The Shrewsbury and Telford Hospital NHS Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC
Thursday 12 October 2023

CNST INFORMATION PACK

TO ACCOMPANY AGENDA ITEM 129/23 – INTEGRATED MATERNITY REPORT

No.	Name of Report	Appendices Included	Where previously received	Date received
1	CNST MIS Year 5 progress report – June 2023	Appendix 1: CNST MIS YEAR 5	Maternity Governance W&C Divisional Committee QSAC	27 June 23 27 June 23 28 June 23
2	CNST MIS Year 5 progress report – July 2023	Appendix 1: NHSR update email Appendix 2: PMRT quarterly report Q1 2023 Appendix 3: Transitional Care audit report Q1 2023 Appendix 4: ATAIN report Q1 2023 Appendix 5: Obstetric Workforce Paper	Maternity Governance W&C Divisional Committee QSAC LMNS	17 July 23 25 July 23 26 July 23 18 Sept. 23
3	CNST MIS Year 5 progress report – August 2023	Appendix 1: MIS Year 5 Update V1.1 July 2023 Appendix 2: Neonatal medical workforce paper Appendix 3: Saving Babies Lives report Appendix 4: Pre-term Birth Appendix 5: Small for gestational age	Maternity Governance W&C Divisional Committee QSAC LMNS	21 Aug 23 22 Aug 23 01 Sept 23 TBC - Oct
4	CNST MIS Year 5 progress report – September 2023	Appendix 1: SBL progress report Appendix 2 : SBL divergence paper Appendix 3: Quad/Board safety champion minutes	Maternity Governance W&C Divisional Committee QSAC LMNS	15 Sept. 23 26 Sept. 23 27 Sept. 23 TBC - Nov
5	Safety Champions Report September 2023	Appendix 1: Safety champions June 23 Appendix 2: Safety champions July 23 Appendix 3: Safety champions August 23	W&C Divisional Committee MTAC QSAC	26 Sept. 23 12 Sept. 23 27 Sept. 23
6	Safety Champions Dashboard Q1	N/A	Maternity Governance Neonatal Governance	September 23 TBC

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 12 October 2023

Agenda item		129/23 Paper 1 within CNST INFORMATION PACK		
Report Title		CNST Maternity Incentive Scheme Year 5		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Annemarie Lawrence, Director of Midwifery		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF4,
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners		
Consultation Communication		N/a		
Executive summary:		1. The Board's attention is drawn to safety action 6 and 8, both of which have risks to delivery as noted within section 12. 2. The risks are that the Trust may not achieve all 10 safety actions this year and therefore will not achieve its CNST rebate 3. We are currently working through the safety actions whilst contributing to a regional collective challenge which will be submited by the Regional Chief Midwife pertaining to SA8.		
Recommendations for the Board:		The Board is asked to: Review and discuss this paper and note the risks to delivery for the scheme.		
Appendices:		Appendix 1: CNST MIS YEAR 5		

1.0 Introduction

1.1 SaTH is a member of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), which is regulated by NHS Resolution (NHSR) and is designed to support the delivery of safer maternity care.

1.2 The scheme incentivises ten maternity safety actions. 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.

1.3 Year 5 guidance was published on 31 May 2023 and references a relevant time period of 30 May 2023 until 7 December 2023 for delivery of the scheme.

1.4 This also includes a self-declaration deadline of **noon on 1 February 2024.**

1.5 The purpose of this paper is to provide the Committee with:

- 1.5.1 Details of the standards within year 5 of the scheme that must be evidenced between now and the reporting deadline.
- 1.5.2 Any risks to the delivery of the scheme under the new safety actions technical guidance.

2.0 Safety Action 1: "Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?"

Required standard	a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from **30 May 2023,** MBRRACE-UK surveillance information should be completed within one calendar month of the death. b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from **30 May 2023** onwards. c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from **30 May 2023.** 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months. d) Quarterly reports should be submitted to the Trust Executive Board from **30 May 2023.**

2.1 This safety action is in keeping with the guidance from year 4

2.2 Completion of the MBRRACE-UK surveillance information is undertaken as standard as part of divisional business as usual (BAU) processes and the tool is completed as soon as possible following notification of the event

2.3 All parents are notified of the PMRT review, and their views sought for inclusion

2.4 QSAC has received a report each quarter since August 2021 detailing all eligible cases and gradings of care.

2.5 In line with the technical guidance of the new scheme, subsequent reports will include any themes identified and their consequent action plans and will evidence that the required standards a), b) and c) have been met.

2.6 **Progress Status: on track**

3.0 Safety Action 2: "Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?"

Required standard

This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.

1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023.

2. July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)

3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:

Midwifery Continuity of carer (MCoC)
Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable.
i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.

ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.

These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Final data for July 2023 will be published in October 2023.

If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information).

4. Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.

5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.

3.1 The required standards detailed above are predominately the same as the standards required for year 4 of the scheme, however Trusts must achieve 10 out of 11 CQIMS in year 5.

3.2 NHS Digital, who oversee this Safety Action, will confirm whether SaTH have uploaded all required data points to the Maternity Services Data Set (including the 11 Clinical Quality Information Metrics) at the required standard of data quality; this will be

confirmed in October 2023 based on the data submitted in the month of July 2023 (which is the month against which the standard is tested).

3.3 This safety action does not appear to be at risk based on the information known to date

3.4 **Progress status: on track**

4. Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

Required standard

a) Pathways of care into transitional care (TC) 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) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.

c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.

4.1 The Trust operates a Transitional Care service and associated pathway that continues to meet the national target of Avoiding Term Admission into the Neonatal Unit (ATAIN).
4.2 Evidence standards for b) requires a quarterly audit of 'Avoiding Term Admission into the Neonatal Unit' (ATAIN) to be conducted and these audits have been embedded into practice as part of the divisions governance cycle of business.
4.3 Evidence standards for c) require a quarterly audit of babies above 34 weeks gestation to evidence admission to Transitional Care in line with the guidance produced for standard a).

4.2 Progress Status: on track

5. Safety Action 4: "Can you demonstrate an effective system of clinical workforce planning to the required standard?"

Required standard

a) **Obstetric medical workforce**

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. currently work in their unit on the tier 2 or 3 rota

or

b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)

or

c. hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations

b) Anaesthetic medical workforce

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 patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

c) Neonatal medical workforce

The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing.

If the requirements **have not been met** in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies.

If the requirements **had been met** previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

d) Neonatal nursing workforce
The neonatal unit meets the BAPM neonatal nursing standards.
If the requirements **have not been met** in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies.
If the requirements **had been met** previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies.
Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

5.1 The above standards have been updated for Year 5 and in keeping with Year 4 of CNST, there is an action plan in place to evidence progress against the standard.
5.3 While the funding is in place to meet this standard, delivery is currently at risk due to staffing challenges within this speciality.
5.4 Progress Status: on track

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

Required standard

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 five reporting period.

6.1 The speciality last completed a full Birthrate Plus (BR+) workforce assessment in the Summer of 2022, with the report shared with the Trust in October 2022.
6.2 The above required standards are evidenced within the bi-annual midwifery staffing report which is presented to Board under standard e); last received at Board in June 2023 with data from Q3/4 of 2022/23.
6.3 Additionally, the service submits a monthly midwifery staffing paper to the Trusts workforce meeting which captures standards c) and d) above; this meeting is chaired by the Director of Nursing (DoN).
6.4 The next bi-annual staffing paper will be written using data from Q1/2 of 2023 so will not be received at Trust Board until Autumn 2023.
6.5 Progress status: on track

7.0 Safety Action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Required standard

1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.

2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available

7.1 The Saving Babies Lives Care Bundle V3 was published in May 2023 alongside Year 5 of CNST MIS.
7.2 This year has seen the introduction of a new 6th element 'Management of pre-existing diabetes
7.3 Trusts are asked to hold quarterly improvement discussions with the ICB using the new national implementation tool once available however this is the Midlands Perinatal tool that SaTH have been using this tool since 2022 which is now being rolled out nationally.
7.4 Progress Status: at risk

8.0 Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Required standard

1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023). Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.

2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.

3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.

8.1 The productive partnership between SaTH and the Maternity Voices Partnership continues to yield important outcomes for service users and staff alike.
8.2 The maternity voices partnership will be known as the maternity and neonatal voices partnership in line with the 3-year delivery plan.
8.3 Mechanisms are in place to ensure service user representation via the MNVP at all key leadership appointments, and various opportunities are available to ensure true coproduction in practice.
8.4 Progress Status: on track

9.0 Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Required standard and minimum evidential requirement

1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.
2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.
3. The plan is developed based on the "How to" Guide developed by NHS England.

9.1 The Trust has been fortunate to be approached to participate in the NHSE Pilot of version 2 of the Core Competency Framework.
9.2 This safety action is at risk due to:

- The stipulation within the technical guidance namely that 'this action should be calculated as the 12 consecutive months from the end date used to inform percentage compliance to meet Safety Action 8 in the year 4 scheme'.
- There is a financial cost associated with the increase in training days required to deliver against this ask. There is a business case currently making its way through divisional processes whereby the number of training days required to meet this ask is increased
- The Midlands regional DoMs group have collectively shared their concerns with region pertaining to this, namely Janet Driver, Regional Chief Midwife for the Midlands who is planning to submit a regional challenge to NHS Resolution on our behalf.

9.3 Progress Status: at risk

10. 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?

Required standard

a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.

b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.

c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.

10.1 Principle 1 of the PQSM model is made up of the following

- To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry.
- That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board.

- That all maternity Serious Incidents (SIs) are shared with trust boards and the LMS, in addition to reporting as required to HSIB.
- To use a locally agreed dashboard to include, as a minimum, the measures set out in Appendix 2, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.
- Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMS) lead and regional chief midwife, formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need.
- To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.

10.2 Standard b) refers to the Trusts claims Scorecard data which should be reviewed alongside incident and complaints data and used to agree targeted interventions aimed at improving patient safety which are then reflected in the Trusts Patient Safety Incident Response Plan. This should be undertaken at least twice in the MIS reporting year and is currently scheduled for July and October 2023.

10.3 standard c) requires that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available by no later than 1st July 2023.

10.4 Progress Status: on track.

11. Safety Action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?

Required standard

A) Reporting of all qualifying cases to HSIB/CQC//MNSI from **30 May 2023** to **7 December 2023.**

B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from **30 May 2023** until **7 December 2023**.

C) For all qualifying cases which have occurred during the period 30 May 2023 to 7 December 2023, the Trust Board are assured that:

i. the family have received information on the role of HSIB/CQC/MNSI and NHS Resolution's EN scheme; and

ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour

11.1 The CQC involvement is new for this year (from October 2023) so this will be added to the information already being given to parents; otherwise, this safety action is unchanged from year 4 and is embedded into our processes as BAU.

11.2 Progress Status: on track.

12. Risks to Delivery

There is a risk that…	The risk is caused by…	The potential impact of the risk is…	The mitigation in place is…
The Trust may not achieve element 6 of SBLCB V3	This is a new element this year which we are working through	Failure of safety action 6	This is a new ask this year for which we are currently working through
The Trust may miss the 90% target for PROMPT training for midwives and support staff	Training having expired for some colleagues within this staff group and the technical guidance for CNST Year 5 has changed	Failure of safety action 8	Training is scheduled to take place as soon as reasonably practical The region are raising a challenge to this action as the previous year the 90% target was for all staff groups whereas this year it is for individual staff groups and goes back to the date of submission for the end date used to inform the year 4 submission.

13. Summary

13.1 SaTH is mostly on track to achieve CNST MIS Year 5, although there is a risk to delivery for Safety Action 8 pertaining to training compliance however this is being challenged through a regional collective.

13.2 **Summary of safety action statuses**

Safety Action #	Completion Status
1	On Track
2	On Track
3	On Track
4	On Track
5	On Track
6	At Risk
7	On Track
8	At Risk
9	On Track
10	On Track

14. Actions requested of the Board of Directors

14.1 Review and discuss this paper, and note the risks to delivery for the scheme.

NHS Resolution

Maternity Incentive Scheme – year five

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

May 2023

Contents

Introduction

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved **all** of the **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 small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Maternity incentive scheme year five: conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution nhsr.mis@nhs.net by **12 noon** on **1 February 2024** and must comply with the following conditions:

- Trusts must achieve **all** ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
- The Trust Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:
    - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
    - There are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before **1 February 2024**.
- The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions'

evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution

- Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested as explained above.
- Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.
- Trusts will need to report compliance with MIS by **1 February 2024** at **12 noon** using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/Integrated Care System.
- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.

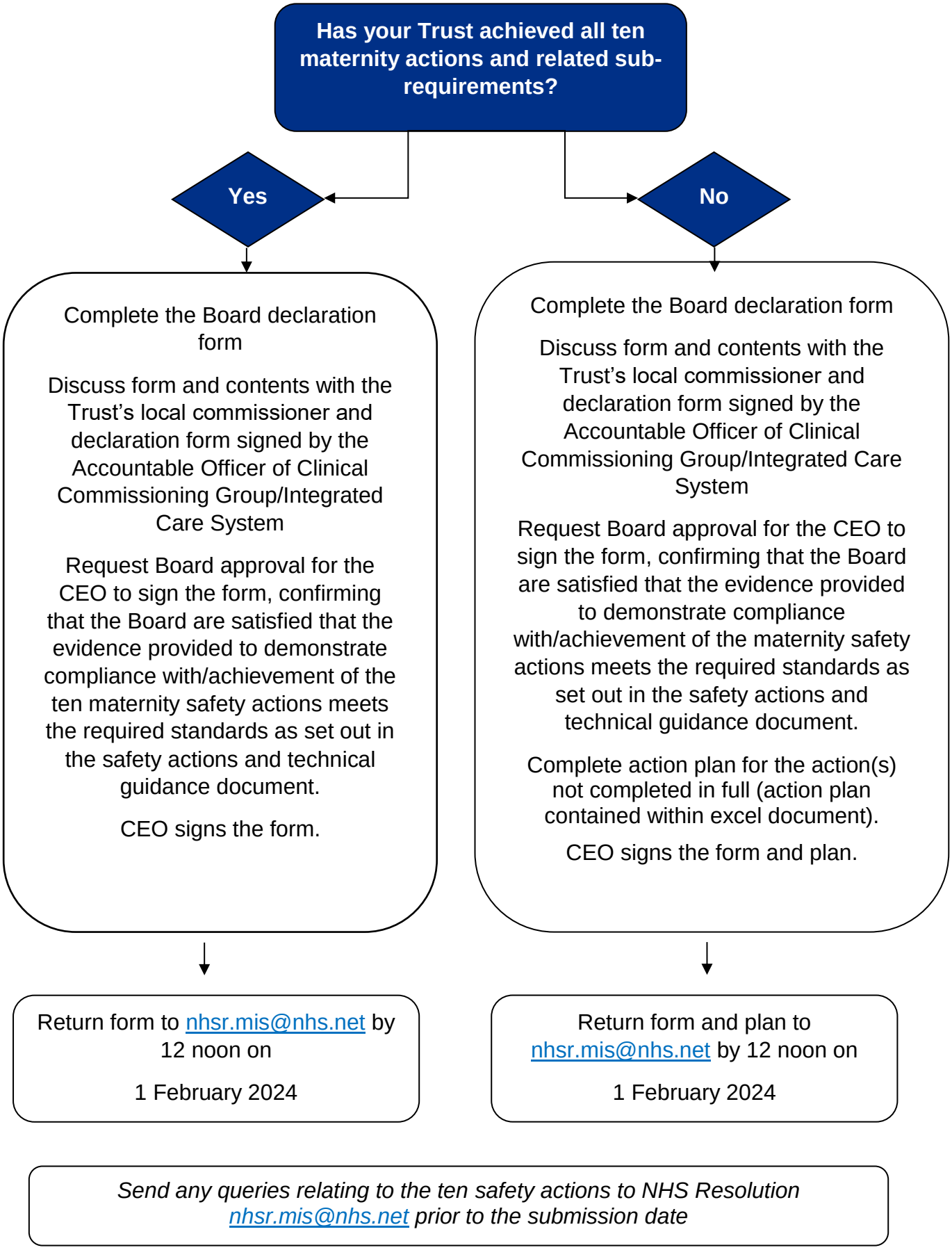
- The Board declaration form will be available on the MIS webpage at a later date.
- Trusts are reminded to retain all evidence used to support their position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described above) it must be made available as it was presented to support Board assurance at the time of submission.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution nhsr.mis@nhs.net prior to the submission date.
- The Board declaration form must be sent to NHS Resolution nhsr.mis@nhs.net between **25 January 2024** and **1 February 2024** at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from submission date.
- Submissions and any comments/corrections received after **12 noon** on **1 February 2024** will not be considered.
- The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.
- There are two possible grounds for appeal
    - alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation
    - technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.
- NHS Resolution clinical advisors will review all appeals to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.
- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.
- Further detail on the results publication, appeals window dates and payments process will be communicated at a later date.

For Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 1 February 2024 to NHS Resolution nhsr.mis@nhs.net. The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form. Action plans should not be submitted for achieved safety actions.


Has your Trust achieved all ten maternity actions and related sub-requirements?
Yes
No
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
CEO signs the form.
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
Complete action plan for the action(s) not completed in full (action plan contained within excel document).
CEO signs the form and plan.
Return form to nhsr.mis@nhs.net by 12 noon on
1 February 2024
Return form and plan to nhsr.mis@nhs.net by 12 noon on
1 February 2024
Send any queries relating to the ten safety actions to NHS Resolution nhsr.mis@nhs.net prior to the submission date

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Required standard	a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from **30 May 2023,** MBRRACE-UK surveillance information should be completed within one calendar month of the death. b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from **30 May 2023** onwards. c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from **30 May 2023.** 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months. d) Quarterly reports should be submitted to the Trust Executive Board from **30 May 2023.**
Minimum evidential requirement for Trust Board	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal). The PMRT must be used to review the care and reports should be generated via the PMRT. A report has been received by the Trust Executive Board each quarter from **30 May 2023** that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Verification process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.
What is the relevant time period?	From **30 May 2023** until add **7 December 2023**

What is the deadline for reporting to NHS Resolution?	**12 noon** on **1 February 2024**

Technical guidance for safety action 1

Further guidance and information is available on the PMRT website: Maternity Incentive Scheme FAQs. This includes information about how you can use the MBRRACE-UK/PMRT system to track your notifications and reviews: www.npeu.ox.ac.uk/pmrt/faqsmis; these FAQs are also available on the MBRRACE-UK/PMRT reporting website www.mbrrace.ox.ac.uk.

Technical Guidance **Guidance for SA 1(a) – notification and completion of surveillance information**	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal death must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
Where are perinatal deaths notified?	Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website. It is planned that a single notification portal (SNP) will be released by NHS England in 2024. Once this is released notifications of deaths must be made through the SNP and this information will be passed to MBRRACE-UK. It will then be necessary for reporters to log into the MBRRACE-UK surveillance system to provide the surveillance information and use the PMRT.
Should we notify babies who die at home?	Notification and surveillance information must be provided for babies who died after a home birth where care was provided by your Trust.
What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK from 30 May 2023 onwards must be notified to MBRRACE-UK within seven working days.
What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route of reporting for neonatal deaths that will be via MBRRACE-UK. Once this single route is established, MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP) and the NCMD. At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required

	mechanism for completing the local review for submission to CDOP. This will also be the required route for providing additional information about the death required by both CDOPs and the NCMD. Work is underway to provide this single route of reporting with plans to have this in place in the forthcoming months
Are there any exclusions from completing the surveillance information?	If the surveillance form needs to the assigned to another Trust for additional information then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts, should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.
Guidance for SA1(b) – parent engagement	
We have informed parents that a local review will take place and they have been asked if they have any reflections or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order that parents' perspectives and questions can be considered during the review this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. The importance of parents' perspectives is highlighted by their inclusion as the first set of questions in the PMRT. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
We have contacted the parents of a baby who has died and they don't wish to have any involvement in the review process. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their perspective and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.

Parents have not responded to our messages and therefore we are unable to discuss the review. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will also be undertaken by the local CDOP. Verbal information can be supplemented by written information. If, for any reason, this does not happen and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of the role of key contact, are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
Guidance for SA1(c) – conducting reviews	
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: • All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) • All stillbirths (from 24+0 weeks' gestation) • Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth) While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet the safety action one standard.
What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session (which might be the first session of several) for that death. As an absolute minimum all the 'factual' questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review. The factual questions are highlighted within the PMRT with the symbol: FQ
What is meant by "reviews should be completed to the draft report	A multidisciplinary review team should have used the PMRT to review the death, then the review progressed to at least the stage of writing a draft report by pressing 'Complete review'. See

stage completed to the draft report stage"?	www.npeu.ox.ac.uk/pmrt/faqsmis for more details of assistance in using the PMRT to complete a review.
What does "multi-disciplinary reviews" mean?	To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include a member from a relevant professional group who is external to the unit who can provide 'a fresh pair of eyes' as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member. Bereavement care staff (midwives and nurses) should form part of the review team to provide their expertise in reviewing the bereavement and follow-up care, and advocate for parents. It should not be the responsibility of bereavement care staff to run the reviews, chair the panels nor provide administrative support. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details about multi-disciplinary review.
What should we do if our post-mortem service has a turn-around time in excess of four months?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than four months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death and complete it with the information you have available. When the post-mortem results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing earlier learning opportunities, especially if the turn-around time is considerably longer than four months. Where the post-mortem turn-around time is quicker, then the information from the post-mortem can be included in the original review.
What is review assignment?	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided.
How does 'assigning a review' impact on safety action 1,	If you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the external validation process.

especially on starting a review?	
What should we do if we do not have any eligible perinatal deaths to review within the relevant time period?	If you do not have any babies that have died between **30 May 2023** and **7 December 2023** you should partner up with a Trust with which you have a referral relationship to participate in case reviews. This will ensure that you benefit from the learning that arises from conducting reviews.
What deaths should we review outside the relevant time period for the safety action validation process?	Trusts should review all eligible deaths using the PMRT as a routine process, irrespective of the MIS timeframe and validation process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 5 MIS requirements.
Guidance for SA1(d) – Quarterly reports to Trust Boards	
Can the PMRT help by providing a quarterly report that can be presented to the Trust Executive Board?	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews over a period, within the PMRT for user-defined time periods. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for quarterly Trust Board reports and should be discussed with Trust maternity safety champions.
Is the quarterly review of the Trust Executive Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for the Trust Executive Board summarising the results from reviews over a period time which have been completed can be generated within the PMRT by authorised PMRT users for a user-defined periods of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. Please note that these reports will only show summaries, issues and action plans for reviews that have been published therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months.
Guidance – Technical issues and updates	
What should we do if we experience technical issues with using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK.

	This can be done through the ‘contact us’ facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk
If there are any updates on the PMRT for the maternity incentive scheme where will they be published?	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the maternity incentive scheme safety action 1, will be communicated via NHS Resolution email and will also be included in the PMRT ‘message of the day’.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required standard	This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023. 2. July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) 3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: **Midwifery Continuity of carer (MCoC)** **Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable.** i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Final data for July 2023 will be published in October 2023.

	If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information). 4. Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023. 5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.
Minimum evidential requirement for Trust Board	The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.
Validation process	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
What is the relevant time period?	From **30 May 2023** until **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024** at 12 noon

Technical guidance for safety action 2

Technical guidance	
The following CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on these three months? • **Proportion of babies born at term with an Apgar score <7 at 5 minutes** • **Women who had a postpartum haemorrhage of 1,500ml or more** • **Women who were current smokers at delivery** • **Women delivering vaginally who had a 3rd or 4th degree tear** • **Women who gave birth to a single second baby vaginally at or after 37 weeks after a previous caesarean section** • **Caesarean section delivery rate in Robson group 1 women** • **Caesarean section delivery rate in Robson group 2 women** • **Caesarean section delivery rate in Robson group 5 women**	No. For the purposes of the CNST assessment Trusts will only be assessed on July 2023 data for these CQIMs. Due to this, Trusts are now directed to check whether they have passed the requisite data quality required for this safety action within the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series, as the national Maternity Services DashBoard will still display these data using rolling counts.
My maternity service has currently suspended Midwifery Continuity of Carer pathways. How does this affect my data submission for CNST safety action 2?	If maternity services have suspended Midwifery Continuity of Carer (MCoC) pathways, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102. This is a satisfactory response for safety action 2 criteria 3i. If your Trust has suspended all MCoC pathways, criteria 3ii is not applicable and does not need to be completed. If your Trust is continuing with some provision of MCoC pathways, then criteria 3ii does still apply.

Will my Trust fail this action if women choose not to receive continuity of carer?	No. This action is focussed on data quality only and therefore Trusts pass or fail it based upon record completeness for each metric and not on the proportion (%) recorded as the metric output. If women choose not to be placed onto a MCoC pathway, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102.
Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass CQIMs and other metrics specified above can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics
What is the Data Quality Submission Summary Tool? How does my Trust access this?	The Data Quality Submission Summary Tool has been developed by NHS England specifically to support this safety action. The tool provides an immediate report on potential gaps in data required for CQIMs and other metrics specified above after data submission, so Trusts can take action to rectify them. It is intended to be used alongside other existing reports and documentation in order for providers to be able to create a full and detailed picture of the quality of their data submissions. Further information on the tool and how to access it is available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/data-quality-submission-summary-tool
For the Data Quality Submission Summary Tool, what does "sustained engagement" mean for the purposes of passing criteria 3?	By "sustained engagement" we mean that Trusts must show evidence of using the tool for at least three consecutive months prior to the submission of evidence to the Trust Board. For example, for a submission made to the Board in November, engagement should be, as a minimum, in August, September and October. This is a minimum requirement and we advise that engagement should start as soon as possible. To evidence this, Trusts should save the Excel output file after running the report for a given month. Three files representing each of the three consecutive months should be provided to your Trust Board as part of the assurance process for the scheme. Note – this only becomes a requirement in the event your Trust fails the requisite data quality for the continuity of carer metrics in criteria 3.

The monthly publications and Maternity Services DashBoard states that my Trusts' data has failed for a particular metric. Where can I find out further information on why this has happened?	Details of all the data quality criteria can be found in the "Meta Data" file (see 'CQIMDQ/CoCDQ Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics The scores for each data quality criteria can be found in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series
The monthly publications and national Maternity Services DashBoard states that my Trusts' data is 'suppressed'. What does this mean?	Where data is reported in low values for clinical events, the published data will appear 'suppressed' to ensure the anonymity of individuals. However, for the purposes of data quality within this action, 'suppressed' data will still count as a pass.
Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services DashBoard please contact maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

Required standard	a) Pathways of care into transitional care (TC) 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) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB. c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.
Minimum evidential requirement for Trust Board	**Evidence for standard a) to include:** Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.
	Evidence for standard b) to include: • Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks. • Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks.

	• Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan. • Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan.
	Evidence for standard c) to include: Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring **OR** An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	**30 May 2023** to **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024**

Technical guidance for safety action 3

Technical guidance	
Does the data recording process need to be available to the ODN/LMNS/ commissioner?	The requirement for a data recording process from years three and four of the maternity incentive scheme was to inform future capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review. This should be in place and maintained in order to inform ongoing capacity planning of transitional care to minimise separation of mothers and babies. This could be captured through existing systems such as BadgerNet or alternatives such as paper based or electronic systems. These returns do not need to be routinely shared with the Operational Delivery Network (ODN), LMNS and/or commissioner but must be readily available should it be requested.
What members of the MDT should be involved in ATAIN reviews?	The expectation is that this is a multi-professional review, as a minimum the care should be reviewed by representation from both maternity and neonatal staff groups. This should include as a minimum; a member of the maternity team (a midwife and / or obstetrician and /or trainee from maternity services) and a member of the neonatal team (neonatal nurse and / or neonatologist/paediatrician and/or trainee from neonatal services).
We have undertaken some reviews for term admissions to NICU, do we need to undertake more and do all babies admitted to the NNU need to be included?	Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the Avoiding Term Admissions into Neonatal Units (ATAIN) work to date. The expectation is that reviews have been continued from year 4 of the scheme. If for any reason, reviews have been paused, they should be recommenced using data from quarter 4 of the 2022/23 financial year (beginning January 2023). This may mean that some of the audit is completed retrospectively. We recommend ongoing reviews, at least quarterly of unanticipated admissions of babies >36 weeks to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan. This review includes A high-level review of the primary reasons for all admissions should be completed, with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed. For example, if 60% of babies are admitted for respiratory problems, then focus on this cohort of babies and complete a deep dive into identified themes or if 40% of babies were admitted with jaundice and 35% of babies were admitted with hypothermia then focus on these two cohorts of babies.

	In addition to this, the number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues and the number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on.
What do mean by quarterly?	Occurring every three months. This would usually mirror the 4 quarters of the financial year, and should cover the period of the MIS **30 May 2023 – 7 December 2023**.
TC audit – what should the audit include and is there a standard audit tool?	An audit tool can be accessed below as a baseline template, however the audit needs to include aspects of the local pathway.  ATAIN%20CASE%20 NOTE%20REVIEW%2(We recommend that Trusts refer to the auditable standards included in their local TC pathway guideline/policy.
How long have the neonatal safety champions been in place for?	Trust Board champions were contacted in February 2019 and asked to nominate a neonatal safety champion. The identification of neonatal safety champions is a recommendation of the national neonatal critical care review and have been in place since February/March 2019.
What is the definition of transitional care?	Transitional care is not a place but a service (see BAPM guidance) and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/

	https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Illness-in-newborn-babies-leaflet-FINAL-070420.pdf Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk)

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required standard	a) **Obstetric medical workforce** 1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums. 2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf 3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-compensatory-rest.pdf 4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations

listed 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/ 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 the Trust Board, the Board-level safety champions as well as LMNS.

b) Anaesthetic medical workforce

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 patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

c) Neonatal medical workforce

The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing.

If the requirements **have not been met** in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies.

If the requirements **had been met** previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies.

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.

	If the requirements **have not been met** in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies. If the requirements **had been met** previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).
Minimum evidential requirement for Trust Board	**Obstetric medical workforce** 1) Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses. Information on the certificate of eligibility (CEL) for short term locums is available here: www.rcog.org.uk/cel This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk 2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS.

	3) Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations. **NB**. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG **Anaesthetic medical workforce** The rota should be used to evidence compliance with ACSA standard 1.7.2.1. **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN). **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form.
What is the relevant time period?	**Obstetric medical workforce** 1. After February 2023 – Audit of 6 months activity 2. After February 2023 – Audit of 6 months activity 3. 30 May 2023 - 7 December 2023 4. 30 May 2023 - 7 December 2023 **Anaesthetic medical workforce** Trusts to evidence position by 7 December 2023 at 12 noon **Neonatal medical workforce** A review has been undertaken of any 6 month period between **30 May 2023 – 7 December 2023** **a) Neonatal nursing workforce** Nursing workforce review has been undertaken at least once during year 5 reporting period **30 May 2023 – 7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024**

Technical guidance for safety action 4

Technical guidance	
Obstetric workforce standard and action	
How can the Trust monitor adherence with the standard relating to short term locums?	Trusts should establish whether any short term (2 weeks or less) tier 2/3 locums have been undertaken between February and August 2023. Medical Human Resources (HR) or equivalent should confirm that all such locums met the required criteria.
What should a department do if there is non-compliance i.e. locums employed who do not meet the required criteria?	Trusts should review their approval processes and produce an action plan to ensure future compliance.
Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.
Where can I find the documents relating to short term locums?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to long term locums?	Trusts should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance for 6 months after February 2023 and prior to submission to the Trust Board and have a plan to address any shortfalls in compliance.
What should a department do if there is a lack of compliance demonstrated in the audit tool regarding the support and supervision of long term locums?	Trusts should review their audits and identify where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if long term locums are employed who are not fully supported/supervised?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.

Where can I find the documents relating to long term locums?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to Standard operating procedures for consultants and SAS doctors acting down?	Trusts should provide documentary evidence of standard operating procedures and their implementation Evidence of implementation/compliance could be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.
What should a department do if there is a lack of compliance, either no Standard operating procedure or failure to implement such that senior medical staff are unable to access compensatory rest?	Trusts should produce a standard operating procedure document regarding compensatory rest. Trusts should identify any lapses in compliance and where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if we do not have a standard operating procedure or it is not fully implemented?	Trusts cannot self-certify if they have no evidence of any standard operating procedures by **October 2023**. They can self-certify if they have been unable to achieve appropriate compensatory rest in individual circumstances such as excessive staffing pressure have prevented the doctor accessing this. They should, however, demonstrate that they have an action plan to ensure future compliance and provide assurance to the Board that this is place.
Where can I find the documents relating to compensatory rest for consultants and SAS doctors?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to consultant attendance out of hours?	For example, departments can audit consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Departments may also wish to monitor adherence via incident reporting systems. Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	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.

Can we self-certify compliance with this element of safety action 4 if consultants have not attended clinical situations on the mandated list?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non-attendances. These can be signed off by the Trust Board.
Where can I find the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/
For queries regarding this safety action please contact: nhsr.mis@nhs.net and RCOG	

Anaesthetic medical workforce

Technical guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard and action	
1.7.2.1	**A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. 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.**

Neonatal medical workforce

Technical guidance	
Neonatal Workforce standards and action	
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If not, Trust Board should agree an action plan and outline progress against any previously agreed action plans. There should also be an indication whether the standards not met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap) alongside a record of the rota tier affected by the gaps. This action plan should be submitted to the LMNS and ODN.
BAPM **"Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021** **or** **"Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018**	

NICU **Neonatal Intensive Care Unit**	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff during office hours and out of hours. **Tier 1** Resident out of hours care should include a designated tier one clinician - Advanced Neonatal Nurse Practitioner (ANNP) or junior doctor ST1-3. NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice. **Tier 2** A designated experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP. NICUs with more than 2500 intensive care days should have an additional experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. (A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative) **Tier 3** Consultant staff in NICUs should be on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on the neonatal unit alone. NICUs undertaking more than 4000 intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day. NICUs undertaking more than 2500 intensive care days per annum should consider the presence of at least 2 consultant led teams during normal daytime hours. NICUs undertaking more than 4000 intensive care days per annum should consider the presence of three consultant led teams during normal daytime hours.
LNU	**Tier 1**

Local Neonatal Unit	At least one resident tier 1 practitioner immediately available dedicated to providing emergency care for the neonatal service 24/7. In large LNUs (>7000 births) there should be two dedicated tier 1 practitioners 24/7 to support emergency care, in keeping with the NICU framework. **Tier 2** 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. LNUs undertaking either >1500 Respiratory Care Days (RCDs) or >600 Intensive Care (IC) days annually should have immediately available a dedicated resident tier 2 practitioner separate from paediatrics 24/7. **Tier 3** Units designated as LNUs providing either >2000 RCDs or >750 IC days annually should provide a separate Tier 3 Consultant rota for the neonatal unit. LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs. All LNUs should ensure that all Consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system and no consultant should undertake fewer than 4 'consultant of the week' service weeks annually. No on-call rota should be more onerous than one in six and all new appointments to units with separate rotas should either have a SCCT in neonatal medicine or be a general paediatrician with a special interest in neonatology or have equivalent neonatal experience and training**.**
SCU **Special Care Unit**	**Tier 1**

	A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. **Tier 2** A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit. **Tier 3** In SCUs there should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology).
Our Trust do not meet the relevant neonatal medical standards and in view of this an action plan, ratified by the Board has been developed. Can we declared compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.
When should the review take place?	The review should take place at least once during the MIS year 5 reporting period.
Please access the followings for further information on Standards	BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021). A BAPM Framework for Practice https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021 Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018). A BAPM Framework for Practice https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018

Neonatal nursing workforce

Technical guidance	
Neonatal nursing workforce standards and action	
Where can we find more information about the requirements for neonatal nursing workforce?	Neonatal nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here: https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf Access to the tool and more information will be available through your Neonatal ODN Education and Workforce lead nurse.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

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

Required standard	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 five reporting period.
Minimum evidential requirement for Trust Board	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

	• Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. ○ The midwife to birth ratio ○ The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	30 May 2023 – 7 December 2023
What is the deadline for reporting to NHS Resolution?	**1 February 2023** at **12 noon**

Technical guidance for Safety action 5

Technical guidance	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice**.	• Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care or care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to midwives at birth when required, supporting junior

	midwives undertaking suturing etc. This should not be counted as losing supernumerary status.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board, and includes a timeline for when this will be achieved. As stated above, completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 5 of MIS.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board, and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Required standard	1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024. 2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available
Minimum evidential requirement for Trust Board	1) The Three Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024. A new implementation tool will be available by the end of June to help maternity services to track and evidence improvement and compliance with the requirements set out in Version Three. The tool will be based on the interventions, key process and outcome measures identified within each element, so providers can begin implementation of the Care Bundle Version 3 now with confidence, while the tool undergoes final user testing. Providers should use the new national implementation tool to track and compliance with the care bundle once this is made available, and share this with the Trust Board and ICB. To evidence adequate progress against this deliverable by the submission deadline in February, **providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.** These percentages will be calculated within the national implementation tool once available. 2) Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following: • Use of the implementation tool once it is made available.

	• Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.

Technical guidance for Safety action 6

Technical guidance	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: https://www.england.nhs.uk/publication/saving-babies-lives-version-three/ This will include details on the Saving Babies' Lives Care Bundle v3 Implementation tool, and a link to the SBLCB v3 Technical Glossary once available which will include the numerators and denominators for all of the process indicators. Any queries related to the **digital aspects** of this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net Some data items are or will become available on the National Maternity DashBoard National Maternity DashBoard or from NNAP Online For any other queries, please email nhsr.mis@nhs.net
What is the rationale for the change in evidential requirements to SA6 in Year 5?	The broad principles that will apply to the implementation of the standards detailed in the Saving Babies' Lives Care Bundle (version 3) are: The use of the implementation tool (once available) will allow Trusts to track implementation and demonstrate local improvement using the process and outcome indicators within all six elements of the care bundle (for some elements this may only require evidence of a protocol, process or appointed post). These data will form the basis of compliance with safety action 6 of this version of the maternity incentive scheme. This approach acknowledges the increased number and/or size of elements in this new version of the care bundle. The indicators for each of the six elements are set out below. Data relating to each of these indicators will need to be provided via the national implementation tool. ***Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and/or Neonatal System e.g Badgernet and included in the MSDS submissions to NHS Digital in an MSDSv2***

	Information Standard Notice compatible format, including SNOMED-CT coding.
What are the indicators for Element 1	*Process Indicators* i. Percentage of women where CO measurement and smoking status** is recorded at: a. Booking appointment b. 36 week appointment ii. Percentage of smokers* that have an opt-out referral at booking to an in-house tobacco dependence treatment service. ii. Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date. *Outcome Indicators* i. Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks. ii. Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks. *a "smoker" is a pregnant women with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). **Smoking status relates to the outcome of the CO test (>4ppm) and the enquiry about smoking habits.
What are the indicators for Element 2	*Process Indicators* i) Percentage of pregnancies where a risk status for Fetal Growth Restriction (FGR) is identified and recorded at booking. ii) Percentage of pregnancies where a Small for Gestational Age (SGA) fetus is antenatally detected, and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital. iii) Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT). *Outcome Indicators* I. Percentage of live births and stillbirths <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR). II. Percentage of live births and stillbirths >3rd birthweight centile born <39+0 weeks gestation

What are the indicators for Element 3	*Process Indicators* i) Percentage of women who attend with Reduced Fetal Movements (RFM) who have a computerised Cardiotocograph (CTG). ii) Proportion of women who attend with recurrent RFM* who had an ultrasound scan to assess fetal growth. *Outcome Indicators* I. Percentage of stillbirths which had issues associated with RFM management identified using PMRT. II. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation. *There is no accepted definition of what recurrent RFM means; one region of the UK has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation.
What are the indicators for Element 4	*Process Indicators* i. Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors and situational awareness. ii. Percentage of staff who have successfully completed mandatory annual competency assessment. ii. Fetal monitoring lead roles appointed. *Outcome Indicators* i. The percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. *Using the severe brain injury definition as used in Gale et al. 2018[48].
What are the indicators for Element 5	*Process Indicators* *i.* Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU).

	ii. Percentage of women giving birth before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth. iii. Percentage of women giving birth before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth. iv. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive intravenous (IV) intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection. v. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth. vi. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. vii. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth. viii. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (1 to 7 above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation). *Outcome Indicators* I. Mortality to discharge in very preterm babies (National Neonatal Audit Programme (NNAP) definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner). II. Preterm Brain Injury (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: ✓ Germinal matrix/ intraventricular haemorrhage ✓ Post haemorrhagic ventricular dilatation ✓ Cystic periventricular leukomalacia III. Percentage of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue. IV. Maternity care providers will provide outcome data to the Trust Board and share this with the LMNS relating to the incidence of women with a singleton

	pregnancy giving birth (non-viable, liveborn and stillborn) as a % of all singleton births: ✓ In the late second trimester (from 16+0 to 23+6 weeks). ✓ Pre-term (from 24+0 to 36+6 weeks).
What are the indicators for Element 6	*Process Indicators* I. Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc). II. Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes. III. Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets. IV. Demonstrate compliance with Continuous Glucose Monitoring (CGM) training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes. V. Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with Diabetic Ketoacidosis (DKA) during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities and availability of expertise. *Outcome Indicators* I. The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the National Pregnancy in Diabetes (NPID) dashBoard (aiming for >95% of women). II. The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the

	start of the third trimester (aiming for >95% of women). Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.
What considerations need to be made to ensure timely submission of data to evidence implementation and compliance with locally agreed progress measures?	If your Trust is planning on using the maternity dashboard to evidence compliance, please be advised that there is a three-month delay between data submission and publication with MSDSv2 data.
What is the deadline for reporting to NHS Resolution?	**1 February 2024** at **12noon**

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Required standard	1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group. 2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board. 3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.
Minimum evidential requirement for Trust Board	**Evidence should include:** • Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff. • Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support. • The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it. • Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses. • Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.

Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	Trusts should be evidencing the position as **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2023** at 12noon

Technical guidance for Safety action 7

Technical guidance	
What is the Maternity and Neonatal Voices Partnership?	An MNVP listens to the experiences of women, birthing people and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. MNVPs ensure that service user voice is at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the local maternity and neonatal system (LMNS). MNVPs ensure service user voice influences improvements in the safety, quality and experience of maternity and neonatal care.
We are unsure about the funding for Maternity and Neonatal Voices Partnerships	It is the responsibility of ICBs to: Commission and fund MNVPs, to cover each Trust within their footprint, reflecting the diversity of the local population in line with the ambition above.

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Required standard and minimum evidential requirement	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework. 2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. 3. The plan is developed based on the "How to" Guide developed by NHS England.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	12 consecutive months from the end date used to calculate percentage compliance to meet Safety Action 8 in the Year 4 scheme

Technical guidance for safety action 8

Technical guidance	
What training should be covered in the local training plan to cover the six modules of the Core Competency Framework?	A **training plan** should be in place to cover all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 2024. Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework.
How will the 90% attendance compliance be calculated?	The training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups. This should be calculated as the 12 consecutive months from the end date used to inform percentage compliance to meet Safety Action 8 in the Year 4 scheme.

Where can I find the Core Competencies Framework and other additional resources?	• https://www.england.nhs.uk/publication/core-competency-framework-version-two/
	• Includes links to the documents:
	  ○ Core competency framework version two: Minimum standards and stretch targets
	  ○ 'How to' guide - a resource pack to support implementing the Core Competency Framework version two
	  ○ Core competency framework: training needs analysis
	• NHS England V1 of the Core Competency Framework https://www.england.nhs.uk/publication/core-competency-framework/
	• https://www.resus.org.uk/library/2021-resuscitation-guidelines/newborn-resuscitation-and-support-transition-infants-birth
	• A link to forthcoming national intrapartum fetal surveillance programme. (ABC?)
	Toolkit for high quality neonatal services (October 2009)
	http://www.londonneonatalnetwork.org.uk/wp-content/uploads/2015/09/Toolkit-2009.pdf

What training should be included for the Core Competency Framework Version 2?	All 6 core modules in V2 of the Core Competency Framework (CCFv2) must be covered as detailed in the minimum standards. Trusts must be able to evidence the four key principles: 1. Service user involvement in developing and delivering training. 2. Training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports. This should include reinforcing learning from what went well. 3. Promote learning as a multidisciplinary team. 4. Promote shared learning across a Local Maternity and Neonatal System.
Which maternity staff should be included for Module 2: Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric consultants • All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor) • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • MSWs • GP trainees
Which maternity staff should be included for Module 3: Maternity emergencies and multiprofessional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric consultants. • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota.

	• Midwives (including midwifery managers and matrons), community midwives; birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) • Obstetric anaesthetic consultants. • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) **who contribute to the obstetric rota.** • Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS year 5 compliance assessment • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS year 5 compliance • At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff
I am a Medical Obstetric Emergencies and Trauma (MOET) instructor, do I still need to attend the maternity emergencies and multiprofessional training (Module 3)?	Yes, you do still need to attend the maternity emergencies and multiprofessional training (Module 3)
Which staff should be included for Module 6: Neonatal basic life support?	Staff in attendance at births should be included for Module 6: Neonatal basic life support. This includes the staff listed below: • Neonatal Consultants or Paediatric consultants covering neonatal units • Neonatal junior doctors (who attend any births) • Neonatal nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. The staff groups below are not required to attend neonatal basic life support training:

	• All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit). • Local policy should determine whether maternity support workers are included in neonatal basic life support training.
I am a NLS instructor, do I still need to attend neonatal basic life support training?	No, if you have taught on a course within MIS year 5 you do **not** need to attend neonatal basic life support training
I have attended my NLS training, do I still need to attend neonatal basic life support training?	No, if you have attended a course within MIS year 5 you do **not** need to attend neonatal basic life support training as well.
Which members of the team can teach basic neonatal life support training?	Registered RC-trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates
What training should be covered for the neonatal emergencies?	Neonatal emergency scenarios must be run with the neonatal team and aligned with Module 6: Neonatal basic life support
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally determined.

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?

Required standard	a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded. b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings. c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.
Minimum evidential requirement for Trust Board	**Evidence for point a) is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically:** • Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues. • Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs). • To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need. **Evidence for point b)** • Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These discussions must be held at least twice in the MIS reporting period at a Trust level quality

	meeting. This can be a Board or directorate level meeting. **Evidence for point c):** Evidence that the Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme. This will include: • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available. • Evidence in the Board minutes that the work undertaken to better understand the culture within their maternity and neonatal services has been received and that any support required of the Board has been identified and is being implemented.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	**Time period for points a and b)** • Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action should be in place based on previous requirements. The expectation is that if work is still in progress, this will have been completed by 1st July 2023. • The expectation is that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance are continuing to take place at Board level monthly. If for any reason they have been paused, they should be reinstated no later than 1 July 2023. • The expectation is for ongoing engagement sessions with staff as per year 4 of the scheme. If for any reason these have been paused, they should be recommenced no later than 1 July 2023. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions. • Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress

	made on identified concerns raised by staff and service users from no later than the 17th July 2023. • Evidence that a review of the Trust's claims scorecard is undertaken alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting by 17th July 2023. At least one additional meeting must have been undertaken before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review as part of the PSIRF plan. **Time period for points c)** • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available no later than 1 July 2023. • Evidence in the Board minutes that the work undertaken to better understand the culture within their maternity and neonatal services has been received and that any support required of the Board has been identified and is being implemented. This must have been undertaken within 9 months of their teams starting the Perinatal Culture and Leadership 'Quad' Programme.
What is the deadline for reporting to NHS Resolution?	By **1 February 2023** at 12 noon
Where can I find additional resources?	implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) Measuring culture in maternity services: Add in link to Safety Culture Programme for Maternal and neonatal services: https://drive.google.com/file/d/1bzAqOcf5A5XHR8HWBZnLzH6qsG_SgXoa/view?usp=sharin Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme The Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace is a dedicated place for Non-Executive Director and Executive Director maternity and neonatal Board safety

	champions to access the culture and leadership programme, view wider resources and engage with a community of practice to support them in their roles.

Technical guidance for safety action 9

Technical guidance	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local pathway for sharing intelligence updated. This revised pathway should: • Describe the local governance processes in place to demonstrate how intelligence is shared from the floor to Board • Formalise how Trust-level intelligence will be shared with the LMNS/ICS quality group and regional quality groups involving the Regional Chief Midwife and Lead Obstetrician
What do we need to include in the dashBoard presented to Board each month?	The dashBoard can be locally produced, based on a minimum data set as set out in the Board level measures. It must include the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; SUV feedback; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. The dashBoard can also include additional measures as agreed by the Trust.
We had not continued to undertake monthly feedback sessions with the Board safety champion what should we do?	Parts a) and b) of the required standards build on the year three and four requirement of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board safety champions to raise concerns relating to safety. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions as described above. Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three of the maternity incentive scheme and the expectation is that this should have been continued. If these have not been continued, this needs to be reinstated by no later than 1 July 2023.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.

What is the rationale for the Board level safety champion safety action?	It is important to ensure all staff are aware of who their frontline and Board safety champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names of the relevant leaders, will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here https://resolution.nhs.uk/2021/10/28/2021-scorecards-launch/?utm_medium=email&utm_campaign=Resolution%20Matters%20October%202021&utm_content=Resolution%20Matters%20October%202021+CID_ac638a61c8ce1ac278298e3233f234af&utm_source=Email%20marketing%20software&utm_term=2021%20Scorecards%20launch https://resolution.nhs.uk/2020/10/27/claims-scorecards-for-2020/
What are the expectations of the Board safety champions in relation to quality improvement work undertaken by MatNeoSIP?	The Board safety Champions will be expected to continue their support for quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Networks. Trusts will be required to undertake improvement including data collection and testing work aligned to the national priorities.
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will be involved in the Perinatal Culture and Leadership Programme. As part of this programme every service will be undertaking work to meaningfully understand the culture of their services. This will either be a SCORE culture survey or an alternative as agreed with the national NHSE team. It is expected that survey findings are shared with the Trust Board to enable an understanding and garner support for the work to promote optimal safety cultures, based on the survey findings.
What if our maternity and neonatal services are not undertaking the SCORE culture survey as part of the national programme?	The national offer to undertake a SCORE culture was a flexible, opt out offer. If your maternity and neonatal services demonstrated that they were already completing work to meaningfully understand local culture, and therefore opted out of the SCORE survey, the expectation is that the Board receives updates on this alternative work.

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?

Required standard	A) Reporting of all qualifying cases to HSIB/CQC//MNSI from **30 May 2023** to **7 December 2023.** B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from **30 May 2023** until **7 December 2023**. C) For all qualifying cases which have occurred during the period 30 May 2023 to 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB/CQC/MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum evidential requirement for Trust Board	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB/CQC/MNSI/EN incidents and numbers reported to HSIB/CQC/MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of HSIB/CQC/MNSI and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Validation process	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against the HSIB/CQC/MNSI database and the National Neonatal Research Database (NNRD) and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard a) and b) have been met in the relevant reporting period. In addition, for standard C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.

What is the relevant time period?	Reporting to HSIB – from **30 May 2023** to **7 December 2023** Reporting period to HSIB **and** to NHS Resolution – from **30 May 2023** to **7 December 2023**
What is the deadline for reporting to NHS Resolution?	By **1 February 2024** at 12 noon

Technical guidance for Safety action 10

Technical guidance	
Where can I find information on HSIB?	Information about HSIB/CQC/MNSI and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to HSIB/MNSI?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [or] • Was therapeutically cooled (active cooling only) [or] • Had decreased central tone AND was comatose AND had seizures of any kind. Once HSIB/CQC/MNSI have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury.
What is the definition of labour used by HSIB and EN?	The definition of labour used by HSIB includes: • Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation. • When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking). • Induction of labour (when labour is started artificially). • When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.
Changes in the EN reporting requirements for Trust from 1 April 2022 going forward	With effect from 1 April 2022, Trusts have been required to continue to report their qualifying cases to HSIB via the electronic portal. In addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed they are progressing an investigation due to clinical or MRI evidence of neurological injury.

	The Trust must share the HSIB/CQC/MNSI report with the EN team within 30 days of receipt of the final report by uploading the HSIB/CQC/MNSI report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading HSIB/CQC/MNSI reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the HSIB/CQC/MNSI report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where HSIB are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury. • Where a family have declined a HSIB investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution.
Cases that do not require to be reported to NHS Resolution	• Cases where families have requested a HSIB/CQC/MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a HSIB/CQC/MNSI investigation where the baby has a normal MRI. • Cases that HSIB are not investigating.
What if we are unsure whether a case qualifies for referral to HSIB/MNSI or NHS Resolution?	For cases from 1 April 2022, if the baby has a clinical or MRI evidence of neurological injury and the case is being investigated by HSIB because of this, then the case should also be reported to NHS Resolution via the claims wizard along with the HSIB reference number (document the HSIB reference in the "any other comments box"). Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard. Should you have any queries, please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or HSIB/CQC/MNSI maternity team (maternity@hsib.org.uk).
How should we report cases to NHS Resolution?	Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once they have been confirmed by HSIB/CQC/MNSI as under investigation. They must also complete the ***EN Report*** form and attach this to the Claims Reporting Wizard: https://resolution.nhs.uk/wp-content/uploads/2023/05/EN-Report-Form.pdf
What happens once we have reported a case to NHS Resolution?	Following the HSIB/CQC/MNSI investigation, and on receipt of the HSIB/CQC/MNSI report and MRI report, following triage, NHS Resolution will overlay an investigation into legal liability. Where families have declined an HSIB investigation, no EN investigation will take place, unless the family requests this.

Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by HSIB and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all incidents to HSIB/CQC/MNSI as soon as they occur and to NHS Resolution as soon as HSIB/CQC/MNSI have confirmed that they are taking forward an investigation. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to HSIB/CQC/MNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and HSIB/CQC/MNSI and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme.

FAQs for year five of the maternity incentive scheme

Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice?	**We expect Trust Boards to self-certify the Trust's declarations following consideration of the evidence provided.** It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we will escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the Care Quality Commission for their consideration if any further action is required, and to the NHS England and NHS Improvement regional director, the Deputy Chief Midwifery Officer, regional chief midwife and Department of Health and Social Care (DHSC) for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the Accountable officer (AO) for their ICB is apprised of the MIS safety action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution The declaration form must be signed by both CEO and the Accountable Officer of Clinical Commissioning Group/Integrated Care System before submission.
Our current commissioning systems are changing, what does this mean in terms of sign off?	There have been structural changes for NHS Commissioning as a result of 2022 Health and Care Act. Where this has caused significant reconfiguration and adjustment of commissioning systems, sign off by the accountable lead for commissioning maternity services can be considered
Will NHS Resolution cross check our results with external data sources?	Yes, we will cross reference results with external data sets from: MBRRACE-UK data (safety action 1 point a, b, c), NHS England& Improvement regarding submission to the Maternity Services Data Set (safety action 2, sub-requirements 2 and 3), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable to HSIB (safety action 10, standard a)). Your overall submission may also be sense checked with CQC maternity data, HSIB data etc.

	For more details, please refer to the conditions of the scheme.
What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the Trust CEO and Accountable Office (IBC). Where relevant, an action plan is completed for each action the Trust has not met. **Please do not send your evidence or any narrative related to your submission to NHS Resolution.** Any other documents you are collating should be used to inform your discussions with the Trust Board. These documents and any other evidence used to assure the Board of your position must be retained. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2023. **It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on 1 February 2024, NHS Resolution will treat that as a nil response.**
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on 1 February 2024**. If not returned to NHS Resolution by 12 noon on **1 February 2024**, NHS Resolution will treat that as a nil response.
What happens if we do not meet the ten actions?	Only Trusts that meet all ten maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet all ten safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.
Our Trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net

Please can you confirm who outcome letters will be sent to?	The maternity incentive scheme outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated link contacts via link on the NHS Resolution website. https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-Trusts/maternity-incentive-scheme/maternity-incentive-scheme/
What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process and Trusts will be allowed 14 days to appeal the decision following the communication of results. The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe. There are two possible grounds for appeal • alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation • technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate. NHS Resolution clinical advisors will review all appeals to ensure validity, to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected and NHS Resolution will correspond with the Trust directly with no recourse to the AAC. Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered. Further detail on the appeals window dates will be communicated at a later date.
Merging Trusts	Trusts that will be merging during the year four reporting period (30 May 2023 – 7 December 2023) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed.

	In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2022/23 and the reporting of claims and management of claims going forward.

Q&A regarding Maternity Safety Strategy and CNST maternity incentive scheme

Q1) What are the aims of the maternity incentive scheme?

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

Using CNST to incentivise safer care received strong support from respondents to our *2016 CNST consultation* where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our *Five year strategy: Delivering fair resolution and learning from harm.*

Q2) Why have these safety actions been chosen?

The ten actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with NHS Digital, NHS England, NHS Improvement, the Care Quality Commission (CQC), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Obstetric Anaesthetists Association, Royal College of Anaesthetists, HSIB, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

The Collaborative Advisory Group (CAG) previously established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme has also advised NHS Resolution on the safety actions.

Q3) Who has been involved in designing the scheme?

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England & Improvement
- NHS Digital
- MBRRACE-UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Anaesthetists
- Royal College of Paediatrics and Child Health
- Care Quality Commission
- Department of Health and Social Care
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff
- HSIB/CQC

Q4) How will Trusts be assessed against the safety actions and by when?

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.

Completed Board declaration forms must be discussed with the commissioner(s) of the Trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at nhsr.mis@nhs.net **by 12 noon on 1 February 2024**

Please note:

- Board declaration forms will be reviewed by NHS Resolution and discussed with the scheme's Collaborative Advisory Group.
- NHS Resolution will use external data sources to validate some of the Trust's responses, as detailed in the technical guidance above.
- If a completed Board declaration form is not returned to NHS Resolution by 12 noon on **1 February 2024**, NHS Resolution will treat that as a nil response.

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 12 October 2023

Agenda item		129/23 Paper 2 within CNST INFORMATION PACK		
Report Title		CNST MIS Year 5 Progress Update		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Annemarie Lawrence, Director of Midwifery		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF4,
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners		
Consultation Communication		N/a		
Executive summary:		SaTH is a participant in year 5 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), which is operated by NHS Resolution (NHSR) and supports the delivery of safer maternity care. The self-declaration deadline is 1 February 2024 This paper sets out SaTH's progress to date and includes information to evidence the risks to delivery of the Safety Actions, which the committee is asked to receive on behalf of the Trust's Board of Directors.		
Recommendations for the Board:		The Board of Directors is asked to: Review this paper and note the risks to delivery for the scheme.		
Appendices:		1. NHSR update email 2. PMRT quarterly report Q1 2023 3. Transitional Care Audit Q1 2023 4. ATAIN report Q1 2023 5. Obstetric Workforce Paper		

1.0 Introduction

1.1 SaTH is a member of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), which is regulated by NHS Resolution (NHSR) and is designed to support the delivery of safer maternity care.

1.2 The scheme incentivises ten maternity safety actions. 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.

1.3 Year 5 guidance was published on 31 May 2023 and references a relevant time period of 30 May 2023 until 7 December 2023 for delivery of the scheme.

1.4 This also includes a self-declaration deadline of **noon on 1 February 2024.**

1.5 **Further guidance was issued on 30 June 2023 (see appendix 1) pertaining to updates to Safety Actions 3 (technical guidance) and 9 (time periods for point c). NHSR advises that NHS England will also be issuing some additional clarification and guidance relating to safety actions 6 (SBL), 8 (training) and 9 (Board assurance) in response to a number of queries they have received.**

1.6 The purpose of this paper is to provide the Committee with:

- 1.6.1 Details of the standards within year 5 of the scheme that must be evidenced between now and the reporting deadline.
- 1.6.2 An update on progress.

2.0 Safety Action 1: "Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?"

2.1 All eligible perinatal deaths should be notified to MBRRACE-UK within 7 working days. For deaths from 30th May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.

- 2.1.1 In Quarter 1 of 2023, (April, May and June) there were 4 stillbirths and 1 neonatal death that fitted the criteria for review using PMRT. These cases were reported to MBRRACE within the timeframe.

2.2 For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30th May 2023 onwards.

- 2.2.1 Of the 5 eligible cases, all 5 families were informed of the review by the bereavement midwives and their perspectives or any questions they have sought.

2.3 For deaths of babies who were born and died in your Trust multi-disciplinary reviews using PMRT should be carried out from 30th May 2023. 95% of reviews should be started within two months of the death and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.

- 2.3.1 Of the cases within Quarter 1, the reviews were started the following month after the death and the team are on track to have the reports published by the required deadlines.

2.4 Quarterly reports will have been submitted to the Trust Executive Board from 30th May 2023 onwards.

- 2.4.1 The Quarter 1 2023 PMRT report was presented to maternity governance meeting on 17 July 2023 following which it will be presented to QSAC in July 2023, and LMNS August 2023 (see appendix 2).

2.5 SaTH is compliant to date with reporting to the MBRRACE-UK surveillance portal, with all deaths being reported within the required timescales.

2.6 **Progress Status: On Track**

3.0 Safety Action 2: "Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?"

3.1 NHS Digital, who oversee this Safety Action, will confirm whether SaTH have uploaded all required data points to the Maternity Services Data Set (including the 11 Clinical Quality Information Metrics) at the required standard of data quality; this will be confirmed in October 2023 based on the data submitted in the month of July 2023 (which is the month against which the standard is tested).

3.2 This safety action does not appear to be at risk based on the information known to date however this will not be known until the July data is published in October 2023.

3.3 **Progress status: On Track**

4.0 Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

4.1 The Trust operates a Transitional Care service and associated pathway that continues to meet the national target of Avoiding Term Admission into the Neonatal Unit (ATAIN).

4.2 Evidence standards for b) requires a quarterly audit of 'Avoiding Term Admission into the Neonatal Unit' (ATAIN) to be conducted and these audits have been embedded into practice as part of the division's governance cycle of business.

4.2.1 The Quarter 1 2023 ATAIN report was presented to maternity governance meeting on 17 July 2023 following which it will be presented to QSAC in July 2023, and LMNS August 2023 (see appendix 3).

4.3 Evidence standards for c) require a quarterly audit of babies above 34 weeks gestation to evidence admission to Transitional Care in line with the guidance produced for standard a) of safety action 3.

4.3.1 The Quarter 1 2023 Transitional Care report was presented to maternity governance meeting on 17 July 2023 following which it will be presented to QSAC in July 2023, and LMNS August 2023 (see appendix 4).

4.0 **Progress Status: On Track**

5. Safety Action 4: "Can you demonstrate an effective system of clinical workforce planning to the required standard?"

5.1 Standard a). The Obstetrics workforce gap analysis paper was presented to divisional committee on 27 June 2023 detailing the position and identifying any gaps including the business continuity plans required to evidence an effective system of workforce planning (see appendix 5).

5.2 Standard a) also requires an audit of 6 months activity to measure compliance and this is being undertaken currently and will be brought as an appendix in due course.

5.3 Standard b) evidence of achieving the ACSA Standard 1.7.2.1 has been requested.

5.4 Standard c) evidence to show that SaTH has a BAPM-compliant Neonatal Medical Workforce has already been provided to QSAC in April 2022. There has been no change to this standard in the May 2023 re-launch hence it remains complete, however, an updated position statement has been requested for completeness which will come to QSAC in due course.

5.5 Standard d) QSAC were appraised of the neonatal nursing workforce action plan in year 4 of the scheme, with the action plan also submitted to the LMNS and the Neonatal

Operational Delivery Network (ODN) in line with the technical guidance. There has been no change to standard d) in year 5 therefore it remains complete however an updated action plan has been requested for completeness which will again be presented to QSAC in due course.

5.6 Progress Status: On Track

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

6.1 The Board of Directors has continued to receive the bi-annual midwifery staffing paper since the year 4 scheme ended, with the last report being present to the Board in June 2023.

6.2 Additionally, the service submits a monthly midwifery staffing paper to the Trusts workforce meeting which captures standards c) and d) of safety action 5; this meeting is chaired by the Director of Nursing (DoN).

6.3 The next bi-annual staffing paper will be written using data from Q1/2 of 2023 so will not be received at Trust Board until Autumn 2023.

6.4 **Progress status: On Track**

7.0 Safety Action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

7.1 This is one of the largest and most complex of all the safety actions because it comprises the six elements of SBL:

- 7.1.1 Reducing smoking in pregnancy
- 7.1.2 risk assessment, prevention and surveillance or pregnancies at risk of fetal growth restriction (FGR)
- 7.1.3 Raising awareness of reduced fetal movements (RFM)
- 7.1.4 Effective fetal monitoring during labour
- 7.1.5 Reducing preterm birth
- 7.1.6 Management of pre-existing diabetes (New for version 3)

7.2 Trusts are asked to hold quarterly improvement discussions with the ICB using the new national implementation tool and the initial discussion meeting has been held, with the first formal planned session scheduled to take place in August 2023.

7.3 There are risks to element 1, 2 and 6 due to new measures introduced, some of which require financial support to implement however the team are working closely with finance to agree this support using the year 4 rebate monies.

7.4 Progress Status: At Risk

8.0 Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

8.1 The productive partnership between SaTH and the Maternity and Neonatal Voices Partnership continues to yield important outcomes for service users and staff alike; the MNVP are out to recruitment for additional roles that will enhance the current offer and afford the capacity to extend the reach to the wider community.

8.2 The CQC maternity survey has a coproduced action plan which was presented at maternity governance meeting on the 17 July 2023; this will feed into the safety champions and LMNS board meeting taking place in August 2023, where progress will be monitored moving forward.

8.3 The maternity and neonatal safety champions regularly seek feedback from staff in local areas as part of the scheduled walkabouts which are undertaken bi-monthly. Feedback is shared via a 'Our staff said, we listened' process which is disseminated to all

via multiple methods including posters within the clinical areas, messages via the DoM drop-in sessions and emails to all/individual visits. Actions are monitored monthly via safety champions.
8.4 Progress Status: On Track

9.0 Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

9.1 The Trust has been fortunate to participate in the NHSE Pilot of version 2 of the Core Competency Framework (CCF) therefore our local training plan reflects the ask within the technical guidance to be aligned to the CCF v2.
9.2 The updated plan has been agreed by the quadrumvirate on 27 June 2023 and will be presented to QSAC and LMNS in August 2023.
9.3 There is a risk to delivery in that all staff groups require 90% attendance over a 12-month consecutive period which is calculated from the end date used to inform percentage compliance to meet Safety Action 8 in the Year 4 scheme.
9.4 At the time of writing this report, the Trust is awaiting updated guidance from NHSR.
9.5 Progress Status: At Risk

10. 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?

10.1 The Trust has a robust maternity and neonatal safety champions process in place which evidences ward to board escalation of any quality issues.
10.2 The safety dashboard captures a minimum dataset which is reviewed monthly, and any issues escalated via the safety champions AAAA which is reported to Divisional Committee, QSAC and MTAC.
10.3 Standard b) refers to the Trusts claims Scorecard data which should be reviewed alongside incident and complaints data and used to agree targeted interventions aimed at improving patient safety which are then reflected in the Trusts Patient Safety Incident Response Plan. This should be undertaken at least twice in the MIS reporting year and is currently scheduled for July's Divisional Committee, and then additionally at safety champions in August and October 2023.
10.4 Standard c) requires that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available by no later than 1 August 2023 *(was previously 1 July 2023 prior to the NHSR update issued on 30 June 2023).*
10.5 **Progress Status: On Track.**

11. Safety Action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?

11.1 This safety action relates principally to the work of the divisional governance team, supported by the legal team.
11.2 As with Safety Action 1, the need to report appropriately to the (HSIB) and the NHS Resolution Early Notification Scheme (ENS) is ongoing, hence this action will not be evidenced as delivered/complete until after the reporting deadline of 7 December 2023.
11.3 Family information on the role of HSIB/NHSR ENS and Duty of candour is monitored weekly, and an audit will be produced to evidence compliance following the reporting deadline which is in keeping with Year 4 of the scheme.
11.4 Progress Status: On Track.

12. Risks to Delivery

There is a risk that…	The risk is caused by…	The potential impact of the risk is…	The mitigation in place is…
The Trust may not achieve version 3 of the SBLCB	New additions to the updated guidance pertaining to elements 1, 2 & 6 which relate to, NRT, digital blood pressure monitors and uterine artery dopplers, and diabetes glucose monitors and dietician services.	Failure of safety action 6 Linked to a risk to patient safety	As this is a new risk, the guidance is
The Trust may miss the 90% target for training for midwives, Drs and support staff	The 12 months consecutive date range begins from the date used to inform compliance for the year 4 scheme therefore compliance must be achieved by October 2023.	Failure of safety action 8	There are a number of sessions planned to try and capture as many staff as possible however this is intrinsically linked with a high staff unavailability rate – where there are risks to patient safety from low staffing numbers and high acuity, training will be cancelled as patient safety must come first.

13. Summary

13.1 SaTH is mostly on track to achieve CNST MIS Year 5, although there is a risk to delivery for Safety Actions 6 and 8 for the reasons specified above. The team are working hard to mitigate these risks wherever possible and reduce the risk of non-compliance.

13.2 **Summary of safety action statuses**

Safety Action #	Completion Status
1	On Track
2	On Track
3	On Track
4	On Track
5	On Track
6	At Risk
7	On Track
8	At Risk
9	On Track
10	On Track

14. Actions requested of the Board of Directors

14.1 Review and discuss this paper and note the risks to delivery for the scheme.

For the attention of all Trust maternity incentive scheme contacts

Following discussions with NHS England this week, there are two key points within the maternity incentive scheme year 5 document that that they have requested we update all Trusts on with immediate effect.

To confirm these two areas are:

Safety Action and location	Current Wording	Should read
SA3 – technical guidance	We recommend ongoing reviews, at least quarterly of unanticipated admissions of babies >36 weeks to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan.	We recommend ongoing reviews, at least quarterly of unanticipated admissions of babies equal to or >37 weeks to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan.
SA9 **Time period for points c)**	Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available no later than 1 July 2023	Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available no later than 1 August 2023

NHS England will also be issuing some additional clarification and guidance relating to safety actions 6 (SBL), 8 (training) and 9 (Board assurance) in response to a number of queries we have received. We apologise sincerely for the delay in this information and any inconvenience this may cause. We will forward this on to all Trusts as soon as it is made available to us. Once all further clarification is received we will also collate this information and ensure this is available on the NHS Resolution website in a single document format for clarity.

Many apologies for any confusion relating to these updates. If you have any questions or concerns, please contact Bridget Dack, NHS Resolution's Maternity Incentive Scheme Clinical Lead, or Selina Dubison, NHS Resolution's Maternity Incentive Scheme Associate via email at nhsr.mis@nhs.net

Please note: This correspondence has only been sent to named contacts specified for your Trust on the MIS contacts list. If you need to update your nominated contacts for either the financial or clinical nominated contact for the MIS please visit our dedicated webpage to submit contact details.

Thank you as always for your hard work towards achieving the highest standards of care in maternity and neonatal services,

Bridget Dack
Maternity Incentive Scheme Clinical Lead
Bridget.dack@nhs.net
Telephone: 02038626463

APPENDIX 2

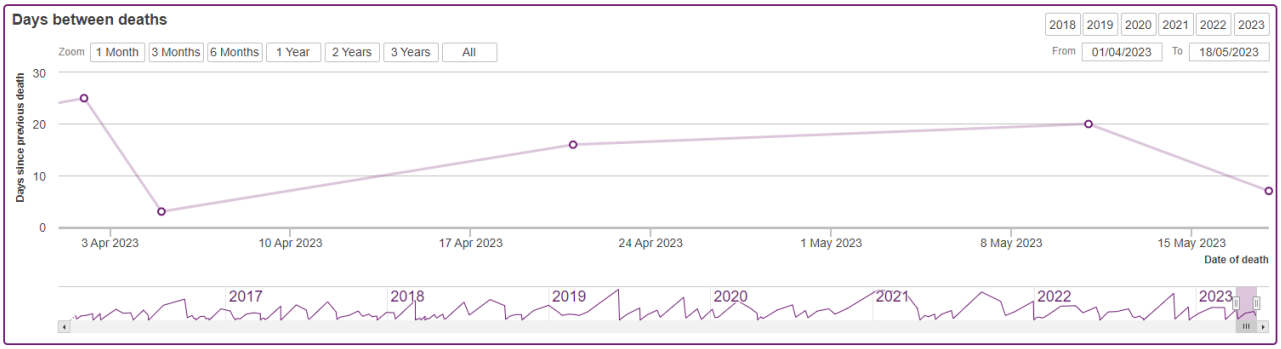
The Shrewsbury and Telford Hospital NHS Trust

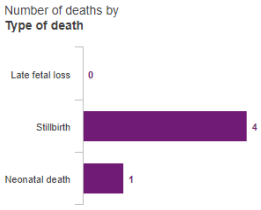
Board of Directors' Meeting
12 October 2023

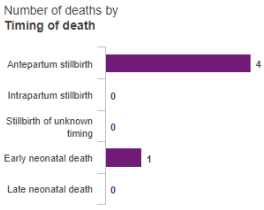
Agenda item	129/23 Paper 2 within CNST INFORMATION PACK **Appendix 2**			
Report Title	Perinatal Mortality Review Tool (PMRT) Quarterly Report Q1			
Executive Lead	Hayley Flavell, Executive Director of Nursing			
Report Author	Elizabeth Pearson			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√		
	For noting			
	For information			
	For consent			
Presented to:	Maternity Governance July 2023			
Executive summary:	There were four stillbirths, 0 late fetal loss and one neonatal death that fitted the criteria for review using PMRT. External Obstetric Consultants have been present at each review of care. Compliance with CNST Safety Action 1 is confirmed in this report.			
Recommendations for the Board of Directors	The Board of Directors is asked to note the report.			
Appendices	MBRRACE generated Trust Board Report			

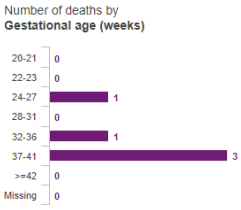
1.0 Deaths reported to MBRRACE

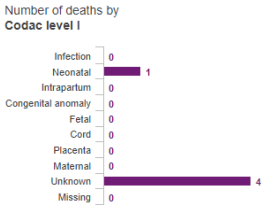
In the time period from 1st April 2023 to 30th June 2023 there were four stillbirths and one neonatal death.











Stillbirths

All four stillbirths were reported as antepartum, before there were any signs of labour.

Stillbirth 1 **86815/1** – Care issues were identified but none that would have made a difference to the outcome. The progress of the mother's labour was not completed in its entirety on the partogram as per guidelines. Individual feedback has been given and the Bereavement Midwives will be attending the Delivery Suite Co-ordinators meeting to discuss how to support staff with documentation completion. Good practice was noted with CO monitoring compliance as high CO readings were noted, and appropriate advice and support was offered with referrals to Smoking Cessation services.

Stillbirth 2 **87080/1** – Care issues were identified but none that would have made a difference to the outcome. This mother was not asked about domestic abuse at booking as per guidelines, and during an admission with hyperemesis her risk factors for venous thromboembolism were not calculated. Information has been shared with the areas to raise awareness of the need to complete full risk assessments.

Stillbirth 3 **87407/1** – Care issues were identified but none that would have made a difference to the outcome. This mother had scans during her pregnancy, the baby was small for gestational age which had not been identified prenatally. There were maternal factors that impacted on the quality of the scan but images have not been reviewed as currently these are not saved. Whilst the ability to quality assure our scan images is required, the panel concluded that the ability to review the images from this case would not have changed the outcome. Compliance with Version 3 Saving Babies Lives is being escalated and planning is in place.

Stillbirth 4 **87534/1** – There were no care issues identified up to the point where it was identified that the baby had died.

Late Fetal Loss
There were no late fetal losses reported in Quarter 1.

Neonatal Deaths
There was one early neonatal death reported, within the first 6 days of life.
86873/1 – There were care issues identified but none that would have changed the outcome. Palliative care was planned for the baby in view of a congenital anomaly diagnosed during pregnancy that was not compatible with life. The panel identified that when a baby has a complex care plan, this must be documented on maternal Badgernet system on the front page to ensure consistent and effective communication between staff.

2.0 Safety Action 1 Compliance: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

(Y5 Relaunch) All eligible perinatal deaths should be notified to MBRRACE-UK within 7 working days. For deaths from 30th May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.

In Quarter 1, (April, May and June 2023) there were there were 4 stillbirths, 0 late fetal losses and 1 neonatal death that fitted the criteria for review using PMRT
These cases were reported to MBRRACE within the timeframe.

Stillbirths Quarter 1	**Notified to MBRRACE**	**Surveillance information completed**
86815/1	**Within 7 days**	**Within the same month**
87080/1	**Within 7 days**	**Within the same month**
87407/1	**Within 7 days**	**Within the same month**
87534/1	**Within 7 days**	**Within a month**
Late Fetal Loss	**Notified to MBRRACE**	**Surveillance information completed**
None		
Neonatal Deaths Quarter 1	**Notified to MBRRACE**	**Surveillance information completed**
86873/1	**Within 7 days**	**Within the same month**

(Y5 Relaunch) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30th May 2023 onwards.

Stillbirths Quarter 1	**Families informed**	**Source**
86815/1	**Yes**	**Bereavement Midwife**
87080/1	**Yes**	**Bereavement Midwife**
87407/1	**Yes**	**Bereavement Midwife**
87534/1	**Yes**	**Bereavement Midwife**
Late Fetal Loss	**Families informed**	**Source**
None		

Neonatal deaths Quarter 1	Families informed	Source
86873/1	Yes	Bereavement Midwife

(Y5 Relaunch) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using PMRT should be carried out from 30th May 2023. 95% of reviews should be started within two months of the death and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.

Stillbirths Quarter 1	Review started	Draft report stage	Published report
86815/1	The following month after the death	3 months after the death	Must be published by October
87080/1	The following month after the death	Within 3 months of the death	Must be published by October
87407/1	The following month after the death	Within 2 months of the death	Must be published by November
87534/1	The following month after the death	Not yet at draft report stage	Must be published by November
Late Fetal Loss	Review started		
None			
Neonatal deaths Quarter 1	Review started	Draft report stage	Published report
86873/1	The following month after the death	3 months after the death	Must be published by October

Each case reported in Quarter 1 has been reviewed and is on track to meet the criteria targets.

(Y5 Relaunch) Quarterly reports will have been submitted to the Trust Executive Board from 30th May 2023.

Quarter 1 report will be presented to Maternity Governance 17th July 2023 and on to the Maternity Safety Champions and Trust Board following acceptance.

3.0 Conclusion

3.1 Compliance has been met with the CNST safety action 1 requirements, and this report concludes and provides evidence that the National Perinatal Mortality Review Tool is being used to review perinatal deaths to the required standard in Quarter 1.

Author name and title
Elizabeth Pearson Quality Governance Lead
Date 09/07/2023

APPENDIX 3

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
12 October 2023

Agenda item	129/23 Paper 2 within CNST INFORMATION PACK **Appendix 3**			
Report Title	Transitional Care Audit Quarterly Report			
Executive Lead	Hayley Flavell, Executive Director of Nursing			
Report Author	Louise Duce, Deputy Director of Nursing – Women and Children's Services			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	
	Our people		Effective	√
	Our service delivery	√	Caring	
	Our governance		Responsive	
	Our partners		Well Led	
	Report recommendations:		**Link to BAF / risk:**	
	For assurance			
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting	√		
	For information			
	For consent			
Presented to:				
Executive summary:	This paper is to provide assurance that transitional care is audited in line with the standards as directed by BAPM and reflected in the maternity guideline. In line with the CNST maternity incentive scheme safety point three this paper supports the process of auditing Transitional Care Services <u>April 23-June 23</u> • Reason for admission – 100 % reason recorded • Reason recorded and appropriate as guidance – 85.7% • Observations frequency as guidance – 85.7% • Use of Green discharge proforma – 71.4% • Daily Neonatal Team review – 96.4% • Appropriate NIPE – 100% • NIPE within 72hrs of discharge- 100% *3 babies applicable for temperature maintenance* - Of those 2 were applicable for 100% had incubator care			
Recommendations for the Board of Directors:	The Board of Directors is asked to note the report.			
Appendices	N/A			

The Shrewsbury and Telford Hospital NHS Trust

Main Paper

Situation

Transitional care is not a place but a service and this can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting.

Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.

The philosopy of transitional care is to keep mothers and babies together, mothers become the primary care provider for their babies with care requirements in excess of normal newborn care but do not require admission in a neonatal unit and ensures a smooth transition to discharge home.

The monthly transitional care audit will be in line with the standards set out in the guideline:

- Reason for admission to Transitional care
- Reason Recorded and appropriate as guidance
- Observations and investigations as guidance and documented appropriately
- The use of green discharge proforma
- Daily neonatal team review
- Appropriate NIPE examination
- Outcomes

This audit was taken on a random selection based on the monthly transitional care audit of 8 transitional care babies per month totalling 24 babies audits over a quarter which is approximately 20-25 % of babies who are admitted under the transitional care pathway, recommendations will be shared on a quarterly basis to the Director of Midwifery, Divisional Director of Nursing, Maternity and Neonatal Governance teams and the Neonatal Triumveriate.

Background

The transitional care guideline has been amalgamated with the neonatal guideline and updated, we have introduced NEWTT (Newborn Early Warning Trigger and Track) on 14/09/2020 which gives a clearer definition of babies requiring transitional care as below:

<u>Criteria for transitional care from birth</u>

- Late Preterm babies from 34 – 35+6 weeks gestation.
- Babies receiving intravenous antibiotics or other intravenous medications.
- Babies at risk of neonatal abstinence syndrome (NAS) requiring observations.
- Congenital anomaly likely to require tube feeding (eg cleft lip/palate).
- Low birth weight ($\leq 2^{nd}$ Centile but more than 1.8 kgs).

Care for transitional care from NNU

- Baby who is having 'step down care' following admission to NNU who are more than 1.6 kgs and maintaining temperature.
- Step down care tolerating a minimum of 3 hourly feeds.

Transitional care babies are cared for in a four bedded bay and 2 side rooms on the postnatal ward, with a staffing model of 1 Band 6 midwife and 1 WSA to support.

Assessment

Data Collection

24 sets of neonatal records were used to complete this audit and Badgernet net used to enable this audit to be completed.

Analysis

All babies noted in the audit were seen daily by the appropriate neonatal team with clear documentation and plan of care.

All babies received NIPEs within the allocated time frame of 72 hours.

71.4% of the sample had green proformas noted within the notes with clear descriptions of where the baby had been admitted to and the reasons behind the admission. The remaining 28.6% who did not have green discharge proforma the Neonatal Discharge letters had already been generated to transfer to postnatal ward for transitional care; there was no evidence of further discharge letter after this point.

Observations frequency as guidance 85.7%, 14.3% of those did not identify the frequency for observations.

Recommendation

- Monthly audits to continue and be reported monthly through local and divisional governance processes.
- All babies regardless of area should have a discharge notification, outcome of audit to be shared with neonatal team.
- The report to be shared at the Maternity Governance Meeting to enable shared learning in regard to skin to skin as a first resolve for temperature management.
- Continue with good practice of NIPE checks within designated time frames.
- NEWTT chart to be on Badgernet to pick up frequency of observations, as this is free text only.
- Frequency of observations need to be clearly identified at point of birth on Badgernet.

APPENDIX 4

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
12 October 2023

Agenda item	129/23 Paper 2 within CNST INFORMATION PACK **Appendix 4**			
Report Title	ATAIN (Avoiding Term Admissions into Neonatal Units) report. Quarter 1 2022-23			
Executive Lead	Hayley Flavell, Executive Director of Nursing			
Report Author	Rachel North, Women and Children's Quality Governance Officer			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance			
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting	√		
	For information			
	For consent			
Presented to:	**Maternity and Neonatal Governance Meetings July 2023**			
Executive summary:	• Rate of admissions to the Neonatal unit for babies >37 weeks is 5.0% for quarter 1 2023. • This is below the national target of 6% and a slight reduction from quarter 4 last year. • The most common reasons for admission for admission are respiratory conditions and infection. • All cases are reviewed in a fortnightly meeting with MDT representation from Obstetrics, Neonatology, Maternity, and the Governance team.			
Recommendations for the Board of Directors:	The Board is asked to note the report.			
Appendices	N/A			

ATAIN (Avoiding Term Admissions into Neonatal Units) Report for Q1 2023

Background

Admission to a neonatal unit can lead to unnecessary separation of mother and baby. There is overwhelming evidence that separating mother and baby at or soon after birth can affect the positive development of the mother-child attachment process and adversely affect maternal perinatal mental health.

Preventing separation except for compelling medical indications is essential in providing safe maternity services.

NHS providers of maternal and neonatal care can use data collected through ATAIN reviews as a resource to:

- Improve the safety of care.
- Keep mothers and babies together whenever it is safe to do so.
- Identify local improvement priorities.
- Develop an action plan to ensure any relevant resources are introduced into clinical practice.

Improving the safety of maternity services is a key priority for the NHS and the number of unexpected admissions of full-term babies (i.e., those born at 37 weeks or more), is seen as a proxy indicator that harm may have been caused at some point along the maternity or neonatal pathway.

ATAIN focuses on four key clinical areas that represent a significant amount of potentially avoidable harm to babies:

- Respiratory conditions
- Hypoglycaemia
- Jaundice
- Asphyxia (perinatal hypoxia-ischemia)

Review Systems

Multi-Disciplinary Team (MDT) meetings continue on a fortnightly basis to review all cases which meet the ATAIN criteria. Term admissions to the neonatal unit are currently monitored utilising the neonatal BadgerNet digital system, Datix submissions, and a manual check of the Neonatal Unit admissions book. A cross reference is made with all three systems as a failsafe to ensure that no case is missed. The metrics collated from these meetings are presented quarterly for assurance, at both Maternity and Neonatal Governance meetings. Any safety concerns are immediately escalated, and any learning is shared with the multi-disciplinary teams in both areas.

The rate of term admissions to the neonatal unit are calculated as a percentage of live, **term** births in line with the NHS Improvement “Reducing harm leading to avoidable admission of full-term babies into neonatal units” paper from 2017.

Rates

The term admission rate for Q1 (April, May June 2023) was 5.0% of all births at >37 weeks, a slight reduction from the previous Q4 figure of 5.3%. The year-to-date term admission rate is 5.0%. This rate remains below the national target of 6%.

A total of 45 term babies were admitted to the NNU in Q1 2023 (comparing with 46 in the previous quarter.)

The numbers of babies admitted each month were:
April 2023 – 3.7% of all births at >37 weeks (n = 11)
May 2023 – 6.3% of all births at >37 weeks (n = 18)
June 2023 5.1% of all births at >37 weeks (n = 16)

Quarter 1 Metrics

Reason for admission	Number of babies > 37/40
Respiratory conditions	23
Infection	9
Neonatal Abstinence Syndrome	1
Hypoglycaemia	3
Gastrointestinal disorders	3
Jaundice	2
Observations (inc. Failed oximetry)	2
Congenital abnormality	1
Social reasons	1
Babies who were transferred out for therapeutic hypothermia	0
Total	45

Respiratory conditions

Respiratory conditions continue to make up most admissions to the NNU, with 23 babies this quarter. 4 of which were elective caesarean births, 5 were emergency caesarean births (4 of which were not in labour) and 10 were vaginal births. One of the respiratory admissions was a ventouse birth, 2 babies were born by forceps and 7 were spontaneous vaginal births. 39 of the babies received Antibiotics during their stay.

Mothers booked for elective caesarean sections prior to 39 weeks gestation are routinely offered the option of antenatal corticosteroids to reduce the risk of neonatal respiratory morbidity as per the 'Caesarean Section – Emergency and Elective' Guideline. The ATAIN review group monitor whether the parents received informed discussion regarding steroids and document this conversation and its outcome in the notes. One of the elective caesarean sections was conducted prior to 39 weeks gestation for appropriate reasons and parents received counselling.

Hypoglycaemia

During quarter 1, there were 3 babies (all born to diabetic mothers) admitted to the neonatal unit due to hypoglycaemia. 2 babies were admitted from the post-natal ward with low blood sugars and were promptly escalated to the neonatal team for review and management. 2 cases were deemed to be appropriate admissions, the third however was

considered by the MDT to have been avoidable due to 2nd stage Management issues. The learning from this has been shared via the 3-minute brief and with Neonatal team huddles.

Neonatal Jaundice

2 babies were admitted to the neonatal unit for treatment of jaundice in quarter 1, both were spontaneous vaginal births. Both babies were admitted form the post-natal ward.

Both babies were admitted from the ward on day 3, when a capillary blood gas taken was over the exchange level. The babies were commenced on phototherapy treatment and screened for infection. The ATAIN MDT identified that for these two babies, the NNU was the most appropriate place to receive this treatment.

Infection

Nine babies were admitted to the neonatal unit with suspected infection this quarter. One of these admissions was deemed to have been avoidable, with missed opportunities to expedite delivery when baby was showing signs of compromise. Baby was discharged home on day 3 and required no further follow up.

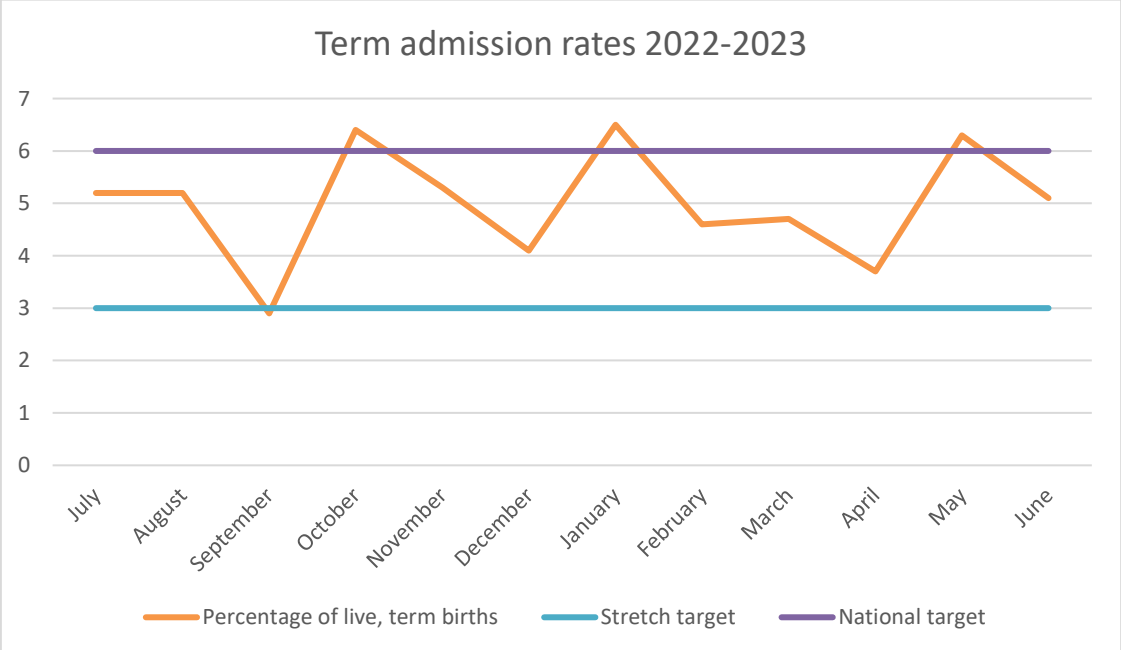
Gastrointestinal disorders

Three babies were admitted to the neonatal unit with suspected gastrointestinal disorders in quarter 1 2023. All were deemed to be have been unavoidable.

Two babies were admitted with abdominal distension and bilious vomiting. One of which was transferred out to Birmingham Children's Hospital for continued treatment and metabolic investigations. The second baby was discharged back to the postnatal ward following a day of monitoring and went home the following day.

One baby was admitted with the delayed passage of meconium and received treatment for this and was discharged the following day.

Summary of Term admission rates for the 2022-2023



Challenges to the ATAIN process

The significant previous challenges to maintain quoracy in the ATAIN meetings is now much improved with good representation from Obstetrics, Neonatology, Maternity, and the Governance team. Clinicians are attending on a rotational basis, with specific dates provided for all staff and a reminder sent out by the Governance team 1 week before the meeting.

At the time of writing the backlog of reviews has now been cleared to our aspirational target where we are undertaking timely and contemporaneous reviews.

A structured and robust process is in place to ensure that the MDT ATAIN reviews can be completed within a 14-day turnaround of incidents occurring. This allows for immediate learning from these incidents to be disseminated to all staff.

Plan for Q2 2023/2024

1. Continue two-weekly MDT meetings to review all eligible cases. These meetings will now be reviewing the most recent term admissions to the NNU.
2. Ensure failsafe processes are in place to confirm all eligible cases are captured for review.
3. Share learning from ATAIN reviews with all staff.
4. To monitor and review more closely the babies admitted with respiratory conditions and/or infection with a view to establish if admission to the neonatal unit can be avoided by alternative methods of treatment.
5. To present the report to Maternity and Neonatal Governance meetings.
6. To establish an action tracker and to review this regularly at ATAIN meetings.

APPENDIX 5 TO PAPER 2 WITHIN CNST INFO PACK
Obstetric Medical Workforce Gap Analysis June 2023

1.0 Background

The final Ockenden Report includes an immediate and essential action (IEA 1.10) as below :-

“All Trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.”

2.0 Current Obstetric Medical Workforce Position and Recruitment

The current budgeted medical staffing for Obstetrics and Gynaecology includes:

26.75 consultants
4 specialist doctors
9.1 tier 2 trainees
10 tier 1 trainees

Of the consultant staff, we currently have 3 vacancies.

One new substantive member of staff is due to start work in Sept 2023, a trust locum in June 2023 and an agency locum in July 2023.

Substantive and Trust Locum consultant posts are currently out to advert.
We are also waiting for approval of a business case to address consultant gaps against the final Ockenden report:-

- Annual leave cover and increased capacity in Diabetic antenatal clinics
- Daily ante-natal and post-natal ward rounds

3.0 Medical Business Continuity

Where we have gaps in our consultant medical rotas these are addressed through:-

- Consultant flexible sessions (unallocated sessions included in some consultant job plans for cover purposes)
- Internal locum shifts
- Employment of fixed term Trust locums
- Employment of fixed term agency locums

There is also an agreed business continuity plan.

4.0 Obstetric and Gynaecology Consultant Leadership and Management Roles

Consultants within the Department have a range of clinical and management lead roles included within their job plans. These provide strong clinical and management leadership as well as development opportunities. There are not considered to be any gaps in the current provision of these lead roles.

All consultant job plans include SPA time for personal development and training.
There is also an allocated personal budget to support training and development.
There are a range of leadership courses available through the Trust with active consultant involvement.

5.0 Obstetric Consultant Medical Succession Planning issues -Fetal Medicine

The main succession planning issue for Obstetrics is currently around fetal medicine. SaTH has, in recent years, developed a strong fetal medicine service lead by three senior consultants and supported by an experienced midwifery sonography team. This has enabled patients to be seen locally who would otherwise require referral to the specialist centres across the Region. Sath is considered unusual as a DGH in being able to provide this level of service. The service has significant benefits for women in reducing travel requirements.

There is a National shortage of consultants with expertise in this area.

Of three consultants who have supported this service historically, one retired at the end of March 2023, one has indicated her intention to retire in August and one is currently unavailable with no confirmed date for return. This third consultant is also potentially close to retirement.

Our preferred succession plan is as below:-

- Recruit two consultants with fetal medicine expertise to re-establish the service. This would need to include agreement for recruitment at risk for one post and would take a minimum of 6-9 months.
- Train 2 tier 2 doctors to support with specialist scanning. This would take approximately 2 years and would require support from consultants in a Specialised Centre. We would look to support this provision through outreach from Regional Specialist Centres.

Board of Directors' Meeting: 12 October 2023

Agenda item		129/23 Paper 3 within CNST INFORMATION PACK		
Report Title		CNST MIS Year 5 Progress Update		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Annemarie Lawrence, Director of Midwifery		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF4,
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners		
Consultation Communication		Divisional Committee Meeting 22 August 2023		
Executive summary:		SaTH is a participant in year 5 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), which is operated by NHS Resolution (NHSR) and supports the delivery of safer maternity care. The self-declaration deadline is 1 February 2024 This paper sets out SaTH's progress to date and includes information to evidence the risks to delivery of the Safety Actions, which the committee is asked to receive on behalf of the Trust's Board of Directors.		
Recommendations for the Board:		The Board of Directors is asked to: Review this report and note the risks to delivery for the scheme.		
Appendices:		Appendix 1 MIS Year 5 Update V1.1 July 2023 Appendix 2 Neonatal medical workforce paper Appendix 3 Saving babies Lives report Appendix 4 Pre-term Birth Appendix 5 Small for gestational age		

1.0 Introduction

1.1 SaTH is a member of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), which is regulated by NHS Resolution (NHSR) and is designed to support the delivery of safer maternity care.

1.2 The scheme incentivises ten maternity safety actions. 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.

1.3 Year 5 guidance was published on 31 May 2023 and references a relevant time period of 30 May 2023 until 7 December 2023 for delivery of the scheme.

1.4 This also includes a self-declaration deadline of **noon on 1 February 2024.**

1.5 **Following further guidance pertaining to safety actions 3 and 9, a second iteration of the guidance was published on the 19th of July 2023 (Appendix 1 – V1.1 July 2023).**

1.6 This new guidance includes updates for safety actions 1,3,6,7,8,9 and 10, with safety action 9 updates being extensive additions to the first iteration of the guidance. The additions centre mainly on the requirements for perinatal clinical quality surveillance and board safety champions.

1.7 The purpose of this paper is to provide the Committee with:

- 1.7.1 Details of the standards within year 5 of the scheme that must be evidenced between now and the reporting deadline.
- 1.7.2 An update on progress.

2.0 Overall Progress Status

2.1 The below chart shows a CNST completion rate as of August 2023 (including compliance with the standards and accrual of supporting evidence) of 5.1% 'Evidenced and Assured', 30.7% 'Delivered Not Yet Evidenced', and 59% 'Not Yet Delivered'.

2.2 The above battery should be viewed in conjunction with the below progress battery which evidences the overall status of progress which is predominantly on track.

2.3 While there are elements in the above progress battery that are on-hold/descoped, these relate to items within Safety Action 2 that are either not yet due within this quarter or relate to Midwifery Continuity of Carer (MCOC) which is currently paused in line with the National letter published in September 2022.

3.0 Safety Action 1: "Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?"

3.1 SaTH is compliant to date with reporting to the MBRRACE-UK website.

3.2 The Board of Directors (BoD) via the delegated authority of QSAC has received a report each quarter since August 2021 that includes details of the deaths reviewed and the consequent action plans.

3.3 Compliance with standard b) is ongoing, with 100% of parents being informed that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought").

3.4 The team are on track to achieve the required standards of c).

3.5 **Progress Status: On Track**

4.0 Safety Action 2: "Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?"

4.1 NHS Digital, who oversee this Safety Action, will confirm whether SaTH have uploaded all required data points to the Maternity Services Data Set (including the 11 Clinical Quality Information Metrics) at the required standard of data quality; this will be confirmed in October 2023 based on the data submitted in the month of July 2023 (which is the month against which the standard is tested).

4.2 This safety action does not appear to be at risk based on the information known to date however this will not be known until the July data is published in October 2023.

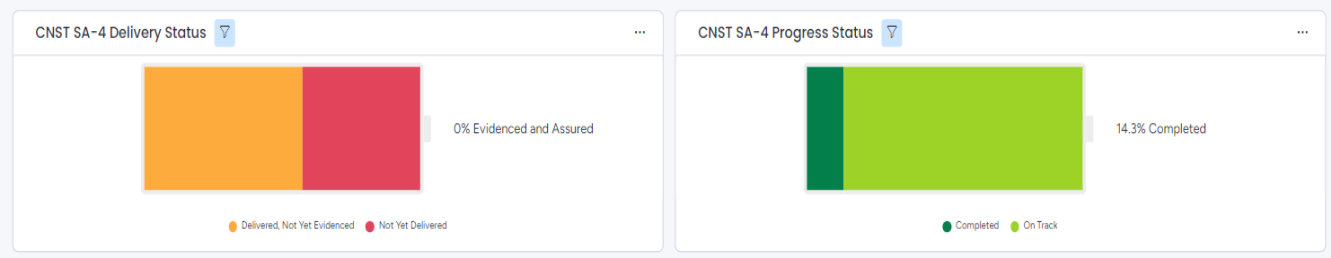
4.3 The battery above contains the on-hold/descoped elements associated with the pause of MCoC in line with the national letter as described above.

4.4 **Progress status: On Track**

5.0 Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

5.1 The Trust operates a Transitional Care service and associated pathway that continues to meet the national target of Avoiding Term Admission into the Neonatal Unit (ATAIN).
5.2 The BoD via the delegated authority of QSAC has continued to receive a report each quarter since August 2021 that includes details of all term admissions, including avoidable admissions and any associated action plans evidencing the required standards for b).
5.3 The BoD via the delegated authority of QSAC has continued to receive a report each quarter on transitional care activity and any associated actions evidencing the requirements for standard c).
5.4 Progress Status: On Track

6.0 Safety Action 4: "Can you demonstrate an effective system of clinical workforce planning to the required standard?"



6.1 Standard a). The Obstetrics workforce gap analysis paper was presented to divisional committee on 27 June 2023 detailing the position and identifying any gaps including the business continuity plans required to evidence an effective system of workforce planning (see appendix 5).
6.2 Standard a) also requires an audit of 6 months activity to measure compliance and this is being undertaken currently and will be brought as an appendix in due course.
6.3 Standard b) evidence of achieving the ACSA Standard 1.7.2.1 has been requested.
6.4 Standard c) evidence to show that SaTH has a BAPM-compliant Neonatal Medical Workforce has already been provided to QSAC in April 2022. There has been no change to this standard in the May 2023 re-launch hence it remains complete, however, an updated position statement has been requested for completeness which can be found within appendix 2.
6.5 Standard d) QSAC were appraised of the neonatal nursing workforce action plan in year 4 of the scheme, with the action plan also submitted to the LMNS and the Neonatal Operational Delivery Network (ODN) in line with the technical guidance. There has been no change to standard d) in year 5 therefore it remains complete however an updated action plan has been requested for completeness which will again be presented to QSAC in due course.
6.6 Progress Status: On Track

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

7.1 The BoD has continued to receive the bi-annual midwifery staffing paper since the year 4 scheme ended, with the last report being present to the Board in June 2023.
7.2 Additionally, the service submits a monthly midwifery staffing paper to the Trusts workforce meeting which captures standards c) and d) of safety action 5; this meeting is chaired by the Director of Nursing (DoN).
7.3 The next bi-annual staffing paper will be written using data from Q1/2 of 2023 so will not be received at Trust Board until Autumn 2023.
7.4 Progress status: On Track

8.0 Safety Action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

8.1 This is one of the largest and most complex of all the safety actions because it comprises the six elements of SBL care bundle (appendix 3).

- 8.1.1 Reducing smoking in pregnancy
- 8.1.2 risk assessment, prevention and surveillance or pregnancies at risk of fetal growth restriction (FGR) (appendix 4)
- 8.1.3 Raising awareness of reduced fetal movements (RFM)
- 8.1.4 Effective fetal monitoring during labour
- 8.1.5 Reducing preterm birth (appendix 5)
- 8.1.6 Management of pre-existing diabetes (New for version 3)

8.2 Trusts are asked to hold quarterly improvement discussions with the ICB using the new national implementation tool and the initial discussion meeting has been held, with the first formal planned session scheduled to take place in August 2023.
8.3 There are risks to element 1, 2 and 6 due to new measures introduced, some of which require financial support to implement however the team are working closely with finance to agree this support using the year 4 rebate monies.
8.4 Progress Status: At Risk

9.0 Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

9.1 The productive partnership between SaTH and the Maternity and Neonatal Voices Partnership continues to yield important outcomes for service users and staff alike; the MNVP are out to recruitment for additional roles that will enhance the current offer and afford the capacity to extend the reach to the wider community.
9.2 The CQC maternity survey has a coproduced action plan which was presented at maternity governance meeting on the 17 July 2023; this will feed into the safety champions and LMNS board meeting taking place in August 2023, where progress will be monitored moving forward.
9.3 The maternity and neonatal safety champions regularly seek feedback from staff in local areas as part of the scheduled walkabouts which are undertaken bi-monthly. Feedback is shared via a 'Our staff said, we listened' process which is disseminated to all via multiple methods including posters within the clinical areas, messages via the DoM drop-in sessions and emails to all/individual visits. Actions are monitored monthly via safety champions.
9.4 Progress Status: On Track

10.0 Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

10.1 The Trust has been fortunate to participate in the NHSE Pilot of version 2 of the Core Competency Framework (CCF) therefore our local training plan reflects the ask within the technical guidance to be aligned to the CCF v2.
10.2 The updated plan has been agreed by the quadrumvirate on 27 June 2023 and will be presented to QSAC and LMNS in August 2023.
10.3 There is a risk to delivery in that all staff groups require 90% attendance over a 12-month consecutive period which is calculated from the end date used to inform percentage compliance to meet Safety Action 8 in the Year 4 scheme.
10.4 Figures at present are positive in terms of our current compliance position however this is dependant upon all remaining staff groups being released to attend planned sessions/impact of industrial action and staff unavailability therefore delivery of this action overall remains at risk.
10.5 Progress Status: At Risk

11. 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?

11.1 The Trust has a robust maternity and neonatal safety champions process in place which evidences ward to board escalation of any quality issues evidencing completion of element a).
11.2 The safety dashboard captures a minimum dataset which is reviewed monthly, and any issues escalated via the safety champions AAAA which is reported to Divisional Committee, QSAC and MTAC.
11.3 Standard b) refers to the Trusts claims Scorecard data which should be reviewed alongside incident and complaints data and used to agree targeted interventions aimed at improving patient safety which are then reflected in the Trusts Patient Safety Incident Response Plan. This should be undertaken at least twice in the MIS reporting year and was carried out at July 2023 Divisional Committee, and then additionally at safety champions in August and October 2023.
11.4 Standard c) requires that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available by no later than 1 August 2023 *(was previously 1 July 2023 prior to the NHSR update issued on 30 June 2023). This has been completed.*
11.5 New guidance published in July 2023 stipulates additional minimum evidence requirements for the Board Safety Champions to meet with the Perinatal 'Quad' Leadership team on a quarterly basis and the first meeting is scheduled to take place before the end of September 2023.
11.6 **Progress Status: On Track.**

12. Safety Action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?

12.1 This safety action relates principally to the work of the divisional governance team, supported by the legal team.
12.2 As with Safety Action 1, the need to report appropriately to the (HSIB) and the NHS Resolution Early Notification Scheme (ENS) is ongoing, hence this action will not be evidenced as delivered/complete until after the reporting deadline of 7 December 2023.

12.3 Family information on the role of HSIB/NHSR ENS and Duty of candour is monitored weekly, and an audit will be produced to evidence compliance following the reporting deadline which is in keeping with Year 4 of the scheme.
12.4 Progress Status: On Track.

13.0 Risks to Delivery

There is a risk that…	The risk is caused by…	The potential impact of the risk is…	The mitigation in place is…
Trust may not achieve version 3 of the SBLCB	New additions to the updated guidance pertaining to elements 1, 2 & 6 which relate to, NRT, digital blood pressure monitors and uterine artery dopplers, and diabetes glucose monitors and dietician services.	Failure of safety action 6 Linked to a risk to patient safety	As this is a new element, the guidance is quite fluid and already there have been 3 iterations for providers to work through.
The Trust may miss the 90% target for training for midwives, Drs and support staff	The 12 months consecutive date range begins from the date used to inform compliance for the year 4 scheme therefore compliance must be achieved by October 2023.	Failure of safety action 8	There are a number of sessions planned to try and capture as many staff as possible however this is intrinsically linked with a high unavailability rate/planned industrial action therefore it is likely that our position will not be known until the qualifying period ends.

14.0Summary

14.1 SaTH is mostly on track to achieve CNST MIS Year 5, although there is a risk to delivery for Safety Actions 6 and 8 for the reasons specified above. The team are working hard to mitigate these risks wherever possible and reduce the risk of non-compliance.

15.0 Summary of safety action statuses

Safety Action #	Completion Status
1	On Track
2	On Track
3	On Track
4	On Track
5	On Track
6	At Risk
7	On Track

8	At Risk
9	On Track
10	On Track

16.0 Actions requested of the Board of Directors

16.1 Review this report and note the ongoing risks to delivery for the scheme.

APPENDIX 1
MIS YEAR 5 Update v1.1 July 2023

Maternity Incentive Scheme – year five

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

V1.1 July 2023

Contents

Introduction

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved **all** of the **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 small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Maternity incentive scheme year five: conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution nhsr.mis@nhs.net by **12 noon** on **1 February 2024** and must comply with the following conditions:

- Trusts must achieve **all** ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
- The Trust Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:
    - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
    - There are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before **1 February 2024**.
- The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions'

evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution

- Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of
  MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions, then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution
  Website).

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested as explained above.
- Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.
- Trusts will need to report compliance with MIS by **1 February 2024** at **12 noon** using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/Integrated Care System.

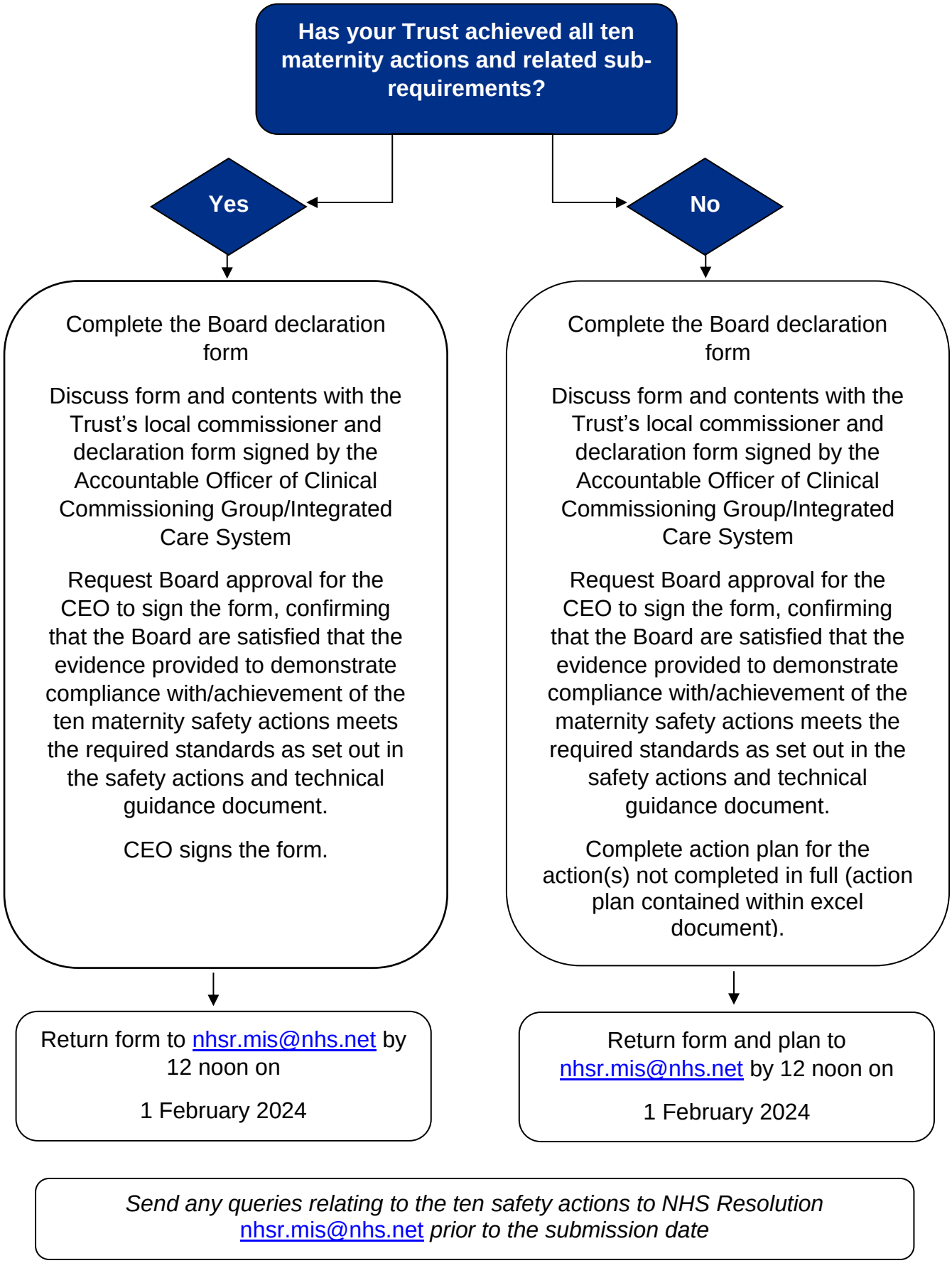
- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.
- The Board declaration form will be available on the MIS webpage at a later date.
- Trusts are reminded to retain all evidence used to support their position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described above) it must be made available as it was presented to support Board assurance at the time of submission.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution nhsr.mis@nhs.net prior to the submission date.
- The Board declaration form must be sent to NHS Resolution nhsr.mis@nhs.net between **25 January 2024** and **1 February 2024** at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from submission date.
- Submissions and any comments/corrections received after **12 noon** on **1 February 2024** will not be considered.
- The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.
- There are two possible grounds for appeal:
    - alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation
    - technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.
- NHS Resolution clinical advisors will review all appeals to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.
- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.
- Further detail on the results publication, appeals window dates and payments process will be communicated at a later date.

For Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 1 February 2024 to NHS Resolution nhsr.mis@nhs.net. The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form. Action plans should not be submitted for achieved safety actions.


Has your Trust achieved all ten maternity actions and related sub-requirements?
Yes
No
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
CEO signs the form.
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
Complete action plan for the action(s) not completed in full (action plan contained within excel document).
Return form to nhsr.mis@nhs.net by 12 noon on
1 February 2024
Return form and plan to nhsr.mis@nhs.net by 12 noon on
1 February 2024
Send any queries relating to the ten safety actions to NHS Resolution nhsr.mis@nhs.net prior to the submission date

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Required standard	a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from **30 May 2023,** MBRRACE-UK surveillance information should be completed within one calendar month of the death. b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from **30 May 2023** onwards. c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from **30 May 2023.** 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months. d) Quarterly reports should be submitted to the Trust Executive Board from **30 May 2023.**
Minimum evidential requirement for Trust Board	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal). The PMRT must be used to review the care and reports should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter from **30 May 2023** that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Verification process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.
What is the relevant time period?	From **30 May 2023** until **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**12 noon** on **1 February 2024**

Technical guidance for safety action 1

Further guidance and information is available on the PMRT website: Maternity Incentive Scheme FAQs. This includes information about how you can use the MBRRACE-UK/PMRT system to track your notifications and reviews: www.npeu.ox.ac.uk/pmrt/faqsmis; these FAQs are also available on the MBRRACE-UK/PMRT reporting website www.mbrrace.ox.ac.uk.

Technical Guidance **Guidance for SA 1(a) – notification and completion of surveillance information**	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal death must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
Where are perinatal deaths notified?	Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website. It is planned that a single notification portal (SNP) will be released by NHS England in 2024. Once this is released notifications of deaths must be made through the SNP and this information will be passed to MBRRACE-UK. It will then be necessary for reporters to log into the MBRRACE-UK surveillance system to provide the surveillance information and use the PMRT.
Should we notify babies who die at home?	Notification and surveillance information must be provided for babies who died after a home birth where care was provided by your Trust.
What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK from **30 May 2023** onwards must be notified to MBRRACE-UK within seven working days.
What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route of reporting for neonatal deaths that will be via MBRRACE-UK. Once this single route is established, MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP) and the NCMD. At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required mechanism for completing the local review for submission

	to CDOP. This will also be the required route for providing additional information about the death required by both CDOPs and the NCMD. Work is underway to provide this single route of reporting with plans to have this in place in the forthcoming months
Are there any exclusions from completing the surveillance information?	If the surveillance form needs to be assigned to another Trust for additional information, then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts, should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.
Guidance for SA1(b) – parent engagement	
We have informed parents that a local review will take place and they have been asked if they have any reflections or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order that parents' perspectives and questions can be considered during the review this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. The importance of parents' perspectives is highlighted by their inclusion as the first set of questions in the PMRT. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
We have contacted the parents of a baby who has died and they don't wish to have any involvement in the review process. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their perspective and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.

Parents have not responded to our messages and therefore we are unable to discuss the review. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will also be undertaken by the local CDOP. Verbal information can be supplemented by written information. If, for any reason, this does not happen and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process, ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of the role of key contact, are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
Guidance for SA1(c) – conducting reviews	
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: • All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) • All stillbirths (from 24+0 weeks' gestation) • Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth) While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet the safety action one standard.
What happens when an HSIB investigation takes place?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by HSIB. Your local review using the PMRT should be started but not completed until the HSIB report is complete. You should consider inviting the HSIB reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the HSIB review to be automatically incorporated into the PMRT review. Depending upon the timing of the HSIB report completion achieving the MIS standards for these babies may therefore be impacted by time frames beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an HSIB INVESTIGATION is taking place, and this will be accounted for in the external validation process.

What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session (which might be the first session of several) for that death. As an absolute minimum all the 'factual' questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review. The factual questions are highlighted within the PMRT with the symbol: FQ
What is meant by "reviews should be completed to the draft report stage"?	A multidisciplinary review team should have used the PMRT to review the death, then the review progressed to at least the stage of writing a draft report by pressing 'Complete review'. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details of assistance in using the PMRT to complete a review.
What does "multi-disciplinary reviews" mean?	To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include a member from a relevant professional group who is external to the unit who can provide 'a fresh pair of eyes' as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member. Bereavement care staff (midwives and nurses) should form part of the review team to provide their expertise in reviewing the bereavement and follow-up care, and advocate for parents. It should not be the responsibility of bereavement care staff to run the reviews, chair the panels nor provide administrative support. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details about multi-disciplinary review.
What should we do if our post-mortem service has a turn-around time in excess of four months?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than four months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death and complete it with the information you have available. When the post-mortem results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing earlier learning opportunities, especially if the turn-around time is considerably longer than four months. Where the post-mortem turn-around time is quicker, then the information from the post-mortem can be included in the original review.

What is review assignment?	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review, the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided.
How does 'assigning a review' impact on safety action 1, especially on starting a review?	If you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the external validation process.
What should we do if we do not have any eligible perinatal deaths to review within the relevant time period?	If you do not have any babies that have died between **30 May 2023** and **7 December 2023** you should partner up with a Trust with which you have a referral relationship to participate in case reviews. This will ensure that you benefit from the learning that arises from conducting reviews.
What deaths should we review outside the relevant time period for the safety action validation process?	Trusts should review all eligible deaths using the PMRT as a routine process, irrespective of the MIS timeframe and validation process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 5 MIS requirements.
Guidance for SA1(d) – Quarterly reports to Trust Boards	
Can the PMRT help by providing a quarterly report that can be presented to the Trust Executive Board?	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews over a period, within the PMRT for user-defined time periods. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for quarterly Trust Board reports and should be discussed with Trust maternity safety champions.
Is the quarterly review of the Trust Executive Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for the Trust Executive Board summarising the results from reviews over a period time which have been completed can be generated within the PMRT by authorised PMRT users for a user-defined periods of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'.

	Please note that these reports will only show summaries, issues and action plans for reviews **that have been published** therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months.
Guidance – Technical issues and updates	
What should we do if we experience technical issues with using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk
If there are any updates on the PMRT for the maternity incentive scheme where will they be published?	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the maternity incentive scheme safety action 1, will be communicated via NHS Resolution email and will also be included in the PMRT 'message of the day'.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required standard	This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023. 2. July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) 3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: **Midwifery Continuity of carer (MCoC)** **Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable.** i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Final data for July 2023 will be published in October 2023.

	If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information). 4. Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023. 5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.
Minimum evidential requirement for Trust Board	The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.
Validation process	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
What is the relevant time period?	From **30 May 2023** until **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024** at 12 noon

Technical guidance for safety action 2

Technical guidance	
The following CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on these three months? • **Proportion of babies born at term with an Apgar score <7 at 5 minutes** • **Women who had a postpartum haemorrhage of 1,500ml or more** • **Women who were current smokers at delivery** • **Women delivering vaginally who had a 3rd or 4th degree tear** • **Women who gave birth to a single second baby vaginally at or after 37 weeks after a previous caesarean section** • **Caesarean section delivery rate in Robson group 1 women** • **Caesarean section delivery rate in Robson group 2 women** • **Caesarean section delivery rate in Robson group 5 women**	No. For the purposes of the CNST assessment Trusts will only be assessed on July 2023 data for these CQIMs. Due to this, Trusts are now directed to check whether they have passed the requisite data quality required for this safety action within the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts.
My maternity service has currently suspended Midwifery Continuity of Carer pathways. How does this affect my data submission for CNST safety action 2?	If maternity services have suspended Midwifery Continuity of Carer (MCoC) pathways, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102. This is a satisfactory response for safety action 2 criteria 3i. If your Trust has suspended all MCoC pathways, criteria 3ii is not applicable and does not need to be completed. If your Trust is continuing with some provision of MCoC pathways, then criteria 3ii does still apply.

Will my Trust fail this action if women choose not to receive continuity of carer?	No. This action is focussed on data quality only and therefore Trusts pass or fail it based upon record completeness for each metric and not on the proportion (%) recorded as the metric output. If women choose not to be placed onto a MCoC pathway, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102.
Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass CQIMs and other metrics specified above can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics
What is the Data Quality Submission Summary Tool? How does my Trust access this?	The Data Quality Submission Summary Tool has been developed by NHS England specifically to support this safety action. The tool provides an immediate report on potential gaps in data required for CQIMs and other metrics specified above after data submission, so Trusts can take action to rectify them. It is intended to be used alongside other existing reports and documentation in order for providers to be able to create a full and detailed picture of the quality of their data submissions. Further information on the tool and how to access it is available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/data-quality-submission-summary-tool
For the Data Quality Submission Summary Tool, what does "sustained engagement" mean for the purposes of passing criteria 3?	By "sustained engagement" we mean that Trusts must show evidence of using the tool for at least three consecutive months prior to the submission of evidence to the Trust Board. For example, for a submission made to the Board in November, engagement should be, as a minimum, in August, September and October. This is a minimum requirement, and we advise that engagement should start as soon as possible. To evidence this, Trusts should save the Excel output file after running the report for a given month. Three files representing each of the three consecutive months should be provided to your Trust Board as part of the assurance process for the scheme. Note – this only becomes a requirement in the event your Trust fails the requisite data quality for the continuity of carer metrics in criteria 3.

The monthly publications and Maternity Services DashBoard states that my Trusts' data has failed for a particular metric. Where can I find out further information on why this has happened?	Details of all the data quality criteria can be found in the "Meta Data" file (see 'CQIMDQ/CoCDQ Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics The scores for each data quality criteria can be found in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series
The monthly publications and national Maternity Services DashBoard states that my Trusts' data is 'suppressed'. What does this mean?	Where data is reported in low values for clinical events, the published data will appear 'suppressed' to ensure the anonymity of individuals. However, for the purposes of data quality within this action, 'suppressed' data will still count as a pass.
Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services DashBoard please contact maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

Required standard	a) Pathways of care into transitional care (TC) 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) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies **equal to or greater than 37 weeks**. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director, or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB. c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.
Minimum evidential requirement for Trust Board	**Evidence for standard a) to include:** Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.
	Evidence for standard b) to include: • Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks. • Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks.

	• Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan. • Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan.
	Evidence for standard c) to include: Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring **OR** An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	**30 May 2023** to **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024**

Technical guidance for safety action 3

Technical guidance	
Does the data recording process need to be available to the ODN/LMNS/ commissioner?	The requirement for a data recording process from years three and four of the maternity incentive scheme was to inform future capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review. This should be in place and maintained in order to inform ongoing capacity planning of transitional care to minimise separation of mothers and babies. This could be captured through existing systems such as BadgerNet or alternatives such as paper based or electronic systems. These returns do not need to be routinely shared with the Operational Delivery Network (ODN), LMNS and/or commissioner but must be readily available should it be requested.
What members of the MDT should be involved in ATAIN reviews?	The expectation is that this is a multi-professional review, as a minimum the care should be reviewed by representation from both maternity and neonatal staff groups. This should include as a minimum; a member of the maternity team (a midwife and / or obstetrician and /or trainee from maternity services) and a member of the neonatal team (neonatal nurse and / or neonatologist/paediatrician and/or trainee from neonatal services).
We have undertaken some reviews for term admissions to NICU, do we need to undertake more and do all babies admitted to the NNU need to be included?	Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the Avoiding Term Admissions into Neonatal Units (ATAIN) work to date. The expectation is that reviews have been continued from year 4 of the scheme. If for any reason, reviews have been paused, they should be recommenced using data from quarter 4 of the 2022/23 financial year (beginning January 2023). This may mean that some of the audit is completed retrospectively. We recommend ongoing reviews, at least quarterly of unanticipated admissions of babies **equal to or greater than 37 weeks** to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan. A high-level review of the primary reasons for all admissions should be included, with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed. For example, if 60% of babies are admitted for respiratory problems, then focus on this cohort of babies and complete a deep dive into identified themes or if 40% of babies were admitted with jaundice and 35% of babies were admitted with hypothermia then focus on these two cohorts of babies.

	In addition to this, the number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues and the number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on.
What do you mean by quarterly?	Occurring every three months. This would usually mirror the 4 quarters of the financial year and should cover the period of the MIS **30 May 2023 – 7 December 2023**.
What should the Transitional Care audit include and is there a standard audit tool?	An audit tool can be accessed below as a baseline template; however, the audit needs to include aspects of the local pathway. ATAIN-CASE-NOTE-REVIEW-PROFORMA-Revised-2022-converted.pdf We recommend that Trusts refer to the auditable standards included in their local TC pathway guideline/policy.
How long have the neonatal safety champions been in place for?	Trust Board champions were contacted in February 2019 and asked to nominate a neonatal safety champion. The identification of neonatal safety champions is a recommendation of the national neonatal critical care review and have been in place since February/March 2019.
What is the definition of transitional care?	Transitional care is not a place but a service (see BAPM guidance) and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/ https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/

	https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Illness-in-newborn-babies-leaflet-FINAL-070420.pdf Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk) Framework: Early Postnatal Care of the Moderate-Late Preterm Infant | British Association of Perinatal Medicine (bapm.org) B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk)

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required standard	a) **Obstetric medical workforce** 1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums. 2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf 3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-compensatory-rest.pdf 4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed 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/ 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. **b) Anaesthetic medical workforce** 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 patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) **c) Neonatal medical workforce** The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements **have not been met** in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements **had been met** previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN). **d) Neonatal nursing workforce** The neonatal unit meets the BAPM neonatal nursing standards. If the requirements **have not been met** in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed

	and include new relevant actions to address deficiencies. If the requirements **had been met** previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).
Minimum evidential requirement for Trust Board	**Obstetric medical workforce** 1) Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses. Information on the certificate of eligibility (CEL) for short term locums is available here: www.rcog.org.uk/cel This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk 2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS. 3) Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working

	as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations. **NB**. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG 4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS. **Anaesthetic medical workforce** The rota should be used to evidence compliance with ACSA standard 1.7.2.1. **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN). **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form.
What is the relevant time period?	**Obstetric medical workforce** 1. After February 2023 – Audit of 6 months activity 2. After February 2023 – Audit of 6 months activity 3. 30 May 2023 - 7 December 2023 4. 30 May 2023 - 7 December 2023 **Anaesthetic medical workforce** Trusts to evidence position by 7 December 2023 at 12 noon **Neonatal medical workforce** A review has been undertaken of any 6 month period between **30 May 2023 – 7 December 2023** **a) Neonatal nursing workforce** Nursing workforce review has been undertaken at least once during year 5 reporting period **30 May 2023 – 7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024**

Technical guidance for safety action 4

Technical guidance	
Obstetric workforce standard and action	
How can the Trust monitor adherence with the standard relating to short term locums?	Trusts should establish whether any short term (2 weeks or less) tier 2/3 locums have been undertaken between February and August 2023. Medical Human Resources (HR) or equivalent should confirm that all such locums met the required criteria.
What should a department do if there is non-compliance i.e. locums employed who do not meet the required criteria?	Trusts should review their approval processes and produce an action plan to ensure future compliance.
Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.
Where can I find the documents relating to short term locums?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to long term locums?	Trusts should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance for 6 months after February 2023 and prior to submission to the Trust Board and have a plan to address any shortfalls in compliance.
What should a department do if there is a lack of compliance demonstrated in the audit tool regarding the support and supervision of long term locums?	Trusts should review their audits and identify where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if long term locums are employed who are not fully supported/supervised?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.
Where can I find the documents relating to long term locums?	Safe staffing | RCOG

	All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to Standard operating procedures for consultants and SAS doctors acting down?	Trusts should provide documentary evidence of standard operating procedures and their implementation Evidence of implementation/compliance could be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.
What should a department do if there is a lack of compliance, either no Standard operating procedure or failure to implement such that senior medical staff are unable to access compensatory rest?	Trusts should produce a standard operating procedure document regarding compensatory rest. Trusts should identify any lapses in compliance and where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if we do not have a standard operating procedure or it is not fully implemented?	Trusts cannot self-certify if they have no evidence of any standard operating procedures by **October 2023**. They can self-certify if they have been unable to achieve appropriate compensatory rest in individual circumstances such as excessive staffing pressure have prevented the doctor accessing this. They should, however, demonstrate that they have an action plan to ensure future compliance and provide assurance to the Board that this is place.
Where can I find the documents relating to compensatory rest for consultants and SAS doctors?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to consultant attendance out of hours?	For example, departments can audit consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Departments may also wish to monitor adherence via incident reporting systems. Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	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.
Can we self-certify compliance with this element of safety action 4 if	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans

consultants have not attended clinical situations on the mandated list?	implemented to prevent subsequent non-attendances. These can be signed off by the Trust Board.
Where can I find the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/
For queries regarding this safety action please contact: nhsr.mis@nhs.net and RCOG	

Anaesthetic medical workforce

Technical guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard and action	
1.7.2.1	**A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. 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.**

Neonatal medical workforce

Technical guidance	
Neonatal Workforce standards and action	
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If not, Trust Board should agree an action plan and outline progress against any previously agreed action plans. There should also be an indication whether the standards not met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap) alongside a record of the rota tier affected by the gaps. This action plan should be submitted to the LMNS and ODN.
BAPM **"Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021** **or** **"Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018**	

NICU **Neonatal Intensive Care Unit**	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff during office hours and out of hours. **Tier 1** Resident out of hours care should include a designated tier one clinician - Advanced Neonatal Nurse Practitioner (ANNP) or junior doctor ST1-3. NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice. **Tier 2** A designated experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP. NICUs with more than 2500 intensive care days should have an additional experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. (A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative) **Tier 3** Consultant staff in NICUs should be on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on the neonatal unit alone. NICUs undertaking more than 4000 intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day. NICUs undertaking more than 2500 intensive care days per annum should consider the presence of at least 2 consultant led teams during normal daytime hours. NICUs undertaking more than 4000 intensive care days per annum should consider the presence of three consultant led teams during normal daytime hours.

LNU **Local Neonatal Unit**	**Tier 1** At least one resident tier 1 practitioner immediately available dedicated to providing emergency care for the neonatal service 24/7. In large LNUs (>7000 births) there should be two dedicated tier 1 practitioners 24/7 to support emergency care, in keeping with the NICU framework. **Tier 2** 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. LNUs undertaking either >1500 Respiratory Care Days (RCDs) or >600 Intensive Care (IC) days annually should have immediately available a dedicated resident tier 2 practitioner separate from paediatrics 24/7. **Tier 3** Units designated as LNUs providing either >2000 RCDs or >750 IC days annually should provide a separate Tier 3 Consultant rota for the neonatal unit. LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs. All LNUs should ensure that all Consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system and no consultant should undertake fewer than 4 'consultant of the week' service weeks annually. No on-call rota should be more onerous than one in six and all new appointments to units with separate rotas should either have a SCCT in neonatal medicine or be a general paediatrician with a special interest in neonatology or have equivalent neonatal experience and training**.**

SCU **Special Care Unit**	**Tier 1** A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. **Tier 2** A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit. **Tier 3** In SCUs there should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology).
Our Trust do not meet the relevant neonatal medical standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.
When should the review take place?	The review should take place at least once during the MIS year 5 reporting period.
Please access the followings for further information on Standards	BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021). A BAPM Framework for Practice https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021 Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018). A BAPM Framework for Practice https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018

Neonatal nursing workforce

Technical guidance	
Neonatal nursing workforce standards and action	
Where can we find more information about the requirements for neonatal nursing workforce?	Neonatal nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here: https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf Access to the tool and more information will be available through your Neonatal ODN Education and Workforce lead nurse.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

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

Required standard	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 five reporting period.
Minimum evidential requirement for Trust Board	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

	• Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.
	
	  ○ The midwife to birth ratio
	
	  ○ The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.
	
	• Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	30 May 2023 – 7 December 2023
What is the deadline for reporting to NHS Resolution?	**1 February 2023** at **12 noon**

Technical guidance for Safety action 5

Technical guidance	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice**.	• Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637 https://www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care or care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to

	midwives at birth when required, supporting junior midwives undertaking suturing etc. This should not be counted as losing supernumerary status.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. As stated above, completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 5 of MIS.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Required standard	1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024. 2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool.
Minimum evidential requirement for Trust Board	1) The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024. A new implementation tool is now available to help maternity services to track and evidence improvement and compliance with the requirements set out in version three. The tool is based on the interventions, key process and outcome measures identified within each element, and is available at https://future.nhs.uk/SavingBabiesLives Providers should use the new national implementation tool to track compliance with the care bundle and share this with the Trust Board and ICB. To evidence adequate progress against this deliverable by the submission deadline in February, **providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.** These percentages will be calculated within the national implementation tool. 2) Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust, using the implementation tool and includes the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.

	• Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.

Technical guidance for Safety action 6

Technical guidance	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: https://www.england.nhs.uk/publication/saving-babies-lives-version-three/ The implementation tool is available at https://future.nhs.uk/SavingBabiesLives and includes a technical glossary for all data items referred to in MSDS Additional resources are in production and will be advertised on this page. Any further queries regarding the tool, please email england.maternitytransformation@nhs.net Any queries related to the **digital aspects** of this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net Some data items are or will become available on the National Maternity Dashboard or from NNAP Online For any other queries, please email nhsr.mis@nhs.net
What is the rationale for the change in evidential requirements to SA6 in Year 5?	The broad principles that will apply to the implementation of the standards detailed in the Saving Babies' Lives Care Bundle (version 3) are: The use of the implementation tool will allow Trusts to track implementation and demonstrate local improvement using the process and outcome indicators within all six elements of the care bundle (for some elements this may only require evidence of a protocol, process, or appointed post). These data will form the basis of compliance with safety action 6 of this version of the maternity incentive scheme. This approach acknowledges the increased number and/or size of elements in this new version of the care bundle. The indicators for each of the six elements are set out below. Data relating to each of these indicators will need to be provided via the national implementation tool. ***Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and/or Neonatal System e.g Badgernet and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding.***

What are the indicators for Element 1	*Process Indicators* 1a. Percentage of women where there is a record of: 1.a.i. CO measurement at booking appointment 1.a.ii. CO measurement at 36-week appointment 1.a.iii. Smoking status** at booking appointment 1.a.iv. Smoking status** at 36-week appointment 1b. Percentage of smokers* that have an opt-out referral at booking to an in-house/in-reach tobacco dependence treatment service. 1c. Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date. *Outcome Indicators* 1d. Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks. 1e. Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks. *a "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). **Smoking status relates to the outcome of the CO test (>4ppm) and the enquiry about smoking habits.
What are the indicators for Element 2	*Process Indicators* 2a. Percentage of pregnancies where a risk status for Fetal Growth Restriction (FGR) is identified and recorded at booking. (This should be recorded on the provider's MIS and included in the MSDS submission to NHS Digital once the primary data standard is in place.) 2b. Percentage of pregnancies where a Small for Gestational Age (SGA) fetus (between 3rd to <10th centiles) is antenatally detected, and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital. 2c. Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT). *Outcome Indicators*

	2d. Percentage of babies <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR). 2e. Percentage of live births and stillbirths >3rd birthweight centile born <39+0 weeks gestation, where growth restriction was suspected.
What are the indicators for Element 3	*Process Indicators* 3a. Percentage of women who attend with Reduced Fetal Movements (RFM) who have a computerised Cardiotocograph (CTG). 3b. Proportion of women who attend with recurrent RFM* who had an ultrasound scan by the next working day to assess fetal growth. *Outcome Indicators* 3c. Percentage of stillbirths which had issues associated with RFM management identified using PMRT. 3d. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation. *There is no accepted definition of what recurrent RFM means; one region of the UK has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation.
What are the indicators for Element 4	*Process Indicators* 4a. Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors, and situational awareness. 4b. Percentage of staff who have successfully completed mandatory annual competency assessment. 4c. Fetal monitoring lead roles appointed. *Outcome Indicators* 4d. The percentage of intrapartum stillbirths, early neonatal deaths, and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. *Using the severe brain injury definition as used in Gale et al. 2018[48].

What are the indicators for Element 5	*Process Indicators* 5a. Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU). 5b. Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth. 5c. Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth. 5d. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive intravenous (IV) intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection. 5e. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth. 5f. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. 5g. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth. 5h. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (5a – 5g above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation). *To minimise the need for local data collection to support these improvements the formal collection of process measure data can be restricted to the seven interventions listed in this section, the use of volume targeted ventilation and caffeine is recommended but these data are not currently recorded or presented with national datasets. In addition, the gestational limits for some of the indicators and/or the groups studies have been adjusted to align with current nationally collected data (e.g., data on babies born only below 34 weeks or data on the number of babies*

	receiving antenatal corticosteroids rather than the number of mothers) *Outcome Indicators* **5i. Mortality to discharge in very preterm babies** (National Neonatal Audit Programme (NNAP) definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner). **5j. Preterm Brain Injury** (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: ✓ Germinal matrix/ intraventricular haemorrhage ✓ Post haemorrhagic ventricular dilatation ✓ Cystic periventricular leukomalacia 5k. Percentage of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation, or perinatal optimisation of preterm birth was a relevant issue. 5l. Maternity care providers will provide outcome data to the Trust Board and share this with the LMNS relating to the incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: ✓ In the late second trimester (from 16+0 to 23+6 weeks). ✓ Pre-term (from 24+0 to 36+6 weeks).
What are the indicators for Element 6	*Process Indicators* 6a. Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc). 6b. Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes.

	6c. Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets. 6d. Demonstrate compliance with Continuous Glucose Monitoring (CGM) training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes. 6e. Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with Diabetic Ketoacidosis (DKA) during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities, and availability of expertise. *Outcome Indicators* 6f. The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the National Pregnancy in Diabetes (NPID) dashboard (aiming for >95% of women). 6g. The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the start of the third trimester (aiming for >95% of women). Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.
What considerations need to be made to ensure timely submission of data to evidence implementation and compliance with locally agreed progress measures?	Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.
Is there a requirement on Trusts to evidence SBLCB process and outcome measures through their data submissions to Maternity Services Data Set?	Trusts should be capturing SBLCB data as far as possible in their Maternity Information Systems/Electronic Patient Records and submitted to the MSDS. MSDS does not capture all process and outcome indicators given in the care bundle. A summary of this appears in the technical appendix for version 2 of the care bundle, available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/tools-and-guidance

	Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.
Would a Trust be non-compliant if <60% of smokers set a quit date?	As stated in SA6, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. The implementation tool will set out the evidence requirement for demonstrating compliance with each intervention. Where element process and outcome measures are listed in the evidence requirement, a performance threshold is recommended, but this is for agreement between a provider and their ICB in view of local circumstances.
The SBLCBv3 that was published on the 31st May 2023 included a typo in Appendix D Figure 6 with BMI as >18.5kg/m and it is not clear what "other features" mean	This has now been amended and states **<18.5kg/m** with further clarity provided regarding "other features".
How do we provide evidence for the interventions that have been implemented?	The evidence requirements for each intervention are set out within the implementation tool. You will need to verify that you have an implemented service locally.
Will the eLfH modules be updated in line with SBLCBv3?	The SBLCB eLearning for Health modules is currently being updated in line with the latest iteration, Version 3 of the Care Bundle and will include a new section to support implementation of element 6. We have asked for the ultrasound element to be reviewed for its relevance, this was developed separately, and we will make sure the completion of the e learning is focussed on elements 1-6.
What is the deadline for reporting to NHS Resolution?	**1 February 2024** at **12 noon**

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Required standard	1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group. 2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board. 3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.
Minimum evidential requirement for Trust Board	**Evidence should include:** • Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff. • Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support. • The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it. • Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses. • Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.
Validation process	Self-certification to NHS Resolution using the Board declaration form.

What is the relevant time period?	Trusts should be evidencing the position as **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2023** at 12 noon

Technical guidance for Safety action 7

Technical guidance	
What is the Maternity and Neonatal Voices Partnership?	An MNVP listens to the experiences of women, birthing people, and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. MNVPs ensure that service user voice is at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the local maternity and neonatal system (LMNS). MNVPs ensure service user voice influences improvements in the safety, quality, and experience of maternity and neonatal care.
We are unsure about the funding for Maternity and Neonatal Voices Partnerships	It is the responsibility of ICBs to: Commission and fund MNVPs, to cover each Trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
What advice is there for Maternity and Neonatal Voices Partnership (MNVP) leads when engaging and prioritising hearing the voices of neonatal and bereaved service users, and what support or training is in place to support MNVP's?	MNVPs should work in partnership with local specialist voluntary, community, and social enterprise (VCSEs) with lived experience to gather feedback. Engagement needs to be accessible and appropriate, particularly for neonatal and bereaved families. It is essential that you consider how you will protect people from being retraumatised through giving feedback on their experience. Training for MNVPs to engage with seldom heard or vulnerable communities may be required to ensure unintentional harm is avoided. MNVPs can also work in collaboration with their trust bereavement leads to ensure adequate support is in place for themselves and the families they may engage with. Attendance at the trust training could be beneficial.
When will the MNVP guidance be published?	We are working with our stakeholders to publish the MNVP guidance as soon as possible. As it is not yet published, it is acknowledged that there may not be enough time ahead of the reporting period for full implementation of all the requirements of the MNVP guidance. Where an element of the guidance is not yet fully implemented, evidence must be presented that demonstrates progress towards full implementation within 12 months.

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Required standard and minimum evidential requirement	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework. 2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. 3. The plan is developed based on the "How to" Guide developed by NHS England.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	12 consecutive months should be considered from 1st December 2022 until 1st December 2023 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for trust boards to review. It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv1

Technical guidance for safety action 8

Technical guidance	
What training should be covered in the local training plan to cover the six modules of the Core Competency Framework?	A **training plan** should be in place to implement all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 2024. NHS England » Core competency framework version two Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework.
How will the 90% attendance compliance be calculated?	The training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups by the end of the 12 month period

Where can I find the Core Competencies Framework and other additional resources?	• https://www.england.nhs.uk/publication/core-competency-framework-version-two/
	• Includes links to the documents:
	  ○ Core competency framework version two: Minimum standards and stretch targets
	  ○ 'How to' guide - a resource pack to support implementing the Core Competency Framework version two
	  ○ Core competency framework: training needs analysis
	• NHS England V1 of the Core Competency Framework https://www.england.nhs.uk/publication/core-competency-framework/
	• https://www.resus.org.uk/library/2021-resuscitation-guidelines/newborn-resuscitation-and-support-transition-infants-birth

What training should be included to meet the requirements of the Core Competency Framework Version 2?	All 6 core modules in V2 of the Core Competency Framework (CCFv2) must be covered as detailed in the minimum standards. Trusts must be able to evidence the four key principles: 1. Service user involvement in developing and delivering training. 2. Training is based on learning from local findings from incidents, audit, service user feedback,

	and investigation reports. This should include reinforcing learning from what went well. 3. Promote learning as a multidisciplinary team. Promote shared learning across a Local Maternity and Neonatal System.
Which maternity staff should be included for Module 2: Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric consultants • All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor) • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • MSWs • GP trainees
Which maternity staff should be included for Module 3: Maternity emergencies and multiprofessional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric consultants. • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota. • Midwives (including midwifery managers and matrons), community midwives; birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) • Obstetric anaesthetic consultants. • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) **who contribute to the obstetric rota.**

	• Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS year 5 compliance assessment • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS year 5 compliance • At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff
Does the multidisciplinary emergency scenarios described in module 3 have to be conducted in the clinical area?	At least one emergency scenario needs to be conducted in the clinical area or at point of care. You need to ensure that 90% of your staff attend a minimum of one emergency scenario that is held in the clinical area, but not all of the scenarios have to be based in a clinical area.
Which staff should be included for Module 6: Neonatal basic life support?	Staff in attendance at births should be included for Module 6: Neonatal basic life support. This includes the staff listed below: • Neonatal Consultants or Paediatric consultants covering neonatal units • Neonatal junior doctors (who attend any births) • Neonatal nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. The staff groups below are not required to attend neonatal basic life support training: • All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit). • Local policy should determine whether maternity support workers are included in neonatal basic life support training.

I am a NLS instructor, do I still need to attend neonatal basic life support training?	No, if you have taught on a course within MIS year 5 you do **not** need to attend neonatal basic life support training
I have attended my NLS training, do I still need to attend neonatal basic life support training?	No, if you have attended a course within MIS year 5 you do **not** need to attend neonatal basic life support training as well.
Which members of the team can teach basic neonatal life support training and NLS training?	Registered RC-trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates. A detailed response to this can be found on the CCF NHS Futures page CCF NHS Futures page - FAQ
What do we do if we do not have enough instructors who are trained as an NLS instructor and hold the GIC qualification?	Your Neonatal Consultants and Advanced Neonatal Practitioners (ANNP) will be qualified to deliver the training. You can also liaise with your Local Maternity and Neonatal System (LMNS) to explore sharing of resources. There may be difficulty in resourcing qualified trainers. Units experiencing this must provide evidence to their trust board that they are seeking mitigation across their LMNS and an action plan to work towards NLS and GIC qualified status by 31st March 2024. As a minimum, training should be delivered by someone who is up to date with their NLS training.
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally determined.
How do we involve services users in developing and <u>delivering</u> training?	Please refer to the "How To" guide for ideas on how to involve service users in the developing and delivering of training. This is **Principle 1** of the CCFv2 that recommends MNVP leads could be a member of the multidisciplinary educational teams (MET) to support the planning and selection of themes/local learning requirements to reflect in the training. Ways in which service users and service user representatives can support the delivery of training include with video case studies, inviting service users to tell their story or inviting charitable/support organisations for example local Downs Syndrome groups; LGBTQIA+ Communities; or advocates for refugees.

	NHS England will be sharing examples of practice over the year and on their NHS Futures page.
The TNA suggests periods of time required for each element of training, for example 9 hours for fetal monitoring training. Is this a mandated amount of time?	The TNA has been inputted with **example** times to demonstrate how the calculations are made for the backfill of staff that is required to put a training plan in place. The hours for each element of training can be flexed by the individual trust in response to their own local learning needs.
Do all the modules within the CCF require a multidisciplinary attendance?	Multidisciplinary team working has an evidence-base and has been highlighted in The Kirkup Report (2022). Key Action 3 (Flawed Team working) was a significant finding with the recommendation to improve teamworking with reference to establishing common purpose, objectives, and training from the outset. It is therefore a requirement that there is a strong emphasis on multidisciplinary training throughout the modules in response to local incidents. The staff groups within the multidisciplinary teams being trained may also vary, depending on the incident/emergency being covered.

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?

Required standard	a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded. b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings. c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.
Minimum evidential requirement for Trust Board	**Evidence for point a) is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically:** • Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues. • Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs). • To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need. **Evidence for point b)** • Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaints data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. This should continue to be undertaken quarterly as detailed in MIS year 4. These discussions

	must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting. **Evidence for point c):** Evidence that the Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme. This will include: • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	**Time period for points a and b)** • Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action should be in place based on previous requirements. The expectation is that if work is still in progress, this will have been completed by 1st December 2023. • The expectation is that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance are continuing to take place at Board level monthly. If for any reason they have been paused, they should be reinstated no later than 1 July 2023. • The expectation is for ongoing engagement sessions with staff as per year 4 of the scheme. If for any reason these have been paused, they should be recommenced no later than 1 July 2023. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions. • Progress with actioning named concerns from staff engagement sessions are visible to both maternity

	and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than the 17th July 2023. • Evidence that a review of the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting by 17th July 2023. At least one additional meeting must have been undertaken before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review as part of the PSIRF plan. This should continue to be undertaken quarterly as detailed in MIS year 4. **Time period for points c)** • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have **registered** to the dedicated FutureNHS workspace to access the resources available no later than 1 August 2023. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of quarterly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 2 meetings held by 1 February 2024
What is the deadline for reporting to NHS Resolution?	By **1 February 2024** at 12 noon
Where can I find additional resources?	implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) Measuring culture in maternity services: Safety Culture Programme for Maternal and neonatal services: https://drive.google.com/file/d/1bzAqOcf5A5XHR8HWBZnLzH6qsG_SgXoa/view?usp=sharin Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme The Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace is a dedicated place for Non-Executive Director and Executive Director maternity and neonatal Board safety champions to access the culture and leadership

	programme, view wider resources and engage with a community of practice to support them in their roles. The Perinatal Culture and Leadership Programme - Maternity Local Transformation Hub - Maternity (future.nhs.uk) is a dedicated space for NHS England's Perinatal Culture and Leadership Programmes, with resources for senior leaders and their teams to support local safety culture work.

Technical guidance for safety action 9

Technical guidance	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local pathway for sharing intelligence updated. This revised pathway should: • Describe the local governance processes in place to demonstrate how intelligence is shared from the floor to Board. • Formalise how Trust-level intelligence will be shared with the LMNS/ICS quality group and regional quality groups involving the Regional Chief Midwife and Lead Obstetrician.
What do we need to include in the dashBoard presented to Board each month?	The dashboard can be locally produced, based on a minimum data set as set out in the Board level measures. It must include the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; SUV feedback; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. The dashboard can also include additional measures as agreed by the Trust.
We had not continued to undertake monthly feedback sessions with the Board safety champion what should we do?	Parts a) and b) of the required standards build on the year three and four requirement of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board safety champions to raise concerns relating to safety. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions as described above. Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three of the maternity incentive scheme and the expectation is that this should have been continued. If these have not been continued, this needs to be reinstated by no later than 1 July 2023.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.

What is the rationale for the Board level safety champion safety action?	It is important to ensure all staff are aware of who their frontline and Board safety champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names of the relevant leaders, will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here 2021 Scorecards launch - NHS Resolution https://resolution.nhs.uk/2020/10/27/claims-scorecards-for-2020/
What are the expectations of the Board safety champions in relation to quality improvement work undertaken by the maternity and neonatal quality improvement programme?	The Board safety Champions will be expected to continue their support for quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Networks. Trusts will be required to undertake improvement including data collection and testing work aligned to the national priorities.
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will be involved in the Perinatal Culture and Leadership Programme. As part of this programme every service will be undertaking work to meaningfully understand the culture of their services. This diagnostic will either be a SCORE culture survey or an alternative as agreed with the national NHSE team. It is expected that diagnostic findings are shared with the Trust Board to enable an understanding and garner support for the work to promote optimal safety cultures, based on the diagnostic findings.
What if our maternity and neonatal services are not undertaking the SCORE culture survey as part of the national programme?	The national offer to undertake a SCORE culture is a flexible, opt out offer. If your maternity and neonatal services demonstrated that they were already completing work to meaningfully understand local culture, and therefore opted out of the SCORE survey, the expectation is that the Board receives updates on this alternative work.
What are the expectations of the NED and Exec Board safety champion in relation to	As detailed in previous years MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provide an opportunity to share

their support for the Perinatal Culture and Leadership Programme (PCLP), culture surveys and ongoing support for the Perinatal 'Quad' Leadership teams? / What should be discussed at the bi-monthly meetings between the Board Safety Champion(s) and the Perinatal 'Quad' Leadership teams?	safety intelligence, examples of best practice and identified areas of challenge. The meetings should be conducted in an appreciative way, with the perinatal teams being open and transparent and the Board Safety Champions being curious and supportive. As a minimum the content should cover: - Learning from the Perinatal Culture and Leadership Development Programme so far - Plans to better understand their local culture. This will be use of the SCORE culture survey, or suitable alternative as agreed by the national NHS England team. - Updates on the SCORE survey, or alternative when undertaken. - Updates on identified areas for improvement following the local diagnostic, along with any identified support required from the Board. NB, a formal report following this work should be presented at Board by the Perinatal leadership team. Progress with interventions relating to culture improvement work, and any further support required from the Board
Clarification as to evidence required to meet the standard: *Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available.*	The NED and Exec Board Safety Champion will be able to evidence they have registered on the FutureNHS Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace through minutes of a trust board meeting providing confirmation of specific resources accessed and how this has been of benefit. This will be reported as part of the board submission to NHS Resolution.
How often should the Board Safety Champions be meeting and engaging with the perinatal 'Quad' team?	Meetings between the Board Safety Champion(s) and Quad member(s) should be occurring a minimum of quarterly. We would expect a minimum of two meetings during this reporting period.
Who is expected to have undertaken the Perinatal Culture and Leadership Quad programme?	The expectation is that the senior perinatal leadership team (the Quad) have undertaken the PCLP. This will be representation from the midwifery, obstetric, neonatal, and operational professional groups, usually consisting of the

	DoM/HoM, clinical lead / CD for obstetrics, clinical lead for neonates and the operational manager.
Is there an expectation that the board safety champions have undertaken the programme?	The Board Safety Champions should be supporting the Quad and their work as part of the PCLP, but there is no expectation for them to attend the programme.
Evidence that a monthly review – Most Trust meet bi-monthly (every other month) & are unable to meet this requirement	A review must be undertaken at every board meeting. If this is bi-monthly that will be sufficient, but this is the minimum requirement.
Examples have been requested for how to review the data from scorecards	The key to making this exercise meaningful is the triangulation of the data. Categorisation of the historic claims on the scorecard and any action taken, then presenting these alongside current incidents and complaints. This allows identification of potential themes or trends, identification of the impact of any learning, and allows you to act quickly if any historic themes re-emerged. An example is now available from the MIS team at NHS Resolution, and staff are happy to talk through this process if it is helpful.
The perinatal quality surveillance model requires review in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife to provide evidence of trust-level intelligence being shared and actions reported on areas of concern. This needs to happen before 1st July and therefore does not give trusts enough time to carry out this review	The expectation is that this process should already be in place as it was a requirement in previous years, with the year 4 requirement for this to be in place by 16th June 2022. However, in recognition of the challenges of embedding a new quality surveillance model the timeframe of the 1st July has been amended to 1st December 2023 to allow additional time for trusts.
Clarification as to what constitutes a trust board, can sub committees be categorised as a board?	This refers solely to the Board of the trust, and it is a requirement that the board oversees the quality of their perinatal services at every meeting.

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) *(known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023)* and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

Required standard	A) Reporting of all qualifying cases to HSIB/ MNSI from 6 December 2022 to **7 December 2023.** B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until **7 December 2023**. C) For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB//MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum evidential requirement for Trust Board	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB//MNSI/EN incidents and numbers reported to HSIB//MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of HSIB/MNSI and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Validation process	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against the HSIB/MNSI database and the National Neonatal Research Database (NNRD) and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard a) and b) have been met in the relevant reporting period. In addition, for standard C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's

	involvement, completion of this will also be monitored, and externally validated.
What is the relevant time period?	Reporting to HSIB – from 6 December 2022 to **7 December 2023** Reporting period to HSIB **and** to NHS Resolution – from 6 December 2022 to **7 December 2023**
What is the deadline for reporting to NHS Resolution?	By **1 February 2024** at 12 noon

Technical guidance for Safety action 10

Technical guidance	
Where can I find information on HSIB?	Information about HSIB/ MNSI and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/ From October 2023 this website will no longer be available and the HSIB maternity programme will be hosted by the CQC. Further details will be circulated once available.
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website: • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to HSIB/MNSI?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [or] • Was therapeutically cooled (active cooling only) [or] • Had decreased central tone AND was comatose AND had seizures of any kind. Once HSIB/MNSI have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury.
What is the definition of labour used by HSIB and EN?	The definition of labour used by HSIB includes: • Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation. • When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking). • Induction of labour (when labour is started artificially). • When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.
Changes in the EN reporting requirements for Trust from	With effect from 1 April 2022, Trusts have been required to continue to report their qualifying cases to HSIB via the electronic portal. In addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed

1 April 2022 going forward	they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must share the HSIB//MNSI report with the EN team within 30 days of receipt of the final report by uploading the HSIB/MNSI report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading HSIB/MNSI reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the HSIB/MNSI report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where HSIB are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury. • Where a family have declined a HSIB investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution. There is more information here: ENS Reporting Guide - July 2023 (for Member Trusts) - NHS Resolution
Cases that do not require to be reported to NHS Resolution	• Cases where families have requested a HSIB/MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a HSIB/MNSI investigation where the baby has a normal MRI. • Cases that HSIB/MNSI are not investigating.
What if we are unsure whether a case qualifies for referral to HSIB/MNSI or NHS Resolution?	For cases from 1 April 2022, if the baby has a clinical or MRI evidence of neurological injury and the case is being investigated by HSIB/MNSI because of this, then the case should also be reported to NHS Resolution via the claims wizard along with the HSIB/MNSI reference number (document the HSIB reference in the “any other comments box”). Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard. Should you have any queries, please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or HSIB/MNSI maternity team (maternity@hsib.org.uk).
How should we report cases to NHS Resolution?	Trusts’ will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once they have been confirmed by HSIB/ MNSI as under investigation. They must also complete the ***EN Report*** form and attach this to the Claims Reporting Wizard: https://resolution.nhs.uk/wp-content/uploads/2023/05/EN-Report-Form.pdf
What happens once we have	Following the HSIB/MNSI investigation, and on receipt of the HSIB/MNSI report and MRI report, following triage, NHS Resolution will overlay an

reported a case to NHS Resolution?	investigation into legal liability. Where families have declined an HSIB/MNSI investigation, no EN investigation will take place, unless the family requests this.
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by HSIB and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all incidents to HSIB/MNSI as soon as they occur and to NHS Resolution as soon as HSIB/MNSI have confirmed that they are taking forward an investigation. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to HSIBMNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and HSIB/MNSI and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme.

FAQs for year five of the maternity incentive scheme

Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice?	**We expect Trust Boards to self-certify the Trust's declarations following consideration of the evidence provided.** It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we will escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the Care Quality Commission for their consideration if any further action is required, and to the NHS England and NHS Improvement regional director, the Deputy Chief Midwifery Officer, regional chief midwife and Department of Health and Social Care (DHSC) for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the Accountable officer (AO) for their ICB is apprised of the MIS safety action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution The declaration form must be signed by both CEO and the Accountable Officer of Clinical Commissioning Group/Integrated Care System before submission.
Our current commissioning systems are changing, what does this mean in terms of sign off?	There have been structural changes for NHS Commissioning as a result of 2022 Health and Care Act. Where this has caused significant reconfiguration and adjustment of commissioning systems, sign off by the accountable lead for commissioning maternity services can be considered
Will NHS Resolution cross check our results with external data sources?	Yes, we will cross reference results with external data sets from: MBRRACE-UK data (safety action 1 point a, b, c), NHS England& Improvement regarding submission to the Maternity Services Data Set (safety action 2, sub-requirements 2 and 3), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable to HSIB (safety action 10,

	standard a)). Your overall submission may also be sense checked with CQC maternity data, HSIB data etc. For more details, please refer to the conditions of the scheme.
What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the Trust CEO and Accountable Office (IBC). Where relevant, an action plan is completed for each action the Trust has not met. **Please do not send your evidence or any narrative related to your submission to NHS Resolution.** Any other documents you are collating should be used to inform your discussions with the Trust Board. These documents and any other evidence used to assure the Board of your position must be retained. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2023. **It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on 1 February 2024, NHS Resolution will treat that as a nil response.**
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on 1 February 2024**. If not returned to NHS Resolution by 12 noon on **1 February 2024**, NHS Resolution will treat that as a nil response.
What happens if we do not meet the ten actions?	Only Trusts that meet all ten maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet all ten safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.

Our Trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The maternity incentive scheme outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated link contacts via link on the NHS Resolution website. https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-Trusts/maternity-incentive-scheme/maternity-incentive-scheme/
What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process. Trusts will be allowed 14 days to appeal the decision following the communication of results. The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe. There are two possible grounds for appeal: • alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation • technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate. NHS Resolution clinical advisors will review all appeals to ensure validity, to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC. Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered. Further detail on the appeals window dates will be communicated at a later date.

Merging Trusts	Trusts that will be merging during the year four reporting period (30 May 2023 – 7 December 2023) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed. In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2022/23 and the reporting of claims and management of claims going forward.

Q&A regarding Maternity Safety Strategy and CNST maternity incentive scheme

Q1) What are the aims of the maternity incentive scheme?

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

Using CNST to incentivise safer care received strong support from respondents to our *2016 CNST consultation* where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our *Five year strategy: Delivering fair resolution and learning from harm.*

Q2) Why have these safety actions been chosen?

The ten actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with NHS Digital, NHS England, NHS Improvement, the Care Quality Commission (CQC), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Obstetric Anaesthetists Association, Royal College of Anaesthetists, HSIB, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

The Collaborative Advisory Group (CAG) previously established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme has also advised NHS Resolution on the safety actions.

Q3) Who has been involved in designing the scheme?

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England & Improvement
- NHS Digital
- MBRRACE-UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Anaesthetists
- Royal College of Paediatrics and Child Health
- Care Quality Commission
- Department of Health and Social Care
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff
- HSIB/CQC

Q4) How will Trusts be assessed against the safety actions and by when?

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.

Completed Board declaration forms must be discussed with the commissioner(s) of the Trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at nhsr.mis@nhs.net **by 12 noon on 1 February 2024**

Please note:

- Board declaration forms will be reviewed by NHS Resolution and discussed with the scheme's Collaborative Advisory Group.
- NHS Resolution will use external data sources to validate some of the Trust's responses, as detailed in the technical guidance above.
- If a completed Board declaration form is not returned to NHS Resolution by 12 noon on **1 February 2024**, NHS Resolution will treat that as a nil response.

APPENDIX 2

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 12 October 2023

Agenda item		129/23 Paper 3 within CNST INFORMATION PACK **Appendix 2**		
Report Title		CNST Action 4c – Neonatal Medical Workforce 2023		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Dr Patricia Cowley – Neonatal Clinical Director		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners		
Consultation Communication		Women and Children's Divisional Committee 22.8.23		
Executive summary:		British Association of Perinatal Medicine (BAPM) published revised standards for medical staffing for LNUs (Local Neonatal Units) in November 2022. The SATH Neonatal unit meets these updated BAPM national standards of medical staffing. This is a requirement of CNST – action 4c.		
Recommendations for the Board:		The Board is asked to: Take **assurance** from this report, with particular regard to BAPM standards for Neonatal Unit medical staffing and achievement of the requirements of CNST Action 4c.		
Appendices:		None		

Required standard:

British Association of Perinatal Medicine (BAPM) published revised standards for medical staffing for LNUs in November 2022.
The neonatal unit meets these updated BAPM national standards of medical staffing.
The BAPM national standard is articulated in the following document:

The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK November 2022

The requirements are:

1. Tier 1 staffing: *Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general paediatrics in addition.*

- We meet this standard and have done so for >10 years. This can be evidenced by our Tier 1 rotas.

2. Tier 2 staffing: *Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff.*

- The Tier 2 is currently 1 in 8 with some shared cover with paediatrics between 23.00 and 08.30.
- From September 2023, the rotas will be fully separated with 8 WTE staff purely for neonates at Tier 2.

3. Tier 3 staffing: *A minimum of 7 WTE neonatal paediatricians/neonatal consultants on the on-call rota. Minimum of 1 consultant with a designated lead interest in neonatology. At least one LNU Tier 3 consultant should have either a CCT in neonatal medicine or neonatal SPIN module.*

    - The Tier 3 rota moved from 6 WTE to 7 WTE template in April 2023. We currently have one vacancy, but the rota remains 1 in 7.

    - All consultants only have on call commitment to Neonates.

    - We have two consultants with CCT in Neonatal Medicine.

Board of Directors' Meeting
12 October 2023

APPENDIX 3

The Shrewsbury and Telford Hospital NHS Trust

Agenda Item	129/23 Paper 3 within CNST INFORMATION PACK **Appendix 3**			
Report Title	Saving Babies Lives: progress report			
Executive Lead	Hayley Flavell, Executive Director of Nursing			
Report Author	Lindsey Reid, Lead Midwife for Saving Babies' Lives			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	√
	Our partners		Responsive	√
	Our governance	√	Well Led	
	Report recommendations:		**Link to BAF / risk:**	
	For assurance		BAF 1, BAF 2 BAF 3, BAF 4 BAF 7, BAF 8	
	For decision / approval		**Link to risk register:**	
	For review / discussion		CRR 15	
	For noting	√		
	For information			
	For consent			
Presented to:	LMNS programme board			
Executive summary:	The Saving Babies Lives Care Bundle is an evidence-based package of measures designed to reduce perinatal mortality. Reviews conducted to date suggest that implementation of this care bundle has been effective in achieving this vital aim, but that more needs to be done. The importance attached to Saving Babies Lives is reflected in the fact that it forms one of the ten Safety Actions of the Clinical Negligence Scheme for Trusts. This scheme mandates that regular updates on delivery progress must be provided to the Board of Directors; this is the purpose of this paper.			
Recommendations for the Board of Directors:	The Board of Directors is asked to note this report.			
Appendices	Appendix 1 Local agreements Appendix 2 Preterm passports – 2a Clinical 2b Parental			

1.0 **Introduction**.

1.1 The Saving Babies Lives (SBL) care bundle is designed to reduce perinatal mortality, and its implementation constitutes Safety Action 6 of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), of which SaTH is a participant.

1.2 The Trust was able to prove full compliance with the requirements of SBL as part of year 3 and year 4 of CNST.

1.3 SaTH is now part-way through delivery of CNST year 5 (2023-24), which includes implementation of new standards within SBLCB version 3. The purpose of this paper is to:

1.3.1 Provide quarterly reports of information which require sharing (as per SBLCBv3) with the Trust Board and LMNS

2.0 **Background.**

2.1 The first version of the Saving Babies' Lives Care Bundle (SBLCB) was published in March 2016 and focussed predominantly on reducing the stillbirth rate[1]. The care bundle was designed to deliver the then Secretary of State for Health's announced ambition to halve the rates of stillbirths, neonatal and maternal deaths, and intrapartum brain injuries by 2030, with a 20% reduction by 2020. The care bundle consisted of four standards.

2.2 In November 2017, as part of the National Maternity Safety Strategy, the national ambition was extended to include reducing the rate of preterm births from 8% to 6% and the date to achieve the ambition was brought forward to 2025[2]. This is reflected in the NHS Long Term Plan.[3]

2.3 The second version of the care bundle was published in 2019 and included a fifth element: 'Reducing preterm birth'.[4]

2.4 The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020. ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data shows there is more to do to achieve the Ambition in 2025 period (SBLCBv3).

[1] https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf
[2]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf
[3] https://www.longtermplan.nhs.uk/
[4] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

2.5 The 3rd version of the care bundle (SBLCBv3)[5] was released in June of this year. Building on the achievements of the previous versions, Version 3 includes a refresh of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit.

There are now 6 elements of care:

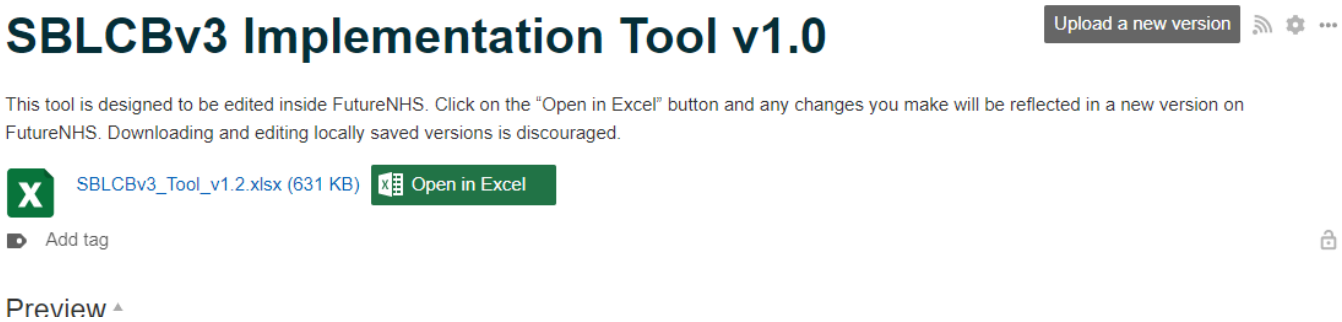
2.5.1 Element 1 Reducing smoking in pregnancy
2.5.2 Element 2 Fetal Growth: Risk assessment, surveillance, and management
2.5.3 Element 3 Raising awareness of reduced fetal movement (RFM)
2.5.4 Element 4 Effective fetal monitoring during labour
2.5.5 Element 5 Reducing preterm birth
2.5.6 Element 6 Management of pre-existing diabetes in pregnancy

2.6 The CNST year 5- Safety action 6 required standard reads

2.6.1 Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.

2.6.2 Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available

The tool has been released and accessed through FutureNHS



2.6.3 Implementation tool process

- Trusts will update progress, load evidence and declare a self-assessment status for each standard (continuous learning standards are not included and therefore not part of the CNST requirements) by a set date.
- LMNS colleagues will then review the tool and evidence. They will then validate the self-assessment status if agreed.
- A review meeting between the Trust and LMNS
- A report for the Trust Board and ICB can be produced from the tool
- There must be the minimum of 2 review meetings before March 2024

[5] https://www.england.nhs.uk/publication/saving-babies-lives-version-three/

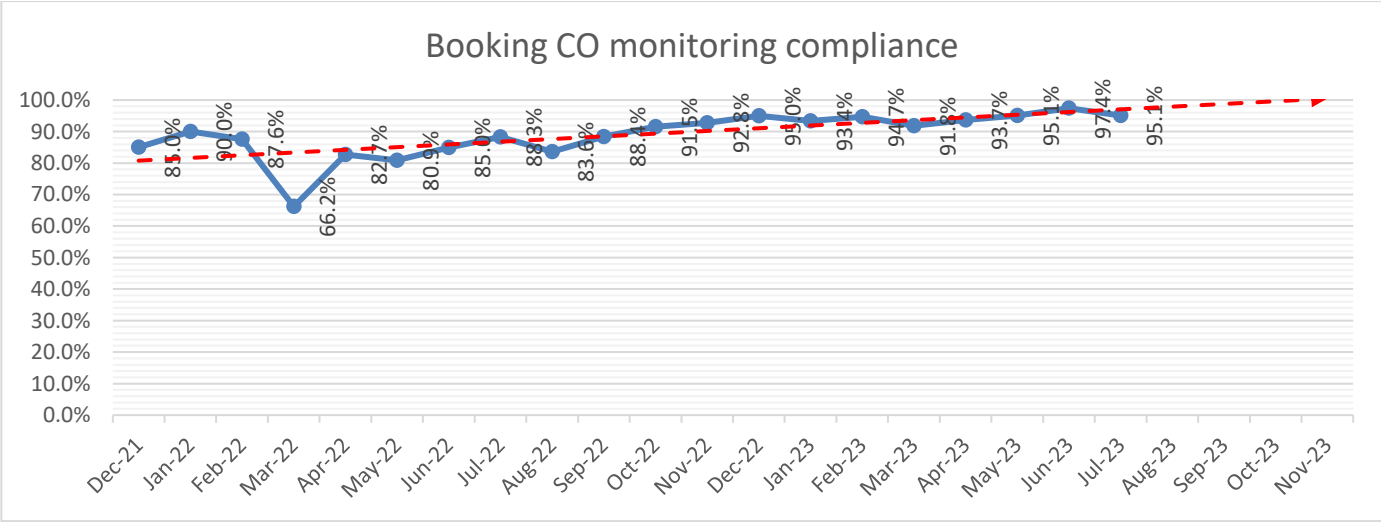
- To achieve CNST year 5, each element must have the minimum of 50% agreed compliance and an overall compliance of 70% for all elements (The percentages are generated within the tool).
- **NB.** This is now a peer review of compliance and there will be no external validation. The Midlands Perinatal Team will however continue to offer support.
- The first review is planned for the week commencing 4/9/23

3.0 **Element 1: Reducing smoking in pregnancy**

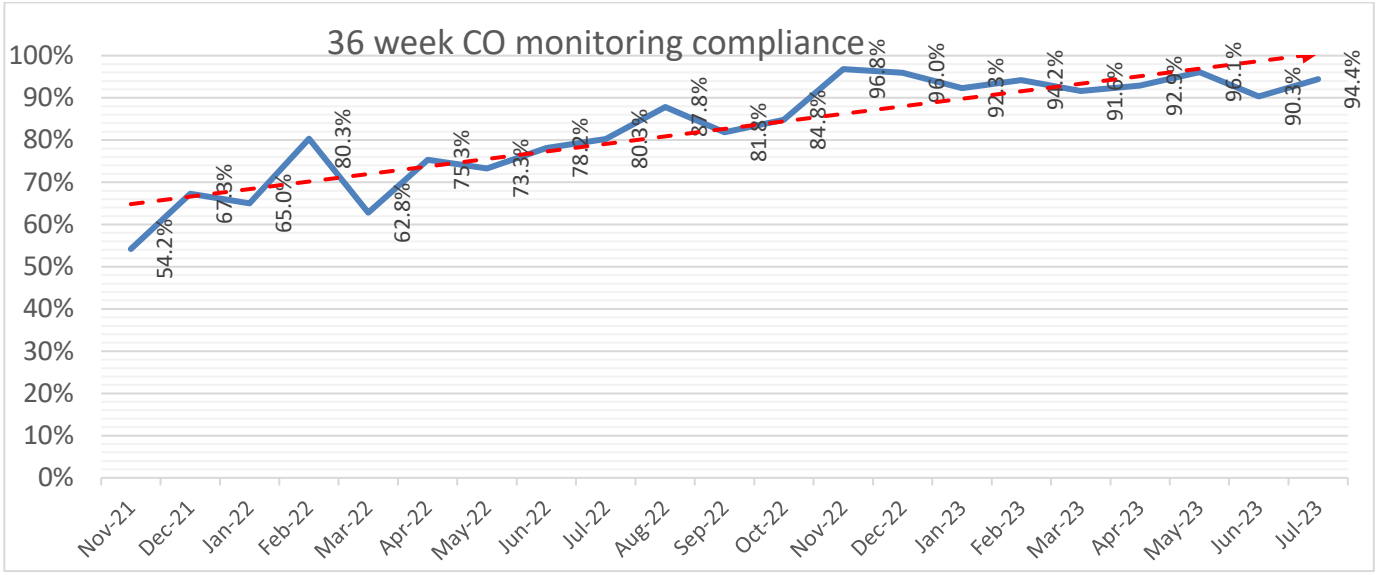
4.1 SBL mandates the following standards:

4.1.1. CO testing offered to all pregnant women at the antenatal booking and 36-week antenatal appointment. (2 standards combined in version 3)

Version 3 compliance change – minimum 90% (previously 80%) – with an action plan to reach 95% (unchanged). The Trust has reached and now exceeded the booking ambition for the last 3 consecutive months. This no long carries an action plan but will continue to be monitored monthly.



36-week antenatal appointment has exceeded 95% but appears to be slightly less consistently robust. The compliance, however, has maintained above 90% since December 2022. This standard will continue to be monitored monthly.



4.1.2 CO testing offered at all other antenatal appointments to groups identified within NICE Guidance NG209.

New phrasing to standard, applies to a pregnant woman with an elevated CO level (4ppm or above) **and** identifies themselves as a smoker.

The Trust reintroduced CO monitoring at every appointment for all women (post Covid-19) and will continue to offer to all.

Compliance has been monitored for all women since November 2022. It currently remains in the lower 80% region.

The ambition targets for this standard are to be set locally (see app1).

4.1.3 Whenever CO testing is offered, it should be followed up by an enquiry about smoking status with the CO result and smoking status recorded.

New standard. Compliance targets are the same as CO monitoring at 36 weeks.
Baseline review July 2023 41.4% (Staff updated to the requirement 23/6/23).
The timeframe targets for this standard are to be set locally (see app1).

5.0 Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)

5.1 In line with the requirements of SBLCBv3 and CNST year 5, a review of Small for Gestational Age births at SaTH is conducted on a quarterly basis by the SBL Lead Midwife. The most recent review is for Quarter 1 2023/2024 and is attached for reference as additional report (no.1).

5.2.1 The review provided the following highlights

A review of babies that were born <3rd centile >37+6 weeks' gestation in quarter 1 did not identify any themes relating to FGR not being detected (CNST monitoring standard). This is reassuring.

5.2 Additions to Element 2

5.2.1 Recommend Vitamin D supplementation to all pregnant women.

The ambition targets for this standard are to be set locally (see app1).

5.2.2 There are some additions to the Fetal growth surveillance algorithm. The new risk categories effect minimal service users and will be accommodated within current service capacity.

6.0 Element 3: Raising awareness of reduced fetal movements (RFM).

6.1 Some of the ambition targets for this element are to be set locally (see app1).

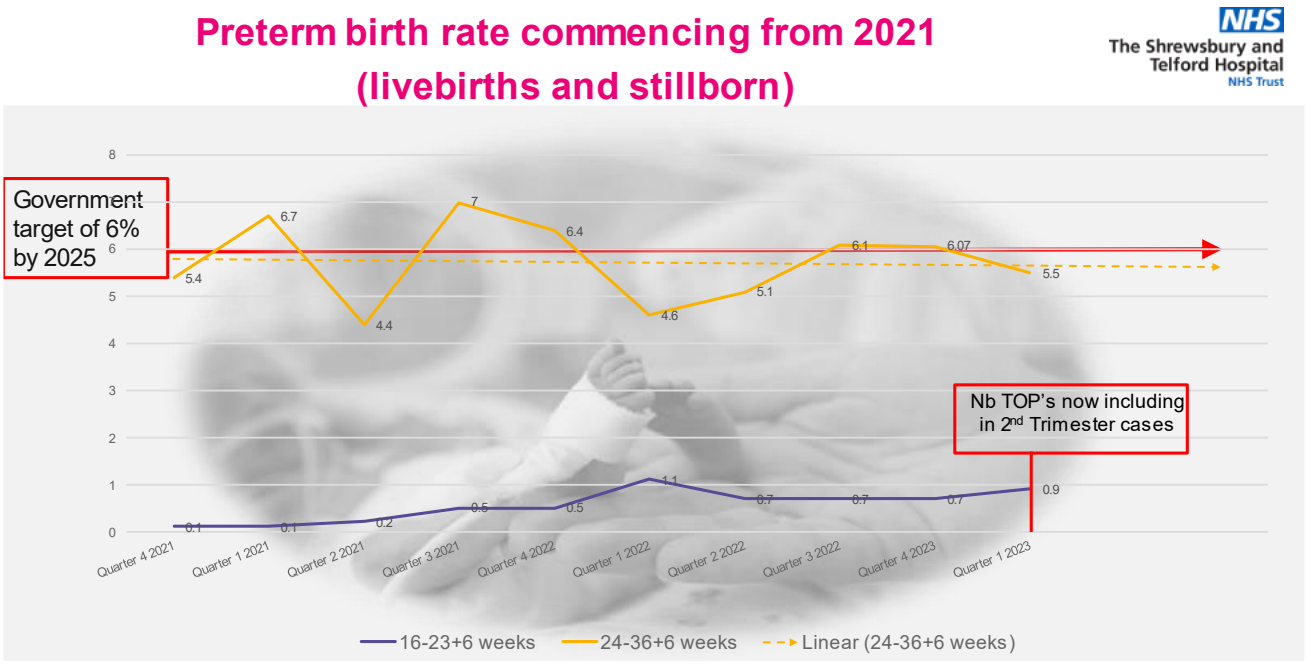
7.0 Element 4: Effective fetal monitoring during labour

7.1 No new local agreements required. Element standards remain targeted at staff education, risk assessment at the onset of labour and peer reviews.

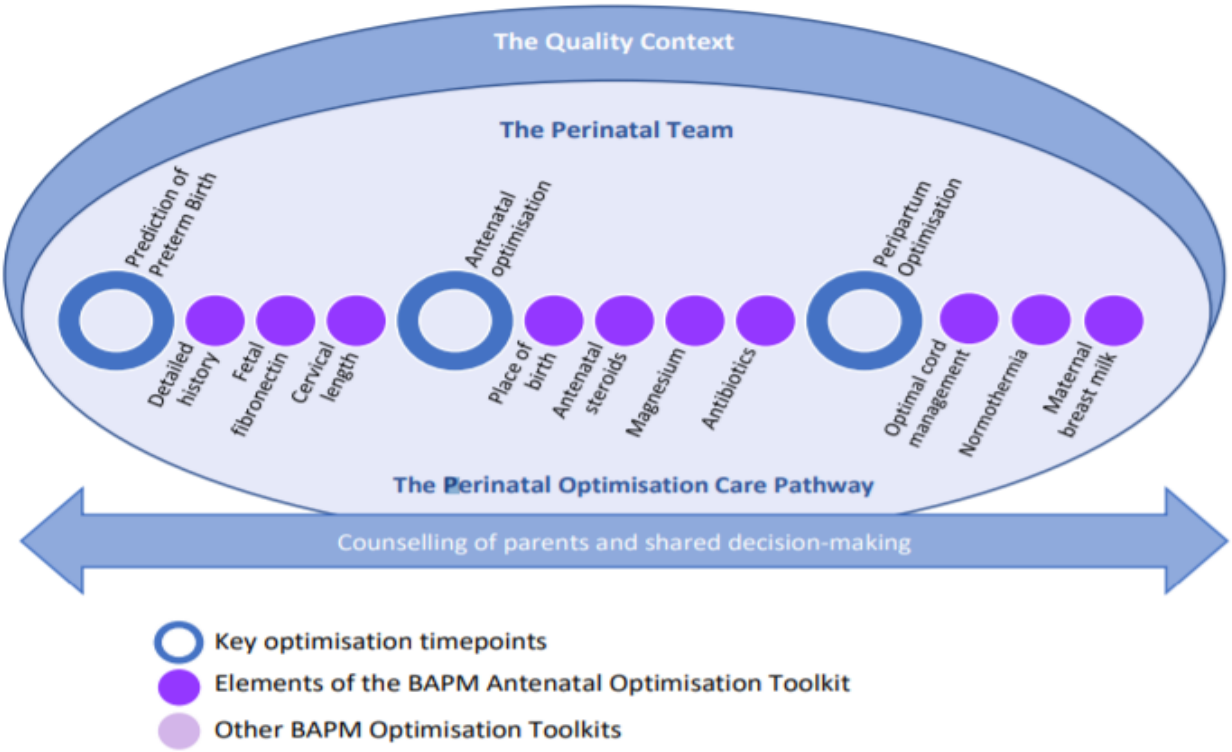
8.0 Element 5: Reducing preterm birth.

8.1 The most recent review, for Quarter 1 of financial year 2023-24 is attached as a separate report (no.2). This review provides information and performance data related to preterm birth rates and perinatal optimisation standards

8.1.1. The key highlight is that the Trust remains below the national preterm reduction target of 6% (8% to 6% by 2025)



8.2 SBLCBv3 has a strong focus in Element 5 of Perinatal Optimisation. This is aligned to the British Association of Perinatal Medicine (BAPM) optimisation pathway.



The Trust includes the above pathway in our local guidance. Although the Trust already provides all the antenatal and peripartum aspects of care, the focus will be providing optimal combined care (dependent on gestation) as gold standard. The

more of the individual aspects provided in combination, potentially the better the neonatal outcome will be.

8.2.1 The Trust will introduce Preterm passports in September for women presenting with a risk of preterm birth. There are 2 documents, one clinical and one for the parents to help them understand and be an active part in care planning and decision making. The passport is part of the Perinatal Optimisation Pathway (BAPM).

8.2.2 To oversee the full pathway Trusts should have a Preterm Birth Team comprising of
a) An Obstetric Consultant lead for preterm birth, delivering care through a specific preterm birth clinic, or within an existing fetal medicine service.
b) An identified local preterm birth/perinatal optimisation Midwife Lead
c) A Neonatal Consultant lead for preterm perinatal optimisation
d) An identified Neonatal Nursing lead for preterm perinatal optimisation

The above team has been established and the Trust Board notified for assurance.

8.2.3 Some of the ambition targets for this element are to be set locally (see app1).

9.0 Element 6: Management of Pre-existing Diabetes in Pregnancy

9.1 Women with Type 1 and Type 2 diabetes have persistently high perinatal mortality with no improvement over the past 5 years. This has become the most significant modifiable risk factor for poor pregnancy outcomes.
Introducing management of Diabetes into the SBLCB allows improvement in two keyways:

- Ensuring there are standard pathways of care for MDT management of these women throughout pregnancy, with increased access to expert and 'joined-up' support for their complex care needs.
- Improving management of glucose control during pregnancy by focusing support on high-risk women who are not achieving safe pregnancy glycaemic targets and by ensuring consistent and high levels of uptake of digital glucose monitoring technology to facilitate this (SBLCBv3)

9.2 SBLCBv3 mandates:

9.2.1 Women with a diagnosis of pre-existing diabetes in pregnancy should be offered care in a one stop clinic, providing care to pre-existing diabetes only, which routinely offers multidisciplinary review and has the resource and skill set to address all antenatal care requirements. The multidisciplinary team should consist, as a minimum, of: Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife.

This standard carries a risk. Currently there is not a Diabetes Dietician within the team. Funding is being reviewed. Capacity from the Dietetic service may be a barrier.

9.2.2 Women with type 2 diabetes should have an objective record of their blood glucose recorded in their hospital records/EPR and be offered alternatives (e.g., intermittently scanned CGM) to blood glucose monitoring if glycaemic targets are not achieved.

Funding is being reviewed. Advice from the current team is that all Type 2 women are provided with a monitor to ensure a better understanding within the 1st year of monitoring.

9.2.3 Ambition targets for this element are set nationally but local compliance timeframes are required (see app1)

10.0 Actions requested of the LMNS Programme Board:

8.1 SBLCBv3 Implementation tool

- 8.1.1 Note the process of compliance for CNST year5

8.2 Relating to Element 1,3 and 4:

- 8.2.1 Note updates

8.3 Relating to Element 2:

- 8.3.1 Take assurance that no trends or missed opportunities were identified for undetected <3rd centile babies.
- 8.3.2 Note updates

8.4 Relating to Element 5:

- 8.4.1 Take assurance from the fact that The Trust is maintaining the national target for the percentage of pre-term births as a proportion of total births.
- 8.4.2 Take assurance that we are reviewing the care of all <34 week preterm babies to try to identify any missed opportunities, trends or themes.
- 8.4.3 Note that the Trust will implement the use of Preterm passports as an aid to increase preterm birth preparation and optimisation.

Appendix 1- Saving Babies' Lives Version Three – targets to be set locally

A proportion of the SBLCBv3 standards ambitions are generated from best performing Trusts. There is a minimum target and a stretch target. To be compliant for CNST, Trusts need to achieve the minimum target.
Some of the newer or revised standards do not yet have a nationally acknowledged ambition. These standards are required to have a local agreement dependent on current service levels. The standards requiring an agreement have been collated below with Trust advice relevant to current service and/or following benchmarking.

Element 1 Reducing smoking in pregnancy

1. CO testing offered at all other antenatal appointments to groups identified within NICE Guidance NG209. (New)

   Requires – local ambition and improvement trajectory based on current system
   Denominator – number of pregnant smokers who have come to the end of their pregnancy

   Advise – based on the monitoring of all women minimum 80% with a stretch target to 90% for 1st year

2. Whenever CO testing is offered, it should be followed up by an enquiry about smoking status with the CO result and smoking status recorded. (New)

   Requires – locally agreed timeframe

   Advise – 6 months to achieve ≥80%

3. The tobacco dependence treatment includes behavioural support and NRT, initially 4 weekly sessions following the setting of the quit date then regularly (as required, however as a minimum monthly) throughout pregnancy to support the woman to remain smokefree.

   a. Number of pregnant smokers with an opt out referral documented who have set a quit date- LMNS to agree local ambition set on current performance- with an action plan to get to 60% and a locally agreed timeframe

   Requires – locally agreed ambitions and timeframe
   Advise- no action plan required. Q1 2023 69%. Minimum 55% with a stretch at 60%

   b. 4 week quit rates

   Requires – locally agreed timeframe
   Advise – There is a minimum set ambition of 50%, stretch of 60%
   On advice from the Trust's Lead PH Midwife – 4 week quits are normally around 30-40%.
   The LMNS can agree a variation. With the knowledge of our smoking population commencing pregnancy higher than the national average, the Trust suggests a minimum ambition of 35% and stretch of 45% with a 1 year timeframe.

4. Feedback is provided to the pregnant woman's named maternity health care professional regarding the treatment plan and progress with their quit attempt (including relapse). Where a woman does not book or attend appointments there should immediate notification back to the named maternity health care professional. (New)

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – no baseline data available as new to service. Suitable communication pathway under investigation. Consideration to service capacity required
   Suggest – minimum ambition 50% documented feedback with a review at 6 months to monitor service capacity.

Element 2 Fetal Growth: Risk assessment, surveillance, and management

1. Assess all women at booking to determine if prescription of Aspirin is needed using an appropriate algorithm (for example Appendix C) agreed with the local ICSs and regional maternity team

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Algorithm -NICE and SBLCB FGR risks already approved and in practice. Current performance- audit of 120 women demonstrated a correct aspirin risk assessment of **100%.**
   Therefore, minimum target 90% with no stretch. No improvement trajectory required. Review will continue through SBLCB monitoring/audit

2. Recommend Vitamin D supplementation to all pregnant women.

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

   Advise – no baseline data available as new standard. Minimum 80% with a stretch target to 90% for 1st year.

3. Women who are designated as high risk for FGR (for example see Appendix D) should undergo uterine artery Doppler assessment between 18+0 to 23+6 weeks gestation

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Current performance- (audit) demonstrated a **90%** compliance (CNST green rag rating).
   Target ambition maintain at ≥90%. No improvement trajectory required.

4. Women who are at low risk of FGR following risk assessment should have surveillance using antenatal fundal height (FH) measurement before 28+6 weeks gestation.

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

Advise – Current performance- (audit) demonstrated a **93.8%** compliance (CNST green rag rating).
Target ambition maintain at ≥90%. No improvement trajectory required.

5. All management decisions regarding the timing of FGR infants and the relative risks and benefits of iatrogenic delivery should be discussed and agreed with the mother. When the estimated fetal weight (EFW) is <3rd centile and there are no other risk factors (see 2.20), initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation.

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Current performance- (audit) demonstrated a **100%** compliance (CNST green rag rating). NB small cohort within the 120 audited
   Target ambition maintain at ≥90%. No improvement trajectory required.

6. In fetuses with an EFW between the 3rd and <10th centile, delivery should be considered at 39+0 weeks. Birth should be achieved by 39+6 weeks. Other risk factors should be present for birth to be recommended prior to 39 weeks

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Current performance- (audit) demonstrated a 100% compliance (CNST green rag rating). NB small cohort within the 120 audited
   Target ambition maintain at ≥90%

<u>Element 3: Raising awareness of reduced fetal movements (RFM).</u>

1. Women who report <u>recurrent</u> RFM are offered an ultrasound scan by the next working day (if no scan within the last 2 weeks)

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

   Advise – Scan timing a new addition – no benchmarking data to understand if capacity an issue.
   Minimum 80% with a 6 month target review

2. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation (Outcome Indicator)

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

   Advise – Previous monitoring has not identified an issue.
   Target ambition maintain at ≥80%. No improvement trajectory required.

Element 5: Reducing preterm birth

1. Maternity care providers will provide outcome data to the Trust Board and share this with the LMNS relating to the incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births:

   a) in the late second trimester (from 16+0 to 23+6 weeks).
   b) preterm (from 24+0 to 36+6 weeks).
   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Data already provided in a quarterly report evidences the Trust has reached and is maintaining the national ambition of 6%. Local ambition target should remain ≤ 6.9% (allowing for quarterly fluctuations).

2. Mortality to discharge in very preterm babies (NNAP definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner)

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

   Advise – new outcome indicator.
   Denominator – no of babies admitted to a neonatal unit whose birth gestation was 24+0 to 31+6 weeks
   Numerator – Deaths of babies 24+0 to 31+6 weeks before discharge from hospital to home or discharged for palliative care.

   Clarification on where the death occurred required (i.e., Birth at SaTH, died in another Trust).
   If the admission and death occurred within the Trust, the data available on Neonatal Badgernet suggests there were 65 admissions, 2 of which sadly died in the last financial year. Therefore 3.1% died.

   Suggest review of outcomes in 6 months, allowing for Perinatal optimisation pathway implementation and clarity on location.

3. Assessment of all women at booking for their risk of preterm birth and stratification to low, intermediate and high-risk pathways.

   Requires – locally agreed timeframe
   Advise – Ambition already set min 80% - stretch 90%
   Current performance- Monitoring of 100 bookings last month demonstrated a **100%** compliance (CNST green rag rating). Prior CNST audit in September 2022 also demonstrated a 100% result.
   Timeframe is not required as standard met.

4. Symptomatic women require assessment using quantitative fetal fibronectin (qfFN) measurements
   Num: Number of symptomatic women for preterm birth assessed using qfFN
   Den: Number of symptomatic women for preterm birth

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – new outcome indicator.
   National shortage of fFN cassettes from Hologic have temporarily stopped the supply. The Trust returned to using the former biochemical test, Partosure. Cassettes are now back in production, but supply is currently limited and regular supply erratic. The Trust will not return to full use until guaranteed regular stock.
   Suggest ambition min 80% - stretch 90% with a 6 month review to allow for recommencing the use of fFN.

5. Test for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Current performance- Monitoring of 100 bookings last month demonstrated a 100% compliance (CNST green rag rating). Prior CNST audit in September 2022 also demonstrated a 97.5% result.
   Timeframe is not required as standard met.
   Target ambition maintain at ≥90%. No improvement trajectory required.

6. Ensure the neonatal team are involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with parents prior to birth. This is especially important at earlier gestational ages.
   In the case of extreme prematurity where complex decision making is required (active survival focused care or comfort care), management should be as outlined in the 2019 BAPM Framework for Practice regarding Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation

   Num: number of women who deliver preterm that have a discussion with the neonatal team regarding care options.
   Den: number of women who deliver preterm

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Updated standard now requiring a compliance ambition.
   Baseline result in Quarter 1 2023 = 68.2% (all women with <34 week births included). Some cases were emergency situations not allowing for a full discussion).

   Ambition min 65% - stretch 80%. 6 month review

7. Women identified to be potentially at increased risk of imminent preterm birth, where active survival focused care is planned, should be made aware of optimisation interventions that may be offered. Families should also be offered information and support for families from charities such as Bliss.
   Num: Number of the relevant optimisation interventions
   Den: Total number of optimisation (calculated from total number of babies born <34 weeks multiplied by the number of appropriated elements (eligibility dependent on gestation)).

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – New standard requiring a compliance ambition.
   Baseline will be generated at the end of quarter 2 2023.

   Ambition min 50% - stretch 70%. 1 year review

8. Place of birth – Women who have symptoms suggestive of preterm labour or who are having a planned preterm birth:
   a) less than 27 weeks gestational age (in a singleton pregnancy)
   b) less than 28 weeks gestational age (in a multiple pregnancy)
   c) any gestation with an estimated fetal weight of less than 800g
   should be managed in a maternity service on the same site as a neonatal intensive care unit (NICU)

   Requires – locally agreed timeframe
   Advise – Ambition already set min 70% - stretch 85%.
   In version 3 there has been a change to how compliance is calculated. A baseline has been generated and reported in the Q1 preterm report: - For last financial year **65%** of women booked at SaTH who were in one of the above preterm criteria, gave birth in a unit with a same site NICU.
   The Trust are working with the Midlands Preterm Network. Cases delivered at a level 2 unit are peer reviewed. No trends identified but the geographical position of the Trust acknowledged as a barrier.

   Timeframe – 1 year within the optimisation pathway.

9. Other optimisation (current and new with a set ambition) combined

   a. Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth.
      Ambition already set min 40% - stretch 55%.
      Current position **47%**

   b. Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth.
      Ambition already set min 80% - stretch 90%.
      Current position **100%**

   c. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth

New standard
Ambition already set min 50% - stretch 75%.
Current position **58.6%**

d. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth.
New standard
Ambition already set min 65% - stretch 80%.
Current position **83.5%**

Requires – locally agreed timeframe
Advise - Timeframe – 1 year within the optimisation pathway.

10. Other optimisation (current and new without set ambition) combined

a. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection

Requires – locally agreed ambition and improvement trajectory based on the current system performance.
Advise – New standard requires a compliance ambition. Baseline Q1 **90%**
Ambition min 80% - stretch 90%.
Timeframe – 1 year within the optimisation pathway. No improvement trajectory required.

b. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth.

Requires – locally agreed ambition and improvement trajectory based on the current system performance.
Advise – New standard requires a compliance ambition. Baseline Q1 **57.1%**
Ambition min 50% - stretch 75%. (same as national ambition for cord clamping).
Timeframe – 1 year within the optimisation pathway.

11. Volume-Targeted Ventilation For babies born below 34 weeks' gestation who need invasive ventilation, use volume-targeted ventilation (VTV) in combination with synchronised ventilation as the primary mode of respiratory support. This reduces the chance of death or bronchopulmonary dysplasia by 27% and intraventricular haemorrhage (grades 3–4) by 47% compared with pressure-limited ventilation modes.
Num: Babies born at less than 34 weeks who receive volume-targeted ventilation in combination with synchronised ventilation as the primary mode of respiratory support, if invasive ventilation is required
Den: Babies born at less than 34 weeks

Requires – locally agreed ambition and improvement trajectory based on the current system performance.
Advise – New standard – awaiting Neonatal advice

12. Caffeine For babies born below 30 weeks' gestation, caffeine reduces the chance of death or disability. Caffeine should be started within 24 hours of birth

Requires – locally agreed ambition and improvement trajectory based on the current system performance.
Advise – New standard. Compliance for Q1 **100%** (source Neonatal dashboard)
Ambition min 85% - stretch 90%. No improvement trajectory required

Element 6: Management of Pre-existing Diabetes in Pregnancy

NB. The Implementation tool suggests 'LMNS required compliance over an agreed compliance timeframe'. Suggested ambitions are documented as a guide, as the Trust already has an established service. Trust advice would be to use the suggested ambitions but set a timeframe.

1. Women with type 1 diabetes should be offered real time continuous glucose monitoring (CGM) and be provided with appropriate education and support to use this.
   a. Num: number of pregnant women who have T1 diabetes that use CGM during pregnancy
   Den: number of pregnant women who have T1 diabetes
   Ambition already set min 80% - stretch 95%.
   Current position **New** – Pregnant T1 in the Trust are provided with a Dexicom continuous monitor. Funding in place.

   Requires – locally agreed timeframe
   Advise - Timeframe – 1 year to review entire element

   c. Annual staff training (MDT only)
   Ambition already set min 80% - stretch 90%.
   Current position **New** – CGM training mandatory within the Trust (no compliance data for the MDT available at time of writing this document)

   Requires – locally agreed timeframe
   Advise - Timeframe – 1 year to review entire element

2. Women with diabetes should have an HbA1c measured at the start of the third trimester and those with an HbA1c above 48mmol/mmol should be offered increased surveillance including additional diabetes nurse/dietetic support, more frequent face to face review and input from their named, specialist Consultant to plan ongoing care and timing of birth decisions.

   Num: Number of pregnant women with T1 and T2 diabetes that have had a HbA1c measured at the start of the 3rd trimester (between 28+0 and 28+6 weeks)
   Den: Number of pregnant women with T1 and T2 diabetes

   Ambition already set min 80% - stretch 95%.
   Current position **–** All pregnant diabetic women are offered HBA1C's monthly throughout pregnancy.

Requires – locally agreed timeframe

Advise – The specific timing set may potentially cause reduced compliance as it will depend on the women's clinic schedule i.e. clinic at 27+5 and then 31+5 gestation. Monitoring will allow the Trust to understand if there will be a compliance issue.

Timeframe – 1 year to review entire element

Appendix 2a

Perinatal Optimisation Pathway Passport

British Association of Perinatal Medicine

This passport must be completed for all women at risk of birth before 34 weeks' gestation and should accompany the baby on admission to neonatal care.

Time of birth: _ _ : _ _ Gestation: /40

Type of birth: Birth weight: g

Time of admission to NNU: _ _ : _ _

Apgars: @1 @5 @10

Booking Hospital:

Name:
DOB:
Hosp No:
NHS No:
Or patient sticker here

1. Place of Birth:

Aim: babies <27/40, EFW <800g or multiple pregnancy <28/40 should be born in maternity centre with a NICU

Born in a maternity centre with the appropriate designation of neonatal unit?

Y ☐ N ☐ N/A ☐

If not, why was intrauterine transfer not achieved?

2. Antenatal Steroids:

Aim: women giving birth before 34 weeks should receive a full course of steroids no longer than 7 days prior to birth

Full course of antenatal steroids (2 doses 12-24hrs apart)?

Y ☐ N ☐ N/A ☐

Last dose: Date: / / Time: :

If a full course of optimally timed steroids was not achieved, why?

3. Antenatal Magnesium

Aim: women giving birth before 30 weeks should receive a loading dose and ideally a 4-hour infusion in the 24 hours prior to birth

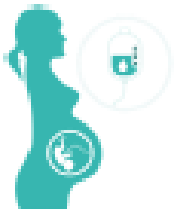
Loading dose given? Y ☐ N ☐ N/A ☐

Was a 4-hour infusion given within 24 hours prior to birth?

Y ☐ N ☐

If optimally-timed Magnesium was not achieved, why?

4. Antibiotic Prophylaxis



Aim: women in established preterm labour should receive intrapartum antibiotic prophylaxis to prevent early onset GBS infection

Required? Y ☐ N ☐

Given > 4hrs before birth? Y ☐ N ☐

If no antibiotic prophylaxis given or antibiotic given within 4h, why?

5a. Early Breast Milk (antenatal info)

Aim: women at risk of preterm birth should receive information about the importance of breast milk

Antenatal counselling and advice for mother re benefits of MBM and early & frequent expressing?

Y ☐ N ☐ N/A ☐

Supplemental information given eg. Written / digital

Y ☐ N ☐ N/A ☐

If not given, why?

6. Optimal Cord Management (OCM)

Aim: the umbilical cord should be clamped at or after one minute following birth

Was the umbilical cord clamped at or after one minute?

Y ☐ N ☐ N/A ☐

Time of OCM: __ minutes __ seconds

If no OCM, why?

7. Thermal Care

Aim: babies should have an admission temperature taken within one hour and this should be between 36.5-37.5C

Admission Temp between 36.5°C to 37.5°C ?

Y ☐ N ☐ N/A ☐

Admission Temp: °C

If normothermia was not achieved, why?

5b. Early Breast Milk

Aim: all mothers should be supported to express within 2 hours of birth

All babies should receive their own mother's milk within 24 hours of birth and ideally within 6 hours

Mother helped to express within 2h of birth?

Y ☐ N ☐ N/A ☐

Date: / / **Time:** :

Colostrum first available: **Date:** / / **Time:** :

Colostrum given to baby: **Date:** / / **Time:** :

If not achieved within first 24h, why?

www.bapm.org/pop www.weahsn.net/periprem

This passport has been modified with kind permission from PERIPrem.

Appendix 2b

Perinatal Optimisation Passport

British Association of Perinatal Medicine

Right Place of Birth

(babies born before 27 weeks' gestation - 28 weeks for multiple births - or who may weigh less than 800 grammes)

I am at the right hospital in case my baby(ies) needs to be born early.

In Progress ○ Complete ○

Antenatal Steroids

(babies born before 34 weeks' gestation)

I have received a full course of steroids to help prepare my baby(ies) for being born early.

In Progress ○ Complete ○

Antenatal Magnesium Sulphate

(babies born before 30 weeks' gestation)

I have received magnesium sulphate to support the brain development of my baby(ies).

In Progress ○ Complete ○

Early Breast Milk

(babies born before 34 weeks' gestation)

I have received information about the benefits of early breast milk and have been shown hand expressing/breast pump techniques to help me try to make early breast milk for my baby(ies) before or within an hour of them being born.

In Progress ○ Complete ○

Antibiotics

(babies born before 34 weeks' gestation where mum was in established labour)

I have received antibiotics to reduce the chance of my baby developing an infection due to Group B Streptococcus.

In Progress ○ Complete ○

Optimal Cord Management

(babies born before 34 weeks' gestation)

After my baby(ies) is born, whenever possible, the perinatal team will support them to receive extra blood from the placenta for at least a minute before the umbilical cord is clamped.

In Progress ○ Complete ○

Thermal Care

(all babies)

After my baby(ies) is born, the perinatal team will aim to maintain their temperature between 36.5 and 37.5oC. They will also help me to hold my baby skin-to-skin as soon as it is safe to do so.

In Progress ○ Complete ○

www.bapm.org/pop www.weahsn.net/periprem

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APPENDIX 4

The Shrewsbury and Telford Hospital NHS Trust

Quarter 1 2023/2024 Review of Preterm Births

Lindsey Reid
Lead Midwife for Saving Babies' Lives
Data collated July 2023

Background

Version 3 of the Saving Babies' Lives Care Bundle (SBLCBv3)((ref 1)), was produced to build on the achievements of version 1 and 2. The 3rd version of the care bundle draws on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. There are 6 elements within the care bundle

Element five - Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented was introduced in version 2.

This element of the care bundle was developed in response to The Department of Health's 'Safer Maternity Care' report which extended the 'Maternity Safety Ambition' to include reducing preterm births from 8% to 6%.

This element focuses on three intervention areas to improve outcomes, which are **prediction** and **prevention** of preterm birth and better **preparation** when preterm birth is unavoidable.

Report aim

The Shrewsbury and Telford Hospital NHS Trust

Historically this report was created to review the element aspect of ‘**Preparation** when preterm birth is unavoidable’.

The review now covers compliance of:

- Neonatal care options discussion prior to birth

- Perinatal Optimisation pathway standards

and provides:

- Singleton preterm birth data (Outcome indicator included in element 5)

Neonatal care options discussion

Ensuring the neonatal team are involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with parents prior to birth. This is especially important at earlier gestational ages.

In the case of extreme prematurity where complex decision making is required (active survival focused care or comfort care), management should be as outlined in the 2019 BAPM Framework for Practice regarding Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation

Perinatal Optimisation pathway standards

The Shrewsbury and Telford Hospital NHS Trust

1. Place of birth

Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU)

PLACE OF BIRTH

British Association of Perinatal Medicine

<27 WEEKS OR <800G in a maternity centre with a co-located NICU

<28 WEEKS IF MULTIPLE BIRTH

2-3 fold higher risk of **severe brain injury** if transferred to a NICU *ex utero*

NNT 8

1.3 times the odds of **death** if born in non-tertiary centre whether transported or not

NNT 20

QUiPP

Work as a team to **identify promptly** women in **suspected, diagnosed** or **established preterm labour**

Collaborate with ambulance services to ensure prompt transfer

Exception reporting for babies <27 weeks born in a maternity unit without a co-located NICU

Helenius et al 2019

www.bapm.org/pop www.weahsn.net/periprem

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Perinatal Optimisation pathway standards

The Shrewsbury and Telford Hospital NHS Trust

2. Antenatal corticosteroids

a. Percentage of live births (less than 34+0 weeks) receiving a full course (2 injections, 12 to 24 hours apart) of antenatal corticosteroids, **within** seven days of birth

b. Percentage of live births (less than 34+0 weeks) occurring **more** than seven days after completion of their first course of antenatal corticosteroids


ANTENATAL STEROIDS
British Association of Perinatal Medicine
FOR ALL BABIES BORN <34 WEEKS
If expected to give birth WITHIN 7 days AND haven't had steroids within the last 2 weeks (including >22 weeks gestation if survival-focused care planned)
Aim to give an optimally timed full course (2 doses 12-24 hours apart)
1-7 days before birth
Use QUiPP and fFN to help prediction of birth
STEROIDS REDUCE THE RISK OF
Neonatal death by 30%
NEC by 50%
Grade 3-4 IVH by 45%
NUMBER OF WOMEN WE NEED TO TREAT TO PREVENT ONE INFANT DEATH
23-24 weeks
25 weeks
Celebrate your successes!
Investigate every missed case
Record in both maternal notes and BadgerNet
Roberts et al 2017, Travers et al 2017
www.bapm.org/pop
www.weahsn.net/periprem
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Perinatal Optimisation pathway standards

3. Magnesium sulphate

Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth

MAGNESIUM SULPHATE

British Association of Perinatal Medicine

FOR ALL BABIES BORN <30 WEEKS

Use of magnesium sulphate in preterm labour **reduces the risk of cerebral palsy by 30%**

PReCePT $MgSO_4$

4g bolus 1g/hr

Administer prior to transfer, ideally within **4-24 hours** of birth.
For emergency deliveries, try to administer at least at loading dose.

For planned deliveries – ensure loading dose and at least 4 hours of maintenance infusion.

1 case of cerebral palsy is prevented for every **37** mothers who receive magnesium sulphate.

There are **no long term side effects** of magnesium sulphate for mothers but during administration they can feel rather **unwell** and feel a **"burning"** sensation

CONTRAINDICATIONS

Myasthenia gravis
It is the patient's right to have the choice to decline

Consider giving magnesium sulphate if transferring out in early labour. Record administration on Badgernet and investigate missed cases.

www.bapm.org/pop www.weahsn.net/periprem

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Perinatal Optimisation pathway standards – added in version 3

The Shrewsbury and Telford Hospital NHS Trust

4. Intrapartum antibiotics

Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection.

INTRAPARTUM ANTIBIOTIC PROPHYLAXIS

British Association of Perinatal Medicine

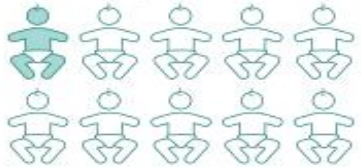
Women in established preterm labour <34 weeks should receive optimally timed Intrapartum Antibiotic Prophylaxis (ie 4-24 hours prior to birth)

Women should receive intrapartum antibiotic prophylaxis **irrespective** of whether they have ruptured **or** intact membranes

The risk of **death** from **GBS sepsis** in preterm infants is **25%**

Intrapartum antibiotics reduce the risk of neonatal **GBS sepsis** in GBS colonised women by **86%**

NNT 10 to prevent 1 infant being born preterm with GBS



Reduce the risk of **delivery** within a week by **20%**

Reduce the risk of abnormal neonatal **cranial ultrasound** findings by **20%**

The antibiotics of choice are Benzylpenicillin or Cephalosporins / Vancomycin in penicillin allergic women.
Confirm agent with your local antimicrobial guidelines.
Record administration of intrapartum antibiotics on Badgernet.

Fairlie et al 2013, Kenyon et al 2013, NICE11, RCOG guideline No.36.

www.bapm.org/pop **www.weahsn.net/periprem**

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Perinatal Optimisation pathway standards – added in version 3

The Shrewsbury and Telford Hospital NHS Trust

5. Cord Management

Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth.

OPTIMAL CORD MANAGEMENT

British Association of Perinatal Medicine

FOR *ALL* BABIES: CORD CLAMPED AT OR AFTER 1 MINUTE AFTER BIRTH

EFFECTS OF OPTIMAL CORD MANAGEMENT (OCM)

decreased mortality by nearly a **third** for preterm infants

Number of infants =<28 weeks that need to get OCM to **save a life** is **20**

Fogarty 2018

Successful implementation of OCM requires effective perinatal team working. Consider the below:

- Perinatal team simulation
- How to stabilise the infant during OCM
- Build a strong perinatal team culture through OCM training
- Thermoregulatory care e.g. use a sterile plastic bag

OCM is **safe** for **multiple pregnancies**

Jegatheesan et al 2018

OCM MULTI DISCIPLINARY TEAM

- Parents
- Obstetric and Midwifery Team
- Neonatal Team
- Theatre Team
- Anaesthetic Team

Record timing of cord clamping in **delivery paperwork** and **Badgernet**, and investigate every missed case

www.bapm.org/pop **www.weahsn.net/periprem**

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Perinatal Optimisation pathway standards – added in version 3

The Shrewsbury and Telford Hospital NHS Trust

6. Normothermia

Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth.

Perinatal Optimisation pathway standards – added in version 3

The Shrewsbury and Telford Hospital NHS Trust

6. Normothermia

Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth.

THERMO REGULATION

British Association of Perinatal Medicine

BABIES BORN <34 WEEKS SHOULD HAVE A FIRST TEMPERATURE MEASURED WITHIN ONE HOUR OF BIRTH, WHICH IS BETWEEN 36.5–37.5°C

WHY DOES IT MATTER?

Hypothermia in preterm infants increases risk of:

- hypoglycaemia
- metabolic acidosis
- respiratory distress and acidosis
- necrotising enterocolitis
- coagulation defects
- intraventricular haemorrhage

McCall et al 2018

FOR EVERY 1°C DECREASE IN ADMISSION TEMPERATURE MORTALITY INCREASES BY 28%

Laptook et al 2007

IMPROVE TEMPERATURE BY: PLACING THE BABY IN A PLASTIC BAG AT BIRTH AND USING A HAT

TAKE CARE TO ENSURE THERMAL STABILITY DURING RESUSCITATION

USE BAPM QI TOOLKIT TO INVESTIGATE HYPOTHERMIA + IMPROVE OUTCOMES

www.bapm.org/normothermia

www.bapm.org/pop www.weahsn.net/periprem

This resource has been modified with kind permission from PERIPrem.

Perinatal Optimisation pathway standards – added in version 3

The Shrewsbury and Telford Hospital NHS Trust

7. Early maternal breast milk (MBM)

Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth.

EARLY BREAST MILK

British Association of Perinatal Medicine

WITHIN 6 HOURS OF LIFE FOR BABIES BORN <34 WEEKS

FIRST MBM CAN BE GIVEN AS MOUTH CARE/NON-NUTRITIVE FEED

Milk production increases with time spent **skin-to-skin** for preterm infants
Lau et al 2007

Expressed breast milk volumes are significantly more if pumping is started **within 2 hours of birth**
Parker et al 2012

Pumping 8-10 times a day improves expressed volumes
Furman et al 2002
Hill et al 2005

Receiving breast milk instead of formula **reduces risk of NEC** by two thirds
Quigley et al 2014

Oropharyngeal colostrum **reduces risk of ventilator associated pneumonia** (by 60%)
Ma et al 2020

Breast milk instead of any formula **protects against ROP** (risk decreased by 70%)
Zhou et al 2015

Breast milk **improves IQ** by at least 5.9 points
Kramer et al 2008

Record time of first breast milk on Badgernet (UNICEF field)

STRONGLY ENCOURAGE AND SUPPORT ANTENATAL AND IMMEDIATE POSTNATAL EXPRESSING

This needs the whole perinatal team!

www.bapm.org/pop www.weahsn.net/periprem

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Methodology of this report

The Shrewsbury and Telford Hospital NHS Trust

A retrospective review of births between 16+0 and 36+6 weeks using Badgernet (maternity information system)

Time period – 1/4/23 – 30/6/23

Cases analysed –954 single and multiple births (≥ 16 weeks)

Method of analysis – Microsoft Excel

Results

Now included in the SBLCB version 3 perinatal optimisation standards – babies born from 22 weeks of gestation where active management is agreed

There were no cases between 22 and 23+6 weeks in this quarter.

Neonatal care options discussion – new for version 3

The Shrewsbury and Telford Hospital NHS Trust

Number of women that delivered preterm that have had a discussion with the neonatal team regarding care options.

Cases in review period 10 <34 weeks

Baseline result **68.2%** documented discussion.

1 case emergency caesarean – no opportunity

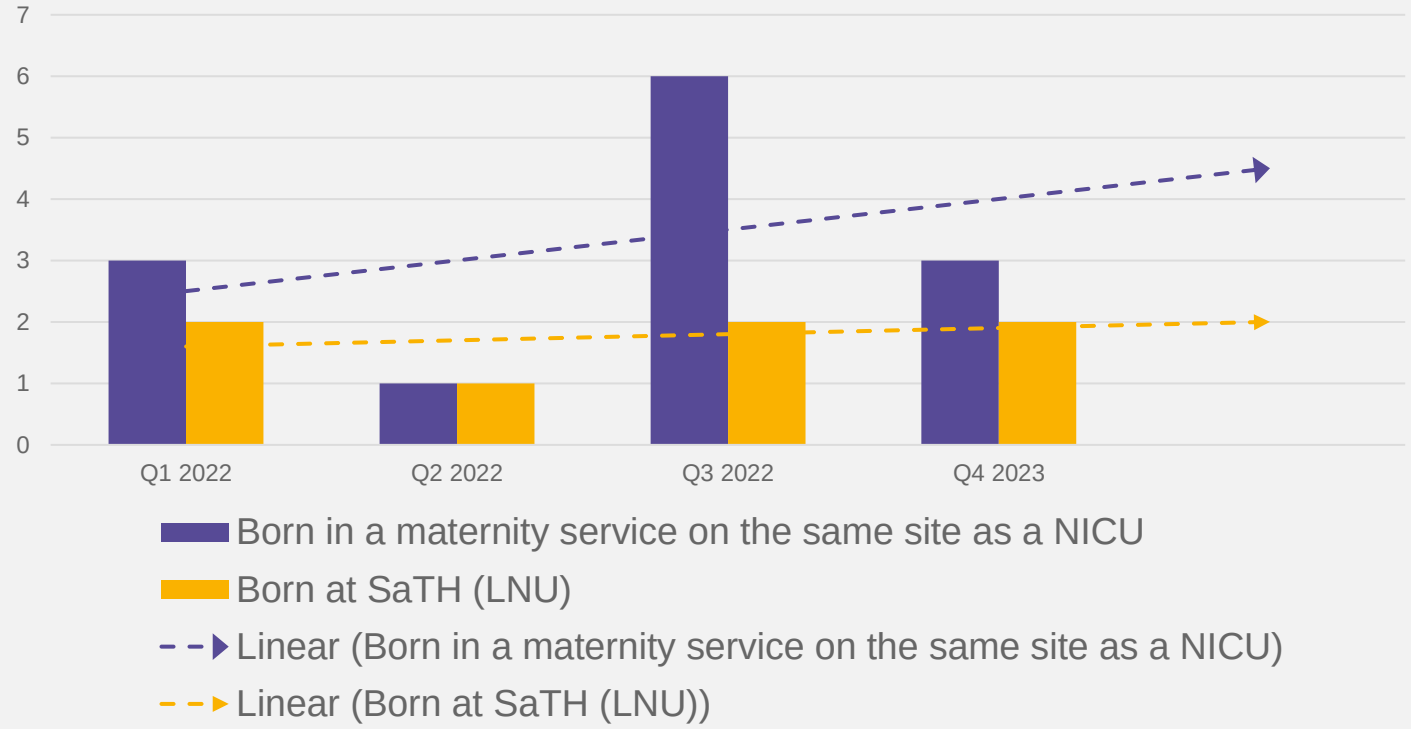
Other cases Neonatal team documented as present but discussion not documented

(No current national ambition – to be agreed locally)

1. Place of birth (financial year 2022-2023)

The Shrewsbury and Telford Hospital NHS Trust

Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU)



For last financial year **65%** of women booked at SaTH who were in one of the above preterm criteria, gave birth in a unit with a same site NICU.

(CNST ambition – minimum 70%, stretch 85%)

2a. Antenatal corticosteroids (Nb. now includes multiples births (ref1))

Percentage of live births (less than 34+0 weeks) receiving a full course (2 injections, 12 to 24 hours apart) of antenatal corticosteroids, within seven days of birth

Excluded 1 (Full course but birth after 7 days)

47% (confirmed Neonatal dashboard)

(CNST ambition – minimum 40%, stretch 55% (reduced from 80% in version 2))

Brief case overviews next slide

Brief case review from table 2a.

The Shrewsbury and Telford Hospital NHS Trust

10 cases, including 2 sets of twins births received a single dose of antenatal steroid.

No missed opportunities identified.

2 cases, spontaneous precipitate births before 1st dose given.

No missed opportunities identified in both cases

2b. Antenatal corticosteroids (Nb. now includes multiples births (ref1))

The Shrewsbury and Telford Hospital NHS Trust

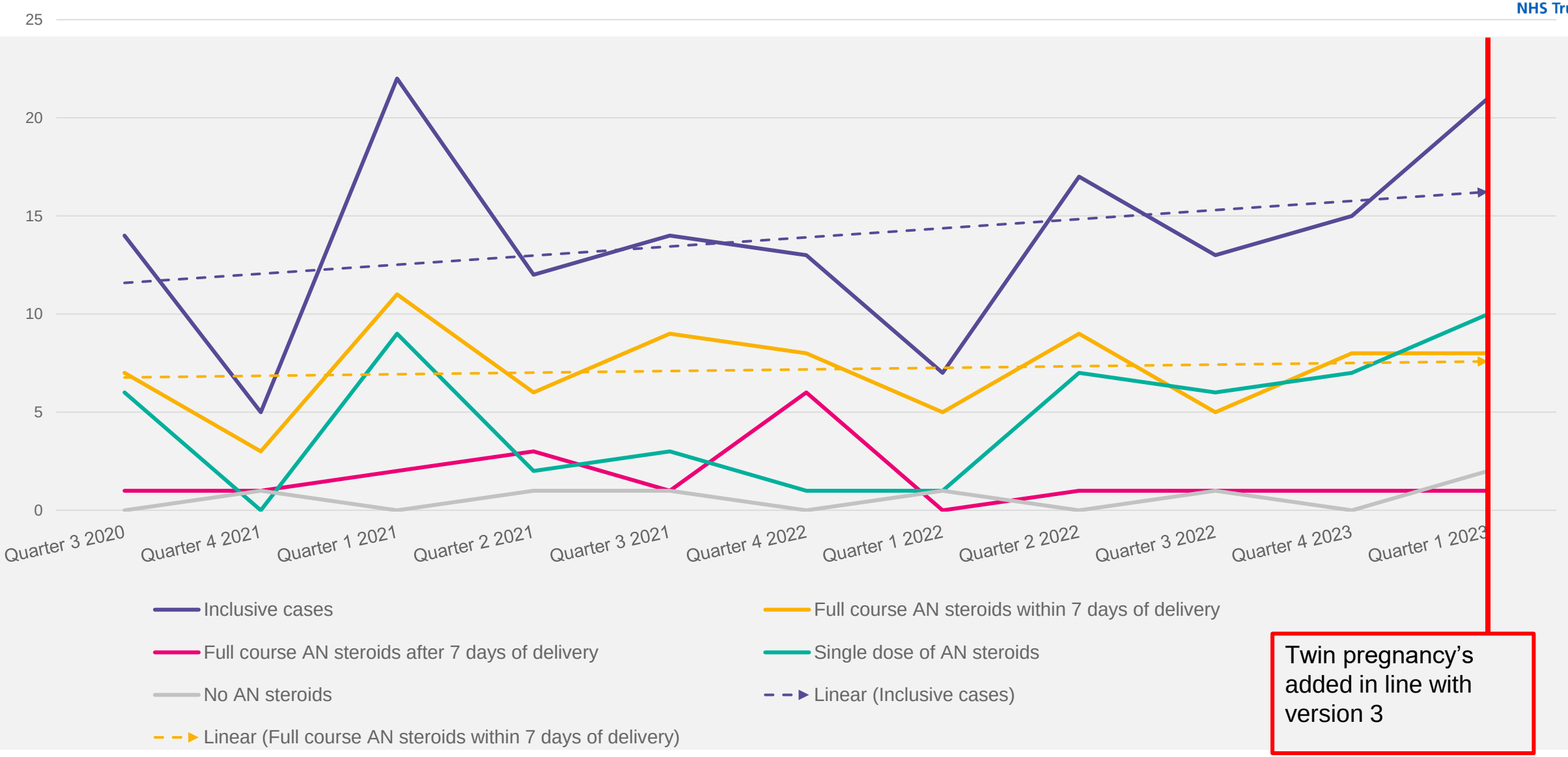
Percentage of live births (less than 34+0 weeks) occurring **more** than seven days after completion of their first course of antenatal corticosteroids

Cases in review period 9

11.1% (percentage should be low)

1 case, Full course given at 30+weeks due to several antepartum haemorrhages (known placental praevia). Delivered at 33+weeks.

Antenatal Steroids



Twin pregnancy's added in line with version 3

3. Magnesium sulphate

The Shrewsbury and Telford Hospital NHS Trust

Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth

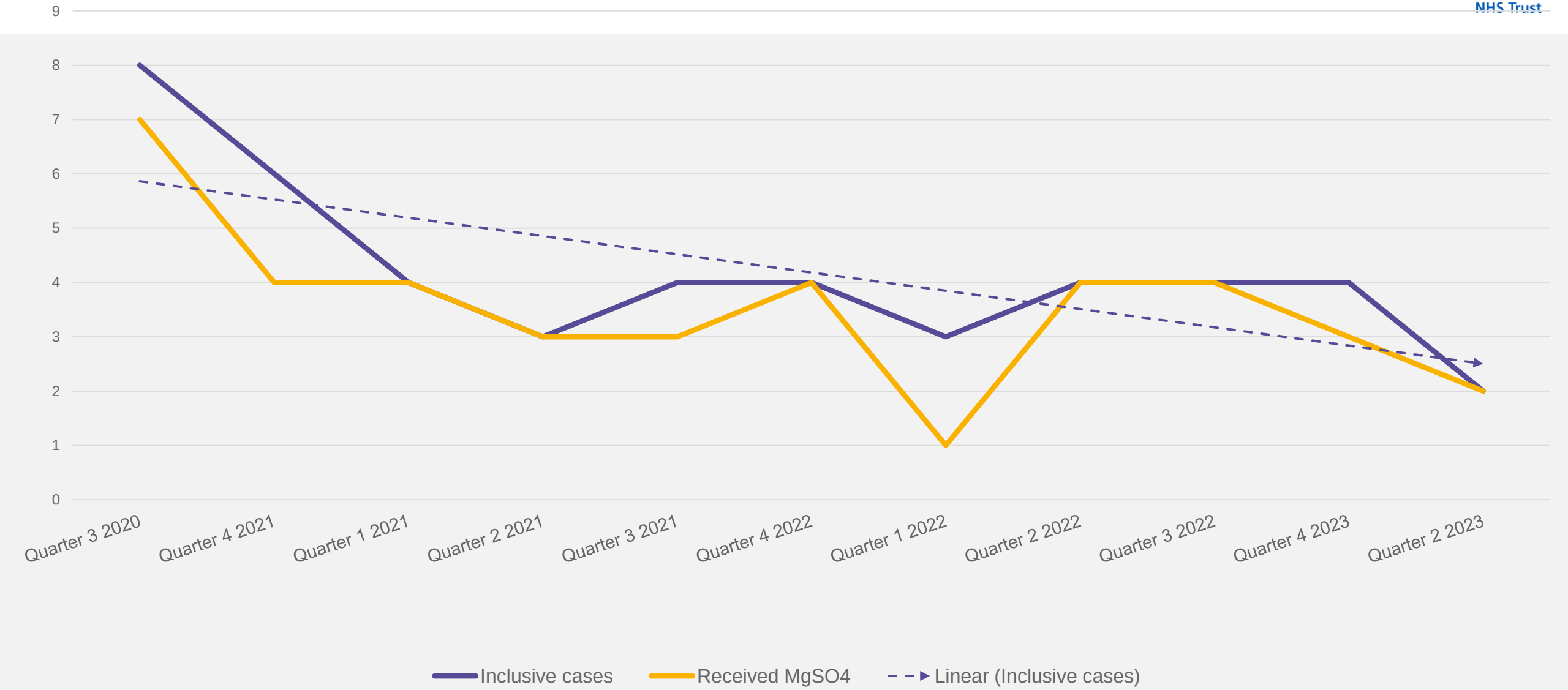
Cases in review period 2

100%

(CNST ambition – minimum 80%, stretch 90%)

Antenatal Magnesium Sulphate (MgSO4) administer for neuroprotection (up to 29+6 weeks gestation)

The Shrewsbury and Telford Hospital NHS Trust



New standards - baseline results

The following new additional version 3 perinatal optimisation standards have a baseline result and will be monitored going forward.

4. Intrapartum antibiotics

The Shrewsbury and Telford Hospital NHS Trust

Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection.

Cases in review period 10

Baseline result 90%

(No current national ambition – to be agreed locally)

5. Cord Management

Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth.

Baseline result 58.6% (source Neonatal dashboard)

(CNST ambition – minimum 50%, stretch 75%)

Case reviews

All 5 other cases had documentation of consideration or attempted but decision made not to defer as resuscitation required.

Alongside Lifestart trolley will increase the opportunity to defer cord clamping once in service.

6. Normothermia

Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth.

Cases in review period 21

a, temperature measured within an hour

Baseline result 100%

b. first temperature between 36.5–37.5°C

Baseline result 83.5% (source Neonatal dashboard)

(Combined CNST ambition – minimum 65%, stretch 80%)

7. Early maternal breast milk (MBM)

The Shrewsbury and Telford Hospital NHS Trust

Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth.

Cases in review period 21

a. Within 24 hours of birth

Baseline result 57.1% 5 women declined MBM

Of those who had MBM 75% were documented as within 6 hours

(No current national ambition – to be agreed locally)

Singleton Preterm births – 16-23+6 weeks

The Shrewsbury and Telford Hospital NHS Trust

The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a percentage of all singleton births:

a. In the late second trimester (from 16+0 to 23+6 weeks)

Cases in review period n=923

The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a. In the late second trimester (from 16+0 to 23+6 weeks)n=923			
Number of cases in review	923		
Number of cases not applicable	0	Total number cases assessed	923
Criteria	16+0 to 23+6 weeks	> 24 weeks	Total % of 16+0 to 23+6 weeks
The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a. In the late second trimester (from 16+0 to 23+6 weeks)	8	915	0.9%

Nb – 2nd Trimester medical terminations of pregnancy now included

Singleton Preterm births – 24-36+6 weeks

The Shrewsbury and Telford Hospital NHS Trust

7. The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a percentage of all singleton births:

b. Preterm (from 24+0 to 36+6 weeks).

Cases in review period n=923

The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: b. Preterm (from 24+0 to 36+6 weeks).			
Number of cases in review	923		
Number of cases not applicable	0	Total number cases assessed	923
Criteria	24+0 to 36+6 weeks	Gestations ≥37 weeks	Total % of 24+0 to 36+6 weeks
The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: b. Preterm (24+0 to 36+6 weeks)	51	872	5.5%

Accumulative Data

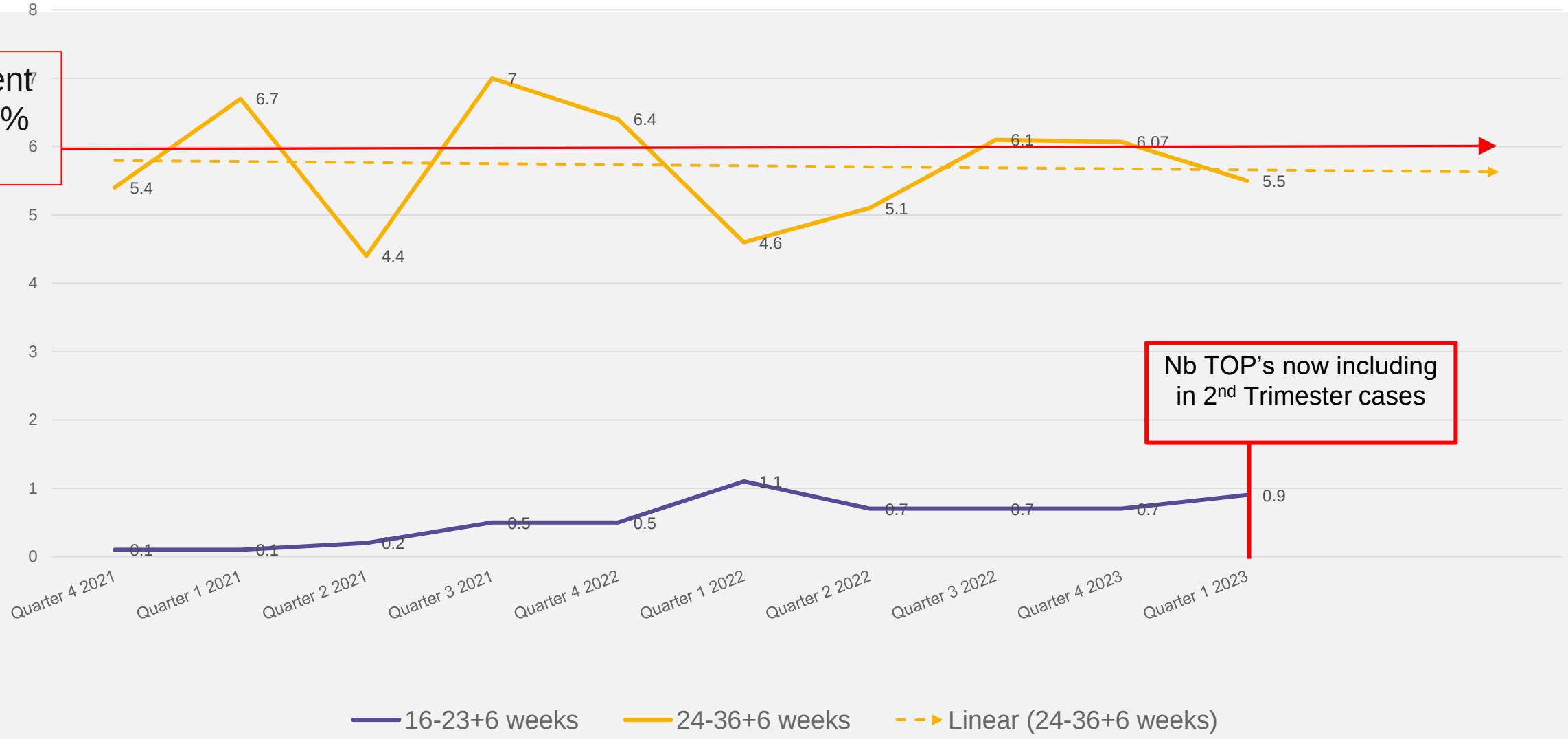
The Shrewsbury and Telford Hospital NHS Trust

The following set of slides show accumulative standards data graphs commencing from 2020

Incidence of preterm births at SaTH
Quarter 4 2021 - Quarter 1 2023

The Shrewsbury and Telford Hospital NHS Trust

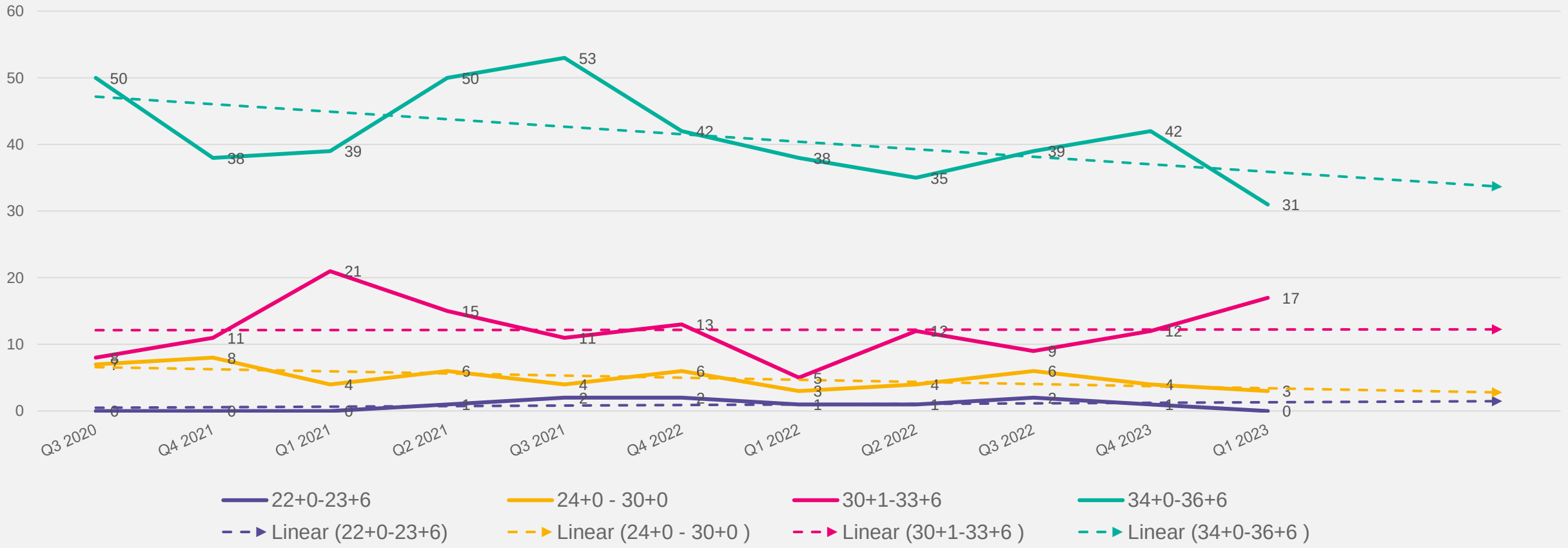
Government target of 6% by 2025



Nb TOP's now including in 2nd Trimester cases

Preterm singleton gestation rates commencing from Quarter 3 2020 (livebirth and stillborn)

The Shrewsbury and Telford Hospital NHS Trust



Partnering · Ambitious
Caring · Trusted

Our Vision: To provide excellent care for the communities we serve

Reference

1. NHS England (2023) Saving Babies' Lives A care bundle for reducing perinatal mortality version 3 NHS England » Saving babies' lives: version 3
2. Antenatal Optimisation Toolkit | British Association of Perinatal Medicine (bapm.org)

APPENDIX 5

The Shrewsbury and Telford Hospital NHS Trust

Saving Babies Lives Element 2

Review of Small for Gestational Age births at SaTH in Quarter 1 2023-2024

and

Accumulative graphical data commencing 2020

Lindsey Reid
Lead Midwife for Saving Babies' Lives

Data collated July 2023

Introduction

Fetal Growth Restriction (FGR) is the most important condition associated with stillbirths;
excluding congenital abnormality, FGR accounts for about 50% stillbirths and neonatal deaths (ref 1 and 2).

A fetus affected by FGR has a 5-11 fold increased risk of in-utero death (ref 3)

FGR is a precursor of cerebral palsy (ref 4)

Introduction

The Shrewsbury and Telford Hospital NHS Trust

The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice for providers and commissioners of maternity care across England to reduce perinatal mortality.

The newest update to the care bundle, version 3 (ref 5) was released in June 2023. It comprises of 6 individual elements

Element 2

Element 2 covers Fetal Growth: Risk assessment, surveillance, and management. Building on the widespread adoption of mid-trimester uterine artery Doppler screening for early onset fetal growth restriction (FGR) and placental dysfunction, Element 2 seeks to further improve FGR risk assessment by mandating the use of digital blood pressure measurement. It recommends a more nuanced approach to late FGR management to improve the assessment and care of mothers at risk of FGR, and lower rates of iatrogenic late preterm birth.

Definitions and Abbreviations

Fetal Growth Restriction (FGR) – birth centile under (<) the 3rd

Small for Gestational Age (SGA) – birth centile under (<) the10th to above (>) the 3rd

Estimated fetal weight (EFW) - fetal weight estimated from ultrasonic fetal biometry (measurements)

Induction of labour – IOL

Perinatal mortality review tool (PMRT)- national standardised perinatal mortality review

Serial Growth Scan (SGS)

Ultrasound Scan (USS)

≥ - equal to and above

≤ - equal to and below

This report does not include slowing growth detected on babies born above 10th centile

Aims

To monitor compliance with the standards contained within SBLCB

Standards

- Monitoring for all babies born below the 10th centile regardless of gestation
- Monitoring of babies born after 39+6 and between the 10th and 3rd centile to provide an indication of detection rates and management of SGA babies (SBLCBv3 Element 2).
- Monitoring of babies under the 3rd centile born after 37+6 weeks. This is a measure of the effective detection and management of FGR (SBLCBv3 Element 2, Outcome indicator).

Methodology

A retrospective quarterly data review of babies born below the 10th centile

Time period– 1/4/23 – 30/6/23 (Quarter 1 2023 -2024)

Cases analysed – 942 babies (live born and stillborn from 24 weeks gestation)

Cases excluded – 9 women who received most of their antenatal care/fetal growth surveillance outside of the Trust

Cases included - 933

Data extracted from Badgernet (Maternity Information Systems)

Method of analysis – Microsoft Excel

Results

The next slide shows SaTH's internally reviewed data.

The Perinatal Institute's (PI) national GAP (Growth Assessment Protocol (ref 6)) user average data is included as a comparative data.

Quarter 1 2023-2024		SaTH reviewed data	Perinatal Institute National GAP user average Data Comparison
Total inclusive births	N	933	-
SGA rate <10th – 0 centile	N %	139 14.8	13.6
SGA detection rate (<10th – 0 centile)	N %	56 40.3	43.8
Babies <10th >3rd centile delivered on or after 40+0 weeks	N %	35 36.0	25.4
SGA rate (<3rd centile)	N %	42 4.5	4.7
SGA detection rate < 3rd centile	N %	29 69.0	62.9
Babies <3rd centile delivered on or after 38+0 weeks	N %	23 (see review of cases) 54.7	48.7

Conclusion

The Shrewsbury and Telford Hospital NHS Trust

All Babies born <10th centile ↑**14.8%**, this is **above** the PI national GAP average of 13.6%.

Antenatal detection (suspected by ultrasound assessment) rate of all babies <10th centile was ↓**40.3%,** this has fallen **below** the PI national average of 43.8%.

Babies <10th and >3rd centile, delivered on or after 40+0 weeks was ↑**36.0%** which is **above** the PI national GAP average of 25.4%.

Babies born <3rd centile ↓ **4.5%** which was just **better** the PI national GAP average of 4.7%. This is a positive result

Antenatal detection (suspected by ultrasound assessment) rate of all babies <3rd centile was ↑ **69.0%** this is **better** than the PI national GAP average of 62.9%.

Babies <3rd centile delivered on or after 38+0 weeks ↑ **54.7%** is **above** the PI national GAP average of 48.7% (see review of cases in next few slides).

< 3rd centile birth review of births >37+6 weeks

The Shrewsbury and Telford Hospital NHS Trust

< 3rd centiles born > 37+6 weeks cases are reviewed to try to identify any themes that require further investigation and improvement plans

The cases reviewed for care provided from booking to birth

NB. Unable to review 3rd trimester scan images for full review as not currently stored

The following slides give an overview of detection and a brief description of cases <3rd centile births > 37+6 weeks

< 3rd centile case overview (n=42)

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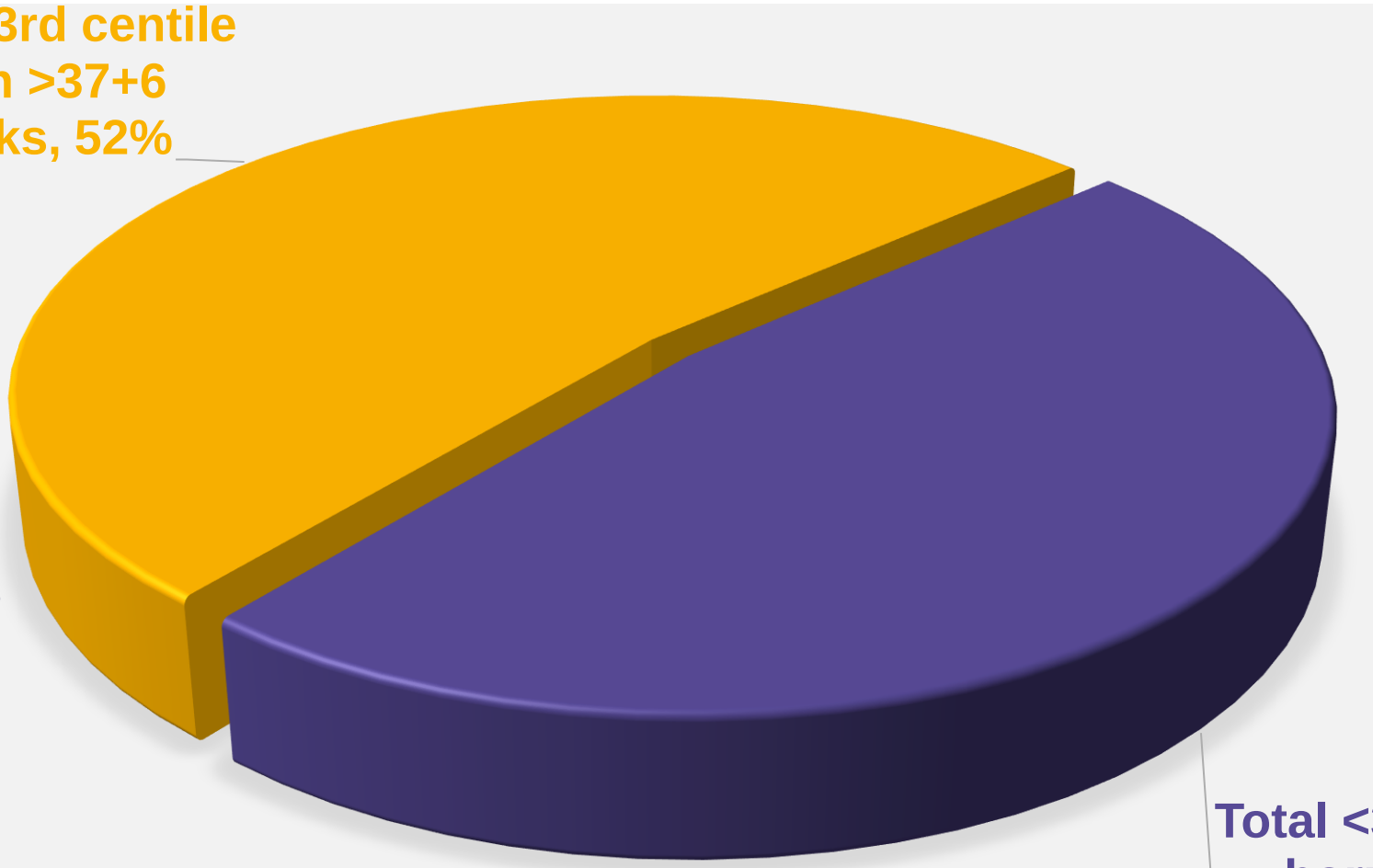


Just over half the < 3rd centile babies were born after 37+6 weeks

<3rd centile cases born >37+6 weeks n=23

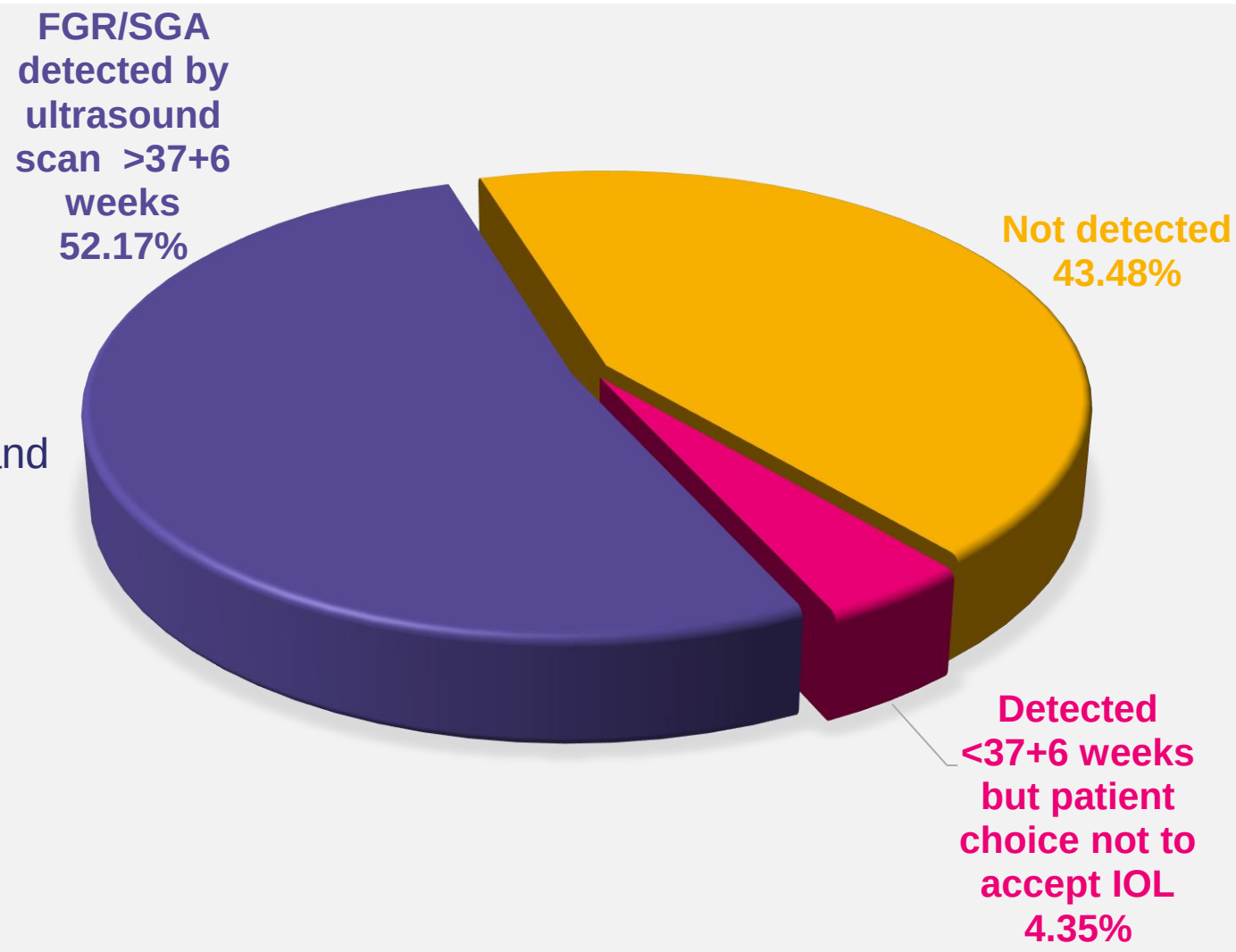
The Shrewsbury and Telford Hospital NHS Trust

Quarter 1 had 23 babies born >37+6 weeks
< 3rd centile

12 were detected <37+6 by USS either final serial growth scan or referral from SFH assessment

1 case was detected prior to 37+6, IOL was offered as per national/local guidance but declined. Offered and accepted daily reviews including CTG until accepted IOL at 38+6 weeks

10 cases not detected
- These cases included women having serial growth scans and scans following a referral from a Community Midwife
(see next slide for brief case review)



Undetected < 3rd centile birth review of births >37+6 weeks

The Shrewsbury and Telford Hospital NHS Trust

Case 1 – 2 x previous FGR babies. High BMI. Serial growth scans demonstrated normal velocity within the normal range of 10th – 50th centile. Ultrasound views documented poor due to maternal BMI – – care followed guidance

Case 2 – P0, low risk at booking. Referred from a serial fundal height assessment. Following 3 scans demonstrated normal velocity within the normal range of 10th – 50th centile – no missed opportunity identified and followed guidance

Case 3 - P1, previous 13th centile. SFH at 32+/40 slow growth. Referred for USS (within 3 days). EFW around 40th centile. Rescan 3 weeks. Slight drop in velocity, rescan 2 weeks. 38+/40 velocity returned to same velocity as 1st scan. 3 weeks between USS and birth – no missed opportunity identified and followed guidance

Case 4 - P0, Booked in Powys. Gestational Diabetes (GDM) diagnosed, SaTH scans from 31+/40. 3 SGS following same velocity – no missed opportunity identified with care provided by SaTH

Case 5 - P0, normal BMI, GDM diagnosed- growth velocity linear – care followed guidance

Undetected < 3rd centile birth review of births >37+6 weeks

The Shrewsbury and Telford Hospital NHS Trust

Case 6 - P1, age 41, BMI 22.5, previous baby 46.5 centile. Referred due to SFH at 28/40 (per guideline), EFW 50th, 31+/40 rescan (per guideline) EFW <50th, 2/52 follow up scan arranged. 34 and 36/40 velocity linear around 30th. 39+0 EFW near 50th but unable to measure HC. IOL for maternal age – care followed guidance

Case 7 - Previous 6th and the 1st centile babies. Age 40. Normal uterine artery screening result SFH at 26/40 <10th, referred for a growth scan which was normal. SGS commenced 32/40. Just above 10th, repeat 2/52, increased velocity, 36+/40 scan normal range. IOL for maternal age – care followed guidance

Case 8 - P1, high BMI, diagnosed GDM. Fortnightly scans ranging from <10th centile to approximately the 20th on last scan at 37+/40. Poor USS views noted in all 3rd T scans due to high BMI – care followed guidance

Case 9 - P0, moderate FGR risk. SFH at 27/40 <10th centile. Referred for scan. Subsequent serial scans shown a fetal growth velocity just above the 10th centile. Elective Caesarean at 39/40 for breech presentation – care followed guidance

Case 10 - P0, low risk for FGR at booking. Referred for scan at 27/40 with SFH < 10th centile. Normal fetal growth. GDM identified and commenced on serial scan pathway within the GDM guidance. EFW velocity remain around the 50th centile. - care followed guidance

Evaluation

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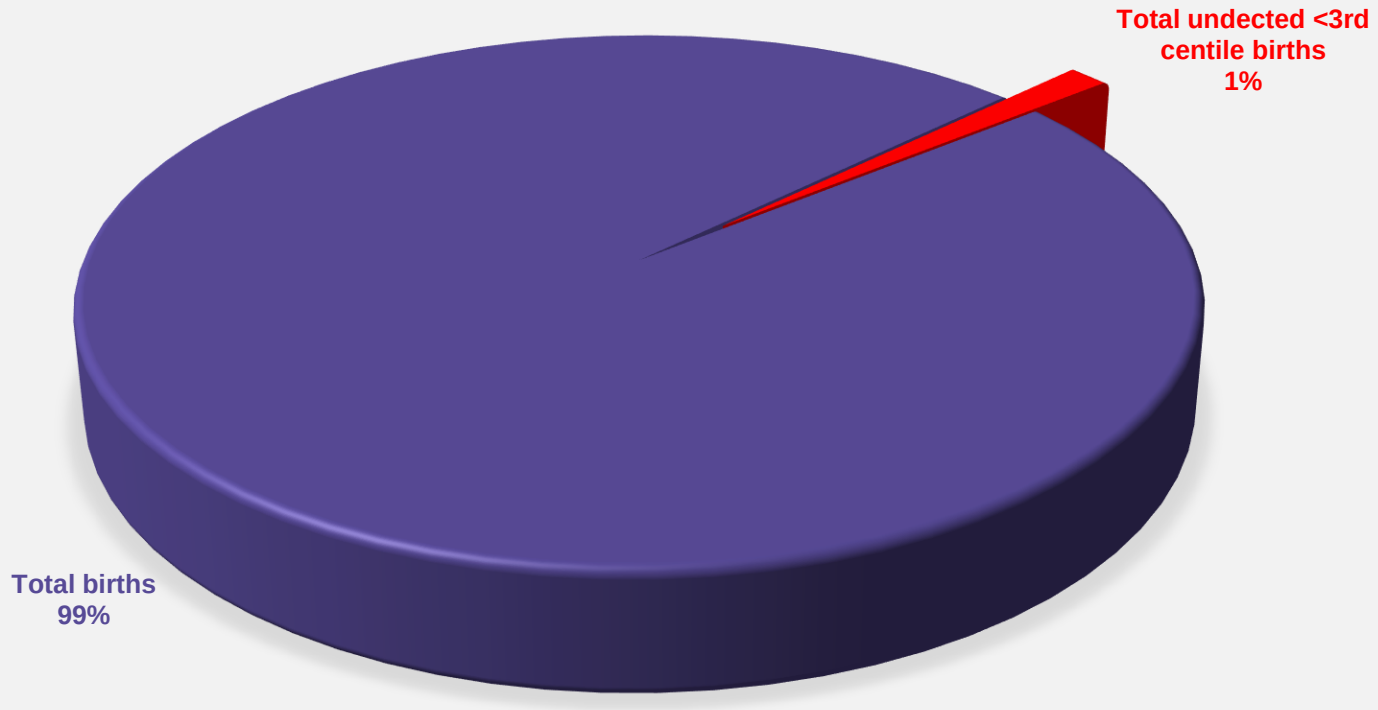
Within the total quarter 1 births (933),

13 babies born < 3rd centile were not identified before birth (any gestation) – ↓ 1.0%



No adverse trends identified

Ultrasound detection

Ultrasound surveillance using EFW is a screening tool and **not** diagnostic due to the inherent issues in calculation of EFW formulas

The most accurate model is Hadlock 3 which is used in SaTH

Reported standard deviation for Hadlock formula is 7.3%, which means;

- **95% of babies have a measured birth weight within 15% of EFW**
- However 1 in 20 babies have a measured birthweight more than 15% of EFW

Additional consideration

- SaTH currently do not save 3rd trimester growth ultrasound images electronically, therefore, complete case evaluation not possible. This has also been highlighted from PMRT case reviews

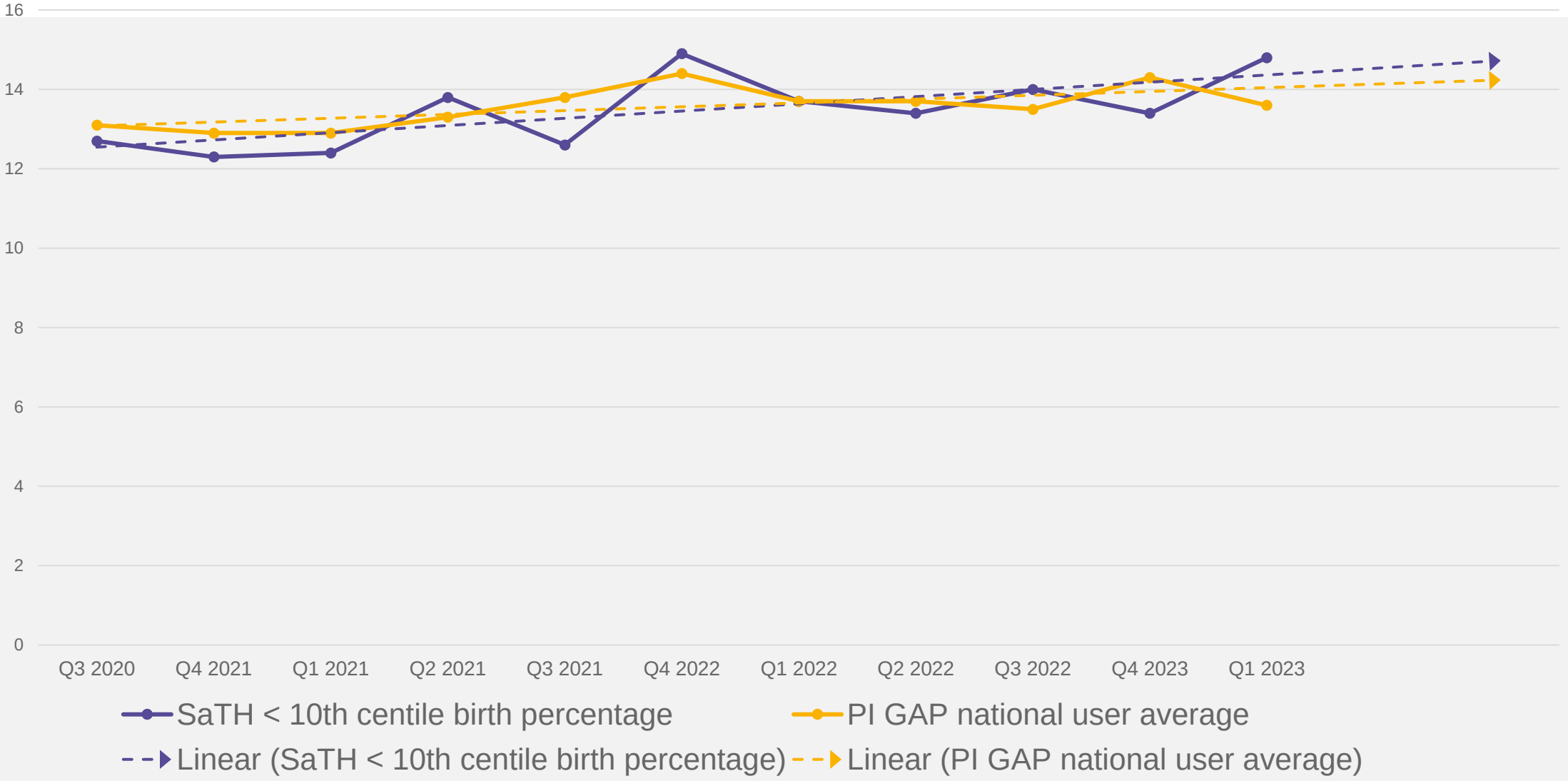
Recommendation

- Consider implementation of electronic storage of 3rd trimester growth scan images

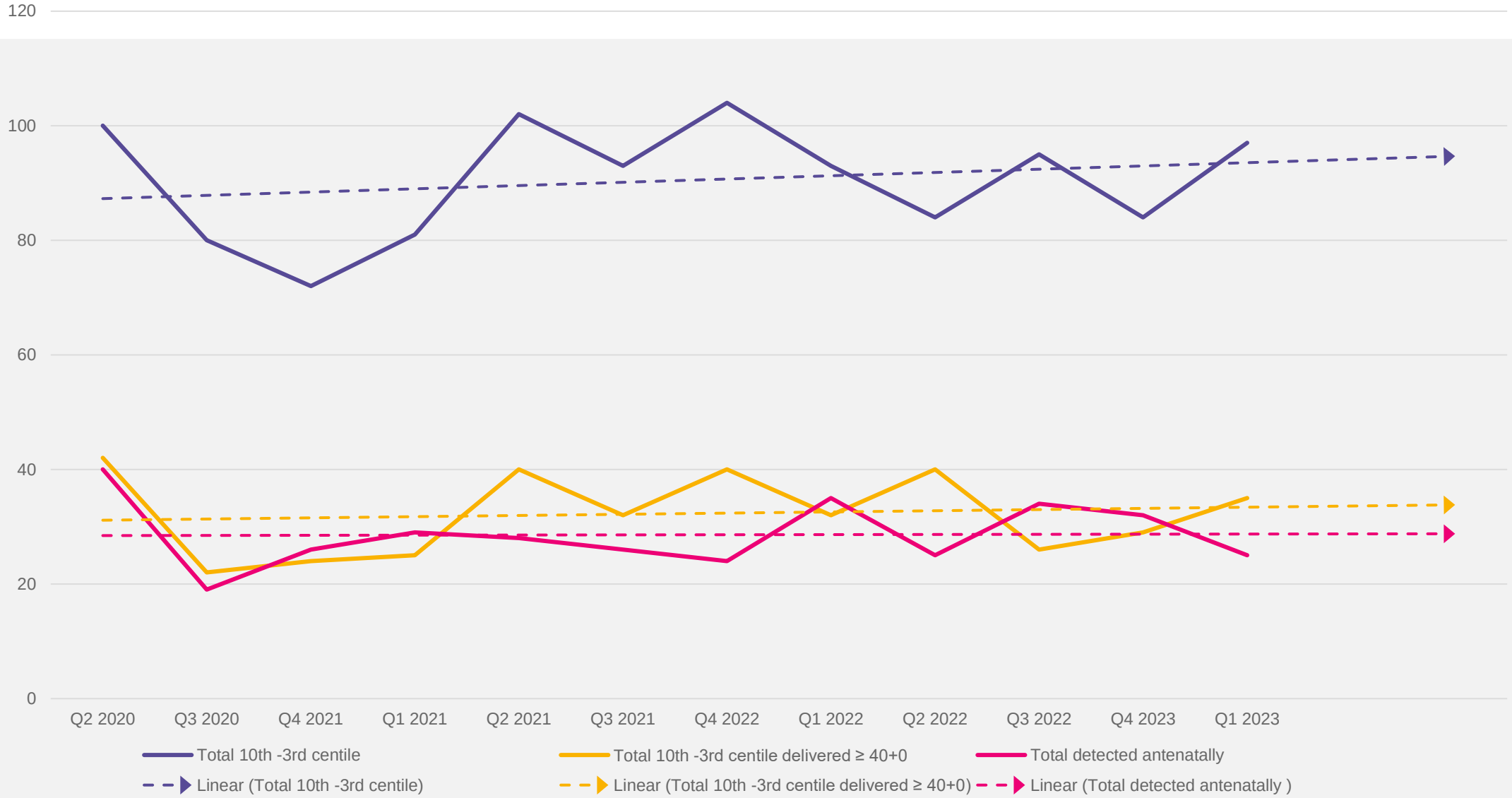
The following slides show accumulative data of:

- All babies born <10th centile at SaTH compared to Perinatal Institute's national GAP average
- Babies born <10th >3rd centile
- Babies born < 3rd centile

Babies born < 10th centile at SaTH compared to the Perinatal Institute's national GAP User average



Expanded 10th to 3rd centile birth data



< 3rd centile birth data

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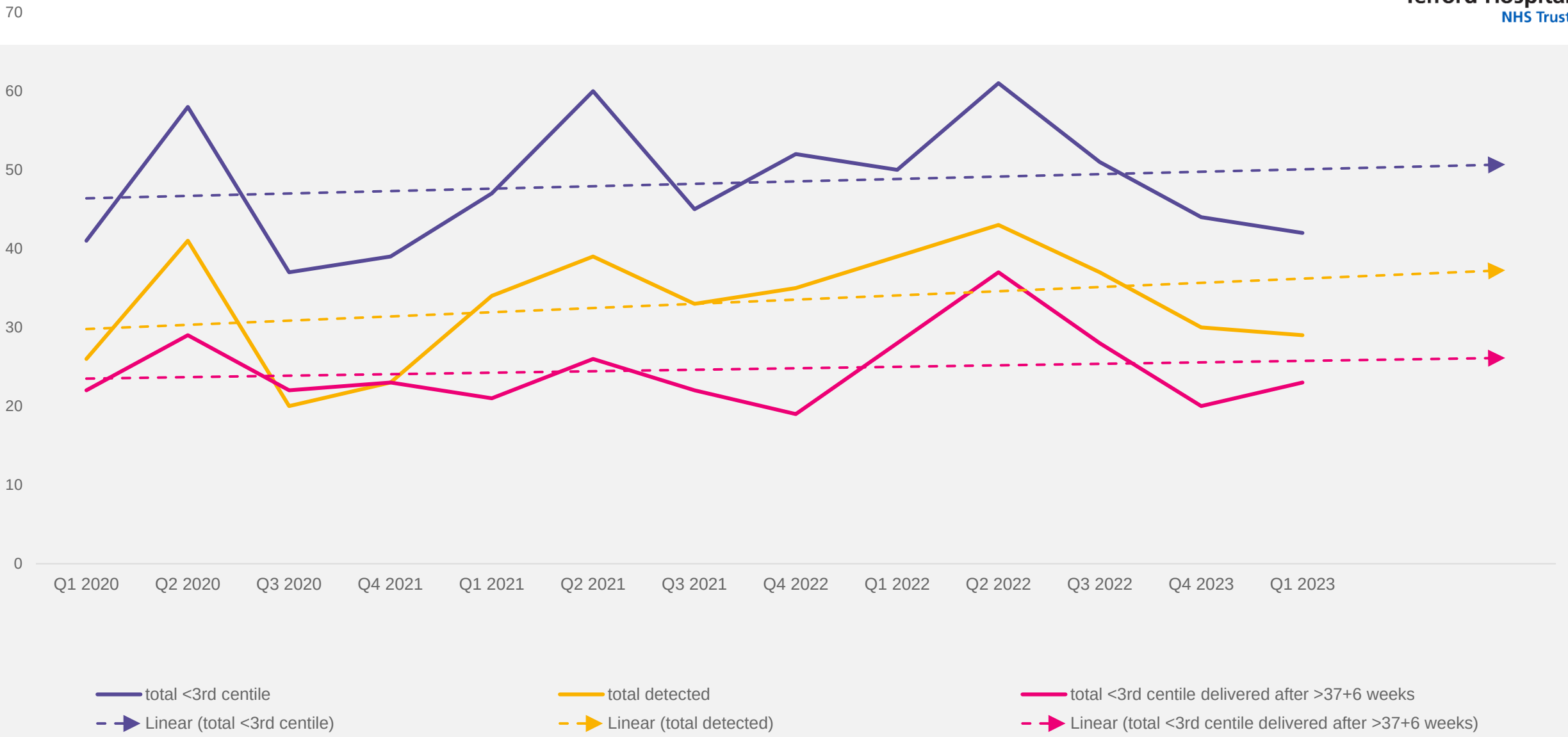


References

1. Gardosi J, Kady SM, McGeown P, Francis A, Tonks A. Classification of stillbirth by relevant condition at death (ReCoDe): population based cohort study. *Br Med J* 2005;**331**:1113-1117.
2. Beamish N, Francis A, Gardosi J. Intrauterine growth restriction as a risk factor for infant mortality. *Arch Dis Child Fetal Neonatal Ed* 2008;**93**(Suppl I):Fa83.
3. Clausson B, Gardosi J, Francis A, Cnattingius S. Perinatal outcome in SGA births defined by customised versus population based birthweight standards. *Br J Obstet Gynacol* 2001;**108**:830-4.
4. Jacobsson B, Ahkin K, Francis A, Hagberg G, Hagberg H, Gardosi J. Cerebral palsy and restricted growth status at birth: population based case-control study. *Br J Obstet Gynacol* 2008;**115**:1250-1255
5. NHS England (2023) Saving Babies' Lives A care bundle for reducing perinatal mortality version 3 NHS England » Saving babies' lives: version 3

Reference

6. GAPguidance.pdf (perinatal.org.uk)

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 12 October 2023

Agenda item		129/23 Paper 4 within CNST INFORMATION PACK		
Report Title		CNST MIS Year 5 Progress Update		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Annemarie Lawrence, Director of Midwifery		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF4,
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register id:**
Responsive	√	Our governance	√	
Well Led	√	Our partners		
Consultation Communication				
Executive summary:		SaTH is a participant in year 5 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), which is operated by NHS Resolution (NHSR) and supports the delivery of safer maternity care. The self-declaration deadline is 1 February 2024. This paper sets out SaTH's progress to date and includes information to evidence the risks to delivery of the Safety Actions.		
Recommendations for the Board:		The Board of Directors is asked to: Review the report and note the significant ongoing risks to delivery for the scheme, for safety actions 6 and 8, which may result in non-compliance for this year of the scheme.		
Appendices:		Appendix 1 – SBL progress report Appendix 2 – SBL divergence paper Appendix 3 – Summary Report /Board safety champion minutes		

1.0 Introduction

1.1 SaTH is a member of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), which is regulated by NHS Resolution (NHSR) and is designed to support the delivery of safer maternity care.

1.2 The scheme incentivises ten maternity safety actions. 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.

1.3 Year 5 guidance was published on 31 May 2023, with version 1.1 and references a relevant time period of 30 May 2023 until 7 December 2023 for delivery of the scheme.

1.4 This also includes a self-declaration deadline of **noon on 1 February 2024.**

1.5 **Following further guidance pertaining to safety actions 3 and 9, a second iteration of the guidance was published on the 19th of July 2023.**

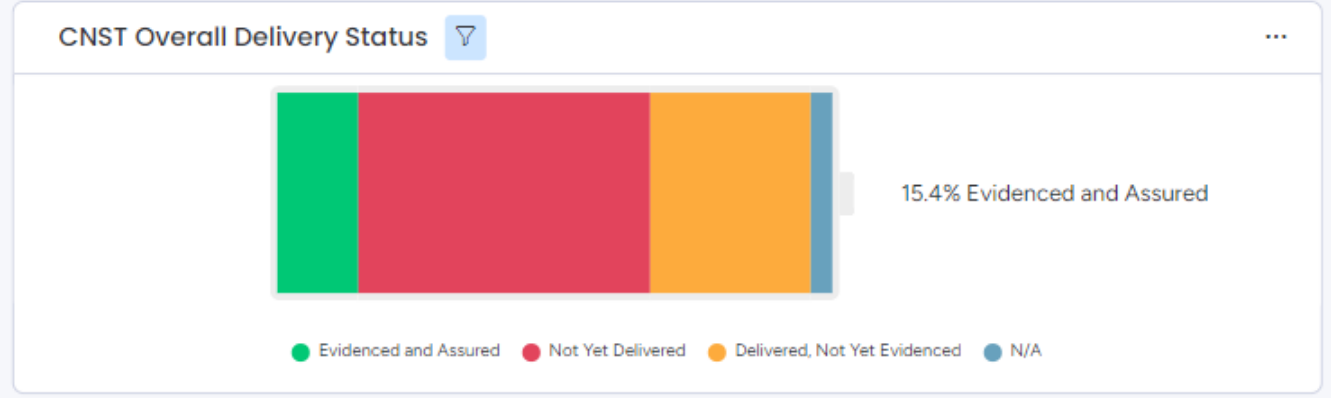
1.6 This new guidance includes updates for safety actions 1,3,6,7,8,9 and 10, with safety action 9 updates being extensive additions to the first iteration of the guidance. The additions centre mainly on the requirements for perinatal clinical quality surveillance and board safety champions.

1.7 The purpose of this paper is to provide the Committee with:

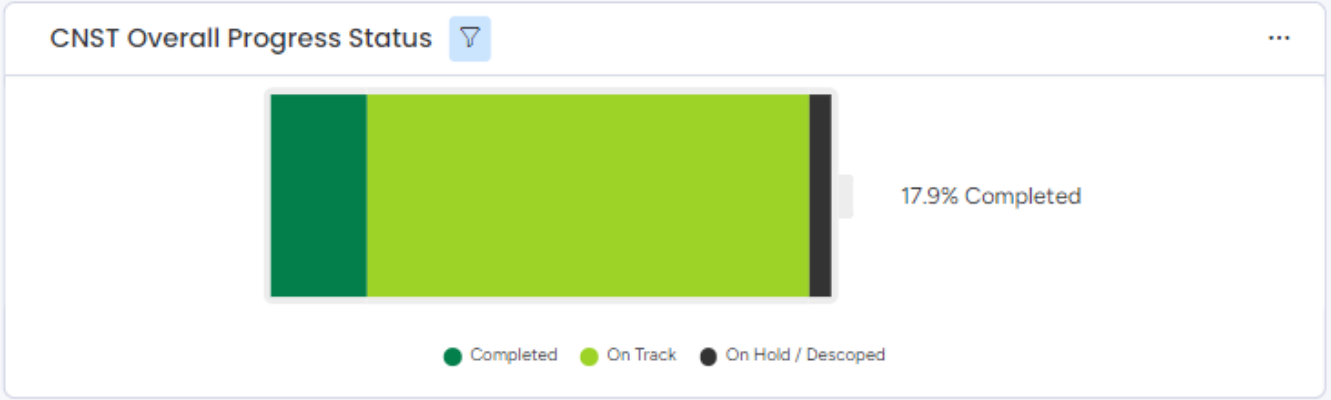
- 1.7.1 Details of the standards within year 5 of the scheme that must be evidenced between now and the reporting deadline.
- 1.7.2 An update on progress.

2.0 Overall Progress Status

2.1 The below chart shows a CNST completion rate as of September 10th 2023 (including compliance with the standards and accrual of supporting evidence) of 15.4% 'Evidenced and Assured', 28.2% 'Delivered Not Yet Evidenced', and 51.3% 'Not Yet Delivered'.

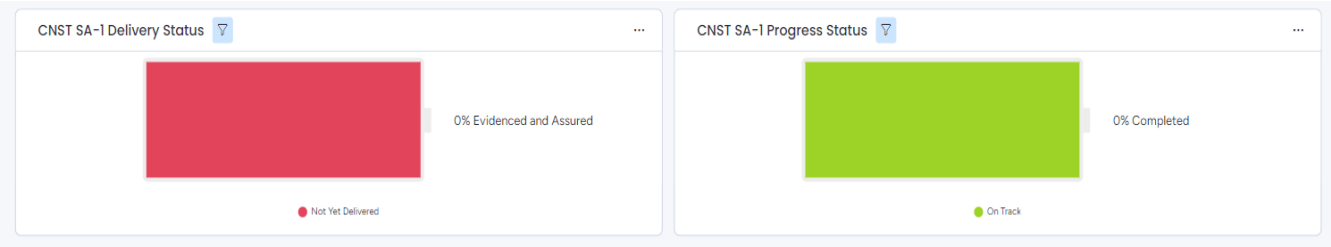


2.2 The above battery should be viewed in conjunction with the below progress battery which evidences the overall status of progress which is predominantly on track.



2.3 While there are elements in the above progress battery that are on-hold/descoped, these relate to Midwifery Continuity of Carer (MCOC) which is currently paused in line with the National letter published in September 2022.

3.0 Safety Action 1: "Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?"



3.1 SaTH is compliant to date with reporting to the MBRRACE-UK website.

3.2 The Board of Directors (BoD) via the delegated authority of QSAC has received a report each quarter since August 2021 that includes details of the deaths reviewed and the consequent action plans.

3.3 Compliance with standard b) is ongoing, with 100% of parents being informed that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought").

3.4 The team are on track to achieve the required standards of c).

3.5 **Progress Status: On Track**

4.0 Safety Action 2: "Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?"

4.1 NHS Digital, who oversee this Safety Action, will confirm whether SaTH have uploaded all required data points to the Maternity Services Data Set (including the 11 Clinical Quality Information Metrics) at the required standard of data quality; this will be confirmed in October 2023 based on the data submitted in the month of July 2023 (which is the month against which the standard is tested).

4.2 This safety action does not appear to be at risk based on the information known to date however this will not be known until the July data is published in October 2023.

4.3 The battery above contains the on-hold/descoped elements associated with the pause of MCoC in line with the national letter as described above.

4.4 The latest CNST Safety Action 2 scorecards were published in August, confirming the Trust have passed March to May and our provisional scores for June 2023 are also a pass.

4.5 **Progress status: On Track**

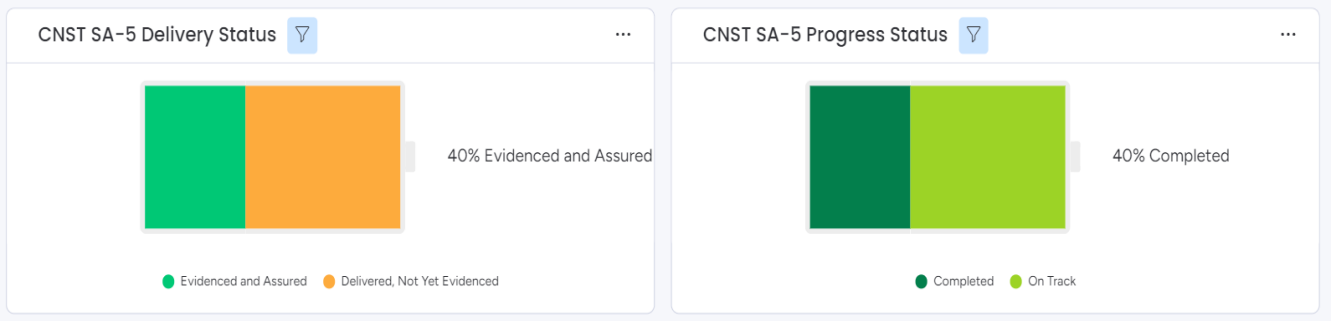
5.0 Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

5.1 The Trust operates a Transitional Care service and associated pathway that continues to meet the national target of Avoiding Term Admission into the Neonatal Unit (ATAIN).
5.2 The BoD via the delegated authority of QSAC has continued to receive a report each quarter since August 2021 that includes details of all term admissions, including avoidable admissions and any associated action plans evidencing the required standards for b).
5.3 The BoD via the delegated authority of QSAC has continued to receive a report each quarter on transitional care activity and any associated actions evidencing the requirements for standard c).
5.4 Progress Status: On Track

6.0 Safety Action 4: "Can you demonstrate an effective system of clinical workforce planning to the required standard?"

6.1 Standard a). The Obstetrics workforce gap analysis paper was previously presented to QSAC on 1 September 2023 detailing the position and identifying any gaps including the business continuity plans required to evidence an effective system of workforce planning.
6.2 Standard a) also requires an audit of 6 months activity to measure compliance and this is being undertaken currently and will be brought as an appendix in due course.
6.3 Standard b) evidence of achieving the ACSA Standard 1.7.2.1 has been requested.
6.4 Standard c) evidence to show that SaTH has a BAPM-compliant Neonatal Medical Workforce has already been provided to QSAC in April 2022 and September 2023.
6.5 Standard d) QSAC were appraised of the neonatal nursing workforce action plan in year 4 of the scheme, with the action plan also submitted to the LMNS and the Neonatal Operational Delivery Network (ODN) in line with the technical guidance. There has been no change to standard d) in year 5 therefore it remains complete however an updated action plan has been requested for completeness which will again be presented to QSAC in due course.
6.6 Progress Status: On Track

7.0 Safety Action 5: “Can you demonstrate an effective system of midwifery workforce planning to the required standard?”



7.1 The BoD has continued to receive the bi-annual midwifery staffing paper since the year 4 scheme ended, with the last report being present to the Board in June 2023.
7.2 Additionally, the service submits a monthly midwifery staffing paper to the Trusts workforce meeting which captures standards c) and d) of safety action 5; this meeting is chaired by the Director of Nursing (DoN).
7.3 The next bi-annual staffing paper will be written using data from Q1/2 of 2023 so will not be received at Trust Board until Autumn 2023.
7.4 Progress status: On Track

8.0 Safety Action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies’ Lives Care Bundle Version Three?

8.1 This is one of the largest and most complex of all the safety actions because it comprises the six elements of SBL care bundle (see appendix 1).

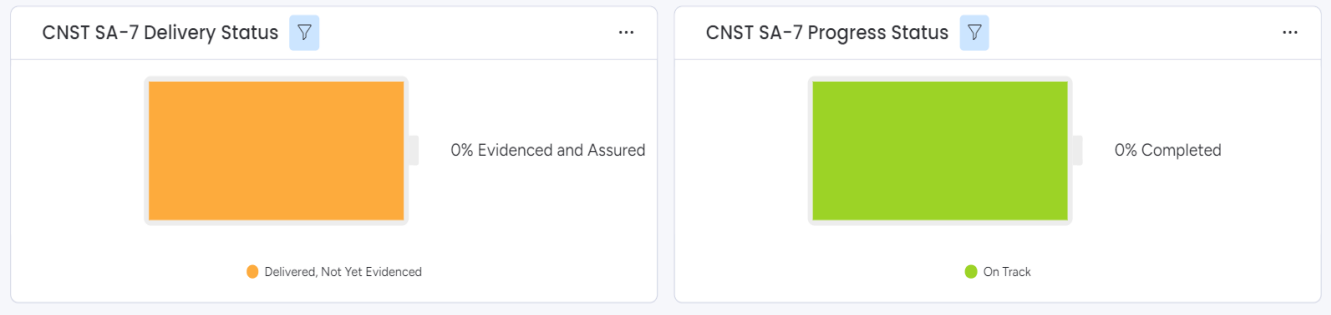
- 8.1.1 Reducing smoking in pregnancy
- 8.1.2 risk assessment, prevention and surveillance or pregnancies at risk of fetal growth restriction (FGR)
- 8.1.3 Raising awareness of reduced fetal movements (RFM)
- 8.1.4 Effective fetal monitoring during labour
- 8.1.5 Reducing preterm birth
- 8.1.6 Management of pre-existing diabetes (New for version 3)

8.2 Trusts are asked to hold quarterly improvement discussions with the ICB using the new national implementation tool and there must be 2 meetings held before March 2024. The initial discussion meeting was held in August 2023, and the first formal meeting took place on the 6 September 2023, evidencing the Trust as on track to complete.
8.3 To achieve CNST year 5, each element within this safety action must have achieved a minimum of 50% compliance and have an overall compliance of 70% for all elements (The percentages are generated within the tool and are evidenced in the below table).

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	60%
Element 2	Fetal growth restriction	Partially implemented	85%	Partially implemented	85%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%
Element 5	Preterm birth	Partially implemented	67%	Partially implemented	67%
Element 6	Diabetes	Partially implemented	17%	Partially implemented	17%
All Elements	TOTAL	Partially implemented	69%	Partially implemented	69%

8.4 As can be evidenced, there are risks to element 6 primarily as this is a new introduction to the care bundle which requires financial support to implement the additional resources required for endocrinology services however the team are working closely with finance to agree this support using the year 4 rebate monies.
8.5 The Trust has submitted a divergence request for the timing of HBA1C monitoring which is supported by our system partners. The outcome of the request will be notified to the Trust within 28 days (see appendix 2).
8.6 Progress Status: At Risk

9.0 Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.



9.1 The productive partnership between SaTH and the Maternity and Neonatal Voices Partnership continues to yield important outcomes for service users and staff alike; the MNVP have recently recruited to a number of new, key roles that will enhance the current offer and afford the capacity to extend the reach to the wider community.
9.2 The CQC maternity survey has a coproduced action plan which was presented at maternity governance meeting on the 17 July 2023; this will feed into the safety champions and LMNS board meeting taking place in August 2023, where progress will be monitored moving forward.
9.3 The maternity and neonatal safety champions regularly seek feedback from staff in local areas as part of the scheduled walkabouts which are undertaken bi-monthly. These walkabouts are managed in conjunction with the 15 Steps walkabouts and subsequent action plans are monitored via safety champions, MNVP Hub meetings, and maternity governance meetings.
9.4 Progress Status: On Track

10.0 Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

10.1 The Trust has been fortunate to participate in the NHSE Pilot of version 2 of the Core Competency Framework (CCF) therefore our local training plan reflects the ask within the technical guidance to be aligned to the CCF v2.
10.2 The updated plan has been agreed by the quadrumvirate on 27 June 2023 and presented to QSAC and LMNS in August 2023, as part of the evidence requirements for this safety action.
10.3 There is a risk to delivery in that all staff groups require 90% attendance over a 12-month consecutive period which is calculated from the end date used to inform percentage compliance to meet Safety Action 8 in the Year 4 scheme.
10.4 Figures at present are being affected by the junior doctor rotation in August, and the new midwifery cohort in September, both of which have contributed to lowering of our overall compliance rates.
10.5 The education team are working collaboratively with the management team to ensure all remaining staff are released to attend planned sessions, but this will again be dependent on the impact of planned industrial action and staff unavailability therefore delivery of this action overall remains at risk.
10.6 Progress Status: At Risk

11. 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?

11.1 The Trust has a robust maternity and neonatal safety champions process in place which evidences ward to board escalation of any quality issues evidencing completion of element a).
11.2 The safety dashboard captures a minimum dataset which is reviewed monthly, and any issues escalated via the safety champions AAAA which is reported to Divisional Committee, QSAC and MTAC.
11.3 Standard b) refers to the Trusts claims Scorecard data which should be reviewed alongside incident and complaints data and used to agree targeted interventions aimed at improving patient safety which are then reflected in the Trusts Patient Safety Incident Response Plan. This should be undertaken at least twice in the MIS reporting year and

was carried out at July 2023 Divisional Committee, and then additionally at safety champions in August and October 2023.
11.4 Standard c) requires that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available by no later than 1 August 2023 *(was previously 1 July 2023 prior to the NHSR update issued on 30 June 2023).* ***This has been completed****.*
11.5 New guidance published in July 2023 stipulates additional minimum evidence requirements for the Board Safety Champions to meet with the Perinatal 'Quad' Leadership team on a quarterly basis, with at least 2 meetings before the end of the reporting period.
11.6 The first meeting took place on 21 August 2023 (see appendix 3), with the second scheduled for November 2023.
11.7 Progress Status: On Track.

12. Safety Action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?

12.1 This safety action relates principally to the work of the divisional governance team, supported by the legal team.
12.2 As with Safety Action 1, the need to report appropriately to the (HSIB) and the NHS Resolution Early Notification Scheme (ENS) is ongoing, hence this action will not be evidenced as delivered/complete until after the reporting deadline of 7 December 2023.
12.3 Family information on the role of HSIB/NHSR ENS and Duty of candour is monitored weekly, and an audit will be produced to evidence compliance following the reporting deadline which is in keeping with Year 4 of the scheme.
12.4 Progress Status: On Track.

13.0 Risks to Delivery

There is a risk that…	The risk is caused by…	The potential impact of the risk is…	The mitigation in place is…
Trust may not achieve version 3 of the SBLCB	New additions to the updated guidance pertaining to elements 6 which relate to the endocrinology service, diabetes glucose monitors and dietician services.	Failure of safety action 6	The Trust has submitted a divergence request for the timing of HBA1C monitoring which is supported by our system partners. The outcome of the request will be notified to the Trust within 28 days (see appendix 2).
The Trust may miss the 90% target for training for	The 12 months consecutive date range begins from the date used to inform compliance for the year 4 scheme therefore	Failure of safety action 8	There are a number of sessions planned to try and capture as many staff as possible however this is intrinsically linked with a high

There is a risk that…	The risk is caused by…	The potential impact of the risk is…	The mitigation in place is…
midwives, Drs and support staff	compliance must be achieved by October 2023.		unavailability rate/planned industrial action therefore it is likely that our position will not be known until the qualifying period ends.

14.0 Summary

14.1 SaTH is mostly on track to achieve CNST MIS Year 5, although there remains a very significant risk to delivery for Safety Actions 6 and 8 for the reasons specified above. The team are working hard to mitigate these risks wherever possible and reduce the risk of non-compliance however this will not be confirmed until after the scheme ends.

15.0 Summary of safety action statuses

Safety Action #	Completion Status
1	On Track
2	On Track
3	On Track
4	On Track
5	On Track
6	At Risk
7	On Track
8	At Risk
9	On Track
10	On Track

16.0 Actions requested of the Board of Directors

16.1 The Board is asked to review the report and note the significant ongoing risks to delivery of the scheme for safety actions 6 and 8, which may result in non-compliance for this year of the scheme.

Board of Directors' Meeting
12 October 2023

APPENDIX 1

The Shrewsbury and Telford Hospital NHS Trust

Agenda Item No.	129/23 Paper 4 within CNST INFORMATION PACK **Appendix 1**			
Report Title	Saving Babies Lives Progress Report			
Executive Lead	Hayley Flavell, Executive Director of Nursing			
Report Author	Lindsey Reid, Lead Midwife for Saving Babies' Lives			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery	√	Caring	√
	Our partners		Responsive	√
	Our governance	√	Well Led	
	Report recommendations:		**Link to BAF / risk:**	
	For assurance		BAF 1, BAF 2 BAF 3, BAF 4 BAF 7, BAF 8	
	For decision / approval		**Link to risk register:**	
	For review / discussion		CRR 15	
	For noting	√		
	For information			
	For consent			
Presented to:	LMNS programme board			
Executive summary:	The Saving Babies Lives Care Bundle is an evidence-based package of measures designed to reduce perinatal mortality. Reviews conducted to date suggest that implementation of this care bundle has been effective in achieving this vital aim, but that more needs to be done. The importance attached to Saving Babies Lives is reflected in the fact that it forms one of the ten Safety Actions of the Clinical Negligence Scheme for Trusts. This scheme mandates that regular updates on delivery progress must be provided to the Board of Directors; this is the purpose of this paper.			
Recommendations for the Board of Directors:	The Board of Directors is asked to note this report.			
Appendices	Appendix 1 Local agreements Appendix 2 Preterm passports – 2a Clinical 2b Parental			

1.0 **Introduction**.

1.1 The Saving Babies Lives (SBL) care bundle is designed to reduce perinatal mortality, and its implementation constitutes Safety Action 6 of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), of which SaTH is a participant.

1.2 The Trust was able to prove full compliance with the requirements of SBL as part of year 3 and year 4 of CNST.

1.3 SaTH is now part-way through delivery of CNST year 5 (2023-24), which includes implementation of new standards within SBLCB version 3. The purpose of this paper is to:

1.3.1 Provide quarterly reports of information which require sharing (as per SBLCBv3) with the Trust Board and LMNS

2.0 **Background.**

2.1 The first version of the Saving Babies' Lives Care Bundle (SBLCB) was published in March 2016 and focussed predominantly on reducing the stillbirth rate[1]. The care bundle was designed to deliver the then Secretary of State for Health's announced ambition to halve the rates of stillbirths, neonatal and maternal deaths, and intrapartum brain injuries by 2030, with a 20% reduction by 2020. The care bundle consisted of four standards.

2.2 In November 2017, as part of the National Maternity Safety Strategy, the national ambition was extended to include reducing the rate of preterm births from 8% to 6% and the date to achieve the ambition was brought forward to 2025[2]. This is reflected in the NHS Long Term Plan.[3]

2.3 The second version of the care bundle was published in 2019 and included a fifth element: 'Reducing preterm birth'.[4]

2.4 The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020. ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data shows there is more to do to achieve the Ambition in 2025 period (SBLCBv3).

[1] https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf
[2]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf
[3] https://www.longtermplan.nhs.uk/
[4] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

2.5 The 3rd version of the care bundle (SBLCBv3)[5] was released in June of this year. Building on the achievements of the previous versions, Version 3 includes a refresh of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit.

There are now 6 elements of care:

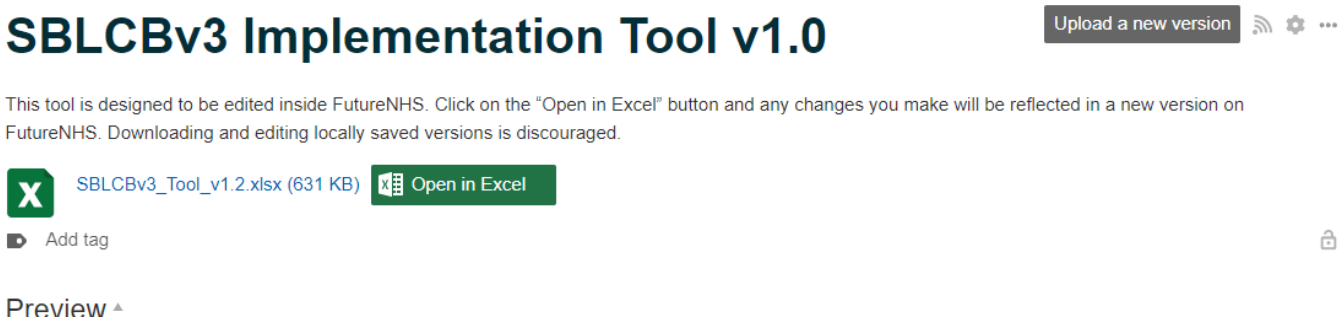
2.5.1 Element 1 Reducing smoking in pregnancy
2.5.2 Element 2 Fetal Growth: Risk assessment, surveillance, and management
2.5.3 Element 3 Raising awareness of reduced fetal movement (RFM)
2.5.4 Element 4 Effective fetal monitoring during labour
2.5.5 Element 5 Reducing preterm birth
2.5.6 Element 6 Management of pre-existing diabetes in pregnancy

2.6 The CNST year 5- Safety action 6 required standard reads

2.6.1 Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.

2.6.2 Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available

The tool has been released and accessed through FutureNHS



2.6.3 Implementation tool process

- Trusts will update progress, load evidence and declare a self-assessment status for each standard (continuous learning standards are not included and therefore not part of the CNST requirements) by a set date.
- LMNS colleagues will then review the tool and evidence. They will then validate the self-assessment status if agreed.
- A review meeting between the Trust and LMNS
- A report for the Trust Board and ICB can be produced from the tool
- There must be the minimum of 2 review meetings before March 2024

[5] https://www.england.nhs.uk/publication/saving-babies-lives-version-three/

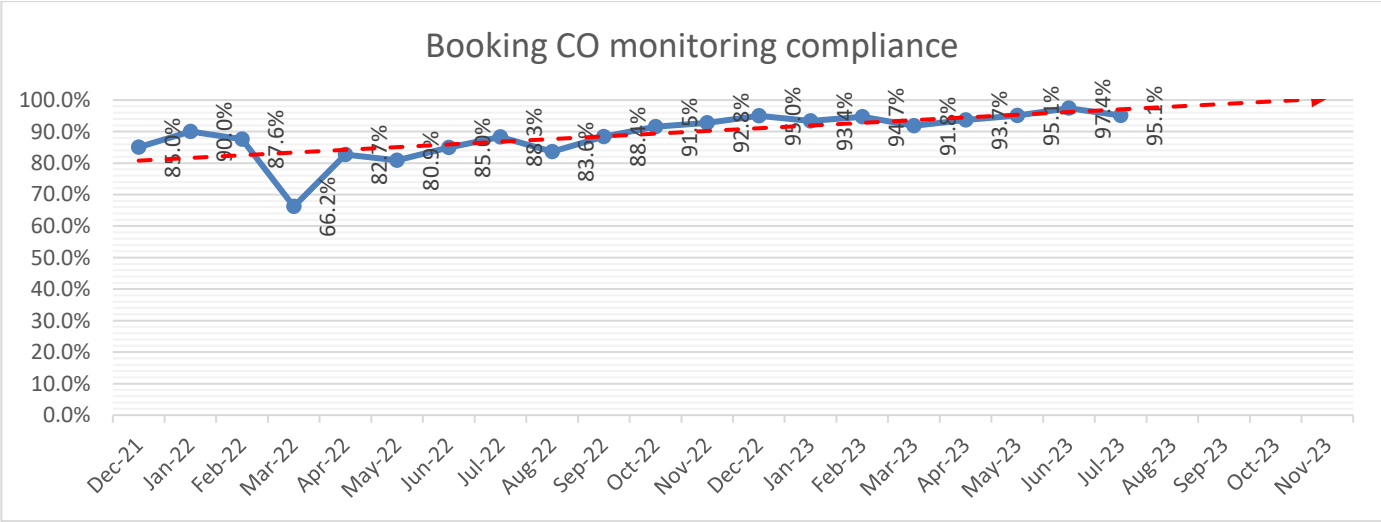
- To achieve CNST year 5, each element must have the minimum of 50% agreed compliance and an overall compliance of 70% for all elements (The percentages are generated within the tool).
- **NB.** This is now a peer review of compliance and there will be no external validation. The Midlands Perinatal Team will however continue to offer support.
- The first review is planned for the week commencing 4/9/23

3.0 **Element 1: Reducing smoking in pregnancy**

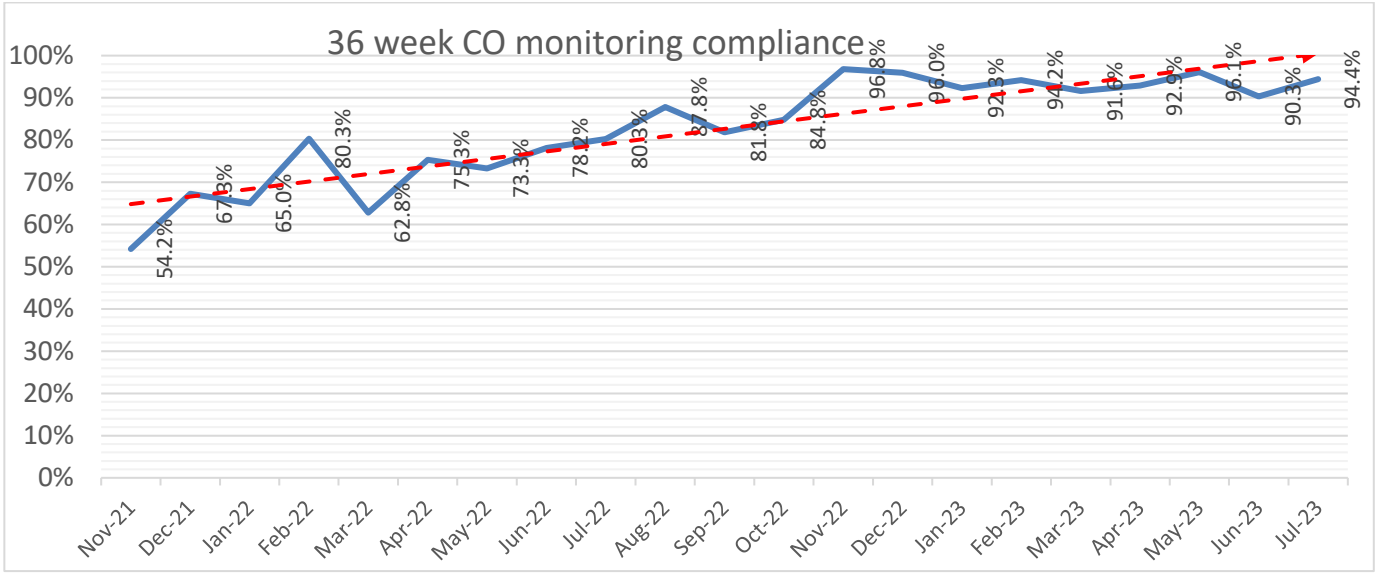
4.1 SBL mandates the following standards:

4.1.1. CO testing offered to all pregnant women at the antenatal booking and 36-week antenatal appointment. (2 standards combined in version 3)

Version 3 compliance change – minimum 90% (previously 80%) – with an action plan to reach 95% (unchanged). The Trust has reached and now exceeded the booking ambition for the last 3 consecutive months. This no long carries an action plan but will continue to be monitored monthly.



36-week antenatal appointment has exceeded 95% but appears to be slightly less consistently robust. The compliance, however, has maintained above 90% since December 2022. This standard will continue to be monitored monthly.



4.1.2 CO testing offered at all other antenatal appointments to groups identified within NICE Guidance NG209.

New phrasing to standard, applies to a pregnant woman with an elevated CO level (4ppm or above) **and** identifies themselves as a smoker.

The Trust reintroduced CO monitoring at every appointment for all women (post Covid-19) and will continue to offer to all.

Compliance has been monitored for all women since November 2022. It currently remains in the lower 80% region.

The ambition targets for this standard are to be set locally (see app1).

4.1.3 Whenever CO testing is offered, it should be followed up by an enquiry about smoking status with the CO result and smoking status recorded.

New standard. Compliance targets are the same as CO monitoring at 36 weeks.
Baseline review July 2023 41.4% (Staff updated to the requirement 23/6/23).
The timeframe targets for this standard are to be set locally (see app1).

5.0 Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)

5.1 In line with the requirements of SBLCBv3 and CNST year 5, a review of Small for Gestational Age births at SaTH is conducted on a quarterly basis by the SBL Lead Midwife. The most recent review is for Quarter 1 2023/2024 and is attached for reference as additional report (no.1).

5.2.1 The review provided the following highlights

A review of babies that were born <3rd centile >37+6 weeks' gestation in quarter 1 did not identify any themes relating to FGR not being detected (CNST monitoring standard). This is reassuring.

5.2 Additions to Element 2

5.2.1 Recommend Vitamin D supplementation to all pregnant women.

The ambition targets for this standard are to be set locally (see app1).

5.2.2 There are some additions to the Fetal growth surveillance algorithm. The new risk categories effect minimal service users and will be accommodated within current service capacity.

6.0 Element 3: Raising awareness of reduced fetal movements (RFM).

6.1 Some of the ambition targets for this element are to be set locally (see app1).

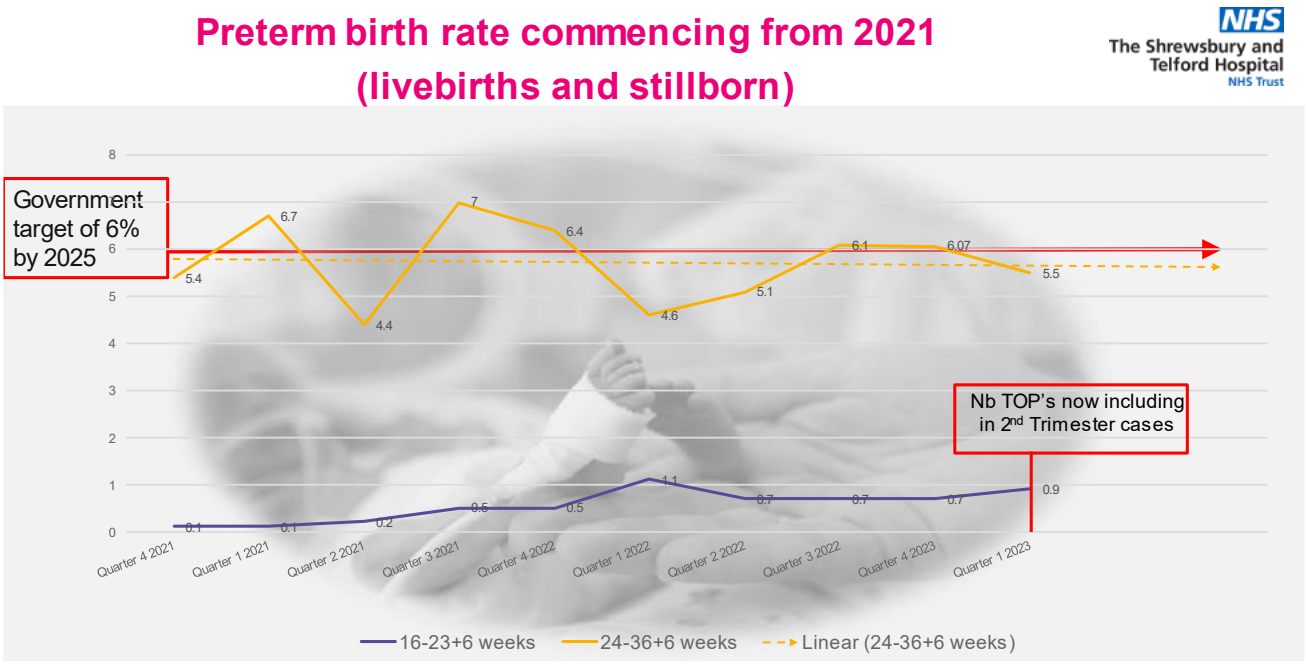
7.0 Element 4: Effective fetal monitoring during labour

7.1 No new local agreements required. Element standards remain targeted at staff education, risk assessment at the onset of labour and peer reviews.

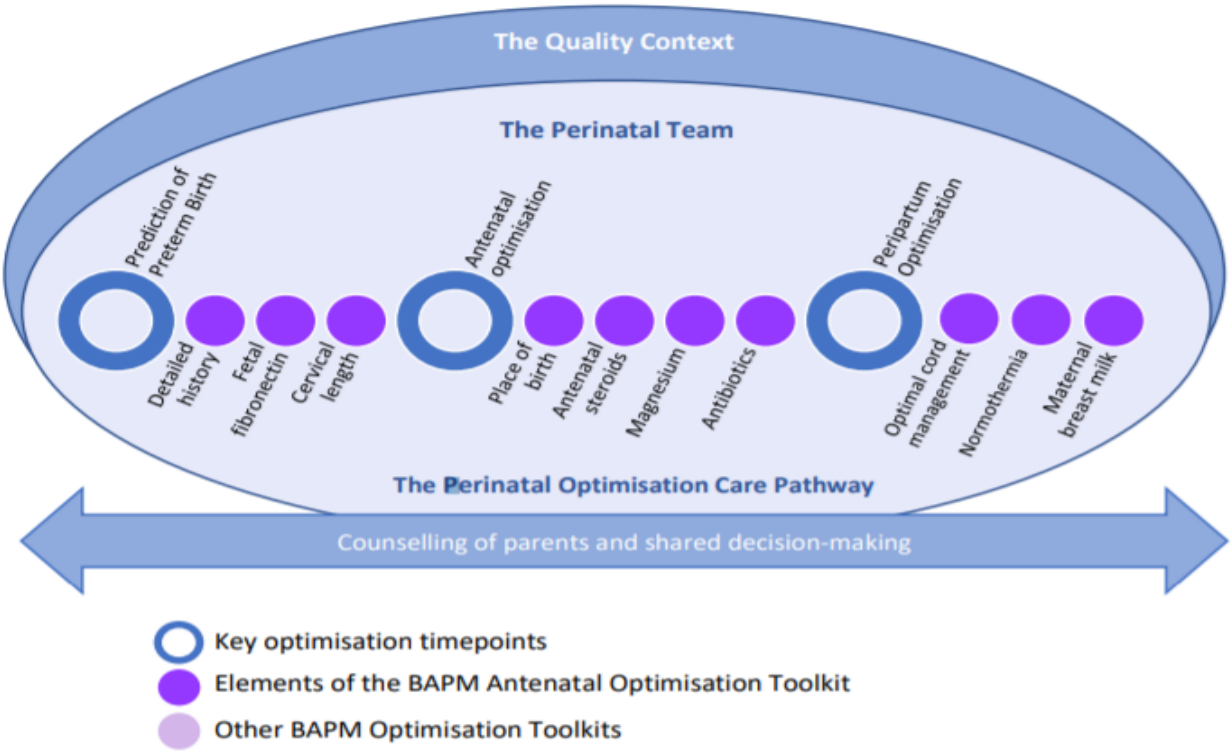
8.0 Element 5: Reducing preterm birth.

8.1 The most recent review, for Quarter 1 of financial year 2023-24 is attached as a separate report (no.2). This review provides information and performance data related to preterm birth rates and perinatal optimisation standards

8.1.1. The key highlight is that the Trust remains below the national preterm reduction target of 6% (8% to 6% by 2025)



8.2 SBLCBv3 has a strong focus in Element 5 of Perinatal Optimisation. This is aligned to the British Association of Perinatal Medicine (BAPM) optimisation pathway.



The Trust includes the above pathway in our local guidance. Although the Trust already provides all the antenatal and peripartum aspects of care, the focus will be providing optimal combined care (dependent on gestation) as gold standard. The

more of the individual aspects provided in combination, potentially the better the neonatal outcome will be.

8.2.1 The Trust will introduce Preterm passports in September for women presenting with a risk of preterm birth. There are 2 documents, one clinical and one for the parents to help them understand and be an active part in care planning and decision making. The passport is part of the Perinatal Optimisation Pathway (BAPM).

8.2.2 To oversee the full pathway Trusts should have a Preterm Birth Team comprising of
a) An Obstetric Consultant lead for preterm birth, delivering care through a specific preterm birth clinic, or within an existing fetal medicine service.
b) An identified local preterm birth/perinatal optimisation Midwife Lead
c) A Neonatal Consultant lead for preterm perinatal optimisation
d) An identified Neonatal Nursing lead for preterm perinatal optimisation

The above team has been established and the Trust Board notified for assurance.

8.2.3 Some of the ambition targets for this element are to be set locally (see app1).

9.0 Element 6: Management of Pre-existing Diabetes in Pregnancy

9.1 Women with Type 1 and Type 2 diabetes have persistently high perinatal mortality with no improvement over the past 5 years. This has become the most significant modifiable risk factor for poor pregnancy outcomes.
Introducing management of Diabetes into the SBLCB allows improvement in two keyways:

- Ensuring there are standard pathways of care for MDT management of these women throughout pregnancy, with increased access to expert and 'joined-up' support for their complex care needs.
- Improving management of glucose control during pregnancy by focusing support on high-risk women who are not achieving safe pregnancy glycaemic targets and by ensuring consistent and high levels of uptake of digital glucose monitoring technology to facilitate this (SBLCBv3)

9.2 SBLCBv3 mandates:

9.2.1 Women with a diagnosis of pre-existing diabetes in pregnancy should be offered care in a one stop clinic, providing care to pre-existing diabetes only, which routinely offers multidisciplinary review and has the resource and skill set to address all antenatal care requirements. The multidisciplinary team should consist, as a minimum, of: Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife.

This standard carries a risk. Currently there is not a Diabetes Dietician within the team. Funding is being reviewed. Capacity from the Dietetic service may be a barrier.

9.2.2 Women with type 2 diabetes should have an objective record of their blood glucose recorded in their hospital records/EPR and be offered alternatives (e.g., intermittently scanned CGM) to blood glucose monitoring if glycaemic targets are not achieved.

Funding is being reviewed. Advice from the current team is that all Type 2 women are provided with a monitor to ensure a better understanding within the 1st year of monitoring.

9.2.3 Ambition targets for this element are set nationally but local compliance timeframes are required (see app1)

10.0 Actions requested of the Board of Directors

The Board of Directors is asked to note this report.

Appendix 1- Saving Babies' Lives Version Three – targets to be set locally

A proportion of the SBLCBv3 standards ambitions are generated from best performing Trusts. There is a minimum target and a stretch target. To be compliant for CNST, Trusts need to achieve the minimum target.
Some of the newer or revised standards do not yet have a nationally acknowledged ambition. These standards are required to have a local agreement dependent on current service levels. The standards requiring an agreement have been collated below with Trust advice relevant to current service and/or following benchmarking.

Element 1 Reducing smoking in pregnancy

1. CO testing offered at all other antenatal appointments to groups identified within NICE Guidance NG209. (New)

   Requires – local ambition and improvement trajectory based on current system
   Denominator – number of pregnant smokers who have come to the end of their pregnancy

   Advise – based on the monitoring of all women minimum 80% with a stretch target to 90% for 1st year

2. Whenever CO testing is offered, it should be followed up by an enquiry about smoking status with the CO result and smoking status recorded. (New)

   Requires – locally agreed timeframe

   Advise – 6 months to achieve ≥80%

3. The tobacco dependence treatment includes behavioural support and NRT, initially 4 weekly sessions following the setting of the quit date then regularly (as required, however as a minimum monthly) throughout pregnancy to support the woman to remain smokefree.

   a. Number of pregnant smokers with an opt out referral documented who have set a quit date- LMNS to agree local ambition set on current performance- with an action plan to get to 60% and a locally agreed timeframe

   Requires – locally agreed ambitions and timeframe
   Advise- no action plan required. Q1 2023 69%. Minimum 55% with a stretch at 60%

   b. 4 week quit rates

   Requires – locally agreed timeframe
   Advise – There is a minimum set ambition of 50%, stretch of 60%
   On advice from the Trust's Lead PH Midwife – 4 week quits are normally around 30-40%.
   The LMNS can agree a variation. With the knowledge of our smoking population commencing pregnancy higher than the national average, the Trust suggests a minimum ambition of 35% and stretch of 45% with a 1 year timeframe.

4. Feedback is provided to the pregnant woman's named maternity health care professional regarding the treatment plan and progress with their quit attempt (including relapse). Where a woman does not book or attend appointments there should immediate notification back to the named maternity health care professional. (New)

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – no baseline data available as new to service. Suitable communication pathway under investigation. Consideration to service capacity required
   Suggest – minimum ambition 50% documented feedback with a review at 6 months to monitor service capacity.

Element 2 Fetal Growth: Risk assessment, surveillance, and management

1. Assess all women at booking to determine if prescription of Aspirin is needed using an appropriate algorithm (for example Appendix C) agreed with the local ICSs and regional maternity team

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Algorithm -NICE and SBLCB FGR risks already approved and in practice. Current performance- audit of 120 women demonstrated a correct aspirin risk assessment of **100%.**
   Therefore, minimum target 90% with no stretch. No improvement trajectory required. Review will continue through SBLCB monitoring/audit

2. Recommend Vitamin D supplementation to all pregnant women.

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

   Advise – no baseline data available as new standard. Minimum 80% with a stretch target to 90% for 1st year.

3. Women who are designated as high risk for FGR (for example see Appendix D) should undergo uterine artery Doppler assessment between 18+0 to 23+6 weeks gestation

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Current performance- (audit) demonstrated a **90%** compliance (CNST green rag rating).
   Target ambition maintain at ≥90%. No improvement trajectory required.

4. Women who are at low risk of FGR following risk assessment should have surveillance using antenatal fundal height (FH) measurement before 28+6 weeks gestation.

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

Advise – Current performance- (audit) demonstrated a **93.8%** compliance (CNST green rag rating).
Target ambition maintain at ≥90%. No improvement trajectory required.

5. All management decisions regarding the timing of FGR infants and the relative risks and benefits of iatrogenic delivery should be discussed and agreed with the mother. When the estimated fetal weight (EFW) is <3rd centile and there are no other risk factors (see 2.20), initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation.

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Current performance- (audit) demonstrated a **100%** compliance (CNST green rag rating). NB small cohort within the 120 audited
   Target ambition maintain at ≥90%. No improvement trajectory required.

6. In fetuses with an EFW between the 3rd and <10th centile, delivery should be considered at 39+0 weeks. Birth should be achieved by 39+6 weeks. Other risk factors should be present for birth to be recommended prior to 39 weeks

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Current performance- (audit) demonstrated a 100% compliance (CNST green rag rating). NB small cohort within the 120 audited
   Target ambition maintain at ≥90%

<u>Element 3: Raising awareness of reduced fetal movements (RFM).</u>

1. Women who report <u>recurrent</u> RFM are offered an ultrasound scan by the next working day (if no scan within the last 2 weeks)

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

   Advise – Scan timing a new addition – no benchmarking data to understand if capacity an issue.
   Minimum 80% with a 6 month target review

2. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation (Outcome Indicator)

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

   Advise – Previous monitoring has not identified an issue.
   Target ambition maintain at ≥80%. No improvement trajectory required.

Element 5: Reducing preterm birth

1. Maternity care providers will provide outcome data to the Trust Board and share this with the LMNS relating to the incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births:

   a) in the late second trimester (from 16+0 to 23+6 weeks).
   b) preterm (from 24+0 to 36+6 weeks).
   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Data already provided in a quarterly report evidences the Trust has reached and is maintaining the national ambition of 6%. Local ambition target should remain ≤ 6.9% (allowing for quarterly fluctuations).

2. Mortality to discharge in very preterm babies (NNAP definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner)

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.

   Advise – new outcome indicator.
   Denominator – no of babies admitted to a neonatal unit whose birth gestation was 24+0 to 31+6 weeks
   Numerator – Deaths of babies 24+0 to 31+6 weeks before discharge from hospital to home or discharged for palliative care.

   Clarification on where the death occurred required (i.e., Birth at SaTH, died in another Trust).
   If the admission and death occurred within the Trust, the data available on Neonatal Badgernet suggests there were 65 admissions, 2 of which sadly died in the last financial year. Therefore 3.1% died.

   Suggest review of outcomes in 6 months, allowing for Perinatal optimisation pathway implementation and clarity on location.

3. Assessment of all women at booking for their risk of preterm birth and stratification to low, intermediate and high-risk pathways.

   Requires – locally agreed timeframe
   Advise – Ambition already set min 80% - stretch 90%
   Current performance- Monitoring of 100 bookings last month demonstrated a **100%** compliance (CNST green rag rating). Prior CNST audit in September 2022 also demonstrated a 100% result.
   Timeframe is not required as standard met.

4. Symptomatic women require assessment using quantitative fetal fibronectin (qfFN) measurements
   Num: Number of symptomatic women for preterm birth assessed using qfFN
   Den: Number of symptomatic women for preterm birth

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – new outcome indicator.
   National shortage of fFN cassettes from Hologic have temporarily stopped the supply. The Trust returned to using the former biochemical test, Partosure. Cassettes are now back in production, but supply is currently limited and regular supply erratic. The Trust will not return to full use until guaranteed regular stock.
   Suggest ambition min 80% - stretch 90% with a 6 month review to allow for recommencing the use of fFN.

5. Test for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Current performance- Monitoring of 100 bookings last month demonstrated a 100% compliance (CNST green rag rating). Prior CNST audit in September 2022 also demonstrated a 97.5% result.
   Timeframe is not required as standard met.
   Target ambition maintain at ≥90%. No improvement trajectory required.

6. Ensure the neonatal team are involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with parents prior to birth. This is especially important at earlier gestational ages.
   In the case of extreme prematurity where complex decision making is required (active survival focused care or comfort care), management should be as outlined in the 2019 BAPM Framework for Practice regarding Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation

   Num: number of women who deliver preterm that have a discussion with the neonatal team regarding care options.
   Den: number of women who deliver preterm

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – Updated standard now requiring a compliance ambition.
   Baseline result in Quarter 1 2023 = 68.2% (all women with <34 week births included). Some cases were emergency situations not allowing for a full discussion).

   Ambition min 65% - stretch 80%. 6 month review

7. Women identified to be potentially at increased risk of imminent preterm birth, where active survival focused care is planned, should be made aware of optimisation interventions that may be offered. Families should also be offered information and support for families from charities such as Bliss.
   Num: Number of the relevant optimisation interventions
   Den: Total number of optimisation (calculated from total number of babies born <34 weeks multiplied by the number of appropriated elements (eligibility dependent on gestation)).

   Requires – locally agreed ambition and improvement trajectory based on the current system performance.
   Advise – New standard requiring a compliance ambition.
   Baseline will be generated at the end of quarter 2 2023.

   Ambition min 50% - stretch 70%. 1 year review

8. Place of birth – Women who have symptoms suggestive of preterm labour or who are having a planned preterm birth:
   a) less than 27 weeks gestational age (in a singleton pregnancy)
   b) less than 28 weeks gestational age (in a multiple pregnancy)
   c) any gestation with an estimated fetal weight of less than 800g
   should be managed in a maternity service on the same site as a neonatal intensive care unit (NICU)

   Requires – locally agreed timeframe
   Advise – Ambition already set min 70% - stretch 85%.
   In version 3 there has been a change to how compliance is calculated. A baseline has been generated and reported in the Q1 preterm report: - For last financial year **65%** of women booked at SaTH who were in one of the above preterm criteria, gave birth in a unit with a same site NICU.
   The Trust are working with the Midlands Preterm Network. Cases delivered at a level 2 unit are peer reviewed. No trends identified but the geographical position of the Trust acknowledged as a barrier.

   Timeframe – 1 year within the optimisation pathway.

9. Other optimisation (current and new with a set ambition) combined

   a. Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth.
      Ambition already set min 40% - stretch 55%.
      Current position **47%**

   b. Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth.
      Ambition already set min 80% - stretch 90%.
      Current position **100%**

   c. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth

New standard
Ambition already set min 50% - stretch 75%.
Current position **58.6%**

d. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth.
New standard
Ambition already set min 65% - stretch 80%.
Current position **83.5%**

Requires – locally agreed timeframe
Advise - Timeframe – 1 year within the optimisation pathway.

10. Other optimisation (current and new without set ambition) combined

a. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection

Requires – locally agreed ambition and improvement trajectory based on the current system performance.
Advise – New standard requires a compliance ambition. Baseline Q1 **90%**
Ambition min 80% - stretch 90%.
Timeframe – 1 year within the optimisation pathway. No improvement trajectory required.

b. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth.

Requires – locally agreed ambition and improvement trajectory based on the current system performance.
Advise – New standard requires a compliance ambition. Baseline Q1 **57.1%**
Ambition min 50% - stretch 75%. (same as national ambition for cord clamping).
Timeframe – 1 year within the optimisation pathway.

11. Volume-Targeted Ventilation For babies born below 34 weeks' gestation who need invasive ventilation, use volume-targeted ventilation (VTV) in combination with synchronised ventilation as the primary mode of respiratory support. This reduces the chance of death or bronchopulmonary dysplasia by 27% and intraventricular haemorrhage (grades 3–4) by 47% compared with pressure-limited ventilation modes.
Num: Babies born at less than 34 weeks who receive volume-targeted ventilation in combination with synchronised ventilation as the primary mode of respiratory support, if invasive ventilation is required
Den: Babies born at less than 34 weeks

Requires – locally agreed ambition and improvement trajectory based on the current system performance.
Advise – New standard – awaiting Neonatal advice

12. Caffeine For babies born below 30 weeks' gestation, caffeine reduces the chance of death or disability. Caffeine should be started within 24 hours of birth

Requires – locally agreed ambition and improvement trajectory based on the current system performance.
Advise – New standard. Compliance for Q1 **100%** (source Neonatal dashboard)
Ambition min 85% - stretch 90%. No improvement trajectory required

Element 6: Management of Pre-existing Diabetes in Pregnancy

NB. The Implementation tool suggests 'LMNS required compliance over an agreed compliance timeframe'. Suggested ambitions are documented as a guide, as the Trust already has an established service. Trust advice would be to use the suggested ambitions but set a timeframe.

1. Women with type 1 diabetes should be offered real time continuous glucose monitoring (CGM) and be provided with appropriate education and support to use this.
   a. Num: number of pregnant women who have T1 diabetes that use CGM during pregnancy
   Den: number of pregnant women who have T1 diabetes
   Ambition already set min 80% - stretch 95%.
   Current position **New** – Pregnant T1 in the Trust are provided with a Dexicom continuous monitor. Funding in place.

   Requires – locally agreed timeframe
   Advise - Timeframe – 1 year to review entire element

   c. Annual staff training (MDT only)
   Ambition already set min 80% - stretch 90%.
   Current position **New** – CGM training mandatory within the Trust (no compliance data for the MDT available at time of writing this document)

   Requires – locally agreed timeframe
   Advise - Timeframe – 1 year to review entire element

2. Women with diabetes should have an HbA1c measured at the start of the third trimester and those with an HbA1c above 48mmol/mmol should be offered increased surveillance including additional diabetes nurse/dietetic support, more frequent face to face review and input from their named, specialist Consultant to plan ongoing care and timing of birth decisions.

   Num: Number of pregnant women with T1 and T2 diabetes that have had a HbA1c measured at the start of the 3rd trimester (between 28+0 and 28+6 weeks)
   Den: Number of pregnant women with T1 and T2 diabetes

   Ambition already set min 80% - stretch 95%.
   Current position **–** All pregnant diabetic women are offered HBA1C's monthly throughout pregnancy.

Requires – locally agreed timeframe

Advise – The specific timing set may potentially cause reduced compliance as it will depend on the women's clinic schedule i.e. clinic at 27+5 and then 31+5 gestation. Monitoring will allow the Trust to understand if there will be a compliance issue.

Timeframe – 1 year to review entire element

Appendix 2a

Perinatal Optimisation Pathway Passport

British Association of Perinatal Medicine

This passport must be completed for all women at risk of birth before 34 weeks' gestation and should accompany the baby on admission to neonatal care.

Time of birth: _ _ : _ _ Gestation: /40

Type of birth: Birth weight: g

Time of admission to NNU: _ _ : _ _

Apgars: @1 @5 @10

Booking Hospital:

Name:
DOB:
Hosp No:
NHS No:
Or patient sticker here

1. Place of Birth:

Aim: babies <27/40, EFW <800g or multiple pregnancy <28/40 should be born in maternity centre with a NICU

Born in a maternity centre with the appropriate designation of neonatal unit?

Y ☐ N ☐ N/A ☐

If not, why was intrauterine transfer not achieved?

2. Antenatal Steroids:

Aim: women giving birth before 34 weeks should receive a full course of steroids no longer than 7 days prior to birth

Full course of antenatal steroids (2 doses 12-24hrs apart)?

Y ☐ N ☐ N/A ☐

Last dose: Date: / / Time: :

If a full course of optimally timed steroids was not achieved, why?

3. Antenatal Magnesium

Aim: women giving birth before 30 weeks should receive a loading dose and ideally a 4-hour infusion in the 24 hours prior to birth

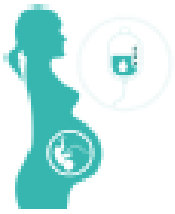
Loading dose given? Y ☐ N ☐ N/A ☐

Was a 4-hour infusion given within 24 hours prior to birth?

Y ☐ N ☐

If optimally-timed Magnesium was not achieved, why?

4. Antibiotic Prophylaxis



Aim: women in established preterm labour should receive intrapartum antibiotic prophylaxis to prevent early onset GBS infection

Required? Y ☐ N ☐

Given > 4hrs before birth? Y ☐ N ☐

If no antibiotic prophylaxis given or antibiotic given within 4h, why?

5a. Early Breast Milk (antenatal info)

Aim: women at risk of preterm birth should receive information about the importance of breast milk

Antenatal counselling and advice for mother re benefits of MBM and early & frequent expressing?

Y ☐ N ☐ N/A ☐

Supplemental information given eg. Written / digital

Y ☐ N ☐ N/A ☐

If not given, why?

6. Optimal Cord Management (OCM)

Aim: the umbilical cord should be clamped at or after one minute following birth

Was the umbilical cord clamped at or after one minute?

Y ☐ N ☐ N/A ☐

Time of OCM: __ minutes __ seconds

If no OCM, why?

7. Thermal Care

Aim: babies should have an admission temperature taken within one hour and this should be between 36.5-37.5C

Admission Temp between 36.5°C to 37.5°C ?

Y ☐ N ☐ N/A ☐

Admission Temp: °C

If normothermia was not achieved, why?

5b. Early Breast Milk

Aim: all mothers should be supported to express within 2 hours of birth

All babies should receive their own mother's milk within 24 hours of birth and ideally within 6 hours

Mother helped to express within 2h of birth?

Y ☐ N ☐ N/A ☐

Date: / / **Time:** :

Colostrum first available: **Date:** / / **Time:** :

Colostrum given to baby: **Date:** / / **Time:** :

If not achieved within first 24h, why?

www.bapm.org/pop www.weahsn.net/periprem

This passport has been modified with kind permission from PERIPrem.

Appendix 2b

Perinatal Optimisation Passport

British Association of Perinatal Medicine

Right Place of Birth

(babies born before 27 weeks' gestation - 28 weeks for multiple births - or who may weigh less than 800 grammes)

I am at the right hospital in case my baby(ies) needs to be born early.

In Progress ○ Complete ○

Antenatal Steroids

(babies born before 34 weeks' gestation)

I have received a full course of steroids to help prepare my baby(ies) for being born early.

In Progress ○ Complete ○

Antenatal Magnesium Sulphate

(babies born before 30 weeks' gestation)

I have received magnesium sulphate to support the brain development of my baby(ies).

In Progress ○ Complete ○

Early Breast Milk

(babies born before 34 weeks' gestation)

I have received information about the benefits of early breast milk and have been shown hand expressing/breast pump techniques to help me try to make early breast milk for my baby(ies) before or within an hour of them being born.

In Progress ○ Complete ○

Antibiotics

(babies born before 34 weeks' gestation where mum was in established labour)

I have received antibiotics to reduce the chance of my baby developing an infection due to Group B Streptococcus.

In Progress ○ Complete ○

Optimal Cord Management

(babies born before 34 weeks' gestation)

After my baby(ies) is born, whenever possible, the perinatal team will support them to receive extra blood from the placenta for at least a minute before the umbilical cord is clamped.

In Progress ○ Complete ○

Thermal Care

(all babies)

After my baby(ies) is born, the perinatal team will aim to maintain their temperature between 36.5 and 37.5oC. They will also help me to hold my baby skin-to-skin as soon as it is safe to do so.

In Progress ○ Complete ○

www.bapm.org/pop www.weahsn.net/periprem

This resource has been modified with kind permission from PERIPrem.

APPENDIX 2

Reviewing local guidance which diverges from Saving Babies' Lives Care Bundle version 3 (SBLCBv3) recommended practice.

Reviewing Local Guidance which diverges from SBLCBv3 recommended practice.

Publishing approval number:

Version number: 2.1

First published: 6.2.20

Updated: 28.07.2023

Prepared by: Midlands Perinatal Team

Contents

1. Introduction

The Midlands Perinatal Team's role is to support full implementation of Saving Babies' Lives Care Bundle (SBLCB) and advise providers and commissioners when local guidance diverges from recommended national guidance. A model has been developed to review practice that diverges from SBLCBv3 national guidance.

The Midlands Perinatal Team will establish a Peer Review Panel composed of Safety Champions and relevant Clinical Leads, external to the trust concerned, to make recommendations. This model includes a:

- Notification Process
- Trust rationale, evidence base and justification for divergence from national guidance
- Peer Review Panel to review rationale and reject or accept modifications and make recommendations to the commissioners and trust.

It is envisaged that local providers will endeavour to consolidate efforts in relation to SBLCB version 3 to align with national guidance. The process in place will build on the role of the Midlands Perinatal Team in providing bespoke support to support trusts to achieve full implementation of SBLCB v3. A divergence from national guidance should be used as a temporary measure, a clear action plan with timelines as to how and when full implementation will be achieved will need to be developed by the trust and monitored by the LMNS and lead commissioner.

2. Notification Process

Providers working with commissioners who require there to be a variation from SBLCB version 3 can sense check their proposal through peers with facilitation from the Midlands Perinatal Team (MPT). Providers and maternity commissioners can seek MPT support via england.midlandsperinatal@nhs.net.

The template in Appendix 1 should be completed outlining the variation, its rationale and any supporting evidence to england.midlandsperinatal@nhs.net this will be reviewed by the Midlands Perinatal Teams, Regional Lead Obstetrician, Regional Chief Midwife and a Peer Review Panel. The Peer Review Panel will review any submissions within 28 days of receipt.

3 The Role of the Peer Review Panel

The MPT will establish a panel external to the index Trust or Commissioner to review the plan, review if it is acceptable clinical practice and consider the response. The panel will be chaired by the MPT Regional Lead Obstetrician or the relevant Regional SBLCB Clinical lead and will comprise of 3 clinicians with recognised relevant expertise in the clinical area. The panel will consider the impact of the proposal on:

- Safety
- Choice

- Deliverability
- Equality impact
- Evidence

The Panel will make recommendations which will then be forwarded to the lead commissioner, LMNS Quality lead and trust lead which then will be agreed locally within 28 days of receipt. Once the local agreement has been made the MPT is to be notified of the outcome.

Appendix 1: Trust divergence from Saving Babies Lives Care Bundle v3 National Guidance Template.

Trust:	The Shrewsbury and Telford NHS Trust
LMNS:	Shrewsbury and Telford
Trust Lead:	Louise Barnett
Commissioning Lead:	Nick White
Date: 28/8/23	
Outline Element Variation: HbA1c compliance timeframe 27+0 – 29+6	
1. Which pathway does this refer to?	Element 6
2. Describe how the proposed pathway varies from recommended practice?	Current practice - Women with pre-existing Diabetes have HbA1c's taken at booking and as a minimum each trimester in the Combined Consultant antenatal clinic. This increases to monthly in the last trimester. The clinics are once per week. Reviewing our current women, a sizable proportion fell just outside of the Tech specification of 28+0 -28+6.
3. What is the rationale for this pathway amendment?	This pathway allows for better long-term monitoring in each trimester and pre-birth preparation. The compliance timeframe agreed between the Trust and the LMNS/ICB 27+0 – 29+6
4. What is the evidence base?	NICE ng3 Recommendations | Diabetes in pregnancy: management from preconception to the postnatal period | Guidance | NICE
5. How have service users been engaged in developing this revised pathway?	NA – current practice
6. What is the difference in resources required as a result of this change?	None – current practice
7. What is the likely service impact of the proposed change?	If the Trust followed the Tech specifications, it would mean women having to attend an additional appointment to have their blood sample taken.

Justification: How will this amendment support improved reduction in stillbirths, perinatal mortality and Hypoxic brain injury?	It provides a more robust checking and follow up system.
Are the Maternity commissioner and trust board in agreement with the proposed changes?	Yes,
Has your Local Maternity & Neonatal System been communicated and involved with the process?	Yes, and agreed

Appendix 2: Midlands Perinatal Team and Expert Panel Recommendations Template:

Trust:	
LMNS:	
Trust Lead:	
Commissioning Lead :	
Panel Review Date:	
Panel Review Members: **Name, job role and trust**	
1	
2	
3	
Recommendations from panel members:	
Risks identified:	

Please notify the MPT of the outcome and local agreement within 28 days of receipt to england.midlandsperinatal@nhs.net	
1. What has been agreed locally with commissioners & LMNS?	
2. What is the process for review?	
3. Has this variation been signed off by the trust board which acknowledges sign off from local commissioners and the Midlands Perinatal Team recommendations?	

APPENDIX 3

The Shrewsbury and Telford Hospital NHS Trust

PERINATAL QUAD / BOARD SAFETY CHAMPIONS MEETING
Monday 21st August 2023
Microsoft Teams
Minutes

Present		
Name	**Title**	**Initials**
JOHN JONES	MEDICAL DIRECTOR & BOARD SAFETY CHAMPION	JJ
TIM LYTTLE	NON-EXECUTIVE DIRECTOR & SAFETY CHAMPION	TL
ANNEMARIE LAWRENCE	DIRECTOR OF MIDWIFERY	AL
JULIE PLANT	DIVISIONAL DIRECTOR OF NURSING	JP
CAROL MCINNES	DIVISIONAL DIRECTOR OF OPERATIONS FOR W&C	CM
ANDREW SIZER	DIVISIONAL MEDICAL DIRECTOR FOR W&C	AS
MEI-SEE HON	CLINICAL DIRECTOR FOR OBSTETRICS	MH
In Attendance		
Apologies		
None	All present	

Agenda No	**Agenda Item Discussed**	**Lead**
2023.01	**Welcome and apologies**	
	AL welcomed everyone to the meeting and gave thanks to all for the flexibility shown in attending today's meeting, recognising the last minute arrangements due to needing to meet by 31st August 2023 to remain within the quarter. AL introduced the purpose of the meetings which were set up as a requirement to meet Year 5 of the Clinical Negligence Scheme Trusts Maternity Incentive Scheme (CNST MIS) and in particular, safety action (SA) 9. Within SA9, element c) there is a requirement that the Maternity and Neonatal Board Safety Champions (BSCs) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures. It is a requirement that BSCs meet with the perinatal quad leadership team at a minimum of quarterly and that any support required of the Board has been identified and is being implemented. Additionally, there must have been a minimum of two meetings held within the reporting period. The meetings give an opportunity to share safety intelligence, examples of best practice and any identified areas of challenge.	

2023.02	**Declarations of Conflicts of Interest**	
	None	
2023.03		
Learning from the Perinatal Culture and Leadership Development Programme (PCLDP)	The quad gave an overview of the PCLDP, advising on the programme detail, including its structure and requirements moving forward which include several in-person modules, individual action learning sets, and engagement sessions. AL explained that the divisional quad comprises of AS, AL, CM and JP however for the purposes of the PCLDP, the quad consisted of AL, MH, CM & JP. This was a stipulation within the initial criteria that was published within the course requirements and, at the time of course commencement, the division did not have a medical director. For a belt and braces approach, both the divisional quad and the perinatal quad attended today's meeting to allow time for clarification with the NHSR. The quad discussed their experience of the course so far and that they had learnt following engagement with other Trusts, that the quad at SaTH were in a much more promising position than others. This was evidenced to others over the period of the course and commented on by course facilitators. We were respectful of each other's roles and appreciative of the contribution we make as a team which in turn makes a difference to our workplace culture.	
2023.04		
Understanding local Culture	AL and CM gave an update on the Score survey which was originally published in 2018 and how this has been received into workstream 2, people and culture with a view to creating an overall cultural improvement plan that encompasses this survey in addition to the most recent staff survey and any other cultural surveys.	
2023.05		
Update on Score Culture Survey	The quad advised that work had begun on this years score survey already as this was linked to the PCLDP work in addition to being part of CNST SA 9. The quad advised of their concerns over the timing of the score survey which will coincide with the national staff survey and will inevitably affect our overall figures. Last year maternity had a 50% completion rate which was one of the highest in the country according to our NHSE maternity improvement advisor (MIA). AL advised that the BSCs will need to appraise the Board that a drop in compliance this year should be expected as staff are unlikely to complete both surveys and we are required to prioritise the Score survey. We anticipate the results of the survey will be ready in the winter as this is when there are scheduled feedback sessions	

	with the course directors.	
2023.06		
Safety Champions Dashboard	All present discussed the requirement for this meeting to review any identified areas for improvement following a review of the safety champions local dashboard and any identified support required from the Board. This is likely to be an evolving picture as the locally agreed dashboard is updated quarterly and would depict the areas of concern if any were evident. AL advised that at present, the Board needed to be aware of the potential impact on this year's staff survey compliance for both maternity and neonates due to the need to complete the score survey as part of CNST MIS. AL advised that when reviewing the dashboard, this needed to be alongside the complaints and incidents data to be able to triangulate any themes. The scorecard on view was last years as it is only published annually in August therefore a new scorecard was expected imminently. The quad agreed that oversight of the safety champions AAA is demonstrated via a standing agenda item at divisional committee, MTAC and QSAC as well as directly to the Board.	
2023.07		
FutureNHS Collaboration platform	Both JJ and TL have previously evidenced their registration to the dedicated FutureNHS workspace and are aware of the requirement to evidence through the minutes of a Trust Board meeting, the resources they have accessed and how this has been of benefit to them in their role as BSCs. This will need to be evidenced and reported as part of the Board submission to NHS Resolution.	
2023.08	**AOB**	
	Requirements of the BSCs – The BSCs are asked to note within the minutes of the next Trust Board meeting that they are meeting with the perinatal quad leadership team as a minimum of quarterly, and any support required of the Board is being identified and implemented.	
	Date of Next meeting:	
	The next meeting is TBC but must be by end of November 2023 for CNST requirements.	

Board of Directors' Meeting
12 October 2023
Paper 5 within CNST INFORMATION PACK

The Shrewsbury and Telford Hospital NHS Trust

Maternity and Neonatal Safety Champions Meeting, Key Issues Report		
Report Date: 08/09/23		**Report of: Maternity and Neonatal Safety Champions Meeting**
Date of meetings: 05/09/23		**Membership Numbers:** Quoracy met = yes
1	**Agendas**	The Committee considered the following: • Feedback session from Neonatal walkabout 5/9/2023 • Welcome, Introductions, Apologies, Quoracy and any Conflicts of Interest • Minutes of last meeting and Action Log Update • Safety Champions AAAA report from August • Maternity Dashboard • Maternity Dashboard AAAA • Maternity CQIM MSDS Report • MSDS Report • CQIM Score Check • Maternity Governance Key Issues AAA • Workforce Plan and Rotation Plan • Neonatal Dashboard • Neonatal Nursing Staffing Paper Update • MLU Update • Saving Babies Lives Report • Maternity and Obstetric Incident Trends – July 2023 • Maternity Mortality and Morbidity Report Q1 2023 • Safety Intelligence Locally Agreed Dashboard Q1 • Key issues to include in AAAA report • CNST Requirements Progress Report Aug 2023 • MIS Year 5 guidance • Any Other Business
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Neonatal nursing/medical staff vacancies remain the biggest safety concern. It is recognised that recruiting to nursing vacancies is a national issue. However, the impact continues to affect staff morale (extra shifts, increase in sickness levels, lack of uplifts to work extra shifts not in line with other units) and concerns were expressed that there is real risk of a serious incident occurring if mitigations are not possible. • The impact of mitigations was noted, for example affecting daytime work when senior medical staff are called overnight. • Concerns felt by staff regarding the decision to close the unit being 'overridden' by senior members of staff to stay open, and there is some concern felt if a midwife, who may not be suitably skilled, is expected to care for a baby when a neonatal nurse is unavailable. Such decisions should always be in line with agreed policies. • Concerns around potential risk to babies on the Postnatal Ward when neonatal nursing expertise is unavailable to administer

		antibiotics. Possible training options for midwives being explored by Head of Midwifery. • Despite support available to staff, the recent coverage of the legal trial involving a neonatal nurse has left some feelings of vulnerability in situations where there was the potential for something to go wrong. • The number of delays in "Decision to deliver" times remains above target. This is due to less urgent caesarean section cases (Category 3) being included in the numbers. Dr Charlesworth will be reviewing all cases and providing a monthly report. • VTE assessment rates remain below target with ongoing monitoring and education. • Despite the appointment of a part-time neonatal data validation admin, validity concerns persist. Badger EPR could be a solution. There are concerns with maternity data as well as neonatology.		
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• No immediate safety concerns from HSIB have been raised. • Achievement of evolving CNST requirements is the subject of very close monitoring. • Steps are being taken to improve the admin support for the MNSCs meetings • Induction rates, while above target, are not an outlier in the region.		
2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• ATAIN review meetings – the action plan (CNST requirement SA3), learning and themes from these meetings are not being fed into the maternity and neonatal governance processes. • Reports of below target Tier 3 reviews of readmissions, whether mother or baby, will be clarified		
2d	**Actions** ***Significant** follow up actions*	N/A		
3	**Report compiled by**	*Dr Tim Lyttle* *Associate Non-Exec Director* *Safety Champion*	**Minutes available from**	*Marie Harris, Quality Governance Administrator, W&C*

APPENDIX 1 TO PAPER 5 WITHIN CNST INFORMATION PACK

The Shrewsbury and Telford Hospital NHS Trust

Maternity & Neonatal Safety Champions Meeting, Key Issues Report		
Report Date: 09/06/23		**Report of: Maternity and Neonatal Safety Champions Meeting**
Date of meetings: 06/06/23		**Membership Numbers:** Quoracy met = yes
1	**Agendas**	The Committee considered the following: • Feedback session Welcome, Introductions, Apologies, Quoracy and any Conflicts of Interest • Minutes of last meeting and Action Log Update • Safety Champions AAA report from May • Maternity Dashboard - April data • Maternity Dashboard AAA • Neonatal Dashboard - April data • Bradycardia drill (MLU safety champions walkabout action) • CQIM Data Quality Metrics (Safety Action 2) • Maternity Services Dataset (MSDS) AAA • MLU Update • Safety Intelligence Locally Agreed Dashboard – clarification of NLS nursing figures • 'Our Staff Said… We Listened' poster for Mar/Apr & May/Jun 23 • Walkabout schedule – arrangements for July 2023 walkabout to Shrewsbury MLU and Outpatients • Key issues to include in AAA report • CNST Y5 Requirements • Any Other Business
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• The Trust has no MRI provision out of hours - a recent incident due to this is currently under review. This is a known issue and currently on the risk register. • Ongoing neonatal staffing levels remain a concern and a full discussion is planned for July's meeting. • VTE assessment levels are lower than acceptable. • There has been ongoing concern regarding the capturing and reporting of accurate neonatal data. A previously unfilled post has now been recruited to, which will help support improvements in this area. • Neonatal data suggests that parents being seen by senior staff on the unit is below target, however this is likely linked to current problems with data capture. • Neonatal nurse NLS training compliance requires clarification.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• PROMPT training compliance continues to be monitored • An extensive action tracker has been developed by the maternity senior leadership to monitor multiple actions across all workstreams reporting to Maternity Governance. • Following a Safety Champions walkabout to the Wrekin MLU in May, a successful obstetric emergency drill took place to test responses to a Bradycardia with transfer to the delivery suite – this was managed appropriately, with good practice and shared learning identified.

2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• The Safety Champions plan to monitor maternity dashboard data around Born Before Arrivals (BBA) and Apgar scores of Term babies data in the coming months. • 7 FTE midwives are working rotationally on the Wrekin MLU with the rostering of additional midwives making up 11.2 FTE required to staff 2 midwives on the unit at any one time.		
2d	**Actions** ***Significant*** *follow up actions*			
3	**Report compiled by**	*Dr Tim Lyttle Associate Non Executive Director, Board Level Safety Champion*	**Minutes available from**	*Marie Harris Quality Governance Administrator, Women & Children's Division*

APPENDIX 2 TO PAPER 5 WITHIN CNST INFORMATION PACK

The Shrewsbury and Telford Hospital NHS Trust

Board & Neonatal Safety Champions Meeting, Key Issues Report		
Report Date: 07/07/2023		**Report of: Maternity and Neonatal Safety Champions Meeting**
Date of meetings: 04/07/2023		**Membership Numbers:** Quoracy met = yes
1	**Agendas**	• Safety Champions AAA report from May • Maternity Dashboard - May data • Maternity Dashboard AAA • Maternity CQIM MSDS Report (Clinical Quality Improvement Metrics - Maternity Services Dataset) CNST Safety Action 2 • Maternity Governance Key Issues AAA May 2023 • Workforce Plan and Rotation Plan Action from June • Neonatal Dashboard - May data • Neonatal Nursing Staffing Paper Update • MLU Update • Maternity Out of Area Data Presentation Apr 22- Feb 23 • Safety Intelligence Locally Agreed Dashboard Q1Fully populated version with June figures once available to be presented in August meeting. • 'Our Staff Said, We Listened' Group ideas to include on Jul/Aug version (May/Jun agreed at last meeting and has been circulated) • Maternity Frontline Safety Champions Poster Awaiting new neonatal rep before print . • Draft SOP for safety concerns raised by staff during walkabouts/by email – new version to be approved. • Terms of Reference for Review Due to be updated August 2023 • Walkabout – Friday 7th July Confirm arrangements Shrewsbury MLU Midwifery Hub and Outpatients Clinic • Key issues to include in AAA report. • CNST Requirements MIS-year-5-FINAL-31-5-23.pdf (resolution.nhs.uk) • Any Other Business
2a	**Alert** *Matters of concerns, gaps in assurance or key risks to escalate to the Board*	• Member of senior nursing staff not available to present report so neonatal nursing staffing remains a concern though there has been some recruitment into more senior posts. Further updates requested for next month.
2b	**Assurance** *Positive assurances and highlights of note for the Board*	• Evidence suggests that is rare for residents of Shropshire, Telford and Wrekin to give birth elsewhere. • Noted that the 90% requirement for each component of training to be met for CNST already unachievable though it is possible this requirement will be modified national given lack of notice for this change. • Terms of reference reviewed with governance officer/scribe not considered to be necessary for quorum.

2c	**Advise** *Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.*	• The VTE assessment remains a non-compulsory field on Badgernet contributing to compliance. • Locally agreed dashboard discussed but not presented this week as full dataset not available but will be returning in August with Q1 data. • Comprehensive midwife workforce plan noted and rotational arrangement to start in October. • Membership of MNSCs reviewed to include quality matron from ICB		
2d	**Actions** ***Significant*** *follow up actions*	• Walkabout confirmed for 7th July 2023 Shrewsbury MLU • Deputy Divisional Director of nursing to be asked to present neonatal staffing position next month. • Board level champions to discuss current membership of group and report back next month		
3	**Report compiledby**	John Jones Executive Safety Champion	**Minutes available from**	Marie Harris MNSC Admin/Scribe CNST Governance Officer

APPENDIX 3 TO PAPER 5 WITHIN CNST INFORMATION PACK

The Shrewsbury and Telford Hospital NHS Trust

Maternity & Neonatal Safety Champions - Key Issues Report

Report Date: 07/08/2023		**Report of:** Maternity and Neonatal Safety Champions Meeting
Date of last meeting: 01/08/2023		**Membership Numbers:** Quoracy met = yes
1	**Agenda**	• Welcome, Introductions, Apologies, Quoracy and any Conflicts of Interest • Minutes of last meeting and Action Log Update • Safety Champions AAA (Minutes not available for presentation at this meeting) • Feedback from the Walkabout undertaken in July • Maternity Dashboard - Maternity Dashboard AAA • Maternity CQIM MSDS Report (Clinical Quality Improvement Metrics - Maternity Services Dataset) CNST Safety Action 2 • Maternity Governance Key Issues AAA • Actions Arising from Maternity Governance • Quarterly PMRT report & Mortality report • Quarterly ATAIN report • Quarterly TC report • Neonatal Dashboard & Neonatal dashboard AAA • Neonatal Nursing Staffing Paper Update – Report to follow • Complaints report • Claims score card – Report to follow • Education Report • MLU Update • Maternity VTE Compliance Paper • CQC Maternity Survey Action Plan • Safety Intelligence Locally Agreed Dashboard Q1Fully populated version with June figures once available to be presented in August meeting • 'Our Staff Said, We Listened' • Group ideas to include on Jul/Aug version • Maternity Frontline Safety Champions Poster • Awaiting new neonatal rep before print • Draft SOP for safety concerns raised by staff during walkabouts/by email – new version to be approved • Terms of Reference for Review Due to be updated August 2023 • CNST Requirements

		• Any Other Business • Key Issues Report to take from the meeting		
2a	**Alert**	• There remain gaps in senior nursing positions in neonatal unit • Frequent gaps in administrative support to MNSC means that there is a risk that report timings crucial to CNST may be missed.		
2b	**Assurance**	• CNST requires all groups to meet threshold for training which carries greater risk for missing target.		
2c	**Advise**	• Walkabout to RSH MLU identified significant improvement in morale related to strong leadership in the team • There were no minutes available from previous meeting • There were some missing papers including complaints scorecard. • Recent appointment to the neonate team should improve accuracy of neonates dashboard moving forward. • % VTE amount has declined and still not a mandated field on badgernet. • Knife to skin metric still being monitored. • We are seeing increase in induction rates.		
t3	**Actions to be considered by the MTAC / QSAC / Trust Board**	• MNSCs need consistent administrative support from maternity governance team that includes tracking of actions against CNST and oversight of cycle of reporting.		
4	**Report compiled by**	Dr John Jones – Maternity Safety Champion	**Minutes available from**	*Rish Bahia – Quality Governance Administrator*

PAPER 6

CQC Maternity Ratings Q1 SC Dashboard	Overall	Safe	Effective	Caring	Well-Led	Responsive
SaTH	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good

Maternity Safety Support Programme	Yes

		QUARTER 1 - 2023/2024			April	May	June	Comment
1.	**PMRT**	Findings of review of all perinatal deaths using the real time data monitoring tool	Stillbirths		2	2	0	100% compliance for reporting to MBRRACE within 7 working days and informing families that a PMRT review will take place and letters sent regarding the review
			Late fetal losses >22 wks		0	0	1	
			Neonatal Deaths		1	0	0	
2.	**HSIB**	Findings of review of all cases eligible for referral to HSIB			0	0	0	No cases fitted the criteria for referral in Q1. 3 active cases for this quarter are 2 x stillbirths and 1 x HIE/Cooling
	Serious Incidents	Findings of all Sis			0	0	1	1 SI June, historic case, impacted head with skull fracture.
3a.	**INCIDENTS**	The number of incidents logged and graded as Moderate Harm or above and what actions are being taken			5	6	3	All cases reported as moderate harm are reviewed in an MDT meeting where level of harm is agreed, escalated or ammended. In April out of 5 reported as moderate harm, one was moved to be reviewed by Estates as it was not related to W&C, 2 were ammended to low harm after MDT review and 2 were ammended to no harm after MDT review. In May out of 6 reported as moderate harm, all were ammended to low harm. In June
3b.	**TRAINING**	Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Obstetricians	PROMPT	95%	94%	100.00%	A minimum of 90% compliance is required for PROMPT, NLS and Fetal Monitoring training as part of the Maternity Incentive Scheme reporting. The Education team continue to ensure that all medical staff are booked to attend FMT and where compliance does not meet the requirements, a process for escalation to the Medical Director is in place. A full review of the training guideline is in progress along with the 3 yr local training plan to meet the requirements of the CNST MIS Safety Action 8 Plan is in place for NLS neo nursing staff to complete training during June/July.
				Fetal Monitoring	95%	95%	95%	
			Midwives	PROMPT	97%	96.4%	96.7%	
				NLS	90%	94%	94.29%	
				Fetal Monitoring	96%	98%	97.33%	
			Other Drs	PROMPT	100%	96%	96%	
				Fetal Monitoring	96%	96%	100%	
			Neonatal Nurses	NLS	71%	71%	71%	
			Anaesthetis	PROMPT	52%	57%	80%	
			WSAs	PROMPT	81%	89.00%	88.00%	
3c.	**STAFFING**	Minimum safe staffing in maternity services to include Obstetric cover on the Delivery Suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	Maty Del Suite acuity		81%	86%	84%	Obs Unit for Drs - Minimum safety staffing level always available on Delivery Suite. Fill rates for delivery suite templates are being adjusted. AN data includes Triage staffing – there are changes underway to review and adjust the templates were necessary.
			Maty 1:1 care in labour		100%	100%	100%	
			Fill rates Delivery Suite RM		am 107% pm 102%	am 103% pm 105%	am 100% pm 102%	
			Fill rates Postnatal RM		am 47% pm 49%	am 96% pm 92%	am 93% pm 91%	
			Fill rates Antenatal RM		am 47% pm 47%	am 96% pm 92%	am 93% pm 91%	
			Obstetric Cover on D Suite		100%	100%	100%	
4.	**SERVICE USER FEEDBACK**	Service User Voice Feedback from MVP and UX system achievements			MVP now incorporates MNVP which includes neonatal representation.Current Co-Production projects: Fetal monitoring service leaflet Community Team promotion to combat no-shows at appointments. Mental Health Team promotion to combat no-shows at appointments. Psychologist interview support for neonatal unit.			
5.	**STAFF FEEDBACK**	Staff feedback from Bi-monthly frontline champion and walkabouts *(CNST requirement quarterly)*			Wrekin MLU ✓	No walkabout (Bi-monthly)	Shrewsbury MLU ✓	'Our Staff Said, We Listened' feedback posters with April/May updates for staff have been distributed widely via email and on display
6.	**EXTERNAL**	Requests from an external body (HSIB/NHSR/CQC or other organisation) with a concern or request for immediate safety actions made directly with Trust			No safety recommendations received from HSIB			The last safety recommendation reported by HSIB was in 2022 and this is related to an aspect of escalation for medical review.
7.	**Coroner Reg 28**	Coroner Regulation 28 made directly to Trust			0	0	0	None made directly to the Trust
8.	**SA 10 CNST**	Progress in achievement of CNST Safety Action 10			✓	✓	✓	There have been no cases referred to HSIB in Q1 therefore nil to report
9.	**ECLAMPSIA**	Number of women who developed eclampsia			0	0	0	Zero cases reported for Q1 – no change from data reported in Q4
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment								44.3% for Maternity Services published 2023
Proportion of specialty trainees in Obs & Gynae responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours								Reported annually - 87% *(source GMC National Trainees Survey 2022)*