Trust Board of Directors Meeting

12 January 2023

Report Title:	CNST (Clinical Negligence Scheme for Trusts) Maternity Incentive Scheme safety standards
Executive/NED Lead:	Giles Thorpe, Chief Nurse
Report author(s):	Andrea Turner – Divisional Director, Women's & Children's Services Sarah Smith – Associate Director of Operations – Women's & Children's Services Amy Bruce – Associate Director of Nursing, Women's and Children's Division
Previously considered by:	Quality and Patient Safety Committee Executive Management Committee

☑ **Approval** ☐ **Discussion** ☐ **Information** ☐ **Assurance**

Executive summary

In August 2021, NHS Resolution launched year 4 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, to continue to support the delivery of safer maternity care. Owing to the COVID-19 pandemic, the scheme was paused from December 2021 – 6 May 2022, and since the relaunch in May 2022 there have been several iterations of the set of 10 safety standards. The latest (and final) version of the scheme was issued in October 2022, additionally revising the submission date to 12 noon on Thursday 2 February 2023. This applies to all acute Trusts that deliver maternity services and are members of the CNST scheme. Members have contributed an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises 10 maternity safety actions ("the standards"). Trusts that can demonstrate they have achieved all 10 standards will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Should the Trust not achieve all 10 maternity safety actions, the Board is required to 'declare' and submit an Action Plan for the actions not achieved. A summary of the declaration is presented at Appendix 2.

Detailed evidence is available to support each of the standards. Reporting on maternity services is included within the Integrated Performance Report and Every Birth Every Day updates to Board. The Quality and Patient Safety Committee considered detailed reports and received a clear presentation against each standard at its meeting held on 20 December 2022 and this and the evidence has been reviewed by the Chief Nurse. This Committee is chaired by the Non-Executive Director Board level maternity safety champion.

The standards are set out in brief overleaf. Compliance is confirmed in nine of the 10 standards.

The Quality and Patient Safety Committee recognised that mitigating action would be presented to the Board regarding safety action 1 to form part of the submission. This is presented as non-compliant for one element. The governance processes implemented to avoid a recurrence of late reporting have been reviewed by the Director of Governance to provide additional assurance to the Board. A Standard Operating Procedures is now in place, which includes a failsafe escalation plan for any element within four weeks of the deadline to ensure this is not missed. An action plan is presented at Appendix 1.

In addition, at the time of the Committee meeting, the evidence had not been fully compiled for standards 4 and 8. These have now been completed and both have been found to be compliant. The evidence has since been submitted and reviewed by the Chief Nurse and an overview is submitted.

Action Required of the Board

The Board is asked to:

i. Approve submission of non-compliance and the mitigating action

ii. Delegate to the Chief Executive the appropriate discussion with the Integrated Care System Accountable Officer and signature to enable submission by 2 February 2023.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☑
SO2	Lead the integration of care	☑
SO3	Develop our centres of excellence	☑
SO4	Support and develop our staff	☑
SO5	Drive technology enabled care	☑

Risk Implications for the Trust *(including any clinical and financial consequences)*	A failure to achieve all 10 of the CNST Maternity Safety Actions, to which this programme of work contributes, will mean the Trust cannot recoup additional contributions already made to the Maternity premium, nor claim a share of unallocated funds (altogether circa £1m)
Trust Risk Appetite	The Board has a cautious view of risk when it comes to patient safety, patient experience or clinical outcomes and places the principle of "no harm" at the heart of every decision it takes. It is prepared to accept some risk if, on balance, the benefits are justifiable and the potential for mitigation actions are strong. When taking decisions involving choices between a wide range of outcomes, it will prioritise the option resulting in the greatest benefit for the most patients.
Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc.)*	A failure to ensure that the Trust meets the necessary standards of safety and quality may bring into question maternity services compliance with the Fundamental Standards of Care which are outlined in the Health and Social Care Act 2008 Regulated Activities (Regulations) 2015
Financial Implications	A failure to achieve all 10 of the CNST Maternity Safety Actions, to which this programme of work contributes, will mean the Trust cannot recoup additional contributions already made to the Maternity premium, nor claim a share of unallocated funds (altogether circa £1m)
Equality and Diversity	No Equality and Diversity implications are identified as part of the completion of this report

Safety action	Evidence of Trust's Position (Please see NHS Resolution Guidance Document for full detail of each item)	Action met? (Y/N)
1)	**Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?** Within this scheme, Safety Action 1 requires Trusts to demonstrate use of the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard. Year 4 of the scheme covers the reporting period from 6th May 2022 to 5th December 2022. As evidence of this, the Trust must demonstrate compliance with the following elements a) i. All eligible perinatal deaths must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. a) ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust. b) At least 50% of all deaths of babies suitable for review, who were born and died in your Trust, including home births, will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death. c) For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. Standards a i), b,c and d have all been met, including completing all of the full investigations within the required timeframe. Two cases have breached a ii with the investigation being started one day outside the required timeframe. All other requirements set out in this standard have been met by ESNEFT, and demonstrated to Trust Board sub-committees in quarterly reports from October 2020 onwards. Whilst we are declaring non-compliance, we will be submitting mitigation, as follows – 1. At the time of the breaches in element a ii, the responsibility for notification of perinatal deaths to MBRRACE and starting the PMRT review within 2 months had transferred from the governance team to the bereavement team and had not had time to fully embed 2. Staff sickness impacted on the second breach and highlighted the lack of a failsafe process 3. The breaches occurred on different sites and within a short time frame of one another, before a new failsafe process was embedded 4. A process of weekly reporting of deadlines and escalation to the governance team and Divisional Management Team was introduced soon after the second breach, and there have been no missed deadlines since this time 5. The other elements of the standard, including completing draft and final reports and including the parents perspectives are all compliant (100% for all) A report has been presented to Quality Patient Safety Committee on 20th December 2022 for information and approval of an Action Plan to ensure compliance going forwards. The governance processes implemented to avoid a recurrence of late reporting have been reviewed by the Director of Governance to provide additional assurance to the Board. An SOP is now in place, which includes a failsafe escalation plan for any element within 4 weeks of the deadline to ensure this is not missed.	**No**

Safety action	Evidence of Trust's Position (Please see NHS Resolution Guidance Document for full detail of each item)	Action met? (Y/N)
2)	**Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** All requirements set out in this standard have been met by ESNEFT. A maternity services Digital Strategy was approved by the Local Maternity Strategy Board 7th September 2022 ESNEFT MSDS submissions have been successfully submitted for the relevant period. On the monthly scorecard issued by NHS Digital for October 2022 data, Trusts were required to meet 12 mandatory criteria, which ESNEFT achieved. A final report was submitted to QPS in December 2022.	**Yes**
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 (ATAIN) Programme?** All requirements set out in this standard have been met by ESNEFT. A separate paper detailing compliance was presented to QPS in December 2022. a) In accordance with this standard, pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. b) These pathways on both sites have been fully implemented and are audited quarterly. Audit findings are shared with the Neonatal Safety Champions and the Local Maternity Neonatal Safety Board and ICS. c) A data recording process is in place for capturing all term babies transferred to the neonatal unit regardless of their length of stay together with a data recording process for capturing existing transitional care activity. d) A second data recording process is also in place and embedded and will be used to inform future capacity management for late preterm babies who could be cared for in a transitional care setting. This data captures babies between 34+0 – 36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, and monitors the number of special care days or normal care days where supplemental oxygen was not required. e) Commissioner returns for Healthcare Resource Groups (HRG) activity as per neonatal Critical care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the ODN, LMNS and commissioners to inform capacity planning as part of the family integrated care component of the National Critical care transformation Review and to inform future development of transitional care to minimise separation of mothers and babies. f) Reviews of babies into the neonatal units continue on a quarterly basis and findings have been shared with the Board Level Safety champion. These reviews include all transfers into the neonatal units regardless of their length of stay. The number of transfers into the neonatal unit which would have met transitional care acceptance criteria are also included together with those who due to the requirement of nasogastric tube feeding were required to be admitted to the neonatal unit as a dedicated transitional care service was not in operation. g) An Action plan to address local findings from the audit of the findings of the pathways into transitional care and from the avoiding Term Admissions Into Neonatal units (ATAIN) has been agreed with the neonatal safety champions and Board level safety champions. Progress with ATAIN action plans has been a standing agenda item at the monthly Maternity Safety Champion Forum from March 2021. Progress with ATAIN action plans, is overseen by the neonatal safety champions, who attend the monthly ATAIN project meetings on their respective sites.	**Yes**

Safety action	Evidence of Trust's Position (Please see NHS Resolution Guidance Document for full detail of each item)	Action met? (Y/N)
	The full ATAIN action plans have been formally shared and agreed with the Board level safety champions in the LMNS/ICB Strategic Board meeting, which takes place every 2 months. The Action plans and quarterly reports will be submitted to LMNS in January for completeness.	
4)	**Can you demonstrate an effective system of medical workforce planning to the required standard?** There are several elements to this standard, with criteria relating to: a) Obstetric medical workforce b) Anaesthetic medical workforce c) Neonatal medical workforce d) Neonatal nursing workforce All elements of this report have been met by ESNEFT. Details are set out in the separate paper appended to this summary report. As assurance that an effective system of workforce planning is in place, the Trust Board is required to have oversight of certain indicators and associated action planning. For Neonates we should have an immediately available resident tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00 - 22.00, seven days a week. For this element we are compliant on the Colchester Site, but not the Ipswich site. The action plan regarding the non-compliance of this action from 2021 has been completed and further actions have been added to include the new issues from 2022. This therefore ensures compliance with this element of the standard. We have provided evidence that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they are able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients. We have provided evidence that there is appropriate compliance with the Consultant Obstetrician attending mandatory scenarios/situations. A full report has been submitted to QPS and Trust Board by 12th January, providing evidence of ESNEFT's final position on this standard.	**Yes**
5)	**Can you demonstrate an effective system of midwifery workforce planning to the required standard?** Trusts must demonstrate an effective system of midwifery workforce planning to the required standard, as follows: a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service d) All women in active labour receive one-to-one midwifery care e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period. All requirements set out in this standard have been met by ESNEFT. The full staffing	**Yes**

Safety action	Evidence of Trust's Position (Please see NHS Resolution Guidance Document for full detail of each item)	Action met? (Y/N)
	report is provided in a separate paper to this summary report. The Trust is currently completing a Birthrate plus assessment and is awaiting the report to feed into the workforce plan. Although there have been occasions that the supernumerary coordinators have been recorded as not supernumerary these occasions have been reviewed and this was not a recurrent event (i.e. occurs on a regular basis and more than once a week) and appropriate escalations/ mitigations had been put in place to avoid the situation. This standard requires that a midwifery staffing oversight report covering staffing / safety issues is submitted to the Board every 6 months, during the MIS Year 4 reporting period. Reporting on maternity services including midwifery staffing is included regularly at Trust Board. The Every Birth Every Day Monitoring and Review Board, chaired by the Chief Executive, includes a work stream on Workforce, and Chair's Key Issues are reported to the Trust Board bimonthly. Maternity Staffing was also presented and discussed as part of the Integrated Patient Safety and Experience Report in Sept 22 at QPS (a Trust Board subcommittee) and Maternity Staffing is included within the Integrated Performance Report at Board. The full Midwifery Staffing report was presented and discussed at December's QPS meeting on 20/12/2022.	
6)	**Can you demonstrate compliance with all five elements of the Saving Babies' Lives (SBL) care bundle?** All elements of this standard have been met. A separate paper detailing compliance was presented to QPS in December 2022. Safety Action 6 requires Trusts to demonstrate compliance with all five elements of SBLCBv2, as follows – 1. Reducing smoking in pregnancy 2. Risk assessment and surveillance for fetal growth restriction 3. Raising awareness of reduced fetal movements 4. Effective fetal monitoring during labour 5. Reducing preterm birth A separate paper detailing compliance was presented to QPS in December 2022. The paper demonstrates compliance with the implementation of all 5 elements of SBLCBv2 on both maternity sites, by meeting all the minimum requirements for the process indicators as set out in the CNST Maternity Incentive Scheme Year 4. In order to strengthen the Saving Babies Lives programme within ESNEFT, an action plan has been developed to address areas for improvement including increased compliance with both CO monitoring and recording, and also recording that women are given information regarding reduced fetal movements prior to 28+0 weeks of pregnancy. There is also further quality improvement work being undertaken to increase compliance with antenatal corticosteroids, and this is also highlighted within the CNST SBL action plan.	**Yes**
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?** All requirements set out in this standard have been met by ESNEFT. A separate paper detailing compliance was presented to QPS in December 2022. ESNEFT works closely with the North East Essex (NEE) and Ipswich and East Suffolk (IES) MVPs.	**Yes**

Safety action	Evidence of Trust's Position (Please see NHS Resolution Guidance Document for full detail of each item)	Action met? (Y/N)
8)	**Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?** All requirements set out in this standard have been met by ESNEFT. Details are set out in the separate paper appended to this summary report. An ESNEFT local training plan is in place, meeting the requirements, and comprising elements as follows, which together cover all six required core modules – 1. Saving Babies Lives Study Day – covering Saving Babies Lives Care Bundle, Fetal surveillance in labour, personalised care - same programme on each site. 2. K2 e-learning – covering fetal surveillance in labour 3. Growth Assessment Protocol (GAP) e-learning completed in e-lfh 4. Maternity Statutory Training Study Day – covers Personalised Care and Care during Labour and the immediate postnatal period. Same programme on each site. 5. PROMPT one day training – covers Maternity emergencies and multi-professional training, including Neonatal Life Support. Minor differences in programme cross-site but still covering all required elements. 6. Additional NLS sessions for neonatal staff The other parts of this standard require that >90% of specified staff groups have attended specific elements of the training, within a 12m period, as follows – a) 90% of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day that includes maternity emergencies b) 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring c) 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Newborn Life Support (NLS) course starting from the launch of MIS year four in August 2021. The paper evidences that >90% of each staff group meet the training requirements.	**Yes**
9)	**Safety action 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?** All requirements set out in this standard have been met by ESNEFT. As assurance of this standard, the Trust Board is required to have oversight of certain indicators. These are covered in a report to QPS on 20 December 2022 and Trust Board in January 2022.	**Yes**
10)	**Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme from 1st April 2021 to 5th December 2022?** All elements of this standard have been met. A separate paper detailing compliance was presented to QPS in December 2022. The Trust is 100% compliant with reporting of all eligible cases for HSIB and NHS Resolution's EN Scheme between April 2021 and 5 December 2022 In addition to reporting to HSIB, there is a requirement that the Trust Board are assured that: 1. The family have received information on the role of HSIB and NHS Resolution's EN Scheme 2. There has been compliance, where required with Regulation 20 of the health and Social Care Act 2008 in respect of duty of candour	**Yes**

Safety action	Evidence of Trust's Position (Please see NHS Resolution Guidance Document for full detail of each item)	Action met? (Y/N)
	The Trust is also 100% complaint with these elements of the standard.	
Full Scheme	The Trust Board of Directors is requested to: • Receive the contents of this report as a statement of ESNEFT's current position in respect of the CNST Maternity Incentive Scheme for year 4. • Recommend that based on this report and further information provided / reviewed at the Quality and Patient Safety Committee on 20/12/2022, the ESNEFT Trust Board approves the Chief Executive signature and submission of the active Board Declaration to NHS Resolution, confirming that ESNEFT has met nine elements out of the ten of the CNST *Maternity Incentive Scheme Safety Action Standards.* The board declaration must be discussed with the commissioners and then submitted to NHS Resolution no later than 12 noon on 2nd February 2023. Supporting documents: ESNEFT Board Declaration template for submission to NHS – to be updated as per final position to be shared with QPS Chair and ESNEFT Trust Board by 12th January 2023.	

Safety action 4

Trusts must demonstrate an effective system of medical workforce planning to the required standard.

As evidence of an effective planning system, Trust Boards must be sighted on the following indicators.

a) Obstetric Medical Workforce

1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlines in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology into their service: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

Compliant - This has been discussed and agreed by consultants and incorporated into the maternity escalation policy.

2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with trust Board, the Board level safety champions as well as LMNS.

Compliant – consultant attendance at the required emergency situations is recorded in the safety huddle template, and audited. Both sites are compliant with no situations where the consultant has been required and has not attended.

b) Anaesthetic medical workforce

We are required to formally record the proportion of ACSA standard 1.7.2.1 that are met. Where Trusts did not meet these standards, they must produce an action plan (ratified by the Trust Board) stating how they are working to meet the standards.

Compliant - Whilst to date ESNEFT has not received ACSA accreditation, we can confirm that our lists and rotas do reflect the requirements set out in those standards, as articulated in the main body of the report and evidenced in the sample rotas included.

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.

Colchester - compliant

On the Colchester site there is a resident duty anaesthetist for delivery suite, 24 hours a day, 7 days a week who holds bleep 400. In addition to this there is a dedicated obstetric anaesthetic consultant on delivery suite from 8am to 6pm Monday – Friday. Both are responsible for covering delivery suite emergencies, epidural requests, follow ups, multidisciplinary ward rounds and any other emergency delivery suite duties. From 5pm there is an on call consultant who covers main theatres and delivery suite out of hours. They are resident in the hospital until 10pm on weekdays and 8am-8pm at weekends and bank holidays. Between 10pm and 8am weekday and 8pm and 8am weekend nights they become non-resident but available to contact via telephone and to attend within 30 minutes in an emergency.

Ipswich - compliant

On the Ipswich site, there is a dedicated duty anaesthetist available for the obstetric unit 24 hours a day, 7 days a week. They hold the emergency bleep (066) and have a responsibility for covering the labour ward as well as the emergency obstetric theatre. They are also expected to participate in the multidisciplinary ward rounds on labour ward.

The duty anaesthetist is clearly displayed on the rota, as are the anaesthetists covering the late and night shifts for obstetrics. The daytime emergency obstetric lists are covered by consultants, senior trainee or staff grade anaesthetists (with a named supervising consultant with overall responsibility).

Out of hours the duty anaesthetist is a senior trainee or staff grade and they are resident within the hospital, supported by a consultant anaesthetist on call for both obstetrics and general emergencies from home.

c) Neonatal medical workforce

The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met in year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.

Compliant - ESNEFT has a compliant rota at Colchester, but does not currently meet compliance for medical staffing in regards to Tier 2 cover at Ipswich. However, an Action Plan is in place and progress has been made against this, and ESNEFT is therefore overall compliant with this element of the standard.

d) Neonatal nursing workforce

The neonatal unit meets the service specification for neonatal nursing standards. If these are not met, If this is not met in year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.

Compliant - ESNEFT has undertaken a workforce review in October 2022, which has been presented at ODN and GIRFT and formulated part of the trust Acuity review, which has been presented at Trust Board. The Neonatal Action plan is discussed at MatNeo meeting monthly.

ESNEFT was awarded Regional funding to help improve QIS numbers of staff at the Ipswich site.

Safety action 8

Maternity Unit Staff Training

Evidencing a local training plan covering all six modules of the Core Competency Framework, and that 90% of each relevant maternity unit staff group has attended an 'in house', one day, multi-professional training day, including a number of required elements.

Can you evidence that -

a) A local training plan is in place to ensure that all the six core modules of the Core Competency Framework, will be included in your unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021.

A local training plan is in place to ensure that all the six core modules of the Core Competency Framework, will be included in your unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021.

The following 6 core modules should be included in the training plan –

- Saving Babies Lives Care Bundle
- Fetal surveillance in labour
- Maternity emergencies and multi-professional training
- Personalised care
- Care during labour and the immediate postnatal period
- Neonatal life support

An ESNEFT local training plan is in place, meeting this requirement. The ESNEFT training plan comprises elements as follows, which together cover all six core modules –

1. Saving Babies Lives Study Day – covering Saving Babies Lives Care Bundle, Fetal surveillance in labour, personalised care (covers part c of standard 8). Same programme on each site.
2. K2 e-learning – covering fetal surveillance in labour
3. Growth Assessment Protocol (GAP) e-learning completed in e-lfh
4. Maternity Statutory Training Study Day – covers Personalised Care and Care During Labour and the immediate postnatal period. Same programme on each site.
5. PROMPT one day training – covers Maternity emergencies and multi-professional training, including Neonatal Life Support (covers part b of standard 8). Minor differences in programme cross-site but still covering all required elements.
6. Additional NLS sessions for neonatal staff

	Saving Babies Lives Study Day	K2 e-learning	Maternity Statutory Training Day	PROMPT Training Day
Saving Babies Lives Care Bundle	✓			
Fetal Surveillance in Labour	✓	✓		
Maternity emergencies and multi-professional training				✓
Personalised Care	✓		✓	
Care during labour and immediate postnatal period			✓	
Neonatal Life Support				✓

b) 90% of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day that includes maternity emergencies starting from the launch of MIS year four in August 2021?

This training is covered in the local one-day PROMPT training day.

Maternity staff attendees should include 90% of each of the following staff groups –

- Obstetric consultants
- All other obstetric doctors (including staff grade doctors, obstetric trainees, sub specialty trainees, obstetric clinical fellows, and foundation year doctors contributing to the obstetric rota
- Midwives (including midwifery managers and matrons, community midwives, birth centre midwives)
- Maternity Support Workers and health care assistants (to be included in maternity skills drills as a minimum)
- Obstetric anaesthetic consultants
- All other obstetric anaesthetic doctors contributing to the obstetric rota

ESNEFT cross-site PROMPT compliance for a consecutive 12m period from 08/12/21 to 07/12/22 is as follows –

Staff Group	Total number	Number compliant	% Compliance
Obstetric consultants	25	25	100%
Obstetric doctors	38	35	92.1%
Midwives	312	291	93.3%
MSWs	101	96	95.0%
Nurses	10	10	100%
Anaesthetic consultants	28	27	96.4%
Anaesthetic doctors	33	30	90.9%

c) 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring, starting from the launch of MIS year four in August 2021.

This element is covered by Saving Babies Lives training days (Appendices 1 and 2).

Maternity staff attendees should include 90% of each of the following staff groups –

- Obstetric consultants
- All other obstetric doctors (including staff grade doctors, obstetric trainees, sub specialty trainees, obstetric clinical fellows, and foundation year doctors contributing to the obstetric rota
- Midwives (including midwifery managers and matrons, community midwives, birth centre midwives)

Saving Babies Lives training day compliance for a consecutive 12m period from 08/12/21 to 07/12/22 is as follows –

Staff Group	Total number	Number compliant	% Compliance
Obstetric consultants	25	25	100%
Obstetric doctors	38	36	94.7%
Midwives	312	298	95.5%

d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Newborn Life Support (NLS) course starting from the launch of MIS year four in August 2021.

This element requires that all staff in attendance at births should attend local neonatal life support training every year. In addition, the team involved in management of the deteriorating newborn infant are required to be compliant with this training.

Staff groups required to attend are as follows –

- Neonatal consultants and paediatric consultants covering the neonatal unit
- Neonatal junior doctors who attend any births
- Neonatal nurses (B5 and above)
- Advanced Neonatal Nurse Practitioners
- Midwives

For maternity unit staff, NLS training is included in the PROMPT study day. For neonatal unit staff, this training is achieved in one of the following training sessions –

- Formal Neonatal Life Support one day training course
- NLS training carried out at junior doctor induction – facilitated by a trained NLS instructor
- In house refresher updates – facilitated by a trained NLS instructor
- PROMPT training – attended by neonatal nurses and midwives
- APLS in the last 12m, including NLS training session

Only Neonatal Band 6 nurses attend deliveries and take part in immediate resuscitation of the newborn. A minimum of two Band 6 nurses are also present in each neonatal unit at any time and take responsibility for management of the deteriorating newborn infant requiring resuscitation. However, since B5s may be involved in the initial management of the deteriorating newborn, they have also been included in the training and the data as per MIS guidance.

Due to current workforce pressures, it was agreed that Trusts may include December 2022, with the cut off date being 5th Jan 2023, as part of evidence for this MIS submission. Cross-site training compliance is therefore given for the period 06/01/22 to 05/01/23 as follows –

Staff Group	Total number	Number compliant	% Compliance
Paediatric / neonatal Consultants	22	20	90.9%
Paediatric / neonatal Doctors	43	41	95.3%
Neonatal nurses (B5 and above)	72	66	91.7%
ANNPs	3	3	100%
Midwives	312	291	93.3%