Appendix 1 - Perinatal Clinical Surveillance Quality Assurance Report July 2024

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	Yes	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available however discusssed regionally as Data to October 2023 and decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised; external review requested to support rise in still birth rate.
	Outlier for rates of neonatal deaths as a proportion of birth	na	No escalation from SCN / LMNS on outlier report; internal thematic review undertaken and shared with BoD; Decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised.
	Rates of HIE where improvements in care may have made a difference to the outcome	na	Very low rates of HIE, sitting way below the lower control limit for the region. No current cases
	Number of PSII's	na	No PSSI's reported in July 2024
	Progress on SBL care bundle V3	no	SBLv3 launched and continued to be a key safety action of MIS Year 5 which was signed off as complaint meeting 81% (>70% was the requirement); Audits and evidencecontinue to be submitted for LMNS review and achieved complaince as at end of March of 97%; compliance will be monitored by LMNS quarterley and updates provided to BoD quarterley
	Outlier for rates of term admissions to the NNU	na	The rate of avoidable term admissions; regular multi-disciplinary reviews of care take place; NW region outlier report no longer published and awaiting national guidance on monitoring processes
Service user and st	MNVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints; to date all complaints have been addressed for maternity in the target timeframesand there is nil to escalate
	Trainee survey	no	No update this month
	Staff survey	no	Trust Staff Survey completed and divisional response has included staff engagement and continuation with the Pulse surveys; Score survey completed for MatNeo and cultural conversations commencing over x 4 sessions; Requirement to report to BOD Feb 2024
	CQC National survey	no	Published Feb 2024 and included within BoD report March 2024; action plan progressing; Sample provided for 2024 survey to be pulished early 2025
	Feedback via Deanery, GMC, NMC	no	Nil to esclate
	Poor staffing levels	no	Current vacancy rate is 7wte; predicted further 5wte between now and Nov 2024 due to leavers, retirements and maternity leave. Recruitment campaigns ongoing for Band 5 and Band 6 Midwives; Concern is will be reliant on newly quaified midwives in Sept 2024 leaving gaps between now and then;
	Delivery Suite Coordinator not super nummary	no	Super nummary status is maintained for all shifts
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	Nil of note; full establishment; governance structure review and revised structure implemented to meet requirements and maternity self assessment tool and continue to meet Ockenden Part 1
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams /Directorates
	False declaration of CNST MIS	no	MIS Year 5 submission and declaration submitted by 12 noon on 1st February 2024 - complaince met; MIS Year 6 publication published April 2024 included within BoD report updates.
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil to report this month; funding options explored; 5 teams in total and two approach model in place; comparison data / research underway; one team disbanded in July 2024
Safety and learning culture	Lack of engagement in MNSI or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead. Quarterly regional meetings arranged with excellent MDT attendance. Quarterly meeting held in Feb 2023; site visit May 2023; nil to escalate; quarterley meetings held with MNSI
	Lack of transparency	no	Being open conversations are regularly had and 100% compliance with duty of candour evident
	Learning from PSII's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all PSSI's, local reviews, rapid evaluations of care, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations. No exceptions to report. Three year single delivery plan for maternity and neonatal services published 31th March 2023 - gap analysis in progress and will monitored via WUTH CG structure and BoD
Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Regular training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture
	Delays in reporting a PSSI where criteria have been met	no	Robust PSIRF framework followed with timely reporting of all cases that meet the PSSI framework; PSIRF with effect from 1/9/2023
	Never Events which are not reported	no	No maternity or neonatal never events in July 2024
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales
Governanc e processes	Unclear governance processes		Clear governance processes in place that follow the PSIRF framework - Within division there is maternity and neonatal review of governance processes: 3 separate meetings. Staff are informed of top risks and incident themes. Governance notice boards updated and newsletters disseminated. Additional quality assurance framework agreed with effect from June 2023 to give the BoD addiitonal assurances in monitoring of MIS, Three year delivery plan etc. Governance structure strengthened
	Business continuity plans not in place	no	Business continuity plans in place
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	Nil to report this month
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Nil to report this month
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	CQC reports published for maternity sites Seacombe Birth Centre and APH site for the domains Safe and Well led; both sites were rated 'GOOD'
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

Trust Board sign-off requirements for MIS year 6

n.b. 'Completed' set to 'No' as defa
Change to 'Yes' and add date whe

	Requirement		Completed	Date
SA1	A quarterly report should be received by the Trust Executive Board each quarter from 2 April 2024 that includes details of the deaths reviewed from 8 December 2023, 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 have been met.	Q1	No	
		Q2	No	
		Q3 (third report may fall outside MIS reporting period)		
SA3	If not already in place, an action plan should be signed off by Trust and LMNS Board for a move towards the transitional care pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	By 30/11/24	No	
SA4	Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance with Trust Board, Trust Board level safety champions and at LMNS meetings.	By 30/11/24	No	
	Trust positions with 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' should be shared with Trust Boards	By 30/11/24	No	
	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.	By 30/11/24	No	
	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.	By 30/11/24	No	
SA5	A midwifery staffing oversight report that covers staffing/safety issues should be received by the Trust Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.	Q1 & Q2	No	
		Q3 & Q4 (second report may fall outside MIS reporting period)		
	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.	By 30/11/24	No	

SA6	Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.	By 30/11/24	No	
SA9	(NED) has been appointed and is visibly working with the Board safety champion (BSC)	By 30/11/24	No	
	Evidence that a monthly review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set. This should be presented by a member of the perinatal leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	By 30/11/24	No	
	Evidence that in addition to the monthly Trust Board/sub-committee review of maternity and neonatal quality as described above, 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) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.	Q1	No	
		Q2	No	
		Q3 (third report may fall outside MIS reporting period)	No	
	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Apr/May	No	
		Jun/Jul	No	
		Aug/Sep	No	
		Oct/Nov	No	
	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	By 30/11/24	No	
	Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of bi-monthly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 3 meetings held in the MIS reporting period.	Q1	No	
		Q2	No	
		Q3	No	
SA10	Trust Board must have sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	By 30/11/24	No	
	Trust Board must have sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme.	By 30/11/24	No	
	Trust Board must have sight of evidence of compliance with the statutory duty of candour.	By 30/11/24	No	

NHS Resolution

Maternity (and perinatal) Incentive Scheme

Year Six v1.1

Conditions of the scheme

Ten maternity safety actions

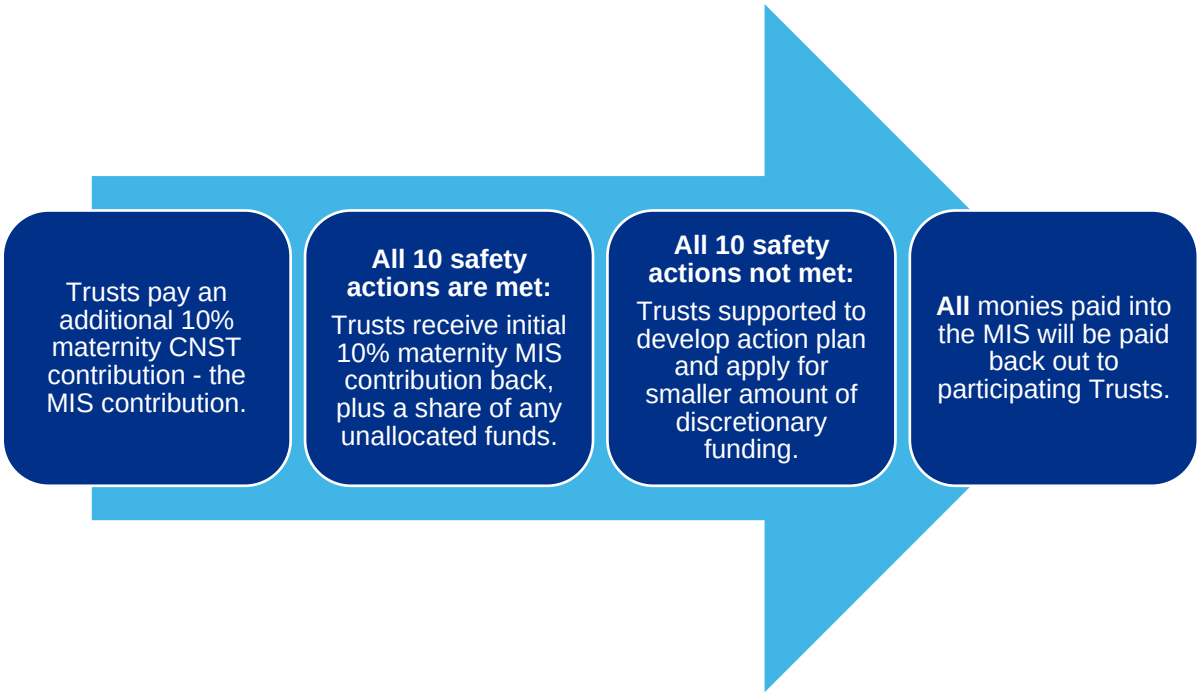
Additional guidance

Contents

Introduction

Now in its sixth year of operation, NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

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



The original ten safety actions were developed in 2017 and have been updated annually by a Collaborative Advisory Group (CAG) including NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC) and the Maternity and Newborn Safety Investigation Programme (MNSI).

Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST MIS fund and they 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 MIS 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 MIS fund and is subject to a cap decided annually by NHS Resolution.

MIS year six: conditions

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution via nhsr.mis@nhs.net by **12 noon** on **3 March 2025** 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 must then give their permission to the Chief Executive Officer (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.
- The Trust's CEO must sign 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 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/ MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2025.

  ☑ Any reports covering an earlier time-period may prompt a review of a previous MIS submission.

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICS) 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.

The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates from 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 MIS results. See 'Reverification'.

NHS Resolution will publish the outcomes of the MIS verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

External verification

Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with:

MBRRACE-UK data (safety action 1 standards a, b and c).

NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria).

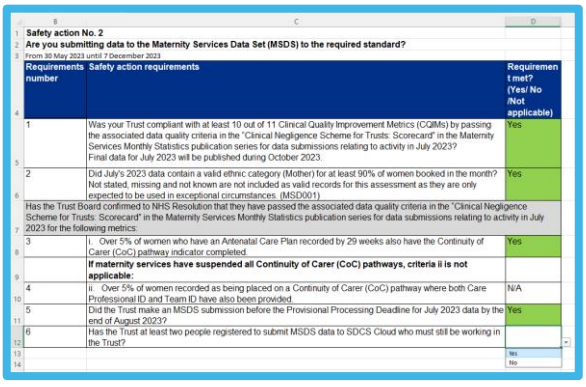
National Neonatal Research Database (NNRD), MNSI and **NHS Resolution** for the number of qualifying incidents reportable (safety action 10, standard a).

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.

Trusts found to be non-compliant following this external verification process cannot report full compliance with the MIS for that year.

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided internally in the Trust to support the Trust Board decision only. This will not be reviewed by NHS Resolution unless requested. See 'Reverification'.
- On the Board Declaration form Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.



1	**Safety action No. 2**		
2	**Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?**		
3	From 30 May 2023 until 7 December 2023		
4	**Requirements number**	**Safety action requirements**	**Requirement met? (Yes/ No /Not applicable)**
5	1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing 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.	Yes
6	2	Did July's 2023 data contain a 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)	Yes
7	Has the Trust Board confirmed 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:		
8	3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
9		**If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:**	
10	4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	N/A
11	5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
12	6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	
13			Yes
14			No

- 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 **12 noon 3 March 2025** 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 AO of Clinical Commissioning Group/Integrated Care System.
- The Board declaration form will be made available on the MIS webpage during the MIS reporting period.

'What Good Looks Like'

Trusts are reminded to retain all evidence used to support their compliance position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described below) 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 via nhsr.mis@nhs.net prior to the 3 March 2025.
- The Board declaration form must be sent to NHS Resolution via nhsr.mis@nhs.net between 17 February 2025 and 3 March 2025 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2025.
- Submissions and any comments/corrections received after 12 noon on 3 March 2025 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 Trust's control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.
- The NHS Resolution MIS clinical team 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.
- Appeals must be made in writing to NHS Resolution on the agreed template within two weeks of the final notification of results. Information on how to do this

will also be communicated to all Trusts when the confirmed MIS results are sent out.

Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a smaller amount of funding to support progress. To apply for funding, such Trusts must submit a completed action plan together with their completed Board declaration form by 12 noon on 3 March 2025 to NHS Resolution nhsr.mis@nhs.net.

Action plans submitted must be:

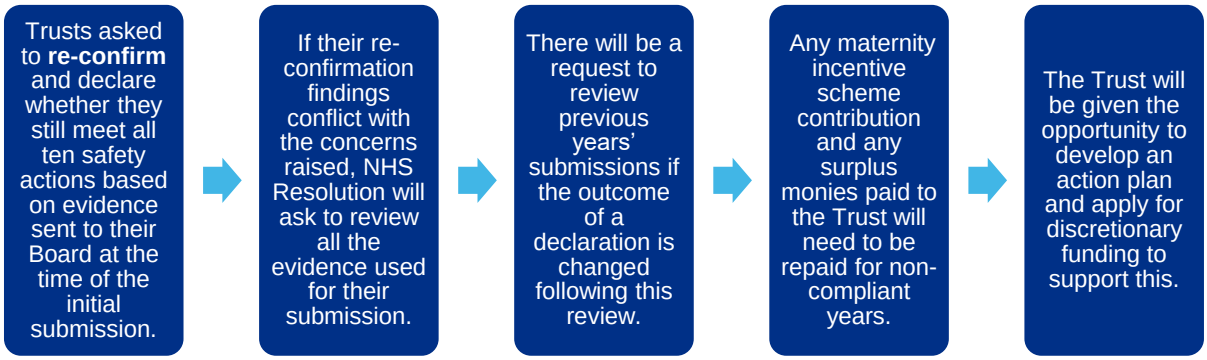
- Submitted on the action plan template in the Board declaration form.
- Signed and dated by the Trust CEO.
- Specific to the action(s) not achieved by the Trust.
- Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and will enable the financial calculation of the funding requested.
- Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE).
- Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
- Action plans should not be submitted for achieved safety actions.

Ruth May, NHS England Chief Nursing Officer wrote to NHS Trusts on 8th April 2021 confirming that commissioners must ensure that any funding awarded to implement the agreed action plan for improvement is ringfenced for the maternity service to support the delivery of the action plan.

Reverification

Reverification is initiated if a concern is raised that a Trust Board may have incorrectly declared compliance with one or more of the ten safety actions' sub-requirements within the MIS. This may be identified through whistleblowing or following a CQC report that may call into question the original declaration. This concern may relate to any completed year of the MIS.

In the first instance, Trusts are asked to complete their own internal review of the evidence that was used to support their compliance for the relevant year at the time of submission. This must be the same evidence that was used to inform the Trust Board at the point of declaration. Trusts will be given the opportunity to downgrade their position at this point.



If following their own internal review, the Trust remains confident that their compliance declaration was correct, the Trust will be asked to provide all of their supporting evidence to NHS Resolution. A full review of the relevant evidence will then be undertaken by two members of the MIS clinical team.

Following this review, any Trusts found to have mis-declared compliance will be notified and will be required to repay the funds originally awarded to them for that MIS year. They will be asked to develop an action plan to introduce safety improvements and work towards full compliance, and they will be advised to bid for discretionary funding to support this action plan. Any discretionary funds agreed must be spent on the improvements in the agreed plan. Any amount of discretionary funding agreed will be deducted from the total MIS rebate amount repayable to NHS Resolution.

If a mis-declaration has been identified (as above), reverification of the previous MIS year will automatically be initiated. When a further mis-declaration is identified, this process will then be repeated for the previous year. This process will be limited to impact the current MIS year, and the two preceding historical MIS years only.

Any funds retrieved from non-compliant Trusts will be redistributed to all Trusts that achieved compliance for the applicable MIS year. This redistribution must take place within the same financial year that NHS Resolution receives the funds.

Need Help?

If you have any queries or concerns regarding any aspect of the MIS, please contact the MIS clinical team on nhsr.mis@nhs.net. There is a new FutureNHS MIS workspace where queries can be submitted and additional information and resources will be provided.

To ensure you receive all correspondence relating to the MIS, please add your name to the MIS contacts list.

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

Required Standard
a) **Notify all deaths**: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. b) **Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards. c) **Review the death and complete the review:** For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 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 and published within six months. d) **Report to the Trust Executive:** Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.
Minimum Evidence Requirement for Trust Board
Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see technical guidance regarding the introduction of the NHS Submit a Perinatal Event Notification system - SPEN). The PMRT must be used to review the care and reports about individual deaths should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter 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 by 3 March 2025. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications. MBRRACE-UK/PMRT will take the data extract for verification on 1 February 2025.
Relevant Time period
From 8 December 2023 to 30 November 2024

Link to technical guidance

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 MSDS-only (see technical guidance) 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 2024. Final data for July 2024 will be published during October 2024. 2. July 2024 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).
Minimum Evidence 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.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

Required Standard
a) Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice Or Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards. b) Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS.
Minimum Evidence Requirement for Trust Board
Evidence for standard a) to include: **For units with TC pathways** • Local policy/pathway of TC admission criteria based on BAPM framework for Transitional Care and meeting a minimum of at least one element of HRG XA04. **For units working towards TC pathways** • An action plan signed off by Trust and LMNS Board for a move towards the TC pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.
Evidence for standard b) to include: 1. By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team. 2. By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

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 certificate of eligibility (CEL) 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 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 be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist 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. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.**
   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
   roles-responsibilities-consultant-report.pdf 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 BAPM national standards of medical staffing.

or

the standards are not met, but there is an action plan with progress against any previously developed action plans.

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.

or

The standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal ODN.

Minimum Evidence Requirement for Trust Board

Obstetric medical workforce

1) Trusts/organisations should audit their compliance via Medical Human Resources.

   Information on the 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.

3) Trusts/organisations should be working towards developing standard operating procedures, 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 senior 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. This can be a representative month of the rota.

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 ODN.

Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

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 has been completed within the last three years.

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 a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator **at the start of every shift**) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

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 Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

Minimum Evidence Requirement for Trust Board

The midwifery staffing report submitted will comprise evidence to support a, b, c and d 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 on duty at the start of every shift and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.

Relevant Time period

From 2 April 2024 to 30 November 2024

Link to technical guidance

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

Required Standard
Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.
Minimum Evidence Requirement for Trust Board
Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include 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, neighbouring Trusts and NHS Futures where appropriate. *The Three-Year Delivery Plan for Maternity and Neonatal Services* set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

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

Required Standard

1. Trusts should work with their LMNS/ICB to 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 (published November 2023) including supporting:

   a) Engagement and listening to families.

   b) Strategic influence and decision-making.

   c) Infrastructure.

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

Minimum Evidence Requirement for Trust Board

1.

a) Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.

b) Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member, (Trusts should work towards the MNVP Lead being a quorate member), such **as:**

- Safety champion meetings
- Maternity business and governance
- Neonatal business and governance
- PMRT review meeting
- Patient safety meeting
- Guideline committee

c) Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as:

- Job description for MNVP Lead
- Contracts for service or grant agreements
- Budget with allocated funds for IT, comms, engagement, training and administrative support
- Local service user volunteer expenses policy including out of pocket expenses and childcare costs

- If evidence of funding support at expected level is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.

2. Evidence of review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as an action plan.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.

Relevant Time period

From 2 April 2024 to 30 November 2024

Link to technical guidance

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

Required Standard
90% of attendance in each relevant staff group at: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal Life Support Training See technical guidance for full details of relevant staff groups. ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for MIS. It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.
Minimum Evidence Requirement for Trust Board
*See technical guidance for details of training requirements and evidence.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 1 December 2023 to 30 November 2024

Link to technical guidance

Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Required Standard

a) All Trust requirements of the PQSM must be fully embedded.

b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.

c) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.

Minimum Evidence Requirement for Trust Board

Evidence for point a) and b)

- Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop trusting relationships between staff, the frontline maternity, neonatal and obstetric safety champions, the perinatal leadership team 'Quad', and the Trust Board to understand, communicate and champion learning, challenges, and best practice.

- Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set at every meeting. This should be presented by a member of the **perinatal** leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.

- Evidence of collaboration with the LMNS/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.

- Evidence of ongoing engagement sessions with staff as per year 5 of the scheme. 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 1 July 2024.

- Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, 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) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.

Evidence for point c):

Evidence that the Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering relevant support where required. This will include:

- Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.

- Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.

Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Required Standard
a) Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024. b) Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 8 December 2023 until 30 November 2024. c) For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that: i. the family have received information on the role of 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 Evidence Requirement for Trust Board
Trust Board sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025. Trusts' reporting will be cross-referenced against the 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 B and C(i) there is a requirement to complete field on NHS Resolution's Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.
Relevant Time period
From 8 December 2023 to 30 November 2024

Link to technical guidance

Technical Guidance

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.	
SA 1(a) – Notify all eligible deaths	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal deaths 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 the Submit a Perinatal Event Notification system (SPEN) will be released by NHS England in 2024. Once this is released notifications of deaths must be made through SPEN and this information will be passed to MBRRACE-UK. It will still then be necessary for reporters to log into the MBRRACE-UK/PMRT system to provide the surveillance information and to 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 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 2024.
SA 1(b) – Seek parents' view of care	
We have informed parents that a local review will take place and they have been asked if they have any feedback 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' feedback, perspectives, and any 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' feedback and 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 feedback 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 their feedback at 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 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.
SA 1(c) – Review the death and complete the review	
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: d) Late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) e) Stillbirths (from 24+0 weeks' gestation) f) 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: 
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 Trust 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 long turn-around time?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than six months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death, complete and publish the report using the information you have available. When the PM 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 six 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 PMRT verification 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 2 April 2024 and 30 November 2024 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 verification process?	Trusts should review all eligible deaths using the PMRT as a routine on-going process, irrespective of the MIS timeframe and verification process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 6 MIS requirements.
What happens when an MNSI (formerly 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 MNSI (formerly HSIB). Your local review using the PMRT should be started (to identify any early and immediate learning which needs to be actioned) but not completed until the MNSI report is complete. You should consider inviting the MNSI reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the MNSI review to be incorporated into the PMRT review. Depending upon the timing of the MNSI report completion achieving the standards for these babies may therefore be impacted by timeframes beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an MNSI investigation is taking place, and this will be accounted for in the external verification process.

SA 1(d) – Report to the Trust Executive Board	
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 of time defined by the user. 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 completed reviews over a period time which can be generated within the PMRT by authorised PMRT users for a user-defined period 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 completed and 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'.

Link to Safety Action 1

Technical Guidance for Safety Action 2	
What are the 11 "MSDS-only" CQIMs in scope for this assessment?	These include: • Babies who were born pre-term • Babies with a first feed of breastmilk • 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 booking • 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 These do not include the following as they rely on linkages between MSDS and other datasets: • Babies breastfed at 6-8 weeks • Babies readmitted to hospital <30 days after birth
Some CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on those for three months?	No. For the purposes of the CNST assessment Trusts will only be assessed on July 2024 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 "CNST: Scorecard" in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts.
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

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 Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series: 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?	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

Link to Safety Action 2

Technical Guidance for Safety Action 3	
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.
How can we evidence progress towards a transitional care service?	A current action plan with specified timescales and progress against these should be reviewed by the Trust and LMNS Boards before the submission deadline
How do we identify our themes of unplanned term admissions?	All term admissions will be reported through DATIX/LFPSE (as per local implementation of PSIRF) and themes identified through this intelligence. ATAIN proforma reviews are no longer mandated.
Who should be involved in the quality improvement initiatives?	The team should include members of maternity and neonatal multidisciplinary team including liaising with service user representative (MNVP) and support sourced from Trust quality improvement and service improvement teams if required.
How do we register our quality improvement initiative?	This will vary depending on local Trust policy. In the absence of any Trust policy, evidence of registering the quality improvement initiative, could be documented in the safety champion minutes.
What is considered as evidence of an update on the quality improvement initiative?	Evidence should include: 1) a presentation to the LMNS which includes an aim statement, measures, change actions and outcomes. 2) Discussion with safety champions and noted in the minutes at least once before the end of the reporting period.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ 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) The Handbook of Quality and Service Improvement Tools: the_handbook_of_quality_and_service_improvement_tools_2010-2.pdf (england.nhs.uk)

Link to Safety Action 3

Technical Guidance for Safety Action 4	
a) Obstetric medical workforce guidance	
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 2024. 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?	No.
Where can I find the documents relating to short term locums?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
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 2024 and prior to submission to the Trust Board.
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?	No.
Where can I find the documents relating to long term locums?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG

How can the Trust monitor adherence with the standard relating to Standard operating procedures for consultants and SAS doctors taking compensatory rest after non-resident on call?	Trusts should have 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 have 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 have this as evidence that they are working towards compliance.
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?	Yes. However while this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.
Where can I find the documents relating to compensatory rest for consultants and SAS doctors?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
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	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans

element of safety action 4 if 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 (MIS Team) or workforce@rcog.org.uk (RCOG).	
b) Anaesthetic medical workforce guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard 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.
c) Neonatal medical workforce guidance	
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 BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)	
NICU **Neonatal Intensive Care Unit**	All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics. Trusts that have more than one NNU providing IC or HD care should have separate cover at all levels of medical staffing appropriate for each level of unit. **Tier 1**

	Rotas should be European Working Time Directive (EWTD) compliant and have a minimum of 8 WTE staff Units with more than 7000 deliveries should have more than one Tier 1 medical support **Tier 2** EWTD compliant rota with a minimum of 8 WTE staff NICUs undertaking more than 2500 IC days per annum should augment their Tier 2 medical cover (more than one staff member per shift) **Tier 3** Minimum of 7 WTE consultants on the on-call rota with 24/7 availability of a consultant neonatologist NICUs undertaking more than 2500 IC days per annum should provide two consultant led teams during normal working hours. Neonatal consultant staff should be available on site in all NICUs for at least 12 hours a day, generally expected to include two ward rounds/handovers For units undertaking more than 4000 IC days per annum, consideration should be given to 24-hour consultant presence All NICU consultants appointed from 2010 should have CCT in Neonatal Medicine.
LNU **Local Neonatal Unit**	Where LNUs have a very busy paediatric/neonatal service and/or have neonatal and paediatric services that are a significant distance apart, the above staffing levels should be enhanced. The threshold should be judged and monitored on clinical governance grounds such as the ability consistently to attend paediatric or neonatal emergencies immediately when summoned. Units with more than 7000 deliveries should have more than one Tier 1 medical support.

	Tier 1 Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general paediatrics in addition. **Tier 2** Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff. **Tier 3** Consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification and substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN. At least one LNU Tier 3 consultant should have either a CCT in neonatal medicine or neonatal SPIN module (if this was available during training). All consultants covering the service must demonstrate expertise in neonatal care (based on training, experience, CPD and on-going appraisal).
SCU **Special Care Unit**	**Tier 1** Rotas should be EWTD compliant (58) and have a minimum of 8 WTE staff who may additionally cover paediatrics if this does not reduce safety and quality of care delivery. There should be a resident Tier 1 practitioner dedicated to the neonatal service during weekday day-time hours and an immediately available resident Tier 1 practitioner 24/7. **Tier 2** Shared rota with paediatrics comprising a minimum of 8 WTE staff. Tiers 1 and/or 2 may be able to be covered by appropriately skilled nursing staff

	Tier 3 A minimum of 7 WTE consultants on the on-call rota with a minimum of 1 consultant with a designated lead interest in neonatology. Tier 3 consultants should have a Certificate of CCT in paediatrics or Certificate of Eligibility for Specialist Registration (CESR) in paediatrics or an equivalent overseas neonatal or paediatric qualification. They must demonstrate knowledge, skills and CPD appropriate for the level of neonatal care through annual appraisal. Minimum of 1 consultant with a designated lead interest in neonatology, who should have completed a special interest (SPIN) module in Neonatology*. (if this was available during training)
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 6 reporting period.
Please access the followings for further information on Standards	BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)
d) Neonatal nursing workforce guidance	
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) 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:

	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.

Link to Safety Action 4

Technical Guidance for Safety Action 5	
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 further details and definitions: 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?	A supernumerary coordinator must be allocated for every shift and must start each shift with protected supernumerary status. It is accepted that there may be short periods when the coordinator is temporarily unavailable due to rapidly changing acuity on the labour ward to ensure safety for women, families and staff in the department. The co-ordinator should exercise professional judgement and escalate, if covering for breaks creates a safety risk to other women on labour ward. As long as there is clear evidence that the local escalation policy has been initiated in these circumstances, and this is not a recurrent daily event, Trusts may declare compliance with this standard.

	If the co-ordinator is regularly required to cover for breaks (more than 2-3 times 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.
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.
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.

Link to Safety Action 5

Technical Guidance for Safety Action 6	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: saving-babies-lives-version-three/ An implementation tool is available for trusts to use if they wish at future.nhs.uk/SavingBabiesLives and includes a technical glossary for all metrics and measures. For any further queries regarding the tool, please email england.maternitytransformation@nhs.net Any queries related to MSDS issues for 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 (Element 1); from NNAP Online (Element 5); and from NPID (Element 6). For any other queries, please email nhsr.mis@nhs.net
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. Where MSDS does not capture all process and outcome indicators given in the care bundle, this is indicated in the Implementation Tool.
What percentage performance is required to be compliant for a given intervention?	Where element process and outcome measures are listed in the evidence requirement of the SBLCB V3 a performance threshold is recommended. However, LMNS/ICBs are able to agree local performance thresholds with a provider in view of local circumstances, and the agreed local improvement trajectory.
How do we provide evidence for the interventions that have been implemented?	Trusts will need to verify with their LMNS/ICB that they have an implemented service locally.
Will the eLfH modules be updated in line with SBLCBv3?	The SBL e-learning for health modules have all been updated to reflect the changes in version 3. A new module for element 6 has also now been developed and published on the e-learning for health site.

Link to Safety Action 6

Technical Guidance for Safety Action 7	
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 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.
What does evidence of MNVP engagement look like?	Engagement can include lots of different methods as detailed in the MNVP Guidance under the section *Engagement and listening to families*. Evidence for this includes: • 15 Steps for Maternity report. • MNVP Annual Report. • Engagement reports. • Expenses paid to service users. • List of organisations engaged. • Online surveys and feedback mechanisms. • Analysis of surveys by demographics of respondents.

Link to Safety Action 7

Technical Guidance for Safety Action 8	
How will the 90% attendance compliance be calculated?	The training requires 90% attendance of relevant staff groups by the end of the 12-month period at: 1. Fetal monitoring training 2. Multi-professional maternity Emergencies training 3. Neonatal Life Support Training
Which maternity staff should be included for 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 and SAS doctors. • 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 Maternity emergencies and multi-professional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric consultants and SAS doctors. • All other obstetric doctors including obstetric trainees (ST1-7), sub speciality trainees, Locally Employed Doctors (LED), foundation year doctors and GP trainees 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 and autonomously practising obstetric anaesthetic doctors. • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) **who contribute to the obstetric**

	rota. This updated requirement is supported by the RCoA and OAA. • 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 6 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 6 compliance. At least one emergency scenario/drill should be conducted in a clinical area during the whole MIS reporting period, ensuring attendance from the relevant wider professional team, including theatre staff and neonatal staff. The clinical area can be any area where clinical activity takes place e.g. Delivery Suite, Clinic, A&E, theatre, a ward. This should not be a simulation suite.
Training attendance for rotational clinical staff	It is the gold standard that all staff attend training in the unit that they are currently working in, so that they can benefit from local learning and training alongside their multi-disciplinary colleagues, however it is appreciated that this may be especially challenging for rotational staff. In the following circumstances, evidence from rotating medical trainees having completed their training in another maternity unit will be accepted: • Staff must be on rotation. • The training must have taken place in any previous Trust on their rotation during the MIS training reporting 12-month period. • Rotations must be more frequent than every 12 months. This evidence may be a training certificate or correspondence from the previous maternity unit.
Does the multidisciplinary emergency training have to be conducted in the clinical area?	Ideally at least one emergency scenario should be conducted in any clinical area as part of each emergency training day. You should aim to ensure that all staff attending emergency training participate in an emergency scenario that is held in a clinical area, but this will not be measured in year 6 of MIS.
Which staff should be included for	Neonatal basic life support. This includes the staff listed below:

Neonatal basic life support?	• Neonatal Consultants/SAS doctors or Paediatric consultants/SAS Doctors 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, SAS, LE Doctors and anaesthetic trainees) contributing to the obstetric rota. • 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 dependant on their role within the service. • If nursery nurses work within the service, this should also be recognised in your local training needs analysis.
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 6 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 6 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.
What do we do if we do not have enough instructors who	Your Neonatal Consultants and Advanced Neonatal Practitioners (ANNP) will be qualified to deliver the training. You can also liaise with your LMNS to explore sharing of resources.

are trained as an NLS instructor and hold the GIC qualification?	It is recognised that for smaller hospitals, such as Level 1 units, there may be difficulty in resourcing qualified trainers. These units 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. As a minimum, training should be delivered by someone who is up to date with their NLS training. Please see the RCUK website for the latest guidance regarding NLS GIC training
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally determined. In line with *The British Association of Perinatal Medicine Neonatal Airway Safety Standard Framework for Practice* (April 2024) *All neonatal staff undertaking responsibilities as an **unsupervised** first attender / primary resuscitator attending any birth must have reached a minimum of 'basic capability' as described in the BAPM Neonatal Airway Capability Framework.* *No specific training course is mandated. However, the Resuscitation Council UK Neonatal Life Support (NLS) provider certification includes all skills required for Basic capability and most skills required for Standard capability.* Staff that attend births **with supervision at all times** will not need to complete this assessment process for the purpose of MIS compliance. *A minimum of 90% of paediatric/neonatal medical staff **who attend neonatal resuscitations unsupervised** should have been trained and assessed in line with the guidance above. Trusts that cannot demonstrate this for MIS year 6 should develop a formal plan demonstrating how they will achieve this for a minimum of 90% of their neonatal and paediatric medical staff **who attend neonatal resuscitations unsupervised** by year 7 of MIS and ongoing.*
The Core Competencies TNA suggests periods of time for each element of training, e.g. 9 hours for fetal monitoring. Is this a mandated amount of time?	We envisage that the fetal monitoring and obstetric emergencies training will require 1 whole day each. The hours for each element of training can be flexed by the individual Trust in response to their own local learning needs.

Link to Safety Action 8

Technical Guidance for Safety Action 9	
Where can I find additional resources?	NHS England, Perinatal Quality Surveillance Model PSIRF (Patient Safety Incident Response Framework) Measuring culture in maternity services: Safety Culture Programme for Maternal and neonatal services 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.
Perinatal Quality Surveillance Model	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local governance for sharing intelligence checked, and when needed, updated. • Describe the local governance processes in place to demonstrate how intelligence is shared from the ward to Board. • Formalise how Trust-level intelligence will be shared and escalated with the LMNS/ICB quality group and from there with regional quality groups which will include the Regional Chief Midwife and Lead Obstetrician.
Reporting to Trust Board	
What do we need to include in the dashboard presented to	The dashboard should be locally produced, based on a minimum data set. It should include themes identified in line with PSIRF, and actions being taken to support; SUV feedback; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. Themes and progress with culture

Board each month?	improvement plans following local cultural surveys or equivalent should also be included. This may include the SCORE culture survey, NHS staff survey, NHS pulse survey, focus groups or suitable alternative. The dashboard can also include additional measures as agreed by the Trust.
Our Trust Board and / or sub-committee only meet 10 times a year. Is this acceptable?	If the Board or appropriate sub-committee do not meet monthly, it is the expectation that maternity and neonatal quality and safety will be discussed every time the Board or sub-committee meet.
Clarification as to what constitutes a Trust Board, can sub committees be categorised as a Board?	In year 6 the standard has been updated to reflect that an appropriate Trust Board sub-committee, chaired by a Trust Board member, can be delegated to undertake the monthly review of perinatal safety intelligence. If a sub-committee of the Board undertakes this work, an exception report or highlight report must still be provided to the Board and discussion evidence in the Board minutes.
Culture Surveys	
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will have participated in the Perinatal Culture and Leadership Programme. As part of this programme every service completed work to meaningfully understand the culture of their services. This diagnostic was either a SCORE culture survey or an alternative as agreed with the national NHSE team. Diagnostic insights and plans for improvement were to be 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. The expectation is that all maternity and neonatal services will understand how it feels to work in their services, either from the SCORE culture survey, or suitable alternative.
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 survey 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.
Perinatal Culture and Leadership Programme	
Who is expected to have	Senior perinatal leadership teams from all Trusts that have a maternity and neonatal service in England have undertaken

undertaken the Perinatal Culture and Leadership Quad programme?	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 perinatal leadership team 'Quad' and their work as part of the PCLP, but there is no expectation for them to attend the programme.
Safety Champions	
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
Do both the NED and Executive BSC and all four members of the 'Quad' have to be present at each meeting?	Ideally the meeting would have both Board Safety Champion (BSC's) and at least two members of the Quad present. If this is not always possible, it would be appropriate for either the Executive or NED BSC and at least one member of the quad to be present. However, the expectation is that each professional group is represented throughout the year, and that the nominated member attending brings all four voices to the conversation.
What are the expectations of the NED and Exec Board safety champion in relation to their support for the Perinatal Culture and Leadership Programme	As detailed in last year's MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provides an opportunity to share safety intelligence, examples of best practice, identified areas of challenge and need for support. 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:

(PCLP), culture surveys and ongoing support for the Perinatal Leadership teams? **What should be discussed at the bi-monthly meetings between the Board Safety Champion(s) and the Perinatal Leadership teams?**	- Learning from the Perinatal Culture and Leadership Development Programme and how they are using this locally. - How they plan to continue being curious about their local culture. This may be in the form of pulse surveys, or team check ins. - Updates on recent local insight into their team's health, as gathered in the above bullet points. Updates on identified areas for improvement following the local diagnostic, along with any identified support required from the Board. NB, this plan will be fluid and iterative, based on continued conversations with perinatal teams. It is not a plan that can be completed and filed as culture is ever changing and something leaders continually need to be curious about. - Progress with interventions relating to culture improvement work, and any further support required from the Board.
Do the non-executive and executive maternity and neonatal Board safety champion not have to register to the dedicated FutureNHS workspace to access the resources available this year?	We encourage all NED and Exec Board Safety Champions to register on the FutureNHS Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace. New content and resources are added throughout the year, and we would encourage all BSC's to continue to access the page to benefit from these. You can also reach out to other Board Safety Champions and develop your own community of peer support. However, this will not be a formal requirement in year 6 of the MIS.
We had not continued to undertake feedback sessions with the Board safety champion, what should we do?	Parts a) and b) of the required standard builds on the year four and five requirements of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board level safety champions to raise concerns relating to safety and identify any support required from the Board. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions with staff 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 and four of the maternity incentive scheme and the expectation is that this should have been continued.
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 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 continuous 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.
Scorecards	
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here.
Why do we need to review the scorecard quarterly alongside current complaint and incident data?	The scorecard is a quality improvement tool that provides insight into claims in support of clinical governance and quality assurance in your organisation. It provides details of all CNST claims, combined with data from the EN scheme and can provide a full picture of maternity related claims in your organisation. The scorecard provides 10 years of claims experience allowing the impact of clinical effectiveness and safety interventions to be assess over time. It can be reviewed alongside other data sets to provide a fuller picture of safety. It highlights themes occurring in claims which can be addressed through staff education and training. The scorecard provides a number of speciality filtered views allowing quick access to the relevant data for your division/speciality. Where data sharing

	agreements exist, members may share scorecard data to support learning across partnerships, networks and regions. The safety and learning team at NHS Resolution can support you in accessing and using your scorecard, nhsr.safety@nhs.net . A short video on using your scorecard can be found here Videos (resolution.nhs.uk) (Extranet login required). The GIRFT/NHS Resolution Learning from Litigation Claims can be found here Best-practice-in-claims-learning-FINAL.pdf (gettingitrightfirsttime.co.uk) and includes advice on engaging with NHS Resolution Safety and Learning resources, including the scorecard.
Examples have been requested for the scorecards.	The key to making this exercise meaningful is the triangulation of the data. Categorisation of the historical 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 historical themes re-emerged. NHS Resolution have developed an example template to share, and this can be accessed via the FutureNHS platform Maternity Incentive Team workspace, or the MIS Team can send a copy out on request. NHS Resolution staff are always happy to talk through this process if it is helpful.

Link to Safety Action 9

Technical Guidance for Safety Action 10	
Where can I find information on MNSI (previously HSIB)?	Information about MNSI and maternity investigations can be found on the MNSI/ website https://mnsi.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 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: (i) when the baby was therapeutically cooled (active cooling only), or (ii) has been diagnosed with moderate to severe encephalopathy, consisting of altered state of consciousness (lethargy, stupor or coma) and at least one of the following: (aa) hypotonia; (bb) abnormal reflexes including oculomotor or pupillary abnormalities; (cc) absent or weak suck; (dd) clinical seizures Trusts are required to report their qualifying cases to MNSI via the electronic portal. Once 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. * This definition was updated from 1 October 2023. Please see our website for further information, this does not change the cases referred to MNSI.
What is the definition of labour used by MNSI and EN?	The definition of labour used by MNSI and EN 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 <u>from 1 April 2022 going forward</u>	As in year 4 of MIS, in addition to reporting their qualifying cases to MNSI, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once MNSI have confirmed they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must input the MNSI reference number to confirm the investigation is being undertaken by MNSI (otherwise it is rejected). The Trust must share the MNSI report, along with the MRI report, with the EN team within 30 days of receipt of the final report by uploading the MNSI report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading MNSI reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the 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 MNSI are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury and have a confirmed reference number. • Where a family have declined a MNSI investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution and advised of this reason for reporting. There is more information here: ENS Reporting Guide - December 2023 (for Member Trusts) - NHS Resolution
Cases that do not require to be reported to NHS Resolution	• Cases where families have requested a MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a MNSI investigation where the baby has a normal MRI. • Cases that MNSI are not investigating.
What if we are unsure whether a case qualifies for referral to	If a baby has a clinical or MRI evidence of neurological injury and the case is being investigated by MNSI because of this, then the case should also be reported to NHS Resolution via the Claims Reporting Wizard along with the MNSI reference number (document the MNSI reference in the "any other comments box").

MNSI or NHS Resolution?	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 MNSI maternity team maternityadmins@mnsi.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 MNSI as under investigation. They must also complete the EN Report form and attach this to the Claims Reporting Wizard: EN-Report-Form.pdf
What happens once we have reported a case to NHS Resolution?	On completion of the MNSI investigation, and on receipt of the MNSI report and MRI report, following triage, NHS Resolution will overlay an investigation into legal liability. Where families have declined an 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. 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 MNSI 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 qualifying cases to MNSI as soon as they occur and to NHS Resolution as soon as 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 MNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and 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.
How can we confirm our cases have been reported to NHS Resolution?	We strongly advise making a note of the Claims Management System (CMS) reference number received once the matter is reported, as this will be confirmation that the case has been successfully reported to NHS Resolution.

Link to Safety Action 10

MIS FAQ	
What do you mean by Trust Board?	Unless explicitly stated, Trust Board can be interpreted as 'the Trust Board or appropriate sub-committee with delegated authority' as long as these sub-committees provide Trust Board with output following their review and discussion.
Why aren't we reporting everything directly to Trust Boards?	Trust Boards have a broad scope of responsibility, covering all aspects of the Trust's governance, strategy, and finances. They provide strategic direction and oversight, while sub-committees such as the Quality Governance Committee takes a more hands-on role in monitoring quality and safety performance reviewing and scrutinising operational detail. It is vital that the most pertinent information that is conveyed to Trust Boards is clearly recognised, and not lost in the operational detail of reporting. A sub-committee's in-depth examination of data, reports, and practices provides the Board with a clear understanding of the Trust's performance on quality and safety, including any immediate priorities or exceptions.
How can I evidence an appropriate sub-committee?	A Board Assurance Framework should highlight the decision-making processes within a Trust and detail those committees with delegated authority from the Board. Individual Terms of Reference from sub-committees should also contain this information. Minutes of sub-committee meetings should demonstrate that the required discussion around MIS standards have taken place, including any output which will be conveyed to the Trust Board. This must be recognised within Trust Board minutes.
What is a Quality Governance Committee, and how does it differ from a Trust Board?	A Quality Governance Committee (QGC) is a committee of the Trust Board responsible for overseeing the Trust's quality and safety governance arrangements. It provides assurance to the Trust Board that the Trust has robust systems in place to identify, assess, and mitigate risks to patient safety. The QGC also reviews the Trust's quality improvement initiatives and provides recommendations to the Trust Board. The information presented to a QGC will be more detailed and specific than the information presented to the Trust Board. They should receive regular updates on the Trust's performance in key quality and safety areas, as well as specific data on individual incidents and concerns. The QGC should also have the opportunity to discuss the Trust's quality improvement plans and provide feedback and recommendations. A QGC is appropriate to review evidence around safety actions, provide additional scrutiny **and then report to the**

	Trust Board, delivering a summary and highlighting any exceptions or particular areas of concern. **It is important to ensure that this process facilitates Trust Board oversight, rather than replaces it.**
Where can I find more information about Board Reporting via Quality Governance Committees?	NHS Providers Board Assurance Toolkit Quality Governance in the NHS
Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice for the Board notification form?	Trust Boards must self-certify the Trust's final MIS declaration 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 CQC 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 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 AO of Clinical Commissioning Group/Integrated Care System before submission.
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

	AO (ICB). Where relevant, an action plan is completed for each action the Trust has not met. **Please send only the Board notification form to NHS Resolution. Do not send your evidence or any narrative related to your submission to NHS Resolution unless requested to do so for the purpose of reverification.** 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 2024 and all Trusts will be notified. 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 3 March 2025, 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 3 March 2025**. If not returned to NHS Resolution by 12 noon on 3 March 2025, NHS Resolution will treat that as a nil response.
Our Trust has queries, who should we contact?	Any queries prior to the 3 March 2025 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 MIS link contacts via the link on the NHS Resolution website.
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	Yes, there will be an appeals process. Trusts will be allowed 14 days to appeal the decision following the communication of results.

appeals this year?	The 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 when final results are confirmed and sent to Trusts.
Merging Trusts	Trusts that will be merging during the year six reporting period (April 2024 – January 2025) 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 2024/25 and the reporting of claims and management of claims going forward.

Appendix 4

MIS year 6 Safety Action 8 – Neonatal Resuscitation further update
16 July 2024

We have continued to work with the leads for the neonatal element of Safety Action 8 to respond to your feedback and have agreed to make the following amendment to the previous update regarding neonatal resuscitation training standards that will continue to support improved safety at neonatal resuscitation, while ensuring that this is also achievable for Trusts.
We apologise for any confusion that making a second change to this safety action may cause.

In line with The British Association of Perinatal Medicine Neonatal Airway Safety Standard Framework for Practice (April 2024)

*All neonatal staff undertaking responsibilities as an **unsupervised** first attender / primary resuscitator attending any birth must have reached a minimum of 'basic capability' as described in the BAPM Neonatal Airway Capability Framework.*
No specific training course is mandated. However, the Resuscitation Council UK Neonatal Life Support (NLS) provider certification includes all skills required for Basic capability and most skills required for Standard capability.

~~*If the first responder is required to attend preterm deliveries <34 weeks without additional support, they should have reached an 'intermediate standard' of capability with additional "immediately available" support as needed in line with the BAPM Neonatal Airway Capability Framework.*~~
~~*The Resuscitation Council UK Advanced Resuscitation of the Newborn Infant (ARNI) certification includes most of the competencies required for Intermediate capability.*~~

While we would strongly encourage Trusts to continue to work towards the BAPM guidance where possible regarding first responders at births <34 weeks, this will not form part of the MIS requirements for compliance.

There is specific guidance within the BAPM framework that details exactly what skills training and assessment must include, and who is able to carry out that assessment locally. I have included a summary in the attached document.

Staff that attend births **with supervision at all times** will not need to complete this assessment process for the purpose of MIS compliance.

Please note that Trusts should be working towards this position for this year (year 6) of the Maternity Incentive Scheme in line with the published MIS year 6 document:

*A minimum of 90% of paediatric/neonatal medical staff **who attend neonatal resuscitations unsupervised** should have been trained and assessed in line with the guidance above.*
Trusts that cannot demonstrate this for MIS year 6 should develop a formal plan demonstrating how they will achieve this for a minimum of 90% of their neonatal and

paediatric medical staff ***who attend neonatal resuscitations unsupervised*** *by year 7 of MIS and ongoing.*

Appendix 5

MIS year 6 Safety Action 8 – Non-obstetric anaesthetic training update
16 July 2024

Thank you all for your patience while we have worked with the leads for the anaesthetic element of Safety Action 8 to respond to your feedback and reach a position that will continue to support improved safety, while ensuring that this is also achievable for Trusts.

Given the disparity across the system of the impact of the changes to this safety action relating to obstetric emergency training for non-obstetric anaesthetic colleagues, a decision has been made to revert back to the requirement as mandated within year 5 of MIS for this year.

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

This removes the requirement within MIS for 70% of non-obstetric anaesthetists on the on-call rota to have attended a minimum ½ day obstetric emergency training session, however we would encourage Trusts to continue to work towards this where possible.

We apologise for any confusion or inconvenience making a change to the standard at this stage may cause. We will publish an amended MIS document and audit tool including this change. I hope that this will provide some additional clarity and resolve some of the challenges that Trusts have reported to us.

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Arrowe Park Hospital, Wirral University Teaching Hospital NHSFT

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/4/2024 to 30/6/2024

There are no published reviews for Arrowe Park Hospital, Wirral University Teaching Hospital NHSFT in the period from 1/4/2024 to 30/6/2024

Report Generated by: Joy Watkinson
Date report generated: 13/08/2024 09:52

Board Report and Action Plan on Implementation of the Saving Babies Lives Care Bundle (Version 3)

Implementation Report

Trust	**Wirral University Teaching Hospital NHS Foundation Trust**
Date of Report	**25-Sep-23**
ICB Accountable Officer	
Trust Accountable Officer	**Janelle Holmes, CEO**
LMNS Peer Assessor Names	**Debby Gould, LMNS Q&S Lead**

Background

Version three of the Saving Babies' Lives Care Bundle (SBLCBv3) published on 31 May 2023, aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The third version of the care bundle brings together six elements of care that are widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
3. Raising awareness of reduced fetal movement (RFM)
4. Effective fetal monitoring during labour
5. Reducing preterm birth
6. Management of diabetes in pregnancy

The Care Bundle is now a universal innovation in the delivery of maternity care in England and continues to drive quality improvement to reduce perinatal mortality. It has been included for a number of years in the NHS Long Term Plan, NHS Planning Guidance, the Standard Contract and the CNST Maternity Incentive Scheme, with every maternity provider expected to have fully implemented SBLCBv2 by March 2020.

ONS and MBRRACE-UK data demonstrate the urgent need to continue reducing preventable mortality. Developed 4 years after SBLCBv2, Version 3 of the Care Bundle (SBLCBv3) has been developed through a collaboration of frontline clinical experts, service users and key stakeholder organisations. All existing elements have been updated, incorporating learning from the Clinical Negligence Scheme for Trusts: Maternity Incentive Scheme (CNST MIS) and insights from NHS England's regional maternity teams. SBLCBv3 aligns with national guidance from NICE and the RCOG Green Top Guidelines where available but it aims to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. SBLCBv3 also includes a new element on optimising care for women with pregnancies complicated by diabetes.

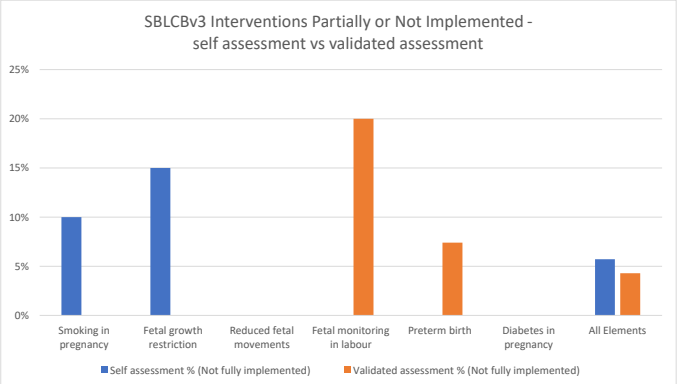
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

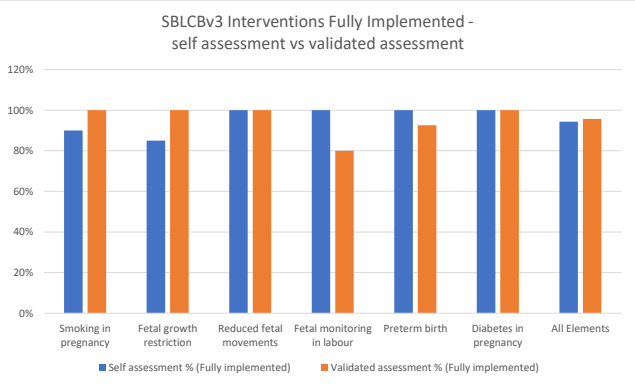
Implementation Grading

Limited Assurance - Activities and control are not suitably designed, or not operating with sufficient effectiveness to provide reasonable assurance that the control environment is effectively managed.

Implementation Progress

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)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Fully implemented	100%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	85%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Fully implemented	100%	Partially implemented	93%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	94%	Partially implemented	96%	CNST Met





Action Plan

Element 1

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
1.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline meets requirements. MSDS DQ check passed in Feb 24. Snapshot audit shows 100% compliance of CO at booking in April 24. Snapshot audit shows 100% compliance of CO at 36 weeks in April
1.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	April 24 audit- 60% (6 of 10 smokers)
1.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline meets requirements. Smoking status at Booking noted at 100% in April 24 snapshot audit. Smoking status at 36/40 noted at 87% in April 24 snapshot audit.
1.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline meets requirements. Opt-out referral rate noted at 100% in April 24 audit so therefore compliant.
1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	NRT supplied by in-reach service
1.6	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	WUTH audit shows 28% set quit date in April 24. ABL data shows 23% set quit date in March 24. WUTH audit shows 17% achieved a 4 week quit in March 24. ABL
1.7	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Clarification received regarding feedback process in collaboration with ABL. WUTH audit shows 92% had feedback in Jan 24, 90% in Feb 24 and
1.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Updated Training compliance noted-96.5% in April 24
1.9	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Updated Training compliance noted-96.5% in April 24
1.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Certificates noted in previous submissions. Please note, Practitioners should complete NCSCT e-learning and assessments annually.

Element 2

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Noted as 100% compliant in March and April 24
2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Noted as 100% compliant in Jan 24. Compliance fell to 90% in Feb/March/April 24 and requires improvement
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	See element 1
2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant Jan-April 24
2.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.6	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	REF2.6- Guideline updated
2.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant Jan-April 24
2.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline validadted by LMNS until June 2024
2.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant Jan-April 24
2.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Overall staff 96% compliance in March and April 2024
2.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.18	Partially implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Q1 of 2024- 46.2% noted in GROW report which meets required compliance at present
2.19	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Antenatal detection of SGA noted as 53.3% for Q1 of 2024 which meets compliance.
2.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Element 3

INTERVENTIONS				
3.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline and Tommys leaflet noted in previous submissions.
3.2	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Computerised CTG audit in April 24 was 100% compliant. USS audit in April 24 was 100% compliant.

Element 4

INTERVENTIONS				
4.1	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	4a (Study Day and K2)- As of April 24: Midwives (93%)150/160, Rotational dr's-(80%) 12/15 and Consultants (92%)13/14 therefore 88% overall which falls below compliance at present.
4.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	March 24 audit shows 95% compliance
4.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	PMRT presentation noted- 1 case had learning from fetal surveillance issues between Jan-March 24.
4.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit 80% compliant in March 24. Compliance of 100% in April 24.
4.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission. Email noted to confirm all roles remain filled.

Element 5

INTERVENTIONS				
5.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	JDs and Job Plans noted for all team members
5.2	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Births 16+0-23+6 was 0% in Jan-April 24 (WUTH SBL dashboard)- LMNS query if this data is accurate Births 24+0-36+6 was 0% in Jan-April 24 (WUTH SBL dashboard)-
5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	100% compliance achieved Feb-April 24
5.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Twins trust audit demonstrates alignment with NICE. Re-audit document noted from September 2023.
5.7	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Evidence noted in 1.1. Progress with Early Pregnancy Intervention in C&M pathway
5.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.9	Fully implemented	Not implemented	Evidence not in place - improvement required.	Shortage of testing kits noted. Please note TVCS my be used with our without qfFN
5.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline noted. WUTH SBL dashboard shows 85% Jan 24, 100% Feb and March 24, 95% in April 24.
5.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Staffing paper noted. CoC powerpoint presentation noted.
5.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.16	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	WUTH SBL dashboard shows 98% in March 24, 100% in April 24, 100% in May 24 (audit sample 27+1 to 34+0). Trust aware of audit requirements as per NWNODN for ongoing
5.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisaton tool states 77% in Feb 24
5.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisaton tools states 100% compliance in Feb 24
5.20	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	44% in March 24 Data also required for steroids >7days before birth
5.21	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Optimisation tool shows 100% compliance with Mag Sulph in Feb 24 Q1 of 2024 NNAP report shows IVH-6.7%, CPVL-0%, PVHD-6.7% in 2023.
5.22	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisation tool shows 100% in Feb 24
5.23	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisation tool shows 78% in March 24
5.24	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisation tool shows 86% in Feb 24 and 83% in April 24

5.25	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisation tool shows 78% in March 24
5.26	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	NWODN Action Plan noted. VTV internal audit noted (100% Feb-April 24)
5.27	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisation tool shows 100% in Feb 24

Element 6

INTERVENTIONS				
6.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
6.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	CGM Audit 100% complaint Jan-March 24. Staff training certificates noted in previous submission (MWs trained
6.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
6.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	100% compliant in Jan-March 24
6.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
6.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission

Appendix 8 - Update on Trust compliance with the Immediate and Essential Actions / Recommendations

			1: WORKFORCE PLANNING AND SUSTAINABILITY	RAG Rating	Comments / Lead Progress
			Full workforce review required in 2022 - Priority to Neonatal and Obstetric Workforce with focus on additional governance related work and training. Neonatal nursing workforce reviewed and additional funding via NODN secured. Midwifery staffing reviewed with BR+ however as per ask re increased uplift for additional training PER HEAD COUNT not wte sme to be reviewed as a priority.		
1: WORKFORCE PLANNING AND SUSTAINABILITY	The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	**1**	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.		Workforce reviews continue 6 monthly to monitor RAG rating of complaince
		2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.		Safety Action 4 and 5 met for CNST Year 5 with all evidence submitted and reviewed by the LMNS for sign off. Action plan in place to achieve Safety Action 4 in Year 6 requiring investment into the Neonatal consultant establishment to demonstrate BAPM compliance; approved via EVC and to be advertised
		3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.		Local uplift to be calculated and compared to BR+ staffing requirements. The uplift of 24% is in keeping with national guidance/local LMNS calculation. Update May 2024 - uplift remains 24%; Birth Rate plus full review to be repeated in Summer 2024 and report will be due Autumn 2024
		4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.		Birthrate+ audit underway and due 30/11/24
	Essential Action : Training				
			Work to update orientation packages for |Band 7 staff with process to allocate a mentor. Decision re NQM with NHSE as moreof a risk. Additional work re support for senior leaders.		
	We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	**5**	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.		National programme being developed however robust preceptorship in place currently. For review once national work completed and recommendation made. Current robust programme in palce and embedded.
		6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.		Shift Coordinators have attended development Programmes including Hiuman Factors training however National Programme awaited. Completion of any national prohramme to be agreed.
		8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.		Orientation pack currently in use but same to be reviewed nationally and to include study time for profrssional development. To continue with current process in the interim.
		9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.		EMC Team based on DS and all midwives have undergone recognised specific HDU training. May 2024 update - continue to develop team and sustain
		10	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		Workforce strategy in place however this will be reviewed and include reference to leadership roles. Compl;eltion date - September 2022; leadership programmes and initiiatves in place
		11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
			2: SAFE STAFFING		
			Escalation policy to be further reviewed re risk assessment specifically for medical Process re assessing staffing in place but review will provide further assurance. This includes review of rotas for Obs and Gynae. RCOG tool to be used once introduced to assess medical staffing. Progress with the roll out of the		
2: SAFE STAFFING	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	**1**	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.		Escalation processes in place and the number of diverts is included on the maternity dashboard. Staffing related incident forms reviewed and reported monthly. Staffing reviewed and reported monthly with Chief Nurse oversight.
		2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.		Completed
		3	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.		Specific job description in place with personal specification. JD has been through matching process.
		4	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.		Jo Lavery and Katherine Wilkinson have reviewed staffing establishments as detailed above - staffing previously has supported CoC - withold complete roll out but continue with partial roll out pending national guidance and regional input. No further teams will be rolled out and an options appraisal prepared to consider next steps.
		5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	N/A	Final position statement on this to be formalised nationally - completion date awaited. Locally MCofC is not withheld - meeting compliance as per staffing numbers.
		6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.		Job plans review in progress Natalie Park, Jon Lund, Mustafa Sadiq and Libby Shaw.to finalise. Review 31/3/23.
		7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.		Facilitators in post to support - guidance awaited re what should be included. Date TBCSarah Weston, Ali Campion, Jo Allen and Karen Cullen
		8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.		Process to be reviewed and agreed with L&D Team within the Trust. Also include specific requirements for appraisals and support for leadership training eg Top Leaders; 4 C's
		9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.		CoC - Engagement, listening events, one-to-one meetings, Block C update, Senior midwife meeting joint with all leads.
		10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.		Locum pack developed and shared across C&M- Libby Shaw and Mustafa Sadiq to check RCOG guidance for locum guidance to further support current process. Locum pack and Gap analysis required with assurance mechanisms. Review following any additional NHSE recomendations.
			3: ESCALATION AND ACCOUNTABILITY		
			Processes in place - same to be auditted with clear SOPs.		
3: ESCALATION AND ACCOUNTABILITY	Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines	**1**	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals		Guidance in place but standalone policy with flowcharts required. Libby Shaw developing SOP as per EBC Guidance. Completion date July 2022.
		2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role		Mustafa Sadiq and Libby Shaw to lead on embedding the Locum package being embedded and evidence of assurance
		3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable		Ward round take place at weekend, twice daily however resident consultant presence not in place 24/7; Added to Risk Register inview of non-compliance but review completed by WUTH therefore no further action required at present.
		4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit		Guidance in place / in policy

	for when a consultant obstetrician should attend.	5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.		Partial guidance in place and currently no dedicated maternity on call rota in place as Trust on call provides OOH cover. Specific Maternity on call put on hold pending further advice and guidance from NHSE in February 2023.
4. Clinical governance and leadership					
			Review of additional resource as detailed above to support. Training in place but to be formalised/auditted.		
4 : CLINICAL GOVERNANCE-LEADERSHIP	Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	1	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans		Mat Neo agenda is in place and other QI work is reported in Governance meetings but there is limited Board oversight - same to be reviewed. Maternty safety champions and regular board meetings. Processes embedded - review in March 2023.
		2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board		Self-assessment tool completed with actons in place and presented to Board. However same to be reviewed following Ockenden and an updated self assessment to go to Board in Sept 2024 to provide continued assurance
		3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services		In place. Structure organogram required
		4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities		In self-assessment tool to include neonates and anaesthetists. Only obstetric time currently supported. Completion date - July 2022; reviwing additional PA's and funding to achieve
		5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		Staff currently trained however review of staff group required and additional training to be identified. For further review in March 2023.
		6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.		Multi-discipinary leads in place. Consultant Midwife coleads with audit/research.
		7	All maternity services must ensure they have midwifery and obstetric co-leads for audits		Audit plan in place - same to be strengthened for Maternity and Neonates.Obstetric leads in place but midwifery leads for the audit plan to be agreed with Mustafa Sadiq Completion date - June 2022.
5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATING AND COMPLAINTS					
			Robust governance processes in place - same to be reviewed with MVP Chair		
5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	1	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.		In place and evidenced. Robust process for reviewing documents before they are sent to families.
		2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.		In place in various forums both internal and external to the Trust
		3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.		Implementation of actions recorded and monitored however audit of same to be reviewed.Link with audit plan
		4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.		Learning put in place immediately. - evidenced on individual reports.
		5	All trusts must ensure that complaints which meet SI threshold must be investigated as such		Clear MDT process in place - SI Panel. Process embedded.
		6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent		Complaint response processes in place however MVP to review and to identify improvements to further strengthen the process
		7	Complaints themes and trends must be monitored by the maternity governance team.		Processes currently in place to incorportae all patient feedback - LEAP to include Feedback Friday - positive and negative feedback and trends to be communicated to all staff.
6: LEARNING FROM MATERNAL DEATHS					
6: LEARNING FROM MATERNAL DEATHS	Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	1	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
7: MULTIDISCIPLANRY TRAINING					
			MDT in place - same to be extended and recorded (ad hoc drills)		
7: MULTIDISCIPLINARY TRAINING	Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	1	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.		Midwifery and middle grades involved in audit - need to expand to neonatal evidence of same and allocated time to be evidenced.
		2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.		SBAR in all training including neonates. Audit of same to be further improved.
		3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.		For all staff attend human factors training however guidance re content awaited from LMNS
		4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.		PROMPT includes all of these topics however all staff groups including neonatal staff to be included in PROMPT - same to be reviewed after national recommendation/s.
		5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.		Jo Allen support for NQM. PMAs. NWAS has toolkit for staff Contact Steph Heyes. Discussed psychological support that was available in ITUs during Covid pandemic - that there was psychological support present at work.This helped staff to attend work becuase they knew the support would be there.
		6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.		Karen Cullen in post for CTG / Fetal Physiology in addition to Ali Campion and Libby Shaw.
		7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory		PROMPT, K2, fetal physiology, CIF meetings, Pass mark for CTG assessment is mandated and reviewed monthly.
8: COMPLEX ANTENATAL CARE					
			Review of High Risk team and support to implement MMN links. Review of preconceptual care and further progress in secondary care.		
8: COMPLEX ANTENATAL CARE	Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	1	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.		Do not currently offer routine pre conception care. Will discuss regionally at what can be offered - will look at what high risk team could provide. Completion date - July 2022; Plan to be developed; Two consultants currently have pre-conception clinics and any referrals sent are accommodated from a specialist referral; Pre-conception counselling education with GP's
		2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019		Twins Trust coming in multi-pregnacy clinic - Mustafa Sadiq is lead.
		3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.		Guidance in place - to link wth Rachel Tildesley and Lauren Evertts. Need to look at audit to support compliance. For FAAP 2023
		4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.		In place but could be subject to audit to demonstrate compliance. For FAAP 2023
		5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).		Guidance in place to support this practice - specific clinic to be reviewed. Audit compliance in March 2023. For FAAP 2023
9: PRETERM BIRTH					
			Both 9 + 10 are in place - audit of processes needed		
		1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.		Policy in place with clear guidance.

9: PRETERM BIRTH	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	**2**	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.		Guidance discussed at time dependant on individual situation. Guidance in place re type of monitoring as per gestation of pregnancy.
		3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.		Regional policy - link in with Angela MacDonald and Sanjeev Rath re any further update
		4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.		Current review of Level 3 neonatal services however as WUTH Level 3 currently this is not applicable.
10: LABOUR AND BIRTH					
10: LABOUR AND BIRTH	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	**1**	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made		Practice in place - Demonstrated in care metrics
		2	Midwifery-led units must complete yearly operational risk assessments.		In place however annual check for 2023 to be undertaken for Deacombe and Eden Suite.
		3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan		All staff included in PROMPT training however schedule of drills to be recorded and ad-hoc taken forward
		4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust		Transfer policy in place regionally and adopted locally - same reviewed and updated with NWAS.
		5	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.		Pathways in place - same being reviewed regionally.
		6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs		Completed and implemented
11: OBSTETRIC ANAESTHESIA					
			Close links with Anaesthetic leads with compliance to standards - same to be auditted		
11: OBSTETRIC ANAESTHESIA	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	**1**	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia		Alice Arch overview: If a post-operative debrief would be useful these can be arranged to be purely or involve a Consultant Anaesthetist and we do this for lots of patients already - we usually offer this at 6-8 weeks post event unless the patient requests it to be earlier or later - and these patients can be referred to the Obstetric Anaesthetic Assessment clinic if they present in subsequent pregnancies; Assurance process developing
		2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.		Currently being undertaken but need to review guidance to ensure all criteria included with audit of same. Completion date - July 2022; part of assurance process 11.1
		3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC		Documentation is recorded in maternity record hwoever need to review audit process. Completion date - July 2022; part of assurance process 11.1; part of assurance process 11.1
		4	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
	Obstetric anaesthesia staffing guidance to include:	**5**	The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.		Staff who do not do regular Obstetric Anaesthesia sessions want to do a Consultant Accompanied CPD session in Obstetric Anaesthesia to keep skills up to date we are more than happy to facilitate this - and several people have already taken up this opportunity. Process to be reviewed. Completion date - July 2022; assurance process to be developed
		6	• The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.		Staffing of same to be reviewed. Completion date - July 2022; assurance process to be developed
		7	• The competency required for consultant staff who cover obstetric services out-of hours, but who have no regular obstetric commitments.		As point 5; assurance process to be developed
		8	• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		All anaesthetists attend PROMPT MDT training; assurance process to be developed
12: POSTNATAL CARE					
			Audit and review of processes / policies re postnatal care		
12: POSTNATAL CARE	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.Postnatal wards must be adequately staffed at all times	**1**	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non maternity ward		Process in place - document to be developed to support process
		2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum		Process in place - document to be developed to support process
		3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary		Process in place - document to be developed to support process
		4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.		Acuity tool used and effective
13: BEREAVEMENT CARE					
13. BEREAVEMENT CARE	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	**1**	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.		Bereavement midwife in post but works Monday to Friday. EMC team upskilled and shift coordinators. With development of bereavement champions in teams. Cover available 24/7
		2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.		EMC staff and coordinators - can be inlcuded in development package for coordinators
		3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome		In place - dual with obstetrics and neonates
		4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway		Pathway in place and in use.
14: NEONATAL CARE					
			Close links with NODN to progress - this links in with the regional transformational work with Exec input to support		
14: NEONATAL CARE	There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers,	**1**	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.		Guidance in place
		2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.		This is a unit with onsite Level 3 NICU
		4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.		Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance
		5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.		Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance

	develop the workforce and enhance the experience of families. This work must now progress at pace.	**6**	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required		Evidence of this happening in practice to be confirmed and to be followed up with Angela McDonald, Adam Brown and Sanjeev Rath
		7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.		NLS Guidance followed - action to be followed up with neonatal team
		8	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.		Staffing review undertaken as above -Adam Brown and Anand to feedback to DMB.
15: SUPPORTING FAMILIES					
			Ensure support covers maternity and neonatal care/services		
15: SUPPORTING FAMILIES	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provisionMaternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	**1**	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.		Perinatal mental health team in post. GIRFT identified need for neonatal support. This is in place regionally
		2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.		Perinatal mental health team in post with further support from Psychiatric Liason team..
		3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care		Psychiatric liaison team and dedicated psychologist to support. WUTH also involved in regional project to further enhance PMH support.

Recommendation reviewed - WUTH ready however awaiting Regional / National Guidance
Fully Embedded
On target to achieve; no risks
Partially Compliant
Non Compliant/risk identified on risk register
NOTE: Completion dates are provisional pending detailed improvement plan.

	Appendix 9 Three Year Single Delivery Plan for Maternity and Neonatal Services - May 2024							
	Theme1: Listening to and working with women and their families with compassion				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 1: Care that is personalised	Personalised care gives people choice and control over how their care is planned and delivered. It is based on evidence, what matters to them, and their individual risk factors and needs	**1**	Women experience care that is always kind and compassionate. They are listened and responded to. Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected. All women are offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices. Plans consider inequalities in the broadest sense, including protected characteristics and Core20PLUS5. The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.		JL	No further action	CQC Patient survey Debrief clinics to go through pregnancy outcomes. Birth Options clinic to evidence discussion of women's preferences Examples of care plans; PMH plans; Risk assessment audits Look at further improving inequalities as per equity and equality plan – Consultant Midwife to support with MNVP involvement.
			2	Women receive care that has a life course approach and preventative perspective, to ensure holistic care for women and the best start in life for babies. This includes NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers, and evidence-based information about screening and vaccination		AK/ER	No further action	Evidence of smoking cessation midwife/work with ABL. Use of NRT. ANNB Screening Programme QA; ANNB Screening action plan to further review screening information
			3	Women have clear choices, supported by unbiased information and evidence- based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Rebirth report, and is co-produced.		AK/ER	31/10/24	No specific work done with Rebirth report – review of same. Clear choices and information is in place including the updated/revamped website. Continue to work with MNVP re equity and equality to ensure all people receiv
			4	All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and foetal medicine networks, and neonatal care, when needed		JKL	No further action	All services with guidelines are in place except perinatal pelvic health services – same being introduced; Set up a perinatal pelvic health service and work closely with LMNS re guidance/requirements; funding secured and JD to be matched; initial discuss with PPHS lead and service to be set up at WUTH; in post setting up services
			5	Women experience personalised, joined-up, high-quality care right through to the postnatal period with handover to health visiting services and a GP check 6-8 weeks after birth. They are provided with practical support and information that reflects how they choose to feed their babies		KW	31/10/24	Processes in place although clarity needed regarding 6-8week GP check post pandemic; Check with HV team re GP follow up check
			6	Parents are partners in their baby's care in the neonatal unit through individualised care plans utilising a family integrated care approach, together with appropriate parental accommodation.		ST/AMC	No further action	FI Care review undertaken with action plan developed following feedback positive in May 2022; repeated in May 2023 and GREEN accreditation achieved
			7	Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units		AK/ER	No further action	Bereavement midwife in post. Bereavement Suite on site. Use of Ron McDonald House is also an option that is used
	Objective 2: Improve equity for mother and babies	The NHS approach to improving equity (Core20PLUS5) involves implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived area It is the responsibility of trusts to: Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings.	**8**	To reduce inequalities for all in access, experience and outcomes		JL	30/9/24	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed; Further work re equality to be undertaken
			9	Targeted support where health inequalities exist in line with the principles of proportionate universalism		JL	30/11/24	MCoC teams to be set up as a wraparound service but the support is already in place from these Leads; MCoC teams in place and embedded in the identified areas; review MCoC
			10	Services listen to and work with women from all backgrounds to improve access, plan and deliver personalized care. Maternity and Neonatal voice partnerships ensure all groups are heard, including those most at risk of experiencing health inequalities.		JL	No further action	
			11	The NHS collaborates with local authority services, other public sector organisations (NHS Constitution Principle 5, 2021) to address the social determinants of health, which are a significant driver of health inequalities (WHO, 2022)		JL/KW	31/10/24	Maternity services to work with PLACE; LMNS and ICB leads to progress
			12	In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services		JL/MB	30/6/24	To achieve requirement to work with the LMNS to meet and no local prisons feed into WUTH; consider a SoP with safeguarding midwife involvement
	Objective 3: Work with service users to improve care	Acting on the insights of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through maternity and neonatal voices partnerships (MNVPs) and by working with other	**13**	MVNPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.		JL	No further action	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed; Further work re equality to be undertaken as detailed above
			14	MNVPs have strategic influence and are embedded in decision making		JL	No further action	MIS evidence supports work and undertaken and co-production
			15	MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formally MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.		JL	No further action	MNVP embedded; full funding of post with agreed workplan from ICB awaited; local workplan in place
	Theme 2: Growing, retaining and supporting workforce				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 4: Grow our workforce	The maternity and neonatal workforce encompasses a wide range of professions, including midwives, maternity support workers, obstetricians, anaesthetists, neonatologists, neonatal nurses, sonographers, allied health professionals, and psychologists. Growing our workforce requires the tailoring of interventions to professional groups, career stage, and local requirements	**16**	Workforce capacity to grow as quickly as possible to meet local needs.		JL	No further action	Workforce plan in place with report to Board every 6 months
			17	Local and national workforce planning to utilise evidence-based tools, endorsed by NICE or the National Quality Board (NQB), that allow for medical and social complexity, training,		JL	No further action	Nursing and Medical workforce planning tools used. BR+ Report in date. Also work with regional Leads
			18	Aligned local and national strategies supporting recruitment to those vacant posts identified through workforce planning		JL	No further action	No specific work done with Rebirth report – review of same. Clear choices and information is in place including the updated/revamped website. Continue to work with MNVP re equity and equality to ensure all people receive information they understand.
	Objective 5: Value and retain our workforce	Our maternity and neonatal staff perform critical, life-changing work every day. We must ensure they are valued and have a fulfilling and sustainable career within the NHS. We need to do more to improve the experience of all our staff, to retain them within the NHS	**19**	Staff feel valued at all stages of their career. This includes support to get off to a good start, opportunities for progression and flexible working, and support when approaching retirement age to allow staff to continue to use their skills and experience.		JL	No further action	
			20	All staff are included and have equality of opportunity		JL	No further action	
			21	A safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination		JL/NP/MS/AK	Ongoing annually	Score survey undertaken for Maternity and Neonates; feedback sessions in November 2023; staff engagement April 2024
	Objective 6:	Staff feel valued when they are supported to develop. We are investing in our staff by ensuring they have ongoing training and career	**22**	All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development		JL	No further action	Evidence collated for Ockenden improvement plan

	Invest in skills	development opportunities. Effective training of frontline clinicians in technical and non-technical skills has been shown to improve outcomes.	**23**	All staff have regular training to maintain and develop their skills in line with their roles, career aspirations, and national standards. Training is multi-disciplinary wherever practical to optimise teamworking		JL	No further action	TNA in place and reviewed annually
	Theme 3: Developing and sustaining a culture of safety, learning and support				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 7: Developing a positive safety culture		**24**	All staff working in and overseeing maternity and neonatal services: -Are supported to work with professionalism, kindness, compassion, and respect. Are psychologically safe to voice their thoughts and are open to constructive challenge. -Receive constructive appraisals and support with their development. -Work, learn and train together as a multi-disciplinary team across maternity and neonatal care.		JL	No further action	MDT training in place. TNA supports training requirements incl psychological safety. Appraisal process in place with good compliance monitored at Board level.
			25	Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.		JL	No further action	Training in place to support
			26	There is a shared commitment to safety and improvement at all levels, including the trust board, and attention is given to 'how' things are implemented not just 'what'		JL	No further action	Evidenced through safety champions meetings; Newly formed divisional MatNeo Assurance Board
			27	Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.		JL	No further action	Trust training and policies support professional behaviour/s. Disciplinary processes support appropriate action when needed
			28	Systems and processes enable effective coordination, rapid mobilisation, and supportive communication based on agreed principles. The team can escalate concerns and, should there be a disagreement between healthcare professionals, they will be supported by a conflict of clinical opinion policy.		JL	No further action	Policy in place – provided for Ockenden evidence
			29	Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief		JL/DC	No further action	Training in place for staff and this is reviewed and provided by the Trust Governance team
	Objective 8: Learning and Improving	Staff working in maternity and neonatal services have an appreciation and understanding of 'what good looks like.' To promote safer care for all, we must actively learn from when things go well and when they do not. To do this, we need a continuous learning and	**30**	Our ambition is framed by the patient safety incident response framework (PSIRF) which provides a consistent approach across clinical specialties, including for maternity and neonatal services		JL/DC	No further action	PSIRF launched in the Trust September 2023; nataional guidance awaited specific for maternity services; embedded
			31	The Healthcare Safety Investigation Branch undertake investigations of incidents which meet their criteria		JL/MD	No further action	MNSI quarterly meetings take place and Trust evidenced 100% reporting by the Trust
	Objective 9: Support and oversight	While some trusts and ICSs do effectively support their maternity and neonatal services to improve and change; others do not. Good oversight is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise	**32**	Robust oversight through the perinatal quality surveillance model (PQSM) that ensures concerns are identified early, addressed, and escalated where appropriate		JL	No further action	Evidence Monthly PQSM report to Board with quarterly detailed maternity /neonatal reports presented
			33	Well led services, with additional resources channelled to where they are most needed		JL	No further action	CQC visit supported well led service at last inspection. Other evidence / outcomes also support
			34	Leadership for change, with a focus on ensuring new service models have the right building blocks for high quality care, especially the workforce.		JL/NP/MS/SR	31/12/24	Leadership training in place and underway x various programmes for Senior Leaders, Quad perinatal leadership programme
	Theme 4: Standards and structures that underpin safer, more personalised and more equitable care				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 10: Standards to ensure best practice	Advances in clinical practice have been crucial in the improvement in maternity and neonatal outcomes over the last decade. Better Births also identified that variation in protocols, policies, and standards between services creates additional burden and hinders the ability to work together to provide effective care.	**35**	Consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities		JL/MS	31/3/25	MIS year 5 submitted and confrimation of all 10 safety actions; SBLv3 implemented 97%; review of MCoC to address women with inequalities; MIS Year 6 published and in progress
			36	Healthcare professionals have access to shared standards and guidelines, including transfer, transport, and referral protocols, so that clinical teams across the ICS work to the same definitions of best practice		JL	31/10/24	Ongoing work with ICB; timeframes to be set
			37	Where local policy varies from national standards, this is subject to careful local scrutiny through governance processes. The whole multidisciplinary team is involved when developing local guidance		JL	No further action	Processes in place to ensure MDT are involved with developing local policy
			38	Policies and guidelines recognise women as the decision-makers in their maternity care and are not used to prevent women from seeking care that is outside these guidelines		AK/ER	No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
			39	Neonatal care is provided in units with clear designation of the level of care to be provided. Units work together across ODNs to optimise capacity and ensure care can be provided in the right place for very pre-term or very sick babies		Leads	No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
	Objective 11: Data to inform learning	The Kirkup report highlighted the need for accurate, up to date data to highlight safety issues promptly. Such data enables providers to learn and act. Work is underway to review what data is needed for monitoring, and in the meantime, the NHS should continue to use the data it already collects	**40**	Standardised data is collected in a consistent way, primarily through the Maternity Services Data Set. Additional data collections are minimised, to focus on gathering the right data to drive insights, understanding and assurances.		JL	No further action	MSDS submitted in addition to completion of a local and regional dashboard
			41	Monitoring trends at both national and local level is enabled by analysing data from different sources alongside themes from MBRRACE-UK , and the national clinical audits patient outcome programme reports		DC	No further action	LMNS support in leading on monitoring trends regionally. Outlier reports are presented to Board quarterly; Improvement plans are developed to address any outlier reports
			42	The national maternity dashboard provides demographic data, clinical quality improvement metrics and national maternity indicators enabling trusts and LMNSs to benchmark their services and inform continuing quality improvement work		JL/DC	No further action	Data submitted to national dashboard; Given limited metrics the national dashboard is not currently reviewed – work to be identified to address an improvement moving forwards.
	Objective 12: Make better use of digital technology	Digital technology will make it easier for women to access the information they need and for services to offer safe and personalised care. There is currently significant variation in the use of digital technology. While some maternity services remain almost entirely paper-based, others support personalised care with apps and benefit from an integrated electronic patient record (EPR).	**43**	Women can access their records and interact with their digital plans and information to support informed decision-making. Parents can access neonatal and early years health information to support their child's health and development. Information meets accessibility standards, with non-digital alternatives available for those who require or prefer them		JL/HW	31/12/24	Processes in place for women to access their records electronically – work to progress to roll out patient portal.
			44	All clinicians are supposed to make best use of digital technology with sufficient computer hardware, reliable WI-Fi, securing networks and training			No further action	Full IT system in place and supported with equipment
			45	Organisation's enable access to key information held elsewhere internally or by partner organisations, such as other trusts and GP practices			No further action	Work across Wirral with the introduction of the single care record is supporting this

Appendix 10

Board of Directors in Public

04 September 2024

Title	Midwifery Staffing Update
Area Lead	Sam Westwell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing & Director of Midwifery (Women's and Children's)
Report for	Information

Executive Summary and Report Recommendations

Executive Summary

As part of the Maternity Incentive Scheme (MIS) there is a requirement to evidence a midwifery staffing review therefore the BR+ review of current midwifery staffing within the maternity service will contribute to the compliance with the requirements of the MIS (Year 6).

As part of the Maternity Incentive Scheme (MIS) published in April 2024 there is a requirement to provide the Trust Board evidence the midwifery establishment is reflective of the evidence-based process (BR+). This will be included in the Monthly Maternity Report to Board of Directors in September 2024 and January 2025.

There is a requirement for providers to change the current model of care delivered within maternity services nationally, through the transformation Programme to that of a continuity of carer model. The final BR+ report identifies a need for additional midwifery staffing to enable progression of a continuity of carer model of care.

It is recommended that the Board of Directors:

- Note the report
- Support the recommendations to explore and identify the funding to secure the workforce model to be able to continue to deliver the maternity continuity of carer model in line with Better Births (2016) and the national ambition with a focus on women/birthing people who are in vulnerable groups.

Key Risks

This report relates to these key risks:

BAF references 1,2,4 and 6
Positives:

- The Trust has several processes that review and record patient quality indicators, incidents and patient experience metrics monthly against staffing data to identify emerging risk/s. This includes a monthly midwife to birth ratio recorded on the maternity dashboard.
- The Trust fulfils its duty to undertake 6 monthly establishment reviews including an update on midwifery staffing. The Trust has also supported a BR+ review at least every 5 years as a minimum, however suggested recommendation is every 3 years.

- The Division uses the BR+ acuity tool to undertake acuity and dependency reviews on Delivery Suite every 4 hours. This has been extended for use on the maternity ward and a LMNS regional platform informing staffing, acuity and dependency.
- The Division has safe staffing governance with a clear process of escalation both locally and across Cheshire and Merseyside.

Negatives:

- The Trust having two models of care for the provision of MCoC which is inequitable, and which has additional implications and risks.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

1	Narrative
1.1	**Background** Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG. Current processes within the maternity service ensure that on a 24/7 basis staff are deployed effectively within the service, including the flexing of staff across both the acute and community care settings including the maternity continuity of carer teams. Staff working on Delivery Suite use an acuity tool that formally assesses acuity on Delivery Suite every 4 hours as a minimum. At times of high acuity, the tool is used more frequently to assess acuity, and reports into a regional platform that was launched in September 2022. Weekly staffing reports are generated from the acuity data, and whilst this does predominantly focus on staffing within Delivery Suite the acuity tool is being expanded to include staffing across all inpatient areas. Monthly staffing reports are generated and shared by the Local Maternity and Neonatal System (LMNS) on this data regionally.

	It is proposed that these reports will further inform and provide assurance regarding safe maternity staffing and will provide assurance to all Maternity Safety Champions including the Executive and Non-Executive Safety Champions who are required to have oversight, assurance and visibility of safe staffing within the maternity service. Currently the quarterly maternity update to the Board of Directors includes reference to maternity staffing and a Divisional nurse / midwifery staffing update is also included in the 6 monthly nurse staffing paper that is presented at the Board of Directors meeting.
1.2	**Current position** The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour. Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwifery led units through to regional tertiary centres, with birth rates ranging from only 10 births annually through to those that have in excess of 9000 births. In addition, it caters for the various models of care in existence, including a traditional model, community-based teams and continuity of carer/caseload teams. Birthrate Plus® is the most widely used tool for workforce assessment classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide inpatient/outpatient antenatal care, intrapartum and postnatal care in either WUTH, community or neighbouring maternity unit. The method used works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick & study leave allowance and for travel in community**.** The last full Birthrate Plus full analysis and report was undertaken in 2021 and in the last three years women/birthing people have more complex needs. In view of a rising c/section and induction of labour rates along with the CQC recommendation to ensure two midwives in maternity triage at times of high acuity a repeat is underway and a report with recommendations to ensure maternity safe staffing levels is anticipated by November 2024.
1.3	**Maternity Incentive Scheme (MIS) Safety Action 5 Required Standards:** 1. The allocated midwifery co-ordinator in charge is been supernumerary at the start of every shift. In the reporting period from January to June 2024 the midwifery co-ordinator has been supernumerary at the start of every shift. 2. The midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service.

	There were 11 occasions over 6 months throughout the 24-hour reporting period from January to June 2024 (Q4 23/24 and Q1 24/25) the midwifery coordinator reported being unable to maintain supernumerary status. This is reported as short-term until the interim plan of the caseload being handed over with the initiation of the continuity midwife arriving or escalation processes followed to ensure further midwifery staff to rectify and ensure the midwifery co-ordinator resumes oversight of all the birth activity within the service. 3. Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staff. The maternity service has robust escalation processes to manage short falls in staffing level during periods of high acuity. 4. The midwife: birth ratio The midwife to birth ratio is reported monthly within the maternity dashboard and has been RAG rated green during the period from January to June 2024 in line with NICE guidance and safe maternity staffing levels. 5. The percentage of specialist midwives employed and mitigation to cover inconsistences. Birthrate plus incorporates a review of specialist midwives employed and the roles are in line with the recommended 10%. The trust has recruitment the additional Pelvic Specialist Midwife post (0.4WTE) in line with the recurrent funding received from NHSE as supported from the Three-Year delivery plan. 6. The provision of all women receiving one to one midwifery care in active labour is reported at care in labour. Maternity services from the period January to June 2024 reports via the Birthrate plus platform 100% of women receiving one to one care in active labour.
1.4	**Continuity of Carer:** The paper is explicit in the need to for Trusts to provide a model of care providing continuity of carer to women during the whole maternity episode. This model of care was initially detailed in Better Births in 2016 and included in the National Maternity Transformation Programme given its evidence based providing improved outcomes for mums and babies. The target date to deliver 100% continuity of carer had been removed, instead providers were requested to develop local plans that work for them ensuring staffing requirements are met along with an upskilled workforce. WUTH had previously submitted a plan with an ambition to achieve by MCoC as the default model by June 2024. Adaptations have been made to the plan in line with the current workforce, safe staffing levels and achieving 50% of women offered this model of care and those in the vulnerable groups are majority included. The benefits of a woman being cared for by the same team of midwives throughout her pregnancy including the delivery and following cannot be underestimated. Clinical outcomes are improved with this model of care, with women reporting positive birth experiences and with the woman less likely to experience postnatal illness. A woman who receives care from a known midwife is more likely to: • Have a vaginal birth

	• Have fewer interventions during birth • Have a more positive experience of labour and birth • Successfully breastfeed her baby • Cost the health system less • Less likely to experience pre-term birth • Less likely to lose their baby before 24 weeks gestation Considering pre-term birth alone, it is well evidenced that the high rates of morbidity and mortality arising from preterm birth impose a considerable burden on finite health care resources. Preterm infants are at increased risk of a range of adverse neonatal outcomes including chronic lung disease, severe brain injury, retinopathy of prematurity, necrotizing enterocolitis and neonatal sepsis. In later life, preterm infants are at increased risk of motor and sensory impairment, learning difficulties and behavioural problems. The economic consequences include the costs of neonatal care as well as the costs associated with living with disabilities. There is a substantial literature on the short and (to a lesser extent) long term clinical consequences of prematurity. The total cost of preterm birth to the public sector has been estimated to be £2.946 billion. The average cost of a pre-term birth and the provision of care is £100,000k which considers 4 weeks ITU care, 4 weeks HDU care and 2 weeks SCBU prior to discharge. This does not include the financial burden of complex investigations, tests and the long term. The incremental cost per preterm child surviving to 18 years compared with a term survivor was estimated at £22885. The corresponding estimates for a very and extremely preterm child were substantially higher at £61781 and £94740, respectively. The Trust has five embedded teams and at present no further teams are anticipated, however in line with national guidance this will be closely monitored. WUTH is undertaking its own research based on models of care and outcomes. Should any ambition in the future to roll out as the default model funding to increase staffing levels and would be required in line with recommendations from Birthrate Plus.
1.5	**NHSE Bid** The planning Guidance for 2021-22 specifically referenced additional funding for maternity services of £95million – Service Development Funding (SDF) extending to £137million in 2022-23. A detailed bid based on midwifery staffing requirements was submitted to NHSE for consideration given the requirements outlined in the Ockenden report. WUTH was successful in its bid to secure additional funding however, the process for distributing Ockenden funding changed between 2021/22 and 2022/23. In order to ensure recurrent funding, the monies were distributed regionally on a fair share basis, and has been allocated to the ICB rather than directly to individual Trusts resulting in a mismatch to the funding allocated last year. Funding allocated to Cheshire & Merseyside ICB for 2022/23 is £3,731,000 which is slightly more than the total FYE allocated to all C&M Trusts last year, however, is the decision regarding the allocation of funding sits with the ICB and the LMNS in deciding which is the best and most sustainable way to split this funding between Trusts. The recurrent funding received in 2024/25 totalled £462k (in line with the revised allocation from the ICB). WUTH maternity services were also allocated £165k for Ockenden II workforce to include retention, bereavement services, maternity support work

investment, preceptorship and obstetrics. Organisations offering full enhanced maternity care were also allocated funds equating to £240k.

The LMNS/ICB have outlined a financial review will be undertaken in Quarter 3 to ensure all LMNS finances have been committed and spent as specified.

1.6 **Findings**

The BR+ Report was based on a 24% uplift to reflect the additional training requirements included in Year 4 of the MIS, (which equated to an additional 40hours per annum per midwife) and was based on the following:

Based on initial 2020 activity and delivering 36% Continuity of Carer the clinical total recommended for Wirral University Teaching Hospitals NHSFT is 137.61WTE, of this 123.85WTE are Registered Midwives bands 5 -7 and 13.76WTE are MSWs providing postnatal care (on the ward/community). This equates to a total of 151.37WTE. The comparative current funded establishment is 141.23WTE which meant there was a variance of 10.14WTE as funded.

Based on current activity and delivery of 45-51% Continuity of Carer the clinical total recommended for Wirral University teaching Hospital is 141.42 WTE, of this 123.49 WTE are Registered Midwives Band 5-7 and 17.93 WTE MSW's providing post-natal care (on the ward/community). Band 8 roles have not been included as they are specialty roles and do not contribute to the delivery of MCoC.

The current establishment in accordance with Birth rate plus confirms and provides assurance of safe staffing levels to deliver MCoC up to 65%, currently approx. 60% of women are in the model of care.

Table 1 summarises further the comparison between Birthrate Plus WTE with current funded WTE.

	BIRTHRATE PLUS WTE Bands 3 to 7	**CURRENT FUNDED WTE** Bands 3 to 7	**VARIANCE with current WTE**
Core Services and with Continuity Teams at 55%	138.69	141.42	+2.73
Core Services and with Continuity Teams at 75%	142.81	141.42	-1.39
Core Services and with Continuity Teams at 100%	152.25	141.42	-10.83

Additional WTE required to meet 100% Continuity of Carer - Table 1

- The NHSE bid supported 10.1WTE funding and WUTH have been able to deliver MCoC to 50-55%.
- No changes will be made to the current model until the Birthrate plus report is available by November 2024.

1.7	**Conclusion** The current staffing model meets the requirements of the last Birthrate Plus recommendations for safe staffing. Midwifery staffing is compliant with the recommendation from both Ockenden and Birthrate Plus. In view of changes a repeat is underway and will be available in November 2024 and an update will be included in the next midwifery staffing paper. Options for maternity models of care have been considered and in line with national guidance maternity continuity of carer teams will continue for women/birthing people with enhanced needs. The allocated funding to maternity services will be spent as specified and for its intended purpose to maintain quality and safety.

2	**Implications**
2.1	**Patients** • There is some risk to patient care and safety in having two models of care as an equitable service is not being delivered, however positive outcomes are evident in women with enhanced needs being on an MCoC pathway. • Patient experience within both models of care is positive and there have been no relating complaints to either. • Ensuring stability and structure with minimal disruption to both models provide continuity antenatally and postnatally.
2.2	**People** • It would not be safe or possible to continue the roll out of this model without securing the additional resource in line with the Birthrate plus recommendations and a skilled workforce. • A two-model approach to midwifery care impacts on wellbeing and employee experience. Internal escalation process is utilised to mitigate, and revised working patterns/escalation processes have been embedded
2.3	**Finance** • The financial impact to deliver the model of care as the default would have financial implications. • Birthrate plus report could recommend a revised staffing model to ensure safe staffing and could have a financial impact.
2.4	**Compliance** • Better Births (2016) recommendations is to improve continuity of carer, teams have been set up across Wirral University Teaching Hospital (WUTH) meeting the current national drive.

Wirral University Teaching Hospital NHS Foundation Trust

Appendix 11

Board of Directors in Public

04 September 2024

Title	Neonatal Staffing Update – A review of the Neonatal Nursing and Medical Workforce
Area Lead	Sam Westwell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing & Director of Midwifery (Women's and Children's)
Report for	Information

Executive Summary and Report Recommendations

Executive Summary

The purpose of this paper is to provide an annual update as to neonatal nursing and medical staffing requirements. The paper also includes an update on the requirements in line British Association of Perinatal Medicine (BAPM).

The report further identifies the staffing requirements to meet all the BAPM standards and the actions being taken to meet safety action 4 of the Maternity Incentive Scheme (MIS) Year 6 compliance.

The paper describes how WUTH are currently performing against the standards, and outline plans to address gaps in the workforce.

It is recommended that the Board of Directors:

- Note the report
- Support the recommendations within the report to meet BAPM standards

Key Risks

This report relates to these key risks:

BAF references 1,2,4 and 6
Positives: -

- The Trust has several processes that review and record patient quality indicators, incidents, and patient experience metrics monthly against staffing data to identify emerging risk/s. These are reported monthly on the neonatal dashboard.
- The Trust fulfils its duty to undertake 6 monthly establishment reviews.
- The Division has safe staffing governance with a clear process of escalation both locally and across Neonatal network.

Negatives: -

- If the BAPM standards are not met there is a risk to the Trust's reputation and maintaining Level 3 status.
- Failure to meet these standards will result in the unit being unable to provide gold standard care as per best practice recommendations of BAPM.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

1	Narrative
1.1	**Level 3 Neonatal Unit Wirral University Teaching Hospital** Neonatology is a vibrant, progressive specialty and services will continue to change, both in terms of organisation and workforce. Outcomes for babies and families in our care improve year on year and although in many neonatal units facilities for parents are less than optimal, the role of parents as partners in their baby's care is rightly gaining widespread acceptance in UK neonatal practice. Neonatal care in the UK should continue to be provided under a network model, with centralisation of care for the smallest and sickest babies. It is essential that core activity levels are maintained in both neonatal intensive care units (NICUs). NICUs (formerly Level 3 units) should admit at least 100 very low birth weight (VLBW) babies per year and undertake at least 2000 intensive care (IC) days per annum. **Neonatal categories/levels of care** • Intensive care: care provided for babies who are the most unwell or unstable and have the greatest needs in relation to staff skills and staff to patient ratios. E.g. any form of mechanical respiratory support via a tracheal tube; *both* non-invasive ventilation and parenteral nutrition; British Association of Perinatal Medicine (BAPM 2011) Categories of care. • High dependency care: care provided for babies who require highly skilled staff but where the ratio of nurse to patient is less than intensive care. BAPM 2011. • Special care: care provided for babies who requires oxygen by nasal cannula; feeding by nasogastric tube, jejunal tube or gastrostomy; has an intravenous cannula; or has any of a number of interventions as described in BAPM 2011. • Transitional care: neonatal transitional care (NTC) care provided by the mother or an alternative resident carer and a health care professional trained in delivering elements of neonatal special care but not necessarily with a specialist neonatal qualification.

	Based on: British Association of Perinatal Medicine (2011) Categories of care and British Association of Perinatal Medicine (2017) A Framework for Neonatal Transitional Care
1.2	**Part 1 - Neonatal Nursing Workforce** **Background** **Neonatal Nurse Staffing Toolkits/ Standards** The Toolkit for High Quality Neonatal Services, the NCCR, Getting it Right First Time (GIRFT) reports and other documents produced describe the anticipated pattern of medical, nursing and allied health professional staff cover in different types of NNU. These recommendations have been further developed within the BAPM Frameworks for Practice for NICUs, LNUs and SCUs. The chance of survival of the smallest and most preterm babies relates not only to nurse staffing ratios but also to the specialist levels of education and experience of nurses delivering care. The nursing role has, through enhanced skills and both advanced and consultant practice status, become increasingly integrated with the work of doctors. Networks should ensure that demand for training and development of specialist, enhanced and advanced neonatal nurse practitioners is met and workforce planning secure. Specialised neonatal nursing requires specific knowledge and skills. All new nurses and midwives should undertake an induction programme which relates specifically to the care of the neonate and their family within a neonatal service. All nurses attending deliveries and/or involved in direct clinical care of the neonate should have undertaken a Newborn Life Support course appropriate to their role as recommended by the Resuscitation Council UK (22) and receive regular training updates. **Neonatal Nurse Staffing Levels for Direct Patient Care** The following recommendations are based on professional consensus. They outline the numbers of nursing staff that should be available on each shift. Variations in the time available to each baby may occur, *e.g.*, during nursing staff breaks or over the initial period of admission of a baby. Because of the acute nature of neonatal practice and the difficulty of predicting patient activity, there will be times when recommended nurse staffing levels are not able to be met, and conversely time when the nursing staff provision is more generous. It is essential that the *average* nurse: patient ratio meets recommended standards. During periods of high activity, it will be necessary to consider multiple factors in deciding if the available nursing staff complement is safe, or if the NNU needs to close. Recommendation staffing levels • Intensive care 1:1 • HDU 1:2 • Special Care 1:4 • TC 1:4

WUTH Nursing Staffing Metrics based on BAPM standards (all data is shared monthly with the Cheshire and Mersey Neonatal Nurse Operational Development Network (NNODN)

Month	NNU_ Unit Level	% Shifts Staffed to BAPM Recommendations	% Shifts with Team Leader	Average nurses on shift	Average nurses required on shift
October 2023	3	94	90.4	8.14	6.34
November 2023	3	93	90	8.7	7.06
December 2023	3	61	69	9.3	9.6
January 2024	3	75.8	56.45	8.7	8.65
February 2024	3	46.5	63.7	7.8	7.78
March 2024	3	45.1	66.12	8.1	8.57
April 2024	3	66.6	85	8.6	7.8
May 2024	3	98.3	95.16	8.35	6.52
June 2024	3	90	96.6	9.02	8.18

To note the figures for % shifts staffed to BAPM recommendations will not be accurate when a higher ration of nurses per patient are on a shift.

BAPM Service and Quality Standards For The Provision Of Neonatal Care In The Uk (2022)

This report will describe how we are currently performing against the standards, and outline plans to address gaps in the workforce.

Standard One: **BAPM Standard Neonatal Nursing Staff – Qualified in Specialty (QIS)**

Description: 59 Qualified Staff in total. Total QIS figure is 68.58% of all qualified staff. Band 7, 8 Staff 100%. Band 6, 26 Staff 100%. Band 5, 22 Staff 1%

Planned Development

August 2024 4 staff are currently awaiting QIS competency outcome results.
A total of 50 staff have completed the FIN programme

Status – Complaint

Standard Two**: Nurses QIS Working in Roles with Enhanced Practice Skills (ENNP)**

Description: Enhanced practice roles exist where QIS nurses have undergone additional training and education.

Status – noncompliant

Standard Three**: Advanced Neonatal Nurse Practitioners (ANNPs)**

Description: ANNPs are now highly valued and indispensable members of most neonatal teams. The BAPM ANNP Capability Framework details development in seniority across four pillars of practice.

Currently 5.61wte band 8a ANNP. Two trainee ANNP completed training in January 2024. This is followed by a one-year preceptorship. Two staff commenced ANNP training at Salford University in January 2023. The 2024 funding request to NHSe for funding for NNAP has been completed in June 24, we are awaiting the outcome of this request.

Status - Compliant

***Standard Four*: Neonatal Consultant Role**

Description: The nurse consultant role is likely to include involvement in education, training and support of members of the neonatal team across a network as well as designing and delivering audit and clinical research projects with a specialist expertise in one area of practice. A job description has been produced in a draft format.

Status - Noncompliant

***Standard Five:* Other Clinical Staff Undertaking Nursing Roles**

Description: This would include but is not exclusive to nursery nurses, maternity care assistants and neonatal support workers. We have 9.2wte neonatal support workers for the service this includes support of the TCU.

Status – Compliant

***Standard Six*: Additional Nursing Roles**

Description: Identified nurses acting as champions for the quality of practice within each unit should have protected time and responsibility in the following areas:
• Infant feeding
• Family care.
• Developmental care.
• QI in perinatal optimisation.
• Safeguarding children.
• Bereavement support and palliative care.
• Discharge planning and outreach nursing

Status – Non-Complaint Gap analysis enclosed

Neonatal Nursing as per BAPM Guidance.d

Current position

- As stated above, WUTH NNU are compliant in 3 of the 6 BAPM standards for nurse staffing. WUTH is currently non-complaint with the enhanced roles of ENNP, Nurse consultant and specialist roles i.e., BFI nurse. To be noted in 2023

	1.61 wte educators had been supported in post, however currently we have only 0.8wte is in post. The recommendations for the unit from the NWNODN would be 2WTE (band 7 and band 6) The unit has benefited by the employment of highly skilled and experienced international nurses, whom have a wide variety of skills and competencies to support the neonate. The employment from funds received from the NNODN of the 0.4 wte clinical psychologist to support the health and well-being of the family and staff members and 0.4wte occupational therapist to support the development requirements of the neonate. The cultural benefits of this professional staff group working within the department is key to Family integrated care and staff health and well-being. **<u>Maternity Incentive Scheme (MIS) Safety Action 4</u>** As part of the Maternity Incentive Scheme (MIS) there is a requirement to demonstrate that as a trust we are fully compliant with all BAPM Service and Quality Standards For The Provision of Neonatal Care In The UK (2022). Failure to meet these standards will result in the unit being unable to provide gold standard care as per best practice recommendations of BAPM. **Previous Actions to address Gaps in Compliance** • Funding was identified in 23/34 to provide a full-time Neonatal Matron. The vacancy has been recruited into and the postholder is in post. • Funding was identified in 23/24 to provide a full time BFI lead. The vacancy has been recruited into and the postholder is in post. **Actions:-** **Other considerations:** • The support of nurses to undertake the QIS should continue with 2 staff per year. • International staff members should be supported to undertake the FIN programme facilitated by the NNODN. • Internal recruitment from international nurses employed by WUTH whom are currently employed in all adult care environments should be supported to gain employment on the NNU. • Increased student placements to support and raise awareness of education and training available for student the NNU should be promoted. • The role of the ENNP should be explored to support advancement of skills and knowledge of staff who have completed the QIS. • Appointment of an information analysist/ quality improvement nurse should be priorities to support data quality/production for internal and external stakeholders.
1.3	**<u>Part 2 – Neonatal Medical Workforce</u>** **Medical staffing** BAPM standards for Neonatal Intensive care Units (NICU) medical staffing are as follows: -

***Standard 1* - All tiers separate rota compliance**

Description - Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have separate cover at each level of staff at all times.

Status – Compliant

***Standard 2* - Tier 1 separate rota compliance 24/7**

Description - Tier 1 staff (ANNP or junior doctor ST1-3) should be available 24/7 and have no responsibilities outside of neonatal care.

Status – Compliant

***Standard 3* - Tier 2 separate rota compliance 24/7**

Description - Tier 2 staff (ANNP or junior doctor ST4 and above) should be available 24/7 and have no responsibilities outside of neonatal care (including neonatal transport).

Status – Compliant

Standard 4 - **Tier 3 separate rota compliance 24/7**

Description - Tier 3 (consultant) staff available 24/7 with principal duties, including out of hours cover, are to the neonatal unit.

Status – Compliant

Standard 5 - Tier 3 presence on the unit

Description - Tier 3 (consultant) presence on the unit for at least 12 hours per day (generally expected to include two ward rounds/handovers).

Status – Working towards full compliance.

The NNU is compliant Monday to Friday, however, was non-compliant at weekends and bank holidays as only x 4 hours of on-site cover provided as standard. Included in the action plan for Safety Action 4 was to prepare a business case for approval and recruitment into the post to meet the standard. The funding has been identified, the business case approved, and the post is out to advert.

<u>Current Position</u>

	As stated above, WUTH will be compliant in all 5 BAPM standards for medical staffing. **Maternity Incentive Scheme (MIS) Safety Action 4** As part of the Maternity Incentive Scheme (MIS) there is a requirement to demonstrate that as a trust we are fully compliant with all BAPM medical staffing standards. Failure to meet these standards will result in the unit being unable to provide gold standard care as per best practice recommendations of BAPM. **Actions to Address Gaps in Compliance** No further actions identified. **Other Considerations** Whilst we are 100% compliant in the provision of Tier 1 & 2 rotas against BAPM standards, this is at times achieved through the use of locum shifts and sometimes necessitates consultants stepping down into junior tiers. This is both costly and to the detriment of the consultant team who are at times required to undertake additional shifts at short notice. The fill rate of T1 and T2 rota sots is variable, especially so for T1. This is mainly due to sub-optimal allocation of trainees from the Merseyside and North Wales deaneries. As such, the team responsible for staffing the rota frequently resort to alternative means of filling rota gaps (i.e. medical training Initiative (MTI) doctors / Locum appointment for training LAT). The current budget for Tier 1 doctors is 6 WTE. The rota is on a 1 in 7 basis and is backfilled with Advanced Neonatal Nurse Practitioners (ANNP). Two of our current experienced ANNP's have handed in their notices following receiving an opportunity to work in the Isle of Mann at band 8b. Warrington Hospital are also employing band 8b ANNP's. There is an immediate risk to our workforce due to neighbouring trusts offering opportunities for ANNP's at 8b level. We have found through multiple unsuccessful recruitment attempts that fully trained ANNP's who are seeking the employment opportunities that we are offering are not available. Therefore, it is essential that we continue to grow our own workforce and offer opportunities to train as ANNP's to our existing nursing staff on the unit. This will allow us to maintain a more robust and resilient ANNP workforce which would help to support gaps in the rota and would in turn reduce spend on locum shifts / consultants acting down. Further in-depth modelling of this requirement needs to be undertaken but in the short term the recommendation would be to fund x 1 candidate per year to undertake the ANNP course at a HEI.
1.4	**Recommendation:** In summary: - • Note the progress of the appointments to strengthen the neonatal workforce in 24/25

	• Note the compliance on appointment of the 1wte neonatal consultant will demonstrate evidence to meet safety action 4 of the MIS Year 6 scheme.

2	Implications
2.1	**Patients** • There is a risk to neonatal care and safety if the nursing and medical workforce standards can not be met in line with BAPM recommendations.
2.2	**People** • Continuation of supporting the nursing roles in NNU to have enhanced and advanced skills to provide gold standard care to neonates. • It would not be possible to meet BAPM standards without the investment to the neonatal nursing and medical workforce.
2.3	**Finance** • The financial impact to deliver the standards in the workforce have been identified along with a statement of case and business case prepared for consideration.
2.4	**Compliance** • Compliance with BAPM is essential to maintain Level 3 status and evidence for safety action 4 Maternity Incentive Scheme.

Angela McDonald Assistant Director for Nursing Children and Neonatal Services.

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically-led triumvirate**	Trust and service organograms showing clinically led directorates/care groups		Organogram updated and reflects this.
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes		Role/s of Triumvirate clear and established
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)**	DoM job description and person specification clearly defined		DOM jd final 2021.docx
		Agenda for change banded at 8D or 9		Went through panel with agreement from Chief Nurse
		In post		
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate		
		Clinical director to executive medical director		Regular Clinical Leads meeting with Medical Director
		DoM to executive director of nursing		Senior Nurse Management Team (SNMT) weekly meeting in addition to twice monthly 1:1
		General manager to executive chief operating officer		Divisional Director has line of sight to COO.

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity services standing item on trust board agenda as a minimum three-monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, Attain, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockendon learning actions		Board papers can be accessed via the website as public. Quarterly update to Board by DoM. NED Safety Champion feeds back to Board monthly by exception.
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Perinatal Quality Surveillance report goes to Board monthly.
		There should be a minimum of three PAs allocated to clinical director to execute their role		Initially 2 PA's allocated but 3 allocated in new job plan
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team		Clear structure in place
		Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave		Effective relationship with HR Business Partner and Senior HR advisors – Divisional Surgeries in place as well as regular catch ups with DoM.
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate		In place, support at monthly Divisional Surgery

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area		In place from an establishment perspective . Finance attend Divisional Surgeries.
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways		Directorate Manager in post supported by Triumvirate.
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups		Agreed actions from CG meetings, LWSG etc. Evidence of stakeholder engagement throughout
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, e.g. senior midwifery leadership assembly		Senior Midwifery meeting; Consultant meeting; DM meetings in place and chaired appropriately. 7 Features of Safety supported and demonstrated within the Division. Training – MDT reinforces a leadership culture.
		Leadership culture reflects the principles of the '7 Features of Safety'.		
	Leadership development opportunities	Trust-wide leadership and development team in place		L&D Team, top leaders programme, effective managers etc. Leadership Masterclasses supported by the Trust.

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Inhouse or externally supported clinical leadership development programme in place		Top Leaders programme, plus externally supported programmes for Midwifery Leaders.
		Leadership and development programme for potential future talent (talent pipeline programme)		Aspiring HOM's programmes completed regionally and nationally.
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship		Directory of Learning & Development opportunities further supports professional development.
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy		Organisational structure defines clear lines of accountability from ward to Board.
		Organisational vision and values in place and known by all staff		Trust Values in place, known and respected by the teams. Staff held to account to deliver against the values.
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]		As above.

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years		In place and can be evidenced. Regional Strategy being reviewed currently.
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan		In place and can be evidenced.
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MNVP, service users and all staff groups.		MDT approach to strategy production supported. Can be evidenced on request. MNVP Partnership active and meets all requirements of Safety Action in Maternity Incentive Scheme.
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]		
		Maternity strategy aligned with trust board LMNS and MNVP's strategies		Maternity Strategy aligned to that of the National Five Year Forward View and other national objectives.
		Strategy shared with wider community, LMNS and all key stakeholders		Completed but not shared widely as separate regional strategy. Trust strategy available on request by external stakeholders including LMNS..

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor		In place – Mr Steve Ryan.
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor		Bi-monthly meetings take place. Job description in place and Safety Champion work log updated with key actions.
		All Safety champions lead quality reviews, e.g. 15 steps quarterly as a minimum involving MNVPs, service users, commissioners and trust governors (if in place)		Regular walkabouts from safety champions, 15 steps repeated in April 2024 and included maternity neonatal and Seaccombe birth, Reports available and action plans in progress
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services		Can be evidenced as part of public board papers.
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMNS) and MatNeoSIP Patient Safety Networks. [MIS]		Pathway in place and included as evidence for Ockenden.
Multi-professional team dynamics	**Multi-professional engagement workshops**	Planned schedule of joint multi-professional engagement sessions with chair shared between triumvirate, i.e. quarterly audit days, strategy development, quality improvement plans		Monthly audit days, multi-professional encouragement to attend.

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Record of attendance by professional group and individual		Record of attendee's held by clinical governance teams.
		Recorded in every staff member's electronic learning and development record		Initially not recorded on ESR however project undertaken with Trust L&D Team to pilot reporting onto ESR in Maternity Services which is now in place.
	Multiprofessional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see		Within ESR and on PROMPT, Block C. TNA in place and shared with LMNS with reporting template.
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority		Recently updated as required for Ockenden
		All staff given time to undertake mandatory and job essential training as part of working hours		As Prompt/Block C plus additional 4 hours to undertake K2
		Full record of staff attendance for last three years		Can be produced on request
		Record of planned staff attendance in current year		Can be produced on request
		Clear policy for training needs analysis in place and in date for all staff groups		As above, updated in 2021

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Compliance monitored against training needs policy and recorded on roster system or equivalent		Discussed and monitored monthly at DMB
		Education and training compliance a standing agenda item of divisional governance and management meetings		As above, in addition also monitored at PSQB, DPR etc.
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]		Can evidence if required – PROMPT supports this requirement. TNA in place outlining requirements of Competency Framework. Quarterly reporting to the LMNS.
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal		
	Clearly defined appraisal and professional revalidation plan for staff	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation		Structure/ line of accountability included in the template of each job description.
		Compliance with annual appraisal for every individual		Sustained >90% consistently. Same monitored through DPR.
		Professional validation of all relevant staff supported by internal system and email alerts		In place within ESR

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities		Robust appraisal system which includes objectives
		Schedule of clinical forums published annually, e.g. labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings		In place within monthly clinical governance gems newsletter
	Multi-professional clinical forums	HR policies describe multi-professional inclusion in all processes where applicable and appropriate, such as multi-professional involvement in recruitment panels and focus groups		Stakeholder panels take place in all
	Multi-professional inclusion for recruitment and HR processes	Organisational values-based recruitment in place		Vales based questions asked at interview
		Multi-professional inclusion in clinical and HR investigations, complaint and compliment procedures		In place
		Standard operating procedure provides guidance for multi-professional debriefing sessions following clinical incidents or complaints		HOT debrief or After Action Reviews based on NHSE template in place
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy		As above.
		Schedule of attendance from multi-professional group members available		Record of attendance kept for all debrief sessions
	Multi-professional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multi-professional attendance.		Bi-weekly sessions
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design		Abundance of evidence available on request

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users		Improvement plan in place but doesn't specifically outline SMART principles which are in place for Mat Neo work..
	Collaborative multi-professional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, i.e. senior responsible officer and delegated responsibility		QI lead in post. Evidence of QIP – MatNeo collaboration.
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP		Evidenced in MatNeo work.
		Identification of the source of evidence to enable provision of assurance to all key stakeholders		Evidenced according to QIP – both locally and regionally.
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access		Divisional Governance team use/store all evidence on shared drive. Same accessible to key staff.
		Clear communication and engagement strategy for sharing with key staff groups		Trust strategy recently updated and staff engagement plan updated within the Division.

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements		Maternity Transformation agenda outlines specific requirements – further supported by NHSE/I regional team and the LMNS.
		Weekly/monthly scheduled multi-professional safety incident review meetings		Weekly for all specialities within W&C
	Multi-professional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS		In place prior to Covid, not reintroduced face to face yet, however Teams Safety Summit held x2 regionally.
		Positive and constructive feedback communication in varying forms		SCORE survey previously undertaken. Repeated as part of leadership programme. Staff engagement survey undertaken annually and gaps actioned accordingly. PULSE survey also quarterly
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach		Audit day and CIF learning. Clinical Gems newsletter for sharing.

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]		In place – same led by Governance team, CI's and ADN/HoM. Trust Vision / Values structure supports standards framework.
		Schedule of focus for behavioural standards framework across the organisation		
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month		In place as described above
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]		In place as described above
		All policies and procedures align with the trust's board assurance framework (BAF)		
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	Governance framework in place that supports and promotes proactive risk management and good governance		In place within the Division with clear structure / oversight of maternity services.
		Staff across services can articulate the key principles (golden thread) of learning and safety		Participated in the EBC learn and support work – also discussed on PROMPT and Block C.
		Staff describe a positive, supportive, safe learning culture		Evidenced through staff engagement survey / feedback.

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams		In place as described above.
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support		Maternity Governance structure reviewed and Q&S matron and Risk Midwife in post  W&C Structure including Ward Mana
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member		Job descriptions clearly articulate roles and responsibilities.
		Team capacity able to meet demand, e.g. risk register, and clinical investigations completed in expected timescales		Difficult at times however clear Trust oversight process through weekly SI panel.

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF		Trust Risk Management Strategy which includes Maternity has been updated. and is in place. maternity-risk-management-strategy-v1-no
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF		Included in strategy
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board		Dashboard in place in addition to Quality Assurance report that goes quarterly to Board of Directors.
		Mechanism in place for trust-wide learning to improve communications		CG Gems, audit day, CIF learning etc,
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication		Perinatal meeting and sharing of joint learning
		Governance communication boards		In place in all clinical areas.
		Publicly visible quality and safety board's outside each clinical area		Q&S Boards outside all areas – visible to the public.

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Learning shared across local maternity system and regional networks		Submit to LMNS and regional attendance at all SIG's to share learning
		Engagement of external stakeholders in learning to improve, e.g. CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups		Trust has number of staff who Chair these regional meetings/groups
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.		Communication Strategy in place and maternity included
		Multi-agency input evident in the development of the maternity specification	N/A due to ICB introduction / PLACE	CCG outlined service specification historically however this will change in April 2022 with the introduction of the ICB. National Maternity Service specification in place.
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Approved through relevant governance process		Process in place between CCG/WUTH. LMNS and ICS will lead from April 2022.
		In date and reflective of local maternity system plan		Specification in place and links in with LMNS plan/Deliverables.
		Full compliance with all current 10 standards submitted		Externally audited by MIAA for assurance

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.		Ongoing action plan in place to meet requirements of all ten safety actions. Trust Board updated re progress of same.
		Clear process defined and followed for progress reporting to LMNS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance		LMNS have oversight of compliance with MIS safety actions and were provided with Board declaration forms in 2021.
		Clear process for multi-professional, development, review and ratification of all clinical guidelines		Process in place within the Division.
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multi-professional meetings for a rolling 12 months programme.		The process if for MDT discussion at weekly Risk meeting – same are circulated for input from all stakeholders and ratified as per Trust policy.
		All guidance NICE complaint where appropriate for commissioned services		NICE Guidance monitored and gap analysis undertaken with any newly published guidance.
		All clinical guidance and quality standards reviewed and updated in compliance with NICE		Process in place and evidenced.
		All five elements implemented in line with most updated version		

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Saving Babies Lives care bundle implemented	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.		Fully implemented and monitored through LMNS.
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan		On target and monitored as safety action in MIS.
		All four key actions in place and consistently embedded		Evidence to support same.
	Application of the four key action points to reduce inequality for BAME women and families	Application of equity strategy recommendations and identified within local equity strategy		Gap analysis undertaken and action plan in place and completed.
		All actions implemented, embedded and sustainable		LMNS – ongoing work regarding LMNS requirements. Any amendments to be added to existing plan. Consultant Midwife leading on same.
	Implementation of 7 essential learning actions from the Ockendon first report	Fetal Surveillance midwife appointed as a minimum 0.4 WTE		In post
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs		In post with required number of PA's
		Plan in place for implementation and roll out of A-EQUIP		A-Equip model – Professional Midwifery Advocates in place.
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team		Plan in place which has had further update.

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered		PMA team developed – additional training sourced when required.
		Service provision and guidance aligned to national bereavement pathway and standards		WUTH piloted national pathway and have led / implemented regionally agreed pathway.
	Maternity bereavement services and support available	Bereavement midwife in post		1.0wte equivalent. Work ongoing to further progress support to women/families.
		Information and support available 24/7		Butterfly team in place providing support as required.
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities		Butterfly and ApplePip Rooms available 24/7.
		Quality improvement leads in place		Minimal hours currently – same being reviewed in conjunction with MatNeo work.

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation		QIP in place linked to Maternity Transformation Programme.
		Recognised and approved quality improvement tools and frameworks widely used to support services		Evidenced through MatNeo work
		Established quality improvement hub, virtual or otherwise		In place as part of MatNeo but same to be further developed.
		Listening into action or similar concept implemented across the trust		LIA type processes in place – use of MatNeo plans/hub.
		Continue to build on the work of the MatNeo Sip culture survey outputs/findings.		Regular meetings with Lead progressing work.
	MatNeo Sip embedded in service delivery	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan		Evidence of same – regional Lead progressing further work with providers.
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)		Plan in place and evidenced. Ockenden evidence further supports this requirement.

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Standing agenda item on key directorate meetings and trust committees		Maternity agenda on cycle/s of business. Not on all agendas but is included on relevant meetings including BoD agenda. Decision taken to implement Mat Neo Assurance Board
		FTSU guardian in post, with time dedicated to the role		In place and evidenced.
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post		Lead within Division and L&D leading on work throughout the Trust to further support.
	Human factors training available	Human factors training part of trust essential training requirements		Included in PROMPT training.
		Human factors training a key component of clinical skills drills		In PROMPT and is evidenced.
		Human factors a key area of focus in clinical investigations and formal complaint responses		Key point included on template used.

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Multiprofessional handover in place as a minimum to include. Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas e.g., antenatal/postnatal ward/triage.		Handover processes updated and in place further supported by twice daily ward rounds on Delivery Suite.
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern		Evidence of twice daily ward rounds in place. Further evidence supports Ockenden requirements.
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's		In place.
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date		SOP developed and huddles taking place
		Audit of compliance against above		All safety huddles recorded and documented. Audit to be commenced

Maternity Self-Assessment Tool Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Annual schedule for Swartz rounds in place		Pre Covid this was in place.
	Trust wide Swartz rounds	Multi-professional attendance recorded and supported as part of working time		Process in place Trust wide.
		Broad range of specialties leading sessions		Inclusive of all Divisions.
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse		Pre Covid this was in place.
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit		Process in place – oversight from Governance team.
		Annual or biannual trust-wide learning to improve events or patient safety conference forum		World Patient Safety Day evidenced learning Trust wide.
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes		In place and story shared.
		In date business plan in place		Cycle of business in place for each meeting.
Comprehension of business/ contingency plans impact on quality. **(i.e. Maternity Transformation plan, Neonatal Review, Maternity Safety plan**	**Business plan in place for 12 months prospectively**	Meets annual planning guidance		In place Trust wide.
		Business plan supports and drives quality improvement and safety as key priority		Trust wide processes in place
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups		Compliance with BR+ given current model of care
		Consultant job plans in place and meet service needs in relation to capacity and demand		In place following review

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
and Local Maternity System plan)		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans		There was disparity in the allocation of PA's – same reviewed as part of the job planning work.
		Business plans ensures all developments and improvements meet national standards and guidance		Operational plan and Strategy supports the MTP and National agenda.
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.		Strategy updated and reflects same.
		Business plans include dedicated time for clinicians leading on innovation, QI and Research		Dedicated research and audit lead. Oversight and Lead for QI.
		That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.		Plans in place to reduce inequalities – further work ongoing to improve same.
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidance's.	**That Employment Policies and Clinical Guidance's meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.		Employment procedures/processes in place.
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.		Complaint with same and evidenced through Consultant Midwife lead on Public Health agenda.