 April

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Planned Shift Cover								**Planned Shift Cover**							**Planned Shift Cover**							**Planned Shift Cover**						
Day - morning	C, ST	C, ST	C, ST	C, NTNC	C, ST	C, ST x2	C, ST x2	C, ST	C, NTNC	C, ST	C, ST	C, NTNC, ST	C, NTNC, ST	C, NTNC, ST	C, ST, NTNC	C, ST	C, NTNC	C, NTNC	C, ST	C, ST x2	C, ST x2	C, NTNC	C, NTNC	C, NTNC	C, NTNC	C, ST	C, ST, NTNC	C, ST, NTNC
Day - afternoon	C, ST	C, ST	C, ST	C, NTNC	C, ST	C, ST x2	C, ST x2	C, ST	C, NTNC	C, ST	C, ST	C, NTNC, ST	C, NTNC, ST	C, NTNC, ST	C, ST, NTNC	C, ST	C, NTNC	C, NTNC	C, ST	C, ST x2	C, ST x2	C, NTNC	C, NTNC	C, NTNC	C, NTNC	C, ST	C, ST, NTNC	C, ST, NTNC
Twilight	C, ST x2	C, ST x2	C, ST x2	C, NTNC x2	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, NTNC, ST	C, ST x2	C, ST x2	C, NTNC, ST	C, NTNC, ST	C, NTNC, ST	C, ST, NTNC	C, ST x2	C, ST, NTNC	C, NTNC, ST	C, ST x2	C, ST x2	C, ST x2	C, NTNC x2	C, NTNC x2	C, NTNC x2	C, NTNC, ST	C, ST, NTNC	C, ST, NTNC	C, ST, NTNC
Overnight	C, ST x2	C, NTNC, ST	C, NTNC, ST	C, NTNC, ST	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, ST, NTNC	C, ST x2	C, ST x2	C, NTNC, ST	C, NTNC, ST	C, NTNC, ST	C, ST x2	C, ST, NTNC	C, ST, NTNC	C, ST, NTNC	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, ST x2
Actual Shift Cover								**Actual Shift Cover**							**Actual Shift Cover**							**Actual Shift Cover**						
Day - morning	C, ST	C, ST	C, ST	C, NTNC	C, ST	C, ST x2	C, ST x2	C, ST x2	C, ST	C, NTNC	C, ST	C, NTNC, ST	C, NTNC, ST	C, NTNC, ST	C, ST, NTNC	C, NTNC	C, ST	C, NTNC, ST	C, ST x2	C, ST x2	C, ST x2	C, ST	C, NTNC	C, NTNC, ST	C, ST	C, ST	C, ST, NTNC	C, ST x2
Day - afternoon	C, ST	C, ST	C, ST	C, NTNC	C, ST	C, ST x2	C, ST x2	C, ST x2	C, ST	C, ST	C, ST	C, NTNC, ST	C, NTNC, ST	C, NTNC, ST	C, ST, NTNC	C, ST	C, ST, NTNC	C, NTNC, ST x2	C, ST	C, ST x2	C, ST x2	C, ST	C, NTNC	C, NTNC	C, ST	C, ST	C, ST, NTNC	C, ST x2
Twilight	C, ST x2	C, ST x2	C, ST x2	C, NTNC x2	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, NTNC, ST	C, ST x2	C, ST x2	C, NTNC, ST	C, NTNC, ST	C, NTNC, ST	C, ST, NTNC	C, ST x2	C, ST, NTNC	C, NTNC, ST	C, ST x2	C, ST x2	C, ST x2	C, NTNC x2	C, NTNC x2	C, NTNC x2	C, NTNC, ST	C, ST, NTNC	C, ST, NTNC	C, ST x2
Overnight	C, ST x2	C, NTNC, ST	C, NTNC, ST	C, NTNC, ST	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, ST, NTNC	C, ST x2	C, ST x2	C, NTNC, ST	C, NTNC, ST	C, NTNC, ST	C, ST x2	C, ST, NTNC	C, ST, NTNC	C, ST, NTNC	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, ST x2	C, ST x2

Key	**Planned Activities**
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ST	Trainee
NTNC	non-training, non-career
L(S)	Locum (who has been present in the unit for > 1 month)
G	Gap - no cover

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LU	Locum who has been in the unit < 1 month.

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MIDDLE GRADE ROTA

FOR MATERNITY UNIT COVER ONLY

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Planned Shift Cover							
Day - morning							
Day - afternoon							
Twilight							
Overnight							
Actual Shift Cover							
Day - morning							
Day - afternoon							
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MIDWIFERY SERVICES WORKFORCE PLANNING & DECISION MAKING

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

FINAL REPORT

Birthrate Plus ®: THE SYSTEM

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988.

The Royal College of Midwives [RCM] and Royal College of Obstetricians and Gynaecologists [RCOG] recommend the use of Birthrate Plus® which was endorsed by the RCM Council in 1999, and in the Audit Commission Report; First Class Delivery (1997). Birthrate Plus® received endorsement by NICE in June 2016 as a workforce planning system and also for the Intrapartum Acuity Tool. There is no other research-based methodology for workforce planning in maternity services and traditional methods are of little value in today's health service.

Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwife units through to regional referral centres, and from units that undertake 10 births p.a. through to those that have in excess of 8000 births. In addition BR+ caters for the various models of providing care, such as traditional, community based teams and caseload working. It is sensitive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The methodology remains responsive to changes in government policies on maternity services and clinical practices. Any maternity unit and service must be able to assess its staffing needs using a tried and tested system of workforce planning. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs, and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care.

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to which these deviate from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery. Other categories classify women admitted to the delivery suite for other reasons than for labour and delivery.

Together with the casemix, the number of midwife
hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

In addition BR+ determines the staffing required for antenatal inpatient and outpatient services, postnatal care of women and babies in hospital and community care of the local population birthing in either the main hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles to manage maternity services. Skill mix adjustment of the clinical staffing between midwives and competent & qualified support staff can be applied, if requested

Factors affecting Maternity Services for inclusion within the Birthrate Plus® Study

The Governance agenda, which includes evidence based guidelines, on-going monitoring and audit of clinical practices and clinical training programmes, will have an impact upon the required midwifery input; plus other key health policies. Birthrate Plus® allows for inclusion of the requisite resources to undertake such activities.

Wards provide care to 'normal' uncomplicated postnatal women needing basic midwifery care, which is often over-shadowed by other women who are more complex cases. This results in insufficient time being spent with such women who may require considerable assistance with breast feeding and general care of their baby.

The encouragement of early transfer home does mean that the level of midwifery input during their hospital stay is considerable, in order to ensure that the mothers are prepared for coping at home. It is a known fact that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided.

Community based care is expanding with the emphasis being placed on 'normal/low risk/need care being provided in community by midwives and GPs. Reduced antenatal admissions and shorter postnatal stays result in an increase in community care. Midwives are undertaking the newborn examination instead of paediatricians, either in hospital or at home.

Cross border activity can have significant impact on community resources in two ways. Some women receive ante and postnatal care from their "home" maternity service, but give birth in another. Because these count as extra to the workload related to that recorded in relation to the annual births of a unit they have been termed as "imported" cross border" cases. Some units provide intrapartum and some degree of immediate postnatal to women from another maternity service, but who "export" their community care. Adjustments to midwifery establishments have been made to accommodate the community flows.

With the publication of the latest NICE guideline on Antenatal Care that recommends that all women be 'booked' by 12 weeks gestation, more women are meeting their midwife earlier than previously happened before 10 weeks. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss so the total number of postnatal women is less than antenatal. In most maternity services approximately 10% of women are 'booked' and then have no further contact with the midwife.

SUMMARY: RESULTS/FINDINGS

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of 23% for annual, sick & study leave allowance, 15% for travel in community and 1% for midwifery supervision.

The overall clinical midwifery establishment is summarised as follows:

	ANNUAL BIRTHS/CASES	**CLINICAL WTE**
LEICESTER ROYAL INFIRMARY	5698	186.03
LEICESTER GENERAL HOSPITAL	4418	133.11
UHL COMMUNITY	12481 *(12193 hospital births & 288 home births/BBAs)*	140.97
ST MARY'S MELTON	172 *(Plus additional a/n & p/n work)*	6.96 *(Excludes minimum staffing per 24 hours)*

Detailed summaries are included on pages 9 - 11

Discussion of Findings

1. The main factor in the results is the casemix based on 3 months' data, January to March 2016 collected from the Maternity Information System by the locally appointed project midwife and validated by the BR+ Team to ensure the data quality is 100%.

2. Within the methodology are national standards which include the minimum standard of 1 midwife to 1 woman for care in the labour, delivery and an additional % m/w increase is applied to Categories III (20%); IV (30% & V (40%). Community antenatal care is based on NICE guidance, as is postnatal care with allocation of average midwife hours for the women to cover their standards a/n & p/n assessments, Parentcraft, socio-economic issues and all clinical needs.

3. The annual births are based on the 2015/16 FY and for LRI & LGH do include all births in the Delivery Suites and Birth Centres.

4. The hospital staffing is based on the 2 models of care, namely births and postnatal care of delivery suite births and those in the co-located birth centres.

5. The community cases are based on those women birthing in both maternity units and having all ante & postnatal community care locally plus any women, who may birth in neighbouring units, but belong to the CCG area. The total number of community cases is 12653 including home births and St Mary's.

6. As with most maternity services, there are women who will see a midwife in early pregnancy as per NICE Antenatal Guidelines and the 'Early Contact' recommendation, but do not progress further with their pregnancy (n=1250).

7. The casemix is unique to each individual unit and reflects the health and social needs of the local population, as well as clinical practices and decision-making. (See Appendix 1).

8. The casemix is analysed in 3 ways, namely, generic for all births taking place; those in the Delivery Unit and births in the co-located Birth Centre. This is to provide a comparative casemix with similar maternity services and also to enable calculation of midwifery staffing based on the models of care for respective place of birth.

LRI	CAT I	CAT II	CAT III	CAT IV	CAT V
GENERIC	8.0	16.8	19.9	26.4	28.9
DELIVERY SUITE	0.5	6.5	24.6	32.7	35.7

LGH	CAT I	CAT II	CAT III	CAT IV	CAT V
GENERIC	7.1	16.1	20.8	28.2	27.8
DELIVERY SUITE	1.9	10.8	23.7	32.0	31.6

9. The Delivery Unit casemix will predominantly be those women in categories III to V thus impacting on the workload for this service. The Birth Centre models of care are based on a casemix of category I and II and any higher category activity is included as transfers and included in DS casemix.

10. The assessment of midwives for the Birth Centre activity is based on a 'package of care' that includes intra-partum care with 2 midwives at for the birth, postnatal care until transfer home and examination of the new-born. Time for unplanned attendees to the BC is factored in and Parent Education is within all clinical hours allocated. There are a number of women, who commence labour in the Birth Centre but are transferred to Delivery Suite prior to or at delivery due to maternal or fetal complications. The care given to the women is included in the Birth Centre staffing whilst the actual birth and post delivery care is within the D/S establishment.

11. Category V include emergency CS, and often women with obstetric/medical problems, such as increased diabetes, obesity related problems, mental health and high incidence of fetal medicine related conditions that require specialist care. Category IV cases are usually those having an elective CS or epidural for pain relief with a normal birth. Women with low birth weight/preterm babies; high-risk inductions of labour and PPH will fall into this group. Category III women as moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries as well as normal births with continuous fetal monitoring will fall into this group.

12. LRI: The generic casemix indicates that approximately 25% of births are in the lower categories I & II with 75% in the moderate to high categories, of which 55% are in IV & V. The category IV & V% is similar to many maternity services where the % of high risk women are between 55% or increasingly above 60% for tertiary referral centres.

13. LGH: The generic casemix indicates that approximately 23% of births are in the lower categories I & II with 77% in the moderate to high categories, of which 56% are in IV & V. The category IV & V% is lower than in similar maternity services where the % of high risk women are between 55% or increasingly above 60% for tertiary referral centres.

14. There are close similarities between LRI and LGH casemix, which may be unexpected especially as LRI has Level 3 Neonatal services, so will take higher risk pregnancies for fetal problems. There may be differences in the clinical profile of women, but the casemix does illustrate method of delivery and induction of labour patterns so it could be that LGH has a higher operative delivery rate than LRI, or even induction of labour.

15. The casemix is an indicator of the needs of women and their babies for the postnatal stay in hospital so used to calculate the staffing. It is often where the significant safeguarding/social issues have an impact on midwifery staffing to ensure systems are in place to deal with such matters. Also, many babies require additional observation and monitoring in postnatal wards. PN ward attenders and re-admissions create additional workload and this is factored into the staffing requirements.

16. Often the antenatal activity taking place in hospital is reflective of the higher % in Categories IV & V, as women with medical/obstetric problems, low birth weight &/or preterm infants require more frequent hospital based care. Category A2 women are high risk-antenatal cases that would usually be 'admitted' to a ward for on-going care.

17. All maternity units have significant antenatal activity that is both planned and unplanned cases and often the latter equate to the actual number of women delivering in the service. Individual maternity units deal with this activity in a variety of ways, such as via DAU, the antenatal ward or through a dedicated Triage/Assessment area. Some additional non-birth activity is caring for women who have a fetal loss prior to 24 weeks' gestation. Both units have a 24-hour x 7 days a week service (MAU) with high activity at 11936 annual episodes in LRI and 7603 in LGH.

18. It is not feasible to compare the annual total of antenatal admissions with similar sized units as there are several factors which determine which affect this activity, namely, clinical decision making, maternal and fetal risk factors, bed capacity.

19. Outpatient Clinic services are based on session times and numbers of staff to cover these, rather than on a dependency classification and average hours.

20. The total clinical establishments include the contribution from nursery nurses and/or maternity support workers to the postnatal component of care, which is based on 10% of the total clinical wte. The skill mix % is not a recommendation of Birthrate Plus®, but a rationale for having a sensible skill mix that does not reduce the midwifery establishment to an unsafe level and prevents flexibility of deployment to areas of high risk and needs. *See table of comparison of staffing – page 6*

21. The clinical establishments do not include the following non-clinical midwife roles:
    - Head of Midwifery & Matrons, additional hours for team leaders to participate in strategic planning & wider Trust business
    - Lead Midwife on D/S as per Safer Childbirth recommendations
    - Practice Development role
    - Clinical Governance/Risk Management role
    - IT Systems
    - Baby Friendly Initiative role, which is not to assist women with breast feeding, but to produce & monitor guidelines & undertake audits
    - Additional hours for antenatal screening over & above the time provided in actual clinics
    - Coordination for such work as Safeguarding Children

    The above additional roles can be included based on adding in % of the total clinical establishment, as suggested by Birthrate Plus® and cited in the RCM Staffing Guidance 2009. It is a local decision as to the % increase, but it is usually 8%. Applying an agreed % avoids duplication of roles irrespective of which midwives undertake the non-clinical duties.

22. To provide a total workforce plan, there is a need for Maternity Care Assistants in the Delivery Suite, Outpatient Services and Wards to provide support to women and their babies, but are <u>in addition</u> to the calculated clinical establishments. To assess the requirement of what is usually Band 2 support staff is on the numbers per shift in the various areas based on professional judgment and management decision.

Comparison of Maternity Staffing

The staffing figures below include 23% uplift, 15% travel allowance and midwifery supervision and are for provision of clinical care inclusive of day-to-day management of all areas and coordination in delivery suite. The figures do not include the non-clinical midwifery time – see para. 21, pg. 5.

	Birthrate Plus wte *Bands 3 to 7*	**Current funded wte** *Bands 3 to 7*	**Indication of Variance***
Leicester Royal Infirmary Delivery Suite/Birth Centre & Maternity Wards	178.15	129.73	-48.42*
Leicester General Hospital Delivery Suite/Birth Centre & Maternity Wards	127.87	94.25	-33.62*
LRI & LGH Outpatients & Specialist Midwives Team	13.11	31.75	18.64*
Community & St Mary's Melton	146.43	123.23	-23.20
Totals	465.57	378.95	-86.62

Note: The Birthrate Plus wte can be assessed at 90% as midwives and 10% as Bands 3 & 4 staff working in postnatal services, so contributing to the clinical care of mothers and babies thereby reducing the midwifery wte.

Note * Indication of Variance

The individual variances in staffing for LRI, LGH & Community are not an accurate reflection as the Specialist Midwives contribute to the clinical care, so in practice are actually part of the total establishments for the 3 services rather than part of the outpatients and specialist team. This is how the budget is currently allocated and managed.

The non-clinical midwifery wte at 37.48wte is based on 8% of the clinical total figures but this is a local decision as to the actual % to apply.

SUMMARY of DATA & REQUIRED WTE for **BIRTHRATE PLUS®**

Leicester General Hospital

Final version 01.08.16

Data collected Jan to March 2016

Total births in service **4418**

CASEMIX	Cat I	Cat II	Cat III	Cat IV	Cat V
DS Casemix	1.9	10.8	23.7	32.0	31.6
Generic Casemix	*7.1*	*16.1*	*20.8*	*28.2*	*27.8*

			Required WTE	
Delivery Suite	**No.**			
Delivery Suite Births	3701		43.89	43.89
Other DS Activity	**No. Episodes of care**	**Hours**		
Category X		*via Triage*	0.00	3.69
Category A1		*via Triage*	0.00	
Category A2	280	*15.0*	3.05	
Category R	12	*6.0*	0.05	
Escorted Transfers OUT	6	*4.0*	0.02	
Non-viables	48	*16.5*	0.57	
Co-located Birth Centre				
Births & PN Care	717		10.90	10.98
Unplanned Attenders	10		0.01	
Transfers to D/S	10		0.07	
Antenatal Admissions	2815		13.57	13.57
MAU	7603		9.64	9.64
Inductions	1700		3.08	3.08
Postnatal Ward	**No.**			
Postnatal women	3818		40.50	41.76
Postnatal Ward Attenders	0		0.00	
Postnatal Re-admissions	127		0.68	
BCGs/NIPE			0.58	
Antenatal Clinics		**Weekly hrs**		
Obstetric Clinics		*27.0*	0.89	5.19
Specialist Clinics		*25.5*	0.84	
Midwife Clinics		*15.0*	0.50	
Fetal Medicine			2.95	
DAU (future service)			*3.61*	
CLINICAL WTE REQUIRED				**131.79**
TOTAL CLINICAL WTE REQUIRED (inc. 1% for Midwifery Supervision)				**133.11**
Additional non-clinical midwifery wte @ 8%			10.65	

SUMMARY of DATA & REQUIRED WTE for **BIRTHRATE PLUS®**

Leicester Royal Infirmary

Final version 01.08.16

Data collected Jan to March 2016

Total births in service **5698**

CASEMIX	Cat I	Cat II	Cat III	Cat IV	Cat V
DS Casemix	0.5	6.5	24.6	32.7	35.7
Generic Casemix	*8.0*	*16.8*	*19.9*	*26.4*	*28.9*

			Required WTE	
Delivery Suite	**No.**			
Delivery Suite Births	4354		54.14	54.14
Other DS Activity	**No. Episodes of care**	**Hours**		
Category X		*via MAU*	0.00	10.60
Category A1	*1725*	*5.0*	6.26	
Category A2	322	*15.0*	3.50	
Category R	25	*6.0*	0.11	
Escorted Transfers OUT	64	*4.0*	0.16	
Non-viables	48	*16.5*	0.57	
Co-located Birth Centre				
Births & PN Care	1344		20.44	22.14
Unplanned Attenders	845		0.56	
Transfers to D/S	164		1.15	
Antenatal Admissions	3832		18.10	18.10
MAU	11936		13.89	13.89
Inductions	2150		3.90	3.90
Postnatal Ward	**No.**			
Postnatal women	4570		51.75	53.62
Postnatal Ward Attenders	390		0.19	
Postnatal Re-admissions	190		1.01	
BCGs/NIPE			0.67	
Antenatal Clinics		**Weekly hrs**		
Obstetric Clinics		*85.0*	2.81	7.79
Specialist Clinics		*55.0*	1.82	
Midwife Clinics		*6.0*	0.20	
Fetal Medicine			2.95	
DAU (future service - not in total wte)			*3.61*	

CLINICAL WTE REQUIRED **184.18**

TOTAL CLINICAL WTE REQUIRED (inc. 1% for Midwifery Supervision) **186.03**

Additional non-clinical midwifery wte @ 8%	14.88

SUMMARY of DATA & REQUIRED WTE for

UHL COMMUNITY & St MARYS MELTON

BIRTHRATE PLUS®

Final version 01.08.16

Data collected Jan to March 2016

Total Community Cases **12653**

ST MARYS**

		Required WTE	
Births (Total Care)	172	4.92	**5.66**
Antenatal Attenders	655	0.44	
Transfers to D/S	37	0.30	
Postnatal women	309	1.23	**1.31**
NIPE	151	0.08	

COMMUNITY SERVICES

	No.		
Home Births	288	8.34	**138.01**
Community Cases	12193	127.90	
Community Bookings ONLY	1250	1.25	
NIPE		0.53	

CLINICAL MIDWIFERY WTE REQUIRED		**144.98**
Midwifery Supervision @ 1%	1.45	**146.43**

Note** The above wte will not provide minimum staffing of 1 midwife for 24 hours in St Marys as this requires 5.10wte. Allowing for the wte to cover the workload in the unit, an additional 1.86wte will be needed to provide 24 hour cover.

Additional non-clinical midwifery wte @ 8% **11.71**

Using Ratios of births/cases to wte for projecting staffing needs

To calculate for staffing based on increase in activity, it is advisable to apply ratios of births/cases to midwife wte, as this will take into account an increase in all areas and not just the intrapartum care of women. There will be changes in community, hospital outpatient and inpatient services if the annual number of women giving birth increases.

When using ratios once the total clinical wte is calculated, it excludes the additional non-clinical roles. A skill mix % can be applied to the total clinical wte to work out what of the total clinical 'midwifery' wte can be suitably qualified support staff, namely MSWs Band 3. Nursery Nurses and RGNs working in postnatal services only.

Calculating staffing changes using a ratio to meet increase in births assumes that there will be an increase in activity across ALL models of care and areas including homebirths for the maternity unit. The main factors to consider are whether the extra women are in fact within their current imports, and whether the bookings are in community instead of hospital.

Using the overall ratio of **1:23** births will produce the total clinical wte to which a skill mix can be applied (e.g. 90/10%) in order to calculate the midwife and suitably qualified support staff totals. It is not appropriate to add in extra wte for the support staff replacing midwifery posts. However, the addition of other support staff who do not contribute to the clinical establishment will be necessary.

If there is an increase or decrease in activity, then the appropriate ratio can be applied depending on the level of care to be provided to the women, for example, if the women just have community care as birth in a neighbouring unit, it is only necessary to estimate the increase in community staffing so the ratio of 95 cases to 1 wte is the correct ratio to apply. To use the 23 ratio will overestimate the staffing.

Example; A woman who births in the Delivery Suite but is 'exported' to another community, then the ratio of 31 births to 1 wte should be applied. The main factor in using ratios is to know if having total care for the 'Trust' midwives or only hospital or community.

In addition, a percentage is applied to the clinical total wte to provide sufficient non-clinical midwifery posts and this is usually around 8%.

Midwife Ratios for based on above data and results

- Births at home & St Mary's — 34 births to 1 wte midwife
- Hospital care only of ALL D/S & B/C births - LRI — 31 births to 1 wte midwife
- Hospital care only of ALL D/S & B/C births - LGH — 33 births to 1 wte midwife
- Community care — 94 cases to 1 wte midwife
  This ratio covers women having a birth in LRI & LGH
- OVERALL RATIO for ALL BIRTHS IN UHL — 23 births to 1 wte midwife

Additional Explanation of Ratios

Refer to 'Working with Birthrate Plus'' - a joint publication by Ball & Washbrook and the Royal College of Midwives – May 2014.

Births/cases to midwife wte ratios are useful method of calculating staffing for strategic planning but can be and often misunderstood and incorrectly applied. The commonly quoted ratio of 28 or 29.5 births to 1wte is often applied to a local service when this was not the intention so is inappropriate and can result in a calculation of too few midwives and in some cases, overestimate the establishment. The ratio was produced from extensive Birthrate Plus studies in 2003 and updated in 2006 at the request of the Royal College of Midwives who required a simple measure of assessing the number of midwives needed for annual births in England to inform the Department of Health. So producing a ratio for use at such a strategic level was feasible but based on a range from 24 to 31. Thus to apply the 'national' ratio at a local level was not the intention and nor recommended by Birthrate Plus.

In addition, in the past 3 years or even longer, there has been a noticeable increase in the acuity of women due to obesity, higher BMI, diabetes, mental health, drug & alcohol related conditions, to name the most common, which all impact on the needs of mothers and babies. The increase in the casemix has a bearing on the establishments to ensure safe staffing and clinical risk is appropriately managed.

Recently, the individual results from 31 units in England have been analysed to produce up to date ratios and the average is 26 births to 1 wte with the range being 24 to 30. The studies were completed in 2015/16 and include a range of units both urban and rural with births ranging from 1873 to 7717, and the average annual births at 4140.

Factors that affect ratios:

- High casemix – more than 55% of women in Categories IV & V due to co-morbidities.
- High antenatal admission activity
- Provision of fetal medicine/scanning services
- Increase in hospital postnatal care due to babies requiring additional monitoring and transitional care.
- Increase in community cases – ratios are generally calculated on the annual births and not on total women having community care so if an increase in latter, this reduced the births to wte ratio.

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

Category X women are those who are admitted to the delivery suite, but after assessment/monitoring are found not to be in labour or to need any intervention. These women are either sent home or transferred to the antenatal ward for observation.

Categories A1 & A2 women are those who require some intervention such as intravenous infusion and/or monitoring, e.g. antepartum haemorrhage, pre-eclampsia or premature labour. Such women often spend considerable time on delivery suite before being transferred to the antenatal ward or to another maternity unit with neonatal facilities. However, some women with moderate risk/needs will go home following assessment and treatment.

Category R women are re-admitted after delivery as postnatal cases, often requiring medical care.
Inductions of labour with prostins are recorded, as are escorted transfers to another maternity unit and the non-viable pregnancies.

MATERNITY SUPPORT WORKERS/CARE ASSISTANTS

Due to changes in skill mix with the increasing use of support staff with a formal qualification in maternity services, there is a need to distinguish between those that can replace midwife hours, and other staff that support the midwife in care of women and their babies. Maternity Support Workers (MSW) refers to those support workers with a formal qualification such as Level 3 NVQ or Nursery Nurse, and who can replace midwife hours. The Maternity Care Assistant (MCA) is used to denote the more basic grade of support worker who supports the midwife. In all clinical areas the use of Care Assistants greatly aids the provision of maternity care, by releasing midwifery staff to be client, rather than ward centred.

Skill Mix Rationale

It is important to distinguish between the situations where support staff assist the midwife and where he/she replaces the midwife.

Birthrate Plus® (1996) makes it clear the ward and clinic staffing levels for midwives are based upon the premise that they are supported by MCA and clerical staff and these staff needs are assessed on a shift by shift basis.

The decision about the percentage of midwife time, which might be replaced, by MSW time must that of the local service managers.

Antenatal care: As this calls for midwife skills so it is not recommended to replace the midwives with an MSW, but units should ensure that midwives are well supported by clerical and MCA staff.

Intrapartum care: Birthrate Plus® does not recommend any replacement of midwife time by MSW time. To do so would undermine the basic quality standard of one to one care throughout labour plus the increased % of midwife time required for high needs categories.

Postnatal care in Hospital: Many services now suggest 20 - 25% of midwife time can be replaced by MSW input. Once a local decision has been made, the calculations of wte staff for each ward can readily be adjusted.

Postnatal Care in Community: Many services now suggest that 25% of midwife time can be replaced by MSW time. This would allow for full assessment and planning of care by the midwife, with a minimum of three visits and additional visits being undertaken by the MSW working under the direction of the midwife in charge of each woman's care.

Based on adjustments made by other maternity units, an average of 10% of the clinical total wte can be competent and qualified support staff usually being Bands 3 & 4.

The skill mix % is not a recommendation of Birthrate Plus®, but a rationale for having a sensible skill mix that does not reduce the midwifery establishment to an unsafe level and prevents flexibility of deployment to areas of high risk and needs. Some services are moving towards an 85/15% split with more MSWs working in community and increasing support staff on the p/n ward to work with transitional care babies.

Note: In addition, there is a need for Maternity Care Assistants in the Delivery Suite, Outpatient Services and Wards to provide support to women and their babies, but are in addition to the calculated clinical establishments. To assess the requirement of Band 2 support staff is on the numbers per shift in the various areas based on professional judgment and management decision. For example, 2 per shift on D/S at all times inclusive of the leave allowance.

Update Report

Communications:

Thank you again for your ongoing support to reduce the tragedy of stillbirth in England. It is crucial that we get as accurate a picture as possible of the levels of care bundle implementation. The survey is the only way we have to do this and to understand local challenges and context to local stillbirth rates. We want to thank you again for your ongoing support with this and the time taken out of your busy schedules to support the success of the care bundle.

We had a very good response rate for Survey 8, with 79% of all trusts in the country providing a response. 95% of responding providers are carrying out improvement activities across all 4 elements. 13% of responding providers are implementing all four elements of the Care Bundle at 100%, compared to 12% for Survey 7.

Once again we have provided a collection of case studies received from the last survey round and we hope you find these helpful.

Programme Developments:

Independent evaluation

As you will be aware, NHSE commissioned an external evaluation of the care bundle. This is being delivered by Professor Alex Heazell and his team at the University of Manchester. The evaluation aims to discover the challenges and successes of implementation, the impact on maternity services and perinatal outcomes and any key factors that might affect implementation.

The evaluation team at University of Manchester are currently in the data gathering phase which is scheduled to run until the end of the year and is progressing well. The data collection includes surveying patients and staff across the 20 participating NHS trusts, alongside the collection of birth outcomes before and after the Care Bundle was introduced. Unfortunately, the delivery of the evaluation has been slightly delayed, with the findings now expected in Summer 2018.

The results of our implementation surveys will feed into the University of Manchester's report. For details of the pilot sites and a general update on the evaluation, please see the 'Evaluation Info' tab. Kate and the University of Manchester team will provide us with key updates to share when available. Working alongside Professor Alex Heazell from Manchester University, element leads and other key stakeholders, we are currently developing the second iteration of the Saving Babies Lives Care Bundle which will be available for publication in Summer 2018.

Stillbirth Information Hub

The Stillbirth Information Hub has been launched, which has been designed for healthcare professionals to share information to promote safer practice and reduce the rate of avoidable stillbirth. The Hub will host information such as best practice models, local guidelines, research, case studies, and links to third sector work. It will also provide a secure environment for clinicians to share their knowledge.

The Stillbirth Information Hub is completely free to access. Gaining access is simple:

Step 1: You will need a Microsoft account
• If your local intranet is based on Microsoft Office 365 it is likely you already have a Microsoft account
• If you do not have a Microsoft account, visit https://login.live.com/, select the 'No account? Create one!' link and follow the instructions

Step 2: Getting access
• Send your Microsoft account email address to the Hub administrator for your Clinical Network area (see enclosed list of administrators) who will arrange access for you

Hub administrators appointed within our Clinical Networks will be able to provide individuals with access to the Hub and receive content to upload. If you have any queries or feedback on the Stillbirth Information Hub, please do contact them. We have also attached the content submission form should you wish to submit any materials for the Hub.

There is a flyer which we would be grateful if you could distribute within your unit, which states what the Stillbirth Information Hub is, why we built it and how to gain access.

Buddying system

Thank you to those trusts who have declared an interest in being part of the buddying system we proposed in order to help trusts learn from each other regarding Care Bundle implementation. We will be contacting trusts who expressed an interest in order to pair-up in due course.

From the care bundle team.

Saving Babies Lives - Reducing Stillbirths Care Bundle

The purpose of this survey is to find out how many of the Saving Babies' Lives Care Bundle elements are currently being implemented by providers when providing care for women, and to what extent. Please do look at the 'Previous Survey Results' tab, so you can compare your progress to the results of the last survey.

By recording the challenges and successes of implementing the care bundle, we can tailor future guidance accordingly for the aid of Midwives, Obstetricians and the wider multi-disciplinary team. You can use the link below to read about the background to the care bundle and the rationale for each of the elements and their associated activities to help you self-evaluate your current clinical practice.

The survey is a practice snapshot and helps to track a general picture over time. Therefore, please base your responses on an honest estimation of how much your current practice matches the requirements of the care bundle. From this, we will be able to provide an accurate picture to support the evaluation of the care bundle currently being undertaken by the University of Manchester and gain a true understanding of the realities of implementation.

The 'Case Study' page allows providers to share information and experiences of implementing the care bundle. Please use this page to share any helpful examples of lessons you have learnt as a provider from implementing the care bundle. The 'Action Planning' page is there should you wish to record any future plans to aid implementation, for your own reference.

Saving babies Lives - Reducing Stillbirths Care Bundle
Link to Survey

Survey Collection Schedule

Survey 9 Collection Round: March 2018
Circulate: Monday 19th March
Collect: Monday 23rd April

Survey 10 Collection Round: July 2018
Circulate: 1st week of July
Collect: 1st week of August

Survey 11 Collection Round: November 2018
Circulate: 1st week of November
Collect: 1st week of December

Previous Survey Results

Here are your results from the previous survey along with an overview of the results for your Strategic Clinical Network and the National results for England. Recording your previous survey results allows you to track how your Trust is working towards fully implementing the care bundle elements as standard practise.

	Survey 4 March to June 2016	Survey 5 July to October 2016	Survey 6 November to March 2017	Survey 7 April to July 2017	Survey 8 August to November 2017
Element 1: Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist as appropriate	Survey Not Submitted				
1.1. Are you carrying out any improvement activity designed to reduce smoking in pregnancy? If "yes", go to question (1.2). If "no", go to question (1.4).		Yes	Yes	Yes	Yes
1.2. Does it include carrying out carbon monoxide (CO) testing of all pregnant women at antenatal booking appointment? If so to what extent have you implemented this improvement activity?		2 - roughly 75% of this is achieved	1 - Completely	1 - Completely	1 - Completely
1.3. Does it include referring expectant mothers, as appropriate, to a stop smoking service/specialist, based on an opt out system? If so to what extent have you implemented this improvement activity?		1 - Completely	2 - roughly 75% of this is achieved	1 - Completely	1 - Completely
1.4. If you answered "no" to 1.1., are you planning/considering introducing this type of intervention/improvement activity?		Click to Select	Click to Select	Click to Select	Click to Select
Element 2: Identification and surveillance of pregnancies with fetal growth restriction					
2.1. Are you carrying out any improvement activity designed to detect Fetal Growth Restriction? If "yes", go to question (2.2). If "no", please go to question (2.7).		Yes	Yes	Yes	Yes
2.2. Does it include making use of customised antenatal growth charts for all pregnant women by clinicians who have gained competence in their use? If so to what extent have you implemented this improvement activity?		5 - Not at all	5 - Not at all	4 - roughly 25% of this is achieved	1 - Completely
2.3. Does it include making use of a growth chart to aid decision making on classification of risk of fetal growth restriction? If so to what extent have you implemented this improvement activity?		5 - Not at all	5 - Not at all	4 - roughly 25% of this is achieved	1 - Completely
2.4. Does it include screening and monitoring all pregnancies based on the assessment of risk? If so to what extent have you implemented this improvement activity?		5 - Not at all	5 - Not at all	1 - Completely	1 - Completely
2.5. Does it include performing ongoing audits and reporting of Small for Gestational Age (SGA) rates and antenatal detection rates? If so to what extent have you implemented this improvement activity?		5 - Not at all	5 - Not at all	5 - Not at all	4 - roughly 25% of this is achieved
2.6. Does it include producing ongoing case-note audits of selected cases not detected antenatally, to identify barriers? If so to what extent have you implemented this improvement activity?		3 - roughly 50% of this is achieved	3 - roughly 50% of this is achieved	1 - Completely	4 - roughly 25% of this is achieved
2.7. If you answered "no" to 2.1, are you planning/considering introducing this type of intervention/improvement activity?		Yes - Within the next 3 months	Yes - Within the next 3 months	Click to Select	Click to Select

Element 3: Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movement (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM					
3.1. Are you carrying out any improvement activity designed to raise awareness among pregnant women of the importance of Reduced Fetal Movement (RFM)? If "yes", go to question (3.2). If "no", please go to question (3.5).		**Yes**	**Yes**	**Yes**	**Yes**
3.2. Does it include providing pregnant mothers with information and an advice leaflet on reduced fetal movement? If so to what extent have you implemented this improvement activity?		**1 - Completely**	**1 - Completely**	**1 - Completely**	**1 - Completely**
3.3. (a) Does it include giving pregnant mothers this information by 24 weeks of pregnancy at the latest? If so to what extent have you implemented this improvement activity?		**1 - Completely**	**1 - Completely**	**1 - Completely**	**1 - Completely**
3.3. (b) Does it include discussing RFM with pregnant mothers at every subsequent contact? If so to what extent have you implemented this improvement activity?		**1 - Completely**	**1 - Completely**	**1 - Completely**	**1 - Completely**
3.4. Does it include making use of a checklist to manage the care of pregnant woman who report reduced fetal movement? If so to what extent have you implemented this improvement activity?		**1 - Completely**	**1 - Completely**	**1 - Completely**	**1 - Completely**
3.5. If you answered "no" to 3.1, are you planning/considering introducing this type of intervention/improvement activity?		**Click to Select**	**Click to Select**	**Click to Select**	**Click to Select**
Element 4: Effective fetal monitoring during labour					
4.1. Are you carrying out any improvement activity designed to carry out effective fetal monitoring during labour? If "yes", go to question (4.2). If "no", please go to question (4.5).		**Yes**	**Yes**	**Yes**	**Yes**
4.2. Does it include ensuring that all staff who care for women in labour undertake an annual training and competency assessment on cardiotocograph (CTG) interpretation/ intermittent auscultation?		**1 - Completely**	**1 - Completely**	**1 - Completely**	**1 - Completely**
4.3. Does it include making use of a fresh eyes/buddy system to review cardiotocograph (CTG) interpretation/ intermittent auscultation? If so to what extent have you implemented this improvement activity?		**4 - roughly 25% of this is achieved**	**4 - roughly 25% of this is achieved**	**3 - roughly 50% of this is achieved**	**3 - roughly 50% of this is achieved**
4.4. Does it include a protocol for escalation if concerns are raised? If so to what extent have you implemented this improvement activity?		**1 - Completely**	**1 - Completely**	**1 - Completely**	**1 - Completely**
4.5. If you answered "no" to 4.1, are you planning/considering introducing this type of intervention/improvement activity?		**Click to Select**	**Click to Select**	**Click to Select**	**Click to Select**

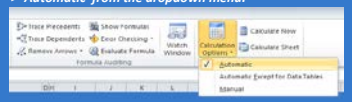
The purpose of this survey is to gather information on how much of current standard practice aligns with the interventions that make up the Saving Babies' Lives Care bundle. Each intervention is made up of improvement activities. Improvement activities are the actions that make up the elements of the care bundle.

Collecting this survey over specified intervals allows us to track how many maternity units are working towards fully achieving the Care Bundle elements as standard practice within their provider Trusts. Please base your responses on your assessment of how much of your current activities match the requirements of the care bundle.

PLEASE CLICK THE ARROW TO USE THE DROP DOWN MENU TO SELECT YOUR ANSWERS.

Please note:

The calculation setting for this workbook should be set to 'Automatic' in order for all of the functions to work correctly. In order to check this setting, please click:
-> 'Formulas' in the top ribbon
-> 'Calculation Options' to the right
-> 'Automatic' from the dropdown menu.



In addition, please ensure that you select 'enable content' when prompted by the security dialog box at the top.

NHS England

Survey Number	9th
Survey Date	Mar-18

Reducing Stillbirths Care Bundle Elements

Element 1: Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist as appropriate

1.1. Are you carrying out any improvement activity designed to reduce smoking in pregnancy? *If "yes", go to question (1.2). If "no", go to question (1.4).*	Yes
1.2. Does it include carrying out carbon monoxide (CO) testing of all pregnant women at antenatal booking appointment? If so to what extent have you implemented this improvement activity?	2 - roughly 75% of this is achieved
1.3. Does it include referring expectant mothers, as appropriate, to a stop smoking service/specialist, based on an opt out system? If so to what extent?	3 - roughly 50% of this is achieved
1.4. If you answered "no" to **1.1.**, are you planning on introducing this type of intervention / improvement activity?	Click to Select

Element 2: Identification and surveillance of pregnancies with fetal growth restriction

2.1. Are you carrying out any improvement activity designed to detect Fetal Growth Restriction? *If "yes", go to question (2.2). If "no", please go to question (2.7).*	Yes
2.2. Does it include making use of customised or standardised antenatal growth charts for all pregnant women by clinicians who have gained competence in their use? If so to what extent have you implemented this activity?	1 - Completely
2.3. Does it include making use of a growth chart to aid decision making on classification of risk of fetal growth restriction? If so to what extent have you implemented this improvement activity?	1 - Completely
2.4. Does it include screening and monitoring all pregnancies based on the assessment of risk? If so to what extent have you implemented this improvement activity?	1 - Completely
2.5. Does it include performing ongoing audits and the reporting of Small for Gestational Age (SGA) rates and antenatal detection rates? If so to what extenty?	4 - roughly 25% of this is achieved
2.6. Does it include producing ongoing case-note audits of selected cases not detected antenatally, to identify barriers? If so to what extent?	3 - roughly 50% of this is achieved
2.7. If you answered "no" to **2.1**, are you planning on introducing this type of intervention / improvement activity?	Click to Select

Element 3: Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movement (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM

3.1. Are you carrying out any improvement activity designed to raise awareness among pregnant women of the importance of Reduced Fetal Movement (RFM)? *If "yes", go to question (3.2). If "no", please go to question (3.5).*	Yes
3.2. Does it include providing pregnant mothers with information and an advice leaflet on reduced fetal movement? If so to what extent have you implemented this improvement activity?	1 - Completely

3.3. (a) Does it include giving pregnant mothers this information by 24 weeks of pregnancy at the latest? If so to what extent have you implemented this improvement activity?	1 - Completely
3.3. (b) Does it include discussing RFM with pregnant mothers at every subsequent contact? If so to what extent have you implemented this improvement activity?	1 - Completely
3.4. Does it include making use of a checklist to manage the care of pregnant woman who report reduced fetal movement? If so to what extent have you implemented this improvement activity?	1 - Completely
3.5. If you answered "no" to **3.1**, are you planning on introducing this type of intervention / improvement activity?	Click to Select
Element 4: Effective fetal monitoring during labour	
4.1. Are you carrying out any improvement activity designed around effective fetal monitoring during labour? ***If "yes", go to question (4.2). If "no", please go to question (4.5).***	Yes
4.2. Does it include ensuring that all staff who care for women in labour undertake an annual training and competency assessment on cardiotocograph (CTG) interpretation / intermittent auscultation?	1 - Completely
4.3. Does it include making use of a fresh eyes/buddy system to review cardiotocograph (CTG) interpretation / intermittent auscultation? If so to what extent?	1 - Completely
4.4. Does it include a protocol for escalation if concerns are raised? If so to what extent have you implemented this improvement activity?	1 - Completely
4.5. If you answered "no" to **4.1**, are you planning on introducing this type of intervention / improvement activity?	Click to Select
Please fill in the following details	
Name of person completing the form	Elaine Broughton
Job Title	Head of Midwifery
Hospital Name	UHL NHS Trust
Trust Name	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
Trust Code	RWE
SCN Area	East Midlands
Please provide information here if the drop-down boxes do not include the correct information for your trust	Free Text Box

Case Study

We would like to find out more about how your Trust is implementing the Care Bundle. With each survey round, this page will provide the opportunity to feedback on your experiences of implementation or on any particular successes or challenges. We hope to share and disseminate these examples in order that trusts can be recognised for their good work and so that other trusts learn from them. We believe the success of implementation is in the detail and would be grateful if you could share as much as possible. If you would be happy to share your experiences but would prefer for them not to be shared, please do indicate this below.

Please use the free text space if what you have to share does not fit with any of the questions below. In previous surveys there was a comments section, we encourage you to add your comments and share information here.

Please indicate if you are happy to share your case study Click to Select

Name of Trust / births per year	
Why did you begin to implement the care bundle?	
What influenced your decision to implement either some or the entire care bundle?	
What things made it easier to implement the care bundle?	
What things made it more challenging to implement the care bundle?	
What do you consider to be your greatest success?	
Have you redesigned or commissioned a new service to support implementation?	

What impact is the bundle having on safety and maternity outcomes?	
What impact is the bundle having on women's experience of care?	
What impact is the bundle having on staff experience of delivering care?	
What isn't working as well as you would have hoped and what plans have you got to mitigate?	
What key things have been learnt and how did they influence ways of working?	
Based on what you have learnt/found so far, what would be the most important piece of advice or guidance for successful implementation in other Trusts?	
Any other details not covered above	
Free Text Box	

Saving Babies Lives - Updates & Action Planning

The implementation survey gives a good insight into implementation trends but does not in itself increase levels of implementation of the care bundle. This action planning section is designed to complement the survey and support an increase in the levels of implementation by encouraging the development of explicit actions that outline how progress will be made and address the specific barriers faced by a particular trust.

Action Plan

R	Red: Immediate remedial action required to progress this activity
A	Amber: Action required for successful delivery of this activity
G	Green: Activity on target
B	Black: Completed activity

Recommendation Number	Recommendation	Action plan to address recommendation	Action progress against plan	Action priority 1 = Critical (Under 1 Month) 2 = Essential (1-3 Months) 3 = Recommended (over 3 months)	Action owner	Baseline date	Forecast date	Closure date	Current status
1	Ensure ALL women who are identified as smoking at booking are referred for smoking cessation guidance	Inform community midwives this opt out only and must be done		2	Louise Payne/Elaine Broughton				
2		Surveillance of carbon monoxide monitoring at booking by quarterly booking notes audit		2	Louise Payne/Elaine Broughton				
3									
4									
5									
6									

7									
8									
9									
10									
11									
12									

An Evaluation of the Saving Babies' Lives Care Bundle

Background

UK stillbirth rates remain among the highest of high income countries, and there is unwarranted variation in stillbirth rates across the country, highlighting deviation in best practice. To address these issues nationally, in April 2015 NHS England launched the 'The Saving Babies' Lives' care bundle, a quality improvement policy that brings together four key elements of care based upon best available evidence that are likely to impact on stillbirth rates. The ambition is that by implementing the care bundle across UK maternity units, we can significantly reduce stillbirth rates as well as inequitable practice on a national level. Ensuring the effectiveness of the care bundle in achieving these goals is thus a current priority and is the subject of a comprehensive evaluation to validate best available evidence and key recommendations going forward.

What are the aims of the evaluation?

The care bundle evaluation is a service evaluation of the Saving Babies' Lives care bundle across UK maternity units, developed and funded by NHS England and the University of Manchester. The evaluation aimed to determine the impact of the care bundle on maternity services and perinatal outcomes and identified key barriers and enablers for providers that may affect implementation. To do this, we assessed the impact of the care bundle on resource usage, workforce culture, maternal satisfaction and perinatal mortality and morbidity.

How was the evaluation carried out?

The evaluation encompassed a mixed-methods approach involving both quantitative and qualitative assessment in a target of 20 UK maternity units. It was carried out in two phases. Phase I (Jun-Nov 2016) involved study site recruitment and feasibility of data collection. Phase II involved the full evaluation and data collection over a period of 11 months.

Study Participants

- St Helens and Knowsley Teaching Hospitals
- Norfolk and Norwich University Hospitals
- Gateshead Health FT
- Manchester Foundation Trust
- Sherwood Forest Hospitals Trust
- York Teaching Hospital
- The Mid Yorkshire Hospitals
- North Cumbria University Hospitals
- University Hospitals of Morecambe Bay
- Barnsley Hospital
- Royal United Hospitals Bath
- Countess of Chester Hospital
- Plymouth Hospital NHS Trust
- Doncaster and Bassetlaw Hospitals
- Oxford University Hospitals
- Liverpool Women's
- Taunton and Somerset
- Royal Devon & Exeter
- Birmingham Women's

Work so far on the evaluation project

The evaluation is now complete. 19 NHS trusts took part in the study. Data collection took place between June and December 2017. 2,230 women completed the patient survey, and over 1,000 health professionals completed the staff survey. Over 1,650 hand-held pregnancy records were audited, and routine data from around 500,000 singleton deliveries across the 19 trusts was obtained. Data analysis is now complete, and report writing is currently in progress and anticipated for release in Summer 2018.

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Leicester, Leicestershire and Rutland Maternity Voices Partnership Launch Event

5th June 2018
Orange Rooms, 9 Newarke Street, Leicester, LE1 5SN
10:00-14:00

"A Maternity Voices Partnership (MVP) is a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care."
NATIONAL MATERNITY VOICES, 2017

Agenda

Time	Agenda Item	Lead
10:00	Welcome and introductions	Chris West
10:10	Better Births: transforming local maternity services	Mel Thwaites
10:30	Understanding the current Maternity provision in Leicester, Leicestershire and Rutland	Ian / Elaine?
10:50	What is a MVP?	Jasmine Cajee
11:10	BREAK (Refreshments provided)	
11:30	Workshops • Feedback • Continuity • Choice • How do we engage with women and families	All
12:45	Feedback and closing remarks	Chris West
13:00 – 14:00	LUNCH (Provided) and information stalls	

Better care together

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NHS

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Maternity Services Liaison Committee
Monday, 9th April 2018 9:30am to 11:00am
Eyres Monsell & Gilmorton Children's Centre, Hillsborough Road, Leicester LE2 9PT
AGENDA

Item No	Agenda Item	Paper	Lead
1	**Welcome and Apologies**	**Verbal**	**JR**
2	**Minutes of meeting on 9th October 2017 and Matters Arising**	**Paper A**	**JR**
3	**STP update - Better Births:** • LMS Refresh • Update – feedback from NHS England	**Verbal** **Paper B**	**MT**
4	**Smoking Audit**	**Paper C**	**JA**
5	**Establishment of Maternity Voices Partnership (MVP):** • Terms of Reference • Frequently asked questions • Launch of MVP at event on 7th June 2018 • Feedback from webinar • MVP website/Facebook page/other online resources • Public facing document	**Paper D** **Paper E**	**JC**
6	**Data Sharing Issues**	**Verbal**	**JR**
7	**Maternal Obesity Health Needs Assessment**	**Paper F**	**JR/CM**
8	**Quality:** • Maternity dashboard	**Paper G**	**EB**
9	**Integrated pathways Update** • Continuity and Choice • Regional Strategy to Reduce Infant Mortality • Antenatal / parenting • Smoking in pregnancy • Infant feeding • Healthy Weight • Oral Health • Perinatal Mental Health	**Verbal**	 **EB** **JR/CM** **JR/CM** **JA** **JA** **JR/CM** **JR/CM** **MT**
10	**Cost-effectiveness and Return on Investment (ROI) of interventions associated with the Best Start in Life**	**Paper H**	**JR/CM**
11	**Any Other Business**	**Verbal**	**All**
For information			
• **Diversity, ethnicity and voice programme**			

Next meeting: Monday 11th June 2018 Time: 9.30-11am
Eyres Monsell and Gilmorton Children's Centre
Hillsborough Road, Leicester LE2 9PT

Confirmation of attendance and apologies to:
Tom Pitchers - Admin Support: Better Births
Email: tom.pitchers@leicestercityccg.nhs.uk Telephone: 0116 295 4191

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

PATIENT EXPERIENCE - FRIENDS & FAMILY TEST

The Friends & Family score is obtained by asking patients a single question, "How likely are you to recommend our service to friends and family if they needed similar care or treatment"

Based on their responses, the number of "Extremly Likely" & "Likely" is used to calculate the % recommended score, and the number of "Extremly Unlikely" & "Unlikely" is used to calculate the % not recommended score.

Friends & Family Test : Apr '18

Monthly results : Labour Ward - Leicester Royal Infirmary

SUREVEY ROUTE	
Paper surveys	0
Electronic (SYE)	255

TOTAL SURVEYS (Where FFT question answered)	Total surveys
	255

% recommend	% not recommend
93.7 %	2.7 %

Survey Type	Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely Unlikely	Don't know	TOTAL SURVEYS	% recommend
Maternity Easy Read	12						12	100.0%
Maternity survey	168	59	2	2	5	7	243	93.4%

Recommend Friends and Family Reason

		COMMENT SHARE CONSENT
Extremely Likely	Very helpful and supportive	Not completed

Key		
Mean		Score above the normal (UHL) range*
Mean patient satisfaction score (100 = ideal)		Score within the normal range*
		Score is below the normal range*
RAG	*R = Red B = Blue G = Green N/A = Question not RAG rated*	
** Thresholds based on UHL patient experience survey scores over the last 12 months - updated on a quarterly basis*		
N	Number of patients completing question	

Friends & Family Test : Apr '18

Labour Ward - Leicester Royal Infirmary - Patient Experience Survey results

Question 2016			Mean	RAG	N	Red Threshold	Green Threshold
During your labour, do you feel that midwives and other carers have given you consistent advice?			104	G	2	89.0	98.0
How clean were the labour and delivery rooms you were in?			100	G	2	92.4	95.0
If you had an episiotomy (cut) or tear needing stitches, how long after your baby was born were the stitches done?			100	G	2	79.0	88.0
When you had important questions to ask the doctors, did you get answers that you could understand?			100	G	2	89.0	98.0
During your labour and birth, did you feel you got the pain relief you wanted?			100	G	2	90.0	92.8
Did you receive 1:1 care by a midwife once you were confirmed as being in established labour?			104	G	2	95.0	98.0
Overall, were you treated with respect and dignity?			100	-	2	-	-
When you had important questions to ask the midwives, did you get answers that you could understand?			100	G	2	90.0	98.0
Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?			100	G	2	73.0	98.0

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Friends & Family Test : Apr '18

Labour Ward - Leicester Royal Infirmary - Patient Experience Survey - Comments

30. Please add any comments you wish to make about your care below:

COMMENT	SHARE CONSENT

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

PATIENT EXPERIENCE - FRIENDS & FAMILY TEST

The Friends & Family score is obtained by asking patients a single question, "How likely are you to recommend our service to friends and family if they needed similar care or treatment"

Based on their responses, the number of "Extremly Likely" & "Likely" is used to calculate the % recommended score, and the number of "Extremly Unlikely" & "Unlikely" is used to calculate the % not recommended score.

Friends & Family Test : Apr '18

Monthly results : Leicester Royal Infirmary Ward 6

SUREVEY ROUTE	
Paper surveys	0
Electronic (SYE)	152

TOTAL SURVEYS (Where FFT question answered)	Total surveys
	152

% recommend	% not recommend
94.1 %	2.0 %

Survey Type	Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely Unlikely	Don't know	TOTAL SURVEYS	% recommend
Maternity Easy Read	4						4	100.0%
Maternity survey	96	43	5	1	2	1	148	93.9%

Recommend Friends and Family Reason

		COMMENT SHARE CONSENT
Extremely Likely	again all the midwives were very supportive. Helped me all through the night and never failed to make me feel anything but safe and happy	Not completed
Extremely Likely	all staff friendly and helpful	Not completed
Extremely Likely	amazing staff polite,	Not completed
Extremely Likely	as above	Not completed
Extremely Likely	Brilliant staff	Not completed
Extremely Likely	Care provided by staff was excellent, couldn't do enough for me.	Not completed
Extremely Likely	excellent	Not completed
Extremely Likely	excellent caring staff	Not completed
Extremely Likely	Food was very nice, made sure I was comfortable and were very helpful with advice	Not completed
Extremely Likely	good service	Not completed
Extremely Likely	Great staff always there when you need them	Not completed
Extremely Likely	helpful staff	Not completed
Extremely Likely	I feel so lucky to have been in the care of the nicest talented staff. You all made the experience incredible.	Not completed

Friends & Family Test : Apr '18

Monthly results : Leicester Royal Infirmary Ward 6

Extremely Likely	I'm very happy from staff	Not completed
Extremely Likely	same as above	Not completed
Extremely Likely	the staff are happy to help with any issue no matter how big or small.	Not completed
Extremely Likely	very helpful	Not completed
Extremely Likely	Very positive experiences with staff and facilities.	Not completed
Extremely Likely	very supportive, great staff.	Not completed
Extremely Likely	Ward 6 was also very welcoming and polite staff.	Not completed
Extremely Unlikely	they treat you very good and care about your health	Not completed
Likely	Communication could be improved have to ask before information is given about your care	Not completed
Likely	everyone very nice and caring	Not completed
Likely	exceptional service with good facilities, the mid wife's where especially attentive and caring.	Not completed
Likely	extremely caring and helpful	Not completed
Likely	great midwife support. Short on drs staffing	Not completed
Likely	I am satisfied	Not completed
Likely	it was lovely to have time to spend as a family in the room for a few hours although we were waiting two hours before being moved to a ward as we were waiting for a peadeatrition.	Not completed
Likely	lovely staff	Not completed
Likely	lovely staff yet again, caring and considerate	Not completed
Likely	not much information during theatre recovery, like how long I would be with them etc	Not completed
Likely	Post theatre stayed in delivery suite until moved at 6am	Not completed
Likely	Too long to be released home	Not completed
Likely	very helpful	Not completed
Likely	very helpful. Great staff	Not completed
Likely	very supportive staff	Not completed
Neither likely or unlikely	Average service	Not completed
Neither likely or unlikely	Dont live in this area	Not completed
Neither likely or unlikely	rooms feel overcrowded	Not completed
Neither likely or unlikely	think the child's father should be able to stay overnight	Not completed

Friends & Family Test : Apr '18

Monthly results : Leicester Royal Infirmary Ward 6		
Unlikely	As above	Not completed

Key		
Mean		Score above the normal (UHL) range*
Mean patient satisfaction score (100 = ideal)		Score within the normal range*
		Score is below the normal range*
RAG	*R = Red B = Blue G = Green N/A = Question not RAG rated*	
** Thresholds based on UHL patient experience survey scores over the last 12 months - updated on a quarterly basis*		
N	Number of patients completing question	

Friends & Family Test : Apr '18

Leicester Royal Infirmary Ward 6 - Patient Experience Survey results

Question 2016			Mean	RAG	N	Red Threshold	Green Threshold
During your labour, do you feel that midwives and other carers have given you consistent advice?			95	B	146	89.0	98.0
Thinking about the postnatal care you received in hospital after the birth of your baby, were you given the information or explanations you needed?			92	B	145	89.0	91.9
How clean were the labour and delivery rooms you were in?			97	G	147	92.4	95.0
If you had an episiotomy (cut) or tear needing stitches, how long after your baby was born were the stitches done?			92	G	109	79.0	88.0
Thinking about feeding your baby (breast or bottle) in the first few days after the birth, did you feel that the midwives and other carers gave you consistent advice?			86	G	141	76.0	83.0
During your labour and birth, did you feel you got the pain relief you wanted?			90	B	140	90.0	92.8
Did you receive 1:1 care by a midwife once you were confirmed as being in established labour?			100	G	144	95.0	98.0
Thinking about feeding your baby (breast or bottle) in the first few days after the birth, did you feel that midwives and other carers gave you active support and encouragement?			88	G	139	78.0	85.0
Overall, were you treated with respect and dignity?			97	B	148	89.0	97.0
How would you rate the hospital food?			77	G	142	60.0	67.0
For your postnatal stay in the hospital, how clean was the hospital room or ward you were in?			93	B	147	92.4	95.0
Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?			95	B	132	73.0	98.0

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Friends & Family Test : Apr '18

Leicester Royal Infirmary Ward 6 - Patient Experience Survey - Comments

30. Please add any comments you wish to make about your care below:

	COMMENT SHARE CONSENT
Great friendly staff always there when needed	Not completed
Fantastic, thank you to everyone who helped bring our little boy in to the world and keeping him safe for his first night	Not completed
Midwife Imogen and her student have been amazing and went above and beyond Kant thank you enough. The whole team that worked the night I went into labour were extraordinary. Thank you your all amazing.	Not completed
Everyone has been fantastic!!	Not completed
Midwife Erica was absolutely excellent couldn't of asked for anyone better	Not completed
Really happy with the midwives who helped me deliver my baby and who helped me to latch with baby. Made my birthing experience really smooth.	Not completed
Arabic	Not completed
I wasn't meant to have my baby here and my labour did not go to plan at all. Thanks to the fantastic team here (and despite the challenges) my birthing experience was good. I am really grateful to everyone, their kindness and expertise kept me feeling safe and respected. Thank you	Not completed
We had a very pleasant experience at the Leicester Royal where we welcomed our first child into the world. The staff were all very approachable, non judgemental and happy to help with any issue no matter how big or small.	Not completed
Thank you for all the help and support we recieved. 100% happy with the care we got and how all Midwifes were.	Not completed
Di the midwife on Ward 5 and Sarah the midwife on Delivery Suite were fantastic - they reacted very quickly to my needs. All staff on Ward 6 were friendly and helpful.	Not completed
Excellent	Not completed
Great job by all staff. Thank you. I really appreciate everything you have all done x	Not completed
Loving, caring staff. All members of staff I came into contact with were approachable, friendly and knowledgeable.	Not completed
Pre and postnatal care fantastic	Not completed
Was a pleasure to meet your staff	Not completed
Would be good to get home sooner	Not completed
Treated well and anything I inquired about was answered fully and throughally	Not completed
Fab care at the orchard ward had an amazing midwife midwife n jones was amazing and the younger lady from the university helping her was fab couldn't ask for better Thankyou both very much for helping to delivery our baby girl and midwife jones for catching her sent with lots of love from us all.	Not completed
I very happy ,the midwife was very and all the doctors was very professional,very friendly,I was feeling very comfortable	Not completed
Overall happy with the care provided. I would appreciate the wards and toilets were more clean & a small bin & table be provided in the wards for convenience.	Not completed
Didn't appreciate someone trying to get me to clench my fist in order to take blood when in the hight of a contraction when I delivered the baby five min later!	Not completed
Couldn't fault ward 5 and delivery suite doctors midwives house staff were amazing, unfortunately I didn't feel same experience on ward 6 and my husband felt very unwelcome whilst being here with his daughter.	Not completed

Early notification report form

Please send to your legal services department within 14 days of a notifiable severe brain injury incident as defined by Royal College of Obstetricians and Gynaecologists' Each Baby Counts criteria

Mother's name	
Baby's name	
Date of birth	
Have you advised the family that the relevant records and investigation documents will be shared with NHS Resolution?	Yes No
Please confirm if the family did not agree with these documents being shared with NHS Resolution	Yes No
Preliminary risk assessment (to be used as a guide only)	Substandard care unlikely (<10% chance) Possible substandard care (>25%) Likely substandard care (50% or more)

Section B : Action Plan details for

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action	Q8 In House Training	**To be met by**	Q4 2018/19
Work to meet action	*1. Assessment of number of training places to accommadate the new requirements set out in the standard 2. Review if any places available on current training days 3. Trajectory of reaching 90% of all staff necessary to reach standard*		
Does this Action Plan have Executive Level Sign Off	Yes	**Action plan agreed by HoM and/or clinical director?**	Yes
Action plan owner	*Head of Midwifery and Womens and childrens education lead*		
Lead executive director	*Interim Chief Nurse*		
Details of any request for funding support from the incentive fund, if required			
Reason for not meeting action	*The previous CNST requirement did not include training of Maternity care assistants in multidisciplinary skill or theatre staff also the previous requirement to achieve level 3 compliance was 75% of staff trained which we achieve regularly. We did previously monitor anaesthetist attendance so need to monitor this again. The maternity service is one of the largest in the country and therefore there are 100 MCA'S,around 33 theatre staff, 29 anaestetic consultants we would need to include on training days which are all ready fully subscibed to and therefore we require more capacity in training places and more faculty to enable us to achieve 90% compliance. An indication of this a year ago would have been helpful in achieving this and be fully compliant.*		
Rationale	*The assessment of the number of staff has been carried out and a realistic timeline of when the service can provide sufficient training places to achieve the required standard of in house training*		
Benefits	*The benefits are that by May 2019 the service will have provided training for all staff groups as required in the standard*		
Risk assessment	*The Trust will not receive 10% reductive in the premium-*		

	How?	**Who?**	**When?**
Monitoring	capture attendance on the CNST training template	Education team	Monthly