NHS
Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being Held on 31st January 2023

Subject	Maternity Incentive Scheme (MIS) CNST Year 4 submission
Supporting TEG Member	Chris Morley
Author	Laura Rumsey, Sue Gregory, Andrea Galimberti
Status[1]	Approval

PURPOSE OF THE REPORT

- To present the summary of the Trust's Year 4 CNST submission to the Board of Directors for agreement for formal sign-off.

KEY POINTS

NHS Resolution (NHSR) is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS). The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. The scheme incentivises ten maternity safety actions, which comprise 155 individual standards, every standard within a safety action must be met to be able to declare compliance with that safety action. Trusts that can demonstrate they have achieved all ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.
Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a discretionary payment from the scheme to help to make progress against actions they have not achieved.

As outlined in the summary from the official submission form (**Appendix 1)** the Jessop Wing is not declaring compliance for Year 4 of the MIS. The full spreadsheet containing the detail behind each safety action and the Trust action plan for all safety actions not achieved is available to Board members in the Board library.

The service is applying for funding provided by the scheme to support progress towards compliance with all safety actions. Evidence for all actions declared as compliant has been collated and is available for scrutiny.

Jessop Wing is declaring compliance with Safety Actions 2, 3, 7 and 10 but non-compliance with the following 6 actions:

- Perinatal Mortality Review Tool – required compliance since May 2022. Compliance shown by the end of the reference period but not for the full period+.
- Clinical workforce planning – requires further work to progress the proportion of Qualified in Specialty (QIS) neonatal nurses to be in line with the British Association of Perinatal Medicine (BAPM) standards.
- Midwifery workforce planning – Further work is required on quantifying the Midwifery budgeted establishment to align it with Birth Rate Plus.
- Saving Babies' Lives Care Bundle V2 – in order to meet the evidence required manual auditing will need to be set up whilst the end-to-end maternity information system is implemented. Further work is also required on the smoking cessation pathway.
- Training- the designated training levels were not consistently at 90% for the reference recording period.
- Board assurance on neonatal safety & quality issues – improvements required in feeding actions back to staff following Board level Safety Champion walkarounds.

Improvement action plans are in place for all non-compliant actions aligned to the Maternity Improvement Programme, including requests for funding to be considered by NHS Resolution, for:

- Neonatal staffing – £30,000 to support the Qualified in Specialty training course and back-fill of clinical time.
- Midwifery establishment –£100,000 to support incentivised shift payments pending recruitment to Birth Rate Plus recommended levels.
- Saving Babies' Lives Care Bundle V2 (SBLCBV2) – £47,000 to support the paper-based audit requirements for SBLCBV2.
- Training - £50,000 to support course venues and other costs of running required training courses.

IMPLICATIONS[2]

Aim of the STHFT Corporate Strategy		✓ Tick as appropriate
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Create a Sustainable Organisation	
6	Deliver Excellent Research, Education and Innovation	✓

RECOMMENDATIONS

The Board are asked to:

- To approve the 2022/2023 MIS submission

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Board of Directors	31/01/23	

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the six aims of the STHFT Corporate Strategy 'Making a Difference – The next Chapter 2022-27'

Appendix 1

Section A : Maternity safety actions - Sheffield Teaching Hospitals NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	No	7	3	0
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes	12	0	1
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Yes	19	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	No	6	2	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	No	3	1	1
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle V2?	No	7	24	0
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Yes	7	0	0
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?	No	0	18	0
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	No	22	3	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?	Yes	8	0	0