QUALITY ASSURANCE COMMITTEE

Date of Meeting	**19th September 2022**
Title	**Maternity Incentive Scheme Year 4 Report**
Report of	**Bridget Lees, Chief Nursing Officer and Board Level Safety Champion**
Prepared by and contact details	**Donna Southam, Quality, Safety and Assurance lead midwife** **Donna.southam@mhbt.nhs.uk** **Heather Gallagher, Director of Midwifery** **Heather.gallagher@mhbt.nhs.uk**

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x		x	
	This report provides an overview on the progress with the Maternity Incentive Scheme Year 4. Trusts will need to report compliance with the Maternity Incentive Scheme by Thursday 5 January 2023.			

Summary of Key Issues	In January 2018 NHS Resolution (NHSR) introduced an incentive scheme to the Clinical Negligence Scheme for Trusts (CNST). The Maternity Safety Strategy set out the Department of Health's ambition to reward Trusts who have taken action to improve maternity safety. The scheme incentivises ten maternity safety actions. NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. Following the CQC inadequate overall rating for Maternity, NHSR requested a review of the evidence for year 2 and 3. Following external validation and a local review identified information was lost due to the transfer over to 365, the money received for year 2 was paid back to NHSR and the Trust did not receive funds for year 3. A package of money has been offered of £260,000 however a review of the year one CNST submission had to be undertaken. In order to be eligible for payment under the scheme, the Trusts must submit their completed Board declaration form to NHS resolution by 12 noon on Thursday 5 January 2023 and must comply with conditions detailed within the report. The safety actions are the same as those in previous years of the scheme however the minimum requirements have been revised and, in some safety actions have additional requirements to reflect the national safety agenda. The requirements to meet the 10 safety actions for year four require a higher level of compliance. There must

	be no reports in 2021/22 or 2022/23 that provide conflicting information to the declaration such as a CQC inspection report and HSIB. The precise detail for what is required under each action and how this should be evidenced is in Appendix 1 - Maternity Incentive Scheme Action Plan. The robust action plan has been developed to implement the actions at pace. The Trust is currently on target to meet 5 out of the 10 safety actions, with immediate actions in place to address 4 partial complaint safety actions. If all ten actions cannot be evidenced the Trust will not recover the maternity incentive premium.

Prior Discussions	Committee	Date	Recommendations/ Concerns

Action to be recommended to the Committee/Board	The Committee is asked to receive this report for discussion and assurance of a plan in place to meet the Maternity Incentive Scheme for year four.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x	x	
	Related to patient safety			

Impact on Board Assurance Framework or Corporate Risk Register				
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
NICU	Neonatal Intensive Care Unit
SCBU	Special Care Baby Unit

MIS	Maternity Incentive Scheme
LMNS	Local Maternity and Neonatal System
ATAIN	Avoiding Term Admissions in Neonatal Intensive Care Unit
CGGAG	Care Group Governance Assurance Group
TOR	Terms of Reference
PMRT	Perinatal Mortality Review Tool
CNST	Clinical Negligence Scheme for Trusts
CGGAG	Care Group Governance Assurance Group
CQC	Care Quality Commission
MSDS	Maternity Services Data Set
TC	Transitional Care
ICS	Integrated Care System
MCOC	Maternity Continuity of Carer
HSIB	Health Service Investigation Beau
MVP	Maternity Voice Partnership
SBLCB	Saving Babies Lives Care Bundle

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Maternity Incentive Scheme Year 4 Report

PURPOSE

The purpose of this paper is to provide an update on the status of University Hospital Morecambe Hospitals Trust compliance with the NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year four and to highlight areas of risk with compliance.

BACKGROUND

1. In January 2018 NHS Resolution (NHSR) introduced an incentive scheme to the Clinical Negligence Scheme for Trusts (CNST). The Maternity Safety Strategy set out the Department of Health's ambition to reward Trusts who have taken action to improve maternity safety. The scheme incentivises ten maternity safety actions.

2. NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care

3. UHMBT CNST premium for 2021/22 is £13,227,310. The standard maternity element of this is £5,572,241. The maternity incentive contribution is 10% of this i.e., £557,224. The total maternity contribution is £6,129,46.

4. The Trust submitted the data set required for the ten maternity safety action points at 12 noon on 15 July 2021 as per the submission requirements. The Board declaration form was signed off for all ten maternity safety actions.

5. Following the CQC inadequate overall rating for Maternity services NHSR requested a review of the CNST evidence for year 2 and 3. Following external validation and a local review identified information and evidence of compliance was lost due to the transfer over to 365, the money received for year 2 was paid back to NHSR and the Trust did not receive funds for year 3. A package of money has been offered of £260,000 however a review of the year one CNST submission had to be undertaken.

6. Following the re-launch of the fourth year on 9th August 2021, NHS Resolution, and the Collaborative Advisory Group (CAG) continued to monitor all Trusts' position in relation to Covid-19, staffing and acuity and the challenges faced by Trusts in achieving the Scheme's safety actions. A revision was made to some of the safety actions' sub-requirements. The revised scheme was published on 12th October 2021 extending the Scheme's interim deadlines to support trusts submission.

7. On the 23rd December 2021 NHS Resolution paused the majority of reporting requirements relating to the Maternity Incentive Scheme for a minimum of 3

8. month in recognition of the current pressure on the NHS and maternity services.

9. On the 6th May 2022 the Maternity Incentive Scheme published the revised technical guidance.

10. In order to be eligible for payment under the scheme, the Trusts must submit their completed Board declaration form to NHS resolution (nhsr.mis@nhs.net) by 12 noon on Thursday 5 January 2023 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 maternity safety actions by the Head/Director of Midwifery and Clinical Director for Maternity Services.
- The Board declaration form must be signed and dated by the Trust's Chief Executive Officer (CEO) to confirm that:

-The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions sub requirements as set out in the safety actions and technical guidance.

-There are no reports covering either year 2021/22 or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g., Care Quality Commission inspecting report, Healthcare Safety Investigation Branch investigation reports etc). All such reports should be brought to the MIS team's attention before Thursday 5 January 2023.

- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/ Integrated Care System.
- As in previous years, Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their CNST contribution that relates to the maternity incentive fund (10% of the maternity premium) will also receive a share of any unallocated funds.
- Year four data set required compliance against the revied 10 safety action points for 8 August 2021 to 5 January 2023.

11. If the Trust does not achieve all of the ten actions, it will not recover their contribution to the maternity incentive fund but may be legible for a small discretionary payment from the Scheme to help progress against actions that have not been achieved. This payment would be at a much lower level that the 10% contribution to the incentive fund.

ANALYSIS/DISCUSSION

This year the 10 safety actions are:

- Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
- Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

- Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

- Can you demonstrate an effective system of clinical workforce planning to the required standard?

- Can you demonstrate an effective system of midwifery workforce planning to the required standard?

- Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

- Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

- Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and new-born life support, starting from the launch of MIS year 4?

- Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

- Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?

1. The safety actions are the same as those in previous years of the scheme however the minimum requirements have been revised and, in some safety, actions have additional requirements to reflect the national safety agenda. The requirements to meet the 10 safety actions for year four require a higher level of compliance. There must be no reports in 2021/22 or 2022/23 that provide conflicting information to the declaration such as a CQC inspection report and HSIB. The precise detail for what is required under each action and how this should be evidenced is in Appendix 1 – Maternity Incentive Scheme Action Plan.

2. The Trust is expected to provide a report to the Board demonstrating achievement (with evidence) of each of the ten actions. The Board is expected to consider the evidence and complete a Board declaration form for submission.

3. Trust submissions will be subject to range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England and Improvement regarding submission to the Maternity Services Data Set 9 safety action 2, criteria 2 to 7 inclusive) and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC and for any CQC visits undertaken within the time period, the CQC will cross reference to the maternity incentive scheme via the key lines of enquiry.

4. Reporting of all qualifying Early Notification cases to NHS Resolution's Early Notification (EN) Scheme has been reinstated from the 1st April 2022. The Maternity Governance team have put processes in place with the Trust Legal Team to ensure all cases are reported.

5. WACS working group continues to discuss and update the attached action plan with responsibility for each of the ten actions having been allocated to relevant staff. The group meet monthly to review their progress. The action plan in Appendix 1 provides the current position to date.

6. Updates on the progress against the action plans will be continually reviewed at Care Group Governance Assurance Group, Maternity Safety Champions, Quality Assurance Committee and Trust Board.

RISKS

There are five risks which are currently impacting on the following safety actions.

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

There are several cases between 2021-2022 where the reports are not completed. The Quality, Safety and Assurance Lead Midwife is in contact with the families. There are meetings scheduled to ensure all reviews are completed by the 31st of October 2022 and the families have received their reports and feedback. PMRT is on the WACS risk register with a score of 15.
There is a ToR and PMRT SOP in development. Quarterly reports will be submitted to QAC and Trust Board for monitoring going forward. The Maternity Incentive Scheme requirement was a report should be submitted to Trust Board for each quarter from the 6th May 2002. No report was submitted in Quarter 1. A PMRT report will be submitted to Trust Board in September 2022 (quarter 2) following the external review. Clarification will be sought from NHS Resolutions if the safety standard was not met.

2. **Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?**

Audit meetings have commenced in September 2022. No reviews have taken place since March 2022. Transitional care audits to be refreshed to include the minimum data requirements. A review of the nursing model needs to be undertaken for transitional care in view there is not coverage 24/7.
ATAIN report and action plan presented at Trust Board in July 2022 and at the Maternity Safety Champions meeting in August 2022.
Pathway for information sharing with the LMNS and Integrated Care Board being developed.

3. **Safety Action 4: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**

The requirement is a paper is submitted to Trust board 6 monthly and the last report submitted was December 2021. A Midwifery staffing report will be submitted to Trust board in September 2022 however this is not within the required time frame. Clarification will be sought from NHS Resolution if this impact compliance with this standard.

4. **Safety Action 6 Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?**

There is partial compliance with element 2 of the Saving Babies Lives care bundle in view the current guideline is not in accordance with the bundle. The guideline has been drafted and circulated for comments. The guideline is on the agenda at the next guideline group meeting for approval. Partial Compliance with the Saving Babies Lives Care Bundle has been added to the risk register with a score of 10.

5. **Safety Action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance, and newborn life support, starting from the launch of MIS year 4?**

Training compliance for Anaesthetic and Obstetric staff is below 90% and following a review of bookings up until the 30th December 2022 the trajectory for both staff groups is below 90%. This has been escalated to the Clinical Directors in Obstetric and Anaesthetics and Associate Director of Operations.

- If all ten actions cannot be evidenced the Trust will not recover the maternity incentive premium.

RECOMMENDATIONS

1. The robust action plan has been developed to implement the actions. The Trust is currently on target to meet 5 out of the 10 safety actions, with immediate actions in place to address 4 partial complaint safety actions.

2. The Committee is asked to receive this report for discussion and assurance of a plan in place to meet the Maternity Incentive Scheme for year four.

Appendix One Maternity Incentive Scheme – year four – revised safety actions

Key for RAGBW rating of Actions:

White = Not yet started	Green = On Track	Amber = In progress	Red = Due but not complete	Blue = completed

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress and completion	Date Action Completed and RAG
Safety Action 1:	**Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?**						
	a)	i. All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter. ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website. The perinatal mortality review tool must be used to review the care and reports should be generated via the PMRT. A report has been received by the Trust Board each quarter from 6 May 2022 onwards that includes details of the deaths reviewed 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	Donna Southam Quality, Safety and Assurance Lead Midwife Joe Ogah, Consultant Obstetrician	05/12/23	All cases notified within 7 days and surveillance information completed within one month. A review is currently being undertaken of the cases which the reports have not been completed to assess if they have been started within 2 months. PMRT meetings established from September 2022 and all reviews will be	

	b)	At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.	standard c) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.	Donna Southam Quality, Safety and Assurance Lead Midwife Joe Ogah, Consultant Obstetrician	05/12/23	multidisciplinary including an external expert. The Bereavement Lead Midwives are the primary contact and all women are given the DOC leads contact details. The Quality and Safety Midwife has contacted all women were the report remains on going. There is a PMRT SOP and ToR. Quarterly Board reports commenced in September 2022.	
	c)	For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.	Audit of all cases in progress to ensure compliance A report has been received by the Trust Board each quarter from 6 May 2022 onwards that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review	Donna Southam Quality, Safety and Assurance Lead Midwife Joe Ogah, Consultant Obstetrician	05/12/22		

	d)	Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard c) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.	Donna Southam Quality, Safety and Assurance Lead Midwife	05/12/23		

Safety Action		**Required standard**	**Minimal evidential requirement**	**Lead responsible for action**	**Target Date**	**Evidence of Progress and completion**	**Date Action Completed and RAG**
Safety Action 2:	**Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?**						
		1. By October 2022, Trusts have an up-to-date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme. 2. Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria	1) Criteria 1 will be reported to NHS Resolution as part of trusts' self-declaration using the Board declaration form. For criteria 2 to 7, the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series displays whether trusts have	Karen Bridgeman, Digital Midwife	05/01/23	Maternity has a dedicated Digital Midwife. LMNS is developing a digital strategy. Following this a local maternity strategy to be developed and signed	

		in the “CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria” data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022. 3. July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month. 4. July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month. 5. July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2) 6. July 2022 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) 7. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the “CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria” data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following	passed the requisite data quality thresholds.			off by the Board and ICS. The Digital Midwife is a part of the Regional Digital Midwives Expert Reference group CQIMs are awaited to be republished. Digital Midwife quality assures data prior to submission to MSDS. The last data capture demonstrated 10 out of 11 metrics were compliant.	

		metrics: **Midwifery Continuity of carer (MCoC)** i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion. Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Criteria iii are fundamental building blocks and a necessary step towards measuring whether or not women have received midwifery continuity of carer (though it is not the complete measurement). The data for July 2022 will be published in October 2022. If the data quality for criteria 7 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information).					

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress and completion	Date Action Completed and RAG
Safety Action 3:	**Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?**						
	a)	Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.	Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: Evidence for standard a) to include: • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to BAPM transitional care framework for practice • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	Nicola Askew, Associate Director of Nursing &Therapies for Children and Young	01/09/24	Transitional Care Operational Guideline (expires 31/1/2023). A review of the nursing staffing model for Transitional Care. Quarterly audits to be commenced in September. To be added to the Safety Champion meeting Report to be submitted to	

	b)	The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.	An audit trail is available which provides evidence that ongoing audits from year 3 of the maternity incentive scheme of the pathway of care into transitional care are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. Audit findings are shared with the neonatal safety champion on a quarterly basis. Where barriers to achieving full implementation of the policy are encountered, an action plan should be agreed and progress overseen by both the board and neonatal safety champions	Nicola Askew, Associate Director of Nursing &Therapies for Children and Young	18/07/22	Quality Committee quarterly. Transitional care audits to be incorporated into ATAIN report. All data captured electronic on Badgernet	
	c)	A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.	Data is available (electronic and/or paper based) on all term babies transferred or admitted to the neonatal unit. This will include admission data captured via Badgernet as well as transfer data which may be captured on a separate paper or electronic system. If a data recording process is not already in place to capture all babies	Nicola Askew, Associate Director of Nursing &Therapies for Children and Young	18/07/22	To be captured in the ATAIN audit	

			transferred or admitted to the NNU this should be in place no later than Monday 18 July 2022.			Minimum data available on request	
	d)	A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.	Data is available (electronic or paper based) on transitional care activity (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc.). Secondary data is available (electronic or paper based) on babies born between 34+0-36+6 weeks gestation at birth, who did not have surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered to inform future capacity management for late preterm babies who could be cared for in a TC setting.	Nicola Askew, Associate Director of Nursing &Therapies for Children and Young	18/07/22	To be incorporated into ATAIN audit report Quarterly audit is shared at the Maternity Safety Champion meeting and with the board.	
	e)	Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.	Evidence for standard e) to include Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are available to share on request, for example to support service development and capacity planning, with the	Nicola Askew, Associate Director of Nursing &Therapies for Children and Young	05/01/23	ATAIN Report shared with board in July 2022 and Safety Champions August 2022. Pathway for	

			LMNS, ODN and/or commissioner			sharing to be developed with LMNS and ICS.	
	f)	Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to Badgernet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.	An audit trail is available which provides evidence that ongoing reviews from year 3 of the maternity incentive scheme of term admissions are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. If not already in place, an audit trail is available which provides evidence that reviews from Monday 18 July 2022, now include all term babies transferred or admitted to the NNU, irrespective of their length of stay, are being completed as a minimum of quarterly. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. Evidence that the review includes: the number of transfers or admissions to the neonatal unit that would have met current TC admission criteria but were transferred or	Donna Southam, Quality, Safety and Assurance Lead Midwife Nicola Askew, Associate Director of Nursing &Therapies for Children and Young	18/07/2022		

			admitted to the neonatal unit due to capacity or staffing issues and the number of babies that were transferred or admitted to or remained on NNU because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there. Evidence that findings of all reviews of term babies transferred or admitted to a neonatal unit are reviewed quarterly and the findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting.				
	g)	An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion.		Nicola Askew, Associate Director of Nursing &Therapies for Children and Young Donna Southam, Quality, Safety and Assurance Lead Midwife	18/07/22		
	h)	Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.		Donna Southam, Quality, Safety and Assurance Lead Midwife	18/07/2022	Action plan was shared with the Safety	

						Champions in August 2022 and added to the forward planner quarterly. Shared with Trust Board in July 2022 and added to the forward planner quarterly. Action plan to be shared with the board, ICS and LMNS	

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress and completion	Date Action Completed and RAG
Safety Action 4:	**Can you demonstrate an effective system of clinical workforce planning to the required standard?**						
	a)	**Obstetric Medical Workforce** 1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and	Obstetric medical workforce Sign off at Trust Board level acknowledging engagement with the RCOG document along with an action plan to review any non-attendance to	Mr Mark Davies, Clinical Director of Obstetrics and Gynaecology	16/06/22	SOP available on intranet. Audit commenced and monthly report	

		responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ 2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS.	the clinical situations listed in the document. Trusts should evidence their position with the Trust Board, Trust Board level safety champions and LMNS meetings at least once from the relaunch of MIS year 4 in May 2022.		29/07/22	presented at CGGAG from August 2022. The compliance to be added to the Perinatal Quality Surveillance model going forward.	
	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	The rota should be used to evidence compliance with ACSA standard 1.7.2.1.	Dr Kate Boothroyd, Consultant Anaesthetist Cross Bay Clinical Lead for Anaesthesia	05/01/2023	Compliant with the ACSA standards. Rota to be submitted as evidence Anaesthetic medical workforce report to be submitted to QAC and Board in October	

		immediately to obstetric patients (ACSA standard 1.7.2.1)				2022 demonstrating compliance. Neonatal medical workforce report to be submitted to the board in October 2022	
	c)	**Neonatal medical workforce** The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies.	The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. A review has been undertaken any 6-month period between August 2021 and 5 January 2023.	Linda Womack, Associate Director of Operations	05/01/2023		
	d)	**Neonatal nursing workforce** The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal	The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the Royal College	Nicola Askew, Associate Director of Nursing &Therapies for Children and Young, Donna Southam, Quality, Safety and Assurance Lead Midwife	05/01/2023	Report to be submitted to the board in October 2022 Action plan to be submitted to Royal College of Nursing, LMNS and Neonatal ODN	

		Operational Delivery Network (ODN) Lead.	of Nursing (doreen@crawfordmckenzie.co.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead Neonatal nursing workforce Nursing workforce review has been undertaken at least once during year 4 reporting period (August 2021 and 5 January 2023).				

Safety Action		**Required standard**	**Minimal evidential requirement**	**Lead responsible for action**	**Target Date**	**Evidence of Progress and completion**	**Date Action Completed and RAG**
Safety Action 5:	**Can you demonstrate an effective system of midwifery workforce planning to the required standard?**						
	a)	A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.	Heather Gallagher, Director of Midwifery	05/01/23	BirthRate +undertaken 2021 Midwifery staffing paper submitted in December 2021 Paper due for submission September 2022	
	b)	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.		Heather Gallagher, Director of Midwifery	05/01/23		
	c)	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service		Heather Gallagher, Director of Midwifery	05/01/23		

			• Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. -The midwife to birth ratio -The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.			Quality, Safety and Assurance Lead Midwife to contact NHSR to establish if compliant in view 9-month gap between reports At RLI this information is captured in the Birthrate plus tool At SLBC daily staffing reviewed 3 times a day. At weekend review completed by done on call matron	
	d)	All women in active labour receive one-to-one midwifery care		Heather Gallagher, Director of Midwifery	05/01/23		

	e)	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.		Heather Gallagher, Director of Midwifery	05/01/23	Midwifery staffing paper submitted 6 monthly to Trust Board. Paper submitted in December 2021	

Safety Action		**Required standard**	**Minimal evidential requirement**	**Lead responsible for action**	**Target Date**	**Evidence of Progress and completion**	**Date Action Completed and RAG**
Safety Action 6:	**Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?**						
	1.	Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract	**Element one Process indicators:** A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. B. Percentage of women where CO measurement at 36 weeks is recorded. Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and included in the	Holly Parkinson, Quality Improvement Lead Midwife, Kath Granger, Consultant Obstetrician	05/01/23	Quarterly care bundle survey reinstated in May 2022. Audits being undertaken quarterly for	

	2.	Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.	MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing an average of 80% compliance over a four month period (i.e., four consecutive months in during the MIS year 4 reporting timeframe). If there is a delay in the provider Trust's ability to submit these data to MSDS then compliance can be determined using their interim data recording method. The denominator should still be the total number of women at booking or 36 weeks gestation, as appropriate for each process indicator. A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. In addition, the Trust board should specifically confirm that within their organisation they: 1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric. 2) Have a referral pathway to smoking cessation services (in house or external). 3) Audit of 20 consecutive	Holly Parkinson' Quality Improvement Lead Midwife, Kath Granger' Consultant Obstetrician	05/01/23	all 5 elements. On risk register due to partial compliance with element 2. Guideline in draft and should be approved by the guideline group and CGGAG in September 2022.	
	3.	The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.		Holly Parkinson' Quality Improvement Lead Midwife, Kath Granger' Consultant Obstetrician	05/01/23		

			cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service. 4) Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period: • Percentage of women with a CO measurement ≥4ppm at booking. • Percentage of women with a CO measurement ≥4ppm at 36 weeks. • Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level. **Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded** Women declining CO testing at booking / 36 weeks appointment Standard A and B of element 1 require Trusts to demonstrate that 80% of women had CO testing at booking and at 36 weeks respectively and that this is recorded in the Trusts' information system. In the event of a high number of women declining CO testing a Trust would be at risk of failing standard A and B by not reaching the 80% testing rate. We suggest Trusts proactively monitor their testing rate and consider interventions to maintain adequate compliance. **Element two Process indicator:**				

			1) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan (e.g., Appendix D). Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If there is a delay in the provider Trust Maternity Information System's ability to record these data at the time of submission an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records should have been undertaken to assess compliance with this indicator. A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. In addition, the Trust board should specifically confirm that within their organisation: 2) Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards				

			3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 4) There is a quarterly audit of the percentage of babies born 37+6 weeks' gestation. 5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT). 6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network. 7) They undertake a quarterly review of a minimum of 10 cases of babies that were born 37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g., components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born 37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this				

			directly frees up staff for the provision of clinical care. **Element three Process indicators:** A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation). Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators. A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. **Element four** There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include intermittent auscultation, electronic fetal monitoring with system				

			level issues e.g., human factors, escalation, and situational awareness. The Trust board should specifically confirm that within their organization 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above. Please refer to safety action 8 for more information re training. **Element five Process indicators:** A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. If there is a delay in the provider Trust MIS's ability to record these data then an				

			audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators. The Trust board should receive data from the organisation's Maternity Information System evidencing 80% compliance. A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%. In addition, the Trust board should specifically confirm that within their organisation: • They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife. Further guidance/information on preterm birth clinics can be found on https://www.tommys.org/sites/default/files/2021-03/reducing%20preterm%20birth%20guidance%2019.pdf • Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal				

			ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate, and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway. The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local CCGs following advice from the Clinical Network. • Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network.				
	The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net						

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress	Date Action Completed and RAG

						and completion	
Safety Action 7:	**Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your MVP to coproduce local maternity services?**						

		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	**Evidence should include:** • Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems • Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff. • Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes. • The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it • Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking, and childcare costs in a timely way. • Evidence that the MVP is prioritising hearing the voices of women from	Alison Mayor, Head of Midwifery and Gynaecology / MVP chair		There is a ToR Bi monthly MVP meetings and they are minuted. Witten confirmation has been received from the MVP chair has been remunerated and committee members have been able to claim out of packet expenses. The MVP works programme to be agreed at the LMNS. MVP's have organised a coffee morning with women living in high areas of deprivation	

			Black, Asian, and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality. • Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends, and themes, are shared with the MVP			Invite the MVP chair to maternity governance meetings. Evidence complaint response processes, trends and themes are shared with the MVPs	

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress and completion	Date Action Completed and RAG
Safety Action 8:	**Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance, and newborn life support, starting from the launch of MIS year 4?**						
	a)	A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years	It is recognised that temporary modifications may be necessary in light of the Covid-19 pandemic. In such cases the Board must ensure that these are mitigated and agreed to ensure the safe provision of services. Details of any modifications, and the agreed mitigations will be expected to be shared with the Trust Board by 16 June 2022	Helena Brown' Practice Development Midwife	05/01/23	Face to face training for PROMPT was reinstated in April 2022. All other training is virtual Midwifery and Health Care Worker compliance on target for >90% by December 2022. Trajectory for Obstetric and Anaesthetic staff currently <90% by December	
	b)	90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multi-professional training day, to include maternity emergencies starting from the launch of MIS year four		Helena Brown, Practice Development Midwife	05/01/23		
	c)	90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multi-professional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four		Helena Brown, Practice Development Midwife	05/01/23		

						2022. Escalated to Clinical Directors for immediate action. Monthly compliance monitored at CGGAG, LMNS and perinatal quality surveillance model shared with Trust Board monthly.	
	d)	Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your annual in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four		Helena Brown Practice Development Midwife	05/01/23	Compliance for all staff groups >90%	

Safety Action		**Required standard**	**Minimal evidential requirement**	**Lead responsible for action**	**Target Date**	**Evidence of Progress and completion**	**Date Action Completed and RAG**

Safety Action 9:	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?						
	a)	a) The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-qualitysurveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.	Evidence for points a) and b) • Evidence of a revised pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) new LMNS/ICS quality group and d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model.	Heather Gallagher, Director of Midwifery Bridget Lees, Chief Nursing Officer	16/06/2022	Pathway of safety intelligence being updated to reflect changes in the LMNS/ ICB. Update provided to board regarding mandatory training in monthly DoM report and perinatal quality surveillance model Monthly safety champion walk arounds have been arranged. Claims Scorecard	
	b)	Board level safety champions present a locally agreed dashboard to the Board quarterly, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.	• Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff. • Evidence that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and engagement sessions; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB- The training update should include any modifications made as a result of the pandemic / current challenges	Heather Gallagher, Director of Midwifery Bridget Lees, Chief Nursing Officer	16/06/2022		

			and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. • Evidence of bi-monthly engagement sessions (e.g., staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board. • Evidence of progress with actioning named concerns from staff workarounds are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users. • Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting. Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action is in place no later than 16 June 2022. The expectation			discussed at Divisional Governance in August 2022 with Executive Safety Champion in attendance Action plan for MCoC was discussed at Maternity Safety Champion meeting in April 2022	

			is that work has already commenced on this in line with the Ockenden response (Ockenden, 2021).				
	c)	Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2024, prioritising those most likely to experience poor outcomes.	Evidence of an action plan that describes how the maternity service will work towards Midwifery Continuity of Carer (MCoC) being the default model of care offered to all women by March 2024. The plan covers: • The number of women that can be expected to receive MCoC, when offered as the default model of care • A midwifery redeployment plan into MCoC teams, phased alongside the fulfilment of safe staffing levels • How MCoC teams are established in compliance with national principles and standards. • How rollout will be prioritised to those most likely to experience poor outcomes, including ensuring rollout to 75% of women from Black, Asian, and mixed ethnicity backgrounds and also from the most deprived 10% of neighbourhoods by March 2024. • Developing an enhanced model of MCoC that provides extra support for women from the most deprived 10% of areas. • How care will be monitored locally, and providers ensure accurate and complete reporting on provision of	Heather Gallagher, Director of Midwifery Bridget Lees, Chief Nurse	16/06/2022	MatNeo launch meeting on the 20 September 2022. NED and Maternity Champions booked to attend	

			MCoC using the Maternity Services Dataset • Evidence of Board level oversight and discussion of this revised continuity of carer action plan. An action plan to evidence how MCoC will be the default model of care offered to all women by March 2024, prioritising those most likely to experience poor outcomes, agreed by the Board safety champion by 16 June 2022.				

	d)	d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)	Evidence for point d): Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to: • active participation by staff in contributing to the delivery of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities • engagement in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member • support for clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network • utilise insights from culture surveys undertaken to inform local quality improvement plans • maintain oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement. Attendance or representation at a minimum of two engagement events	Heather Gallagher, Director of Midwifery Bridget Lees, Chief Nursing Officer	05/01/23		

			such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event by the end of MIS year 4 on 5 January 2023. Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 5 January 2023.				

Safety Action		Required standard	Minimal evidential requirement	Lead responsible for action	Target Date	Evidence of Progress and completion	Date Action Completed and RAG
Safety Action 10:	**Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?**						
	a)	Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution.	Donna Southam Quality, Safety and Assurance Lead Midwife	05/01/23	Review to be undertaken to ensure all cases reported to HSIB since 2021 SI and HSIB cases included in monthly reports to board Process and SOP agreed for HSIB/EN scheme	
	b)	Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022	**Trust Board** sight of evidence that families have received information on the role of HSIB and EN scheme	Donna Southam Quality, Safety and Assurance Lead Midwife	05/01/23		
	c)	For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that: 1. the family have received information on the role of HSIB and NHS Resolution's EN scheme; and 2. 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	**Trust Board** sight of evidence of compliance with the statutory duty of candour.	Donna Southam Quality, Safety and Assurance Lead Midwife	05/01/23		

QUALITY ASSURANCE COMMITTEE

Date of Meeting	26th September 2022
Title	Ockendon review update
Report of	Bridget Lees, Chief Nursing Officer and Board Level Safety Champion
Prepared by and contact details	Donna Southam, Quality, Safety and Assurance lead midwife Donna.southam@mhbt.nhs.uk Heather Gallagher, Director of Midwifery Heather.gallagher@mhbt.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x	x	x	x
	To advise, alert and approve. This report provides an overview of the position of the Trust in relation to the compliance with the 7 Immediate actions from the Ockenden Report 2020 and the findings of from the insights visited conducted on the 20th and 21st July 2022.			

Summary of Key Issues	The purpose of this report is to provide an update on the current compliance with seven Immediate and Essential Actions (IEAs) identified against the recommendations of the Ockenden first report, *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust* (December 2020) and a summary of the regional Insight (assurance) visit which took place on the 20th and 21st July 2022. The Trust submitted partial compliance with all the immediate actions in June 2022 and following external validation the Trust was awarded full compliance with immediate action 2 and 7. This was shared in the public domain in May 2022. The Trust received a regional Insight visit on the 20th/ 21st July 2022, as part of the ongoing assurance of compliance and sustainability of improvement, supported by the Regional Chief Midwife. The Trust has received a report with recommendations which are included in appendix 1 following the visit. The Insights team provided a summary of the Ockenden IAEs status (Appendix 2). The Trust was found to be partially compliant with all the seven IEAs. Following the assurance visit feedback being received the maternity Service developed a robust action plan to address the actions identified against each of the IEAs and has established a multidisciplinary working group.

	The service has progressive plans to ensure all areas RAG rated as amber and red have further action taken to achieve full compliance. The action plan will be monitored at CGGAG and shared with the LMNS. The Insights team have accepted the offer to return to the Trust in 3 months' time to support their improvement journey. The next visit will take place in October 2022.

Prior Discussions	Committee	Date	Recommendations/ Concerns

Action to be recommended to the Committee/Board	The Committee is asked to receive this report for discussion and assurance of a plan in place to achieve full compliance with the immediate and essential actions as well as the Insights team feedback and recommendations.

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x	x	x
	This report has a direct impact on patient safety			

Impact on Board Assurance Framework or Corporate Risk Register				
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	5/9/2022
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
MIS	Maternity Incentive Scheme
RCOG	Royal College of Obstetrics and Gynaecology
LMNS	Local Maternity and Neonatal System
CGGAG	Care Group Governance and Assurance Group
PMRT	Perinatal Mortality Review Tool
PROMPT	Practical Obstetric Multi-Disciplinary Professional Training

MVP	Maternity Voice Partnerships
MSDS	Maternity Services Dataset
MDT	Multidisciplinary Team
NICE	National Institute of Clinical Excellence
BSOTS	Birmingham Symptom Specific Obstetric System
SOP	Standard Operating Procedure
IEA	Immediate Essential Action
NRT	Nicotine Replacement Therapy

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

MATERNITY INCENTIVE SCHEME YEAR 4 REPORT

PURPOSE

1. The purpose of this report is to provide an update on the current compliance with seven Immediate and Essential Actions (IEAs) identified against the recommendations of the Ockenden first report, *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust* (December 2020) and a summary of the regional Insight (assurance) visit which took place on the 20th and 21st July 2022.

BACKGROUND

1. The Ockenden report was written in the wake of a review at The Shrewsbury and Telford Hospital NHS Trust following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the hospital. The former Secretary of State for Health and Social Care, Jeremy Hunt instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at that Trust.

2. There were seven Immediate and Essential actions (IEAs) within the first Ockenden report comprising 12 specific urgent clinical priorities. The Trust was tasked to set out plans for their response in relation to the Immediate and Essential actions (IEAs), some of which require direct investment to enable delivery.

3. The trust submitted partial compliance with all the immediate actions in June 2022 and following external validation the Trust was awarded full compliance with immediate action 2 and 7. This was shared in the public domain in May 2022.

4. The Final Ockenden Report published on the 30th March 2022 reports on the care of all families included in this review of maternity services at Shrewsbury and Telford Hospital NHS Trust. It explores internal and external factors that may have contributed to the failings in care. The report is particularly focussed on the Trust's failings in governance processes which directly led to the harm that families experienced.

5. Since the publication of the first report, trusts and maternity services across England have shared their plans to ensure full implementation of the seven IEAs takes place. The NHS has been working with regions, systems and Royal Colleges to implement the IEAs. Significant funding has been provided by the NHS, although we all recognise that much more is needed. The NHS has also reviewed the Maternity Transformation Programme to ensure future plans are in line with the seven IEAs.

6. All Trusts have now assessed their position against the IEAs and submitted evidence to demonstrate compliance which has been independently quality assured. The commitment to system-wide improvement in maternity services has also seen all NHS standard contracts include conditions whereby any provider delivering maternity services must provide and implement an action plan, approved by its governing body,

describing, with timescales, how it will implement the immediate and essential actions set out in the Ockenden Review.

7. The Government's announced additional investment into maternity services in March 2021 for £95.6million across England and in July 2021 a further £2.45m that were allocated to the Royal College of Obstetricians and Gynaecologists (RCOG) to find the best ways of spotting early warning signs of infants in distress. For 2021/22, more than £80m of additional funding has been allocated to be distributed as targeted System Development Funding. This funding will be focused on areas where it will have the biggest impact on delivering the immediate and essential actions and ensuring the safety of women, babies and their families.

8. With a national shortage of midwives, and concerns around continuing attrition of midwives and obstetricians, actions have been taken to increase the workforce by recruiting midwives internationally and £4.5m funding for 2021/22 has been allocated. Additional investment has also been made in Professional Midwifery Advocates, who provide educational and psychological support for Midwives, increasing the number to 800 in England. To support retention of Midwives, NHSE&I has also funded a pastoral care midwife role in every maternity unit during 2021/22.

9. In March 2022 a further investment of £127 million over two years was announced to fund further workforce expansion, leadership development, capital to increase neonatal cot capacity, additional support to the LMNS and retention support.

10. The Trust received an Ockendon assurance visit on the 20th/ 21st July 2022, as part of the ongoing assurance of compliance and sustainability of improvement, supported by the Regional Chief Midwife. The Trust has received a report with recommendations which are included in Appendix 1 following the visit. The Insights team provided a summary of the Ockenden immediate and essential actions status (Appendix 2).

11. This report provides the Committee with an overview of the position of the Trust in relation to the compliance with the 7 Immediate actions from the Ockenden Report 2020 and the findings of from the Insights visited conducted on the 20th and 21st July 2022. There is an action plan in place and a senior multidisciplinary group meets monthly to commit to implementing all immediate and essential actions. The action plan will be monitored at CGGAG and shared with the LMNS.

ANALYSIS/DISCUSSION

1 An Insights visit to the University Hospitals of Morecombe Bay services took place on the 20th and 21st July 2022. The purpose of the visit was to provide assurance against the 7 IAEs from the interim Ockenden report. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the interim Ockenden recommendations were embedded in practice. Conversations were held with various members of the senior leadership team and various frontline staff ranging in job roles. Emerging themes from conversations were organised under the immediate and essential actions heading:

- IEA1 Enhanced Safety

- IEA2 Listening to Women & Families
- IEA3 Staff Training and Working Together
- IEA4 Managing Complex Pregnancy
- IEA5 Risk Assessment Throughout Pregnancy
- IEA6 Monitoring Fetal Well-Being
- IEA7 Informed Consent
- Workforce Planning and Guidelines.

2. The Insights team acknowledged the large geographical area the Trust served and the unique challenges this brought regarding cross site working. In addition, there was acknowledgment the Trust offered an open and transparent overview of the services, identifying areas of good practice and areas that had ongoing challenges. Furthermore, the regional team acknowledged the trust Board was sighted on the challenges within maternity services, and these are recorded on the corporate risk register.

3. The Insights team understood the trust had a new maternity leadership team in place and this would take time to embed and acknowledged the improvement journey had commenced. In addition, the trust had invested in the midwifery leadership team, including the appointment of a Consultant midwife and several specialist midwifery roles.

4. There was acknowledgment the trust was aware the governance processes required to strengthen and had undertaken a review with plans in place to improve. In addition, there was an improvement plan for investigating a back log of serious incidents. The Insights team felt that the delay in reporting on StEIS was in part due to the decision to StEIS report being made at the Executive Review Group, the Insights team felt this could be improved by delegating this to the MDT. It was noted the Trust had invested in a quality, safety and assurance lead midwife to support the governance team.

5. The Insights team identified the midwifery led offer varied by site and felt the trust should review without delay the midwifery led offer at the Barrow site. In addition, BadgerNet had been implemented and the Insights team felt this was positive and would assist the trust with their audit function and capability. The Insights team heard the trust had plans in place to review guidance to ensure it is reflective of NICE guidance

   The trust is partially compliant with all the Immediate actions from the first Ockenden Report 2020:

   - Immediate action 1 Enhanced safety
   - Immediate action 2 Listening to women and families
   - Immediate action 3 Staff training
   - Immediate action 4 Complex pregnancies
   - Immediate action 5 Risk Assessment Throughout Pregnancy
   - Immediate action 6 Monitoring fetal well being
   - Immediate action 7 Informed Consent
   - Workforce Planning and Guidelines.
   - Essential actions for midwifery workforce and NICE guidance.

6. **Immediate action 1 Enhanced Safety** was awarded partial compliance following the Insights visit. There was evidence demonstrating the Senior Leadership team met

frequently however as the Clinical Lead had just been appointed, they had not been present at the meetings. There was acknowledgement the trust had plans in place to address this. The evidence submitted prior to the visit demonstrated the Board are sighted on serious incidents and associated action plans, the Insights team were concerned regarding the volume of incidents with overdue investigations and open actions, the insights team heard the governance processes had been reviewed and there were plans in place to address this. The evidence submitted demonstrated the triangulation of HSIB, Complaints, training and serious incidents took place at divisional level. The MSDS dataset was shared to the required standard with the exception of Continuity of Care data, plans were in place to address this. The evidence submitted demonstrated the Board were sighted on the challenges faced by maternity, the Insights team felt it was not clear how the Board planned to support the team in delivering the action plans. The Trust had an action plan in place for full implementation of PMRT.

7. **Immediate action 2 Listening to Women & Families** was awarded partial compliance following the Insights visit. The regional midwifery team had supported the Trust to undertake a retrospective review of PMRT cases, and some reports have not been shared with families yet, it was acknowledged there were plans in place to address this. It was identified the trust forms part of the MVP and engages positively with the MVP and MVP Chair, the Insights team felt there was strong foundations to build on to ensure true co-production. Furthermore, the Safety Champions meet bi-monthly, the Insights team felt this group could better reflect service user voice by the inclusion of the MVP Chair at these meetings. The evidence submitted suggested the Board did not fully understand the role of the Maternity Safety Champion. The Insights team heard the trust was exploring appointing to a family liaison role, the Insights team felt this would be a positive appointment and should be progressed. It was acknowledged there was a NED safety champion for maternity.

8. **Immediate action 3 Staff Training and Working Together** was awarded partial compliance following the Insights visit. The evidence submitted showed PROMPT training was at 77% for June 2022, with doctors at 54.2%, the Insights team heard there had historically been an absence of obstetric support to attend and deliver training and this was being addressed and there were plans in place to ensure compliance with training. The Trust provided evidence that all external monies provided for training are ringfenced, with assurance these funds did not form part of efficiency planning. The Insights team observed a cohesive culture of multidisciplinary working within sites. The Training Needs Analysis was in draft form, the insights team feel this should be progressed as soon as practicable.

9. **Immediate action 4 Managing Complex Pregnancy** was awarded partial compliance following the Insights visit. The Trust form part of North West (NW) Maternal Medicine Network. The Insights team felt Maternity services could be more proactive within the maternal medicine network. The SoP for maternal medicine had not been written, the Insights team felt that the Trust should without delay improve partnership with the L&SC LMNS as there had been a SoP produced that the Trust could adopt. The Insights team heard audit capacity and capability had improved since the introduction of BadgerNet. The audit submitted as part of the evidence demonstrated service users had a named consultant.

10. **Immediate action 5 Risk Assessment Throughout Pregnancy** was awarded partial compliance following the Insights visit. BadgetNet has a mandatory field to ensure all service users are risk assessed at every contact and this is recorded within the personalised care plan. The antenatal care guidance submitted as evidence was

clear that risk assessments must be carried out at each contact, the Insights team noted the guidance although appeared to have been ratified had the "draft" watermark through the document. The risk assessment and referral audit submitted as part of the evidence demonstrated referrals were made in most cases, the insights team were concerned that 3 (from 66) safeguarding referrals had not been sent, the Trust was advised to investigate as a matter of urgency.

11. **Immediate action 6 Monitoring Fetal Well-Being** was awarded partial compliance following the Insights visit. The Insights team heard the Trust had not adopted BSOTS due to estates and staffing, the Insights team felt it would be a positive quality improvement programme to adopt this model of triage. The telephone triage area at the RLI the Insights team felt was not fit for purpose with calls being taken in the day assessment unit ward area, this poses a risk of breaches of confidentiality and the Trust must address this without delay. PA time for leads was being reviewed to ensure adequate time was allotted to lead posts and the obstetricians had clear roles and responsibilities, the Insights team felt this should be progressed without delay. The Trust had appointed a Saving Babies Lives Care Bundle champion midwife who had oversight of all 5 elements within the care bundle. The Insights team acknowledge this was good practice. The Trust had reintroduced CO monitoring at booking and 36/40 the rates were 87% at booking and 70% at 36/40. They were aiming for CO monitoring at every antenatal contact. The Trust had been successful in providing impatient NRT to women during inpatient stay, this was acknowledged by the Insight team as good practice. The Trust had appointed a fetal monitoring lead at the RLI and FGH site. Both fetal monitoring leads had a job description detailing roles and responsibilities. This was submitted as evidence. The Trust had appointed a fetal monitoring lead consultant and have provided a job description as evidence although the job description was still in draft form.

12. **IEA7 Informed Consent** was awarded partial compliance following the Insights visit. The Insights team heard that BadgerNet a system of electronic patient records had been implemented with the digital handheld notes available to service users in other languages, the Insights team considered this good practice. The Trust has been asked to consider the impact on those who have visual and cognitive impairments and those who are digitally excluded. The MVP Chair informed the Insights team the system was receiving positive feedback. The midwifery led offer varied between sites and the Insights team felt the estates need to be addressed in order to truly respect the wishes of the service users across all locations. The Trust was to submit a business case for a maternity communications officer position, the insights team felt this would be good practice if appointed to.

13. **Workforce Planning & Guidelines** was awarded partial compliance following the Insights visit. The Trust had invested in the maternity leadership team, appointing to several specialist roles including a Director of Midwifery and a Consultant Midwife, the Insights team felt this team was an experienced team and would become a cohesive team over the coming months. The Director of Midwifery is directly managed and accountable to the Chief Nursing Officer. The evidence submitted showed 23.2% of guidance was out of date, a NICE guideline lead had been recently appointed. The Insights team felt the Trust should work closely with the LMNS as a vehicle to support the updating of guidance. The Consultant's had a 1:3 on call rota, the trust is aware of the risk, and this is recorded on the corporate risk register. The Insights team feel there is a risk to service delivery and the safety of service users, the Trust must prioritise addressing this risk. The maternity teams across the bay meet virtually each morning to discuss staffing and acuity to ensure safe staffing, the insights team felt this was good practice.

14. Following the final audit results being received the maternity service have developed a robust action plan to address the actions identified against each of the Immediate Essential actions and has established a senior multidisciplinary working group. The service has progressive plans to ensure all areas RAG rated as amber and red have further action taken to achieve full compliance.

15. The Insights team have accepted the offer to return to the Trust in 3 months' time to support their improvement journey. The next visit will take place in October 2022.

RISKS

1. The partial compliance with seven immediate essential Ockenden actions has been added to the WACS Risk Register. This is a risk of 15.

2. The rating received from the national team will be shared with the CQC as part of the regulatory process. A detailed breakdown was published of each Trust's compliance with the 7 Immediate Actions in May 2022.

RECOMMENDATIONS

1. Following the final audit results being received the maternity service have developed a robust action plan to address the actions identified against each of the Immediate Essential actions and has established a senior multidisciplinary working group. The service has progressive plans to ensure all areas RAG rated as amber and red have further action taken to achieve full compliance.

2. The Committee is asked to receive this report for discussion and assurance of a plan in place to achieve full compliance with the immediate and essential actions as well as the Insights team feedback and recommendations.

APPENDIX ONE Ockenden Insights Visit Action Plan

Recommendation	Action	Designation of Responsible Officer	Target Date	Evidence of Progress and Completion	Monitoring and Evaluation group	Date Action Completed
Recommendations made following Insights Visit						
The Trust had a significant number of action plans for maternity services, the appointment of a project support officer to co-ordinate should be progressed without delay.	Develop a job description and advertise	Heather Gallagher Director of Midwifery (DOM)	30/9/2022	Project support manager in place 2-3 days a week to support WACS	CGGAG and QAC	
A robust assessment process when non-evidence based guidelines are used to ensure the decision is clinically justified.	Develop a SOP detailing the process	Donna Southam Quality Safety, and Assurance Lead Midwife	31/10/2022	In the interim all pathways and guidelines are reviewed at the guideline meeting to ensure they follow national guidance	CGGAG and QAC	
The Trust must also progress the review of guidance without delay to ensure compliance whilst ensuring ratified guidance is not published as draft	Trajectory in place to ensure all guidelines which has passed their review date are updated by 30/1/2023.	Donna Southam Quality, Safety and Assurance Lead Midwife	30/01/2023	Trajectory in place to ensure all guidelines which have passed their review date are updated by 30/1/2023. A review has been undertaken to ensure high risk guidelines are prioritised.	CGGAG and QAC	
The Trust and LMNS need to establish regular proactive engagement.	Pathways and meetings to be confirmed. Dates to be forwarded to the senior	Heather Gallagher DOM	30/09/2022	DoM has contacted Governance Lead Midwife at LMNS and requested dates for all meetings. LMNS undertaking a review of the	CGGAG and QAC	

	team at UHMBT			meeting structures		
The Trust should without delay review the on-call rota for Consultants to ensure compensatory rest.	Review to be undertaken by Clinical Director for Obstetrics and the WACS Associate Director of Operations	Mark Davies Clinical Director (CD) Linda Womack WACS Associate Director of Operations (ADOP)	30/09/2022	Plan following review	CGGAG and QAC	
The Trust should consider the introduction of BSOTS without delay.	Implementation of BSOTS	Holly Parkinson Quality Improvement Lead Midwife	30/11/2022	Project plan to be developed by the 30/9/2022	CGGAG and QAC	
The Trust must address without delay the estates at the Lancaster site for telephone triage	Review of relocation of telephone triage at Royal Lancaster site.	Alison Major Head of Midwifery and Gynaecology (HOM)	30/09/2022	Plan following review	CGGAG and QAC	
The Trust should review its midwifery led offer across sites to ensure this is available to all service users	Review to be undertaken at Furness General Site	Chantelle Winstanley Consultant Midwife	30/10/2022	Plan following review	CGGAG and QAC	
The Trust should without delay put a process in place to ensure a robust system for safeguarding referrals.	Review to be undertaken of the audit	Alison Major HOM	30/09/2022	New reporting workflow to be reviewed in the EPR system to establish if the information sent was correct. If concerns highlighted from the review an immediate process to be put in	CGGAG and QAC	

				place		
The Trust should continue to form part of the MVP and work with the MVP and MVP Chair at the earliest opportunity to ensure co-production	MVP invited to all governance meetings. MVP to be invited to labour ward forums. Discussion at MVP September meeting regarding co-production	Alison Major HOM	Ongoing	MVP minutes	CGGAG and QAC	
Additional issues						
Frequent Leadership meetings with the Clinical Lead in attendance	Appointment of Clinical Lead at Royal Lancaster Hospital. Monitoring attendance going forward	Mark Davies CD O&G	30/09/2022	Attendance monitored by the CD	CGGAG and QAC	
Address the backlog of incidents	All incidents to be closed within 30 days unless further investigation is warranted	Donna Southam Quality, Safety and Assurance Lead Midwife	30/09/2022	Evidenced in monthly CGGAG report	CGGAG and QAC	
Improved process of declaring STESIS reportable incidents	Director of Governance to review and implement a process which ensures STESIS reportable incidents are	Richards Sachs Director of Governance	30/08/2022	3 times a week ERG implemented. STESIS reportable cases can be escalated to the Chief Nursing Officer	CGGAG and QAC	30/8/2022

	declared within 2 working days					
MSDS dataset to include Continuity of Carer	MSDS dataset to capture Continuity of Care compliance	Karen Bridgemen Digital Midwife	30/08/2022	MSDS dataset now includes Continuity of Care	CGGAG and QAC	30/8/2022
Full implementation of PMRT	PMRT undertaken in accordance with NHS Resolution timeframes and PMRT national guidance	Donna Southam Quality, Safety and Assurance Lead Midwife	30/08/2022	PMRT scheduled for 2022. PMRT ToR and PMRT SOP in development. Plan in place to address remaining PMRT cases	CGGAG and QAC	30/10/2022
Invite the MVP to the Maternity Safety Champion meetings	Invitations to be sent to MVP chair for Maternity Safety Champion meeting	Donna Southam Quality, Safety and Assurance Lead Midwife	30/09/2022	Maternity Safety Champion minutes and attendance log	CGGAG and QAC	
Obstetric attendance and support to deliver PROMPT	Lead Obstetrician allocated to lead on education with the lead practice development midwife and forward planner	Mark Davies CD O&G Linda Womack ADOP	30/10/2022	Monthly education meetings to feed into CGGAG	CGGAG and QAC	
Training Needs Analysis to be updated	Training Needs Analysis to be updated	Helena Brown Practice Development Midwife	30/10/2022	Training needs analysis to be approved and on intranet	CGGAG and QAC	
Maternal Medicine SOP	Maternal Medicine SOP to be developed and approved	Mark Davies CD O&G	30/10/2022	Approved SOP available on Intranet	CGGAG and QAC	

		Linda Womack ADOP				
Antenatal Care Guideline was submitted with a draft watermark	Ensure guideline is in final draft	Donna Southam Quality, Safety and Assurance Lead Midwife	30/08/2022	The guideline is available on the intranet	CGGAG and QAC	30/8/2022
Fetal Monitoring Obstetric Job description to be finalised	Approved job description of the Fetal Monitoring Obstetric Lead	Mark Davies CD O&G Linda Womack ADOP	30/09/2022	Final job description	CGGAG and QAC	
Saving Babies Lives Midwife to network with other Saving Babies Lives Midwives in the region	Networking with other Saving Babies Lives Care Bundle Midwife	Holly Parkinson Quality Improvement Midwife	30/09/2022	Ongoing networking and attendance at meetings	CGGAG and QAC	
PA time for leads was being reviewed to ensure adequate time was allotted to lead posts and the obstetricians had clear roles and responsibilities	Review of the Obstetric job plans	Mark Davies CD O&G Linda Womack ADOP	30/09/2022	Allocated PA time in alignment with the maternity self-assessment tool kit	CGGAG and QAC	

APPENDIX TWO Summary of Insight Visit Review of Ockenden Immediate Essential Actions Status

IEA								
1) Enhanced safety	Q1 Dashboards	Q2 – External review of SIs	Q3 – SIs to Board/LMNS	Q4 - PMRT	Q5 - MSDS	Q6 - HSIB	Q7 - PCQSM	Q8 – SIs to Board/LMNS
2) Listening to women and families	N/A	N/A	Q11 – NED	Q12 - PMRT	Q13 – Service user feedback	Q14 – Bimonthly safety champ meetings	Q15 – Service user feedback	Q16 – NED
3) Staff training and working together	Q17 – MDT Training	Q18 – Cons. Ward Rounds	Q19 – Ring-Fenced Funding	Q20 – workforce planning	Q21 – 90% MDT Training	Q22 – Cons Ward Rounds	Q23 – MDT Training Schedule	
4) Managing complex pregnancy	Q24 – MMC Criteria	Q25 – Named Consultant	Q26 – Complex Pregnancies	Q27 – SBLCBv2	Q28 – Named Cons/Audit	Q29 – MMC		
5) Risk assessment throughout pregnancy	Q30 – Risk assessment	Q31 – Place of Birth RA	Q32 – SBLCBv2	Q33 – RA recorded with PCSP				
6) Monitoring fetal well-being	Q34 – Leads in post	Q35 – Leads expertise	Q36 – SBLCBv2	Q37 – 90% MDT Training	Q38 – Leads in post			
7) Informed consent	Q39 – Accessible Information, Place of Birth	Q40 – Accessible Information, All Care	Q41 – Decision making and Informed Consent	Q42 – Women's Choices Respected	Q43 – Service User Feedback	Q44 - Website		
Workforce Planning	Q45 – Clinical Workforce Planning	Q46 – Midwifery Workforce Planning	Q47 – D/HoM Accountable to Exec Dir	Q48 – Strengthening Midwifery Leadership				
Guidelines	Q49 - Guidelines							

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QUALITY ASSURANCE COMMITTEE

Date of Meeting	**26th September 2022**
Title	**NHSR Thematic Review 2017-2022**
Report of	**Heather Gallagher, Director of Midwifery**
Prepared by and contact details	Tamsin Cripps, Head of Midwifery tamsin.cripps@mbht.nhs.uk Alison Mayor, Head of Midwifery alison.mayor@mbht.nhs.uk Nicola Askew, Associate Director of Nursing CYP nicola.askew@mbht.nhs.uk Claire Peckham, Paediatric Consultant Claire.Peckham@mbht.nhs.uk Donna Southam, Quality Safety and Assurance Lead Midwife donna.southam@mbht.nhs.uk Mark Davies, Clinical Director of Obstetrics and Gynaecology Mark.Daviews@mbht.nhs.uk Linda Womack, Associate Director of Operations Linda.Womack@mbht.nhs.uk

Confidentiality	Non-Confidential

Purpose of Report	**To Advise/Alert**	**To Assure**	**To Approve**	**To Update**
	x		x	x
	This report is to advise, alert and approve the action plan developed from the findings of an NHS Resolution Thematic Review presented to the Trust in March 2022. The review covers 12 cases referred from the Trust between 2017 and 2022. The report includes a robust action plan to address the themes identified. The action plan will be reviewed and monitored monthly through the Care Group Governance Assurance Group (CGGAG) and shared with the Trust Board Safety Champions.			

Summary of Key Issues	The Early Notification Scheme was introduced on the 1st April 2017, and reportable cases include babies born, following labour, with a potentially severe brain injury diagnosed in the first seven days of life. The aim of the Early Notification Scheme is to identify learning and share at a national, regional and local level. Secondly, improve the experience for both the families and staff affected. In addition, reduce formal litigation in the courts and the associated legal costs. The number of reported cases between 2017 to 2019 is in line with the national average reported to the Early Notification Scheme. There is no comparable data between 2019-2021 however the case numbers are in keeping with previous reported years. The summary of the main themes are: **1. Neonatal factors:** Lack of presence at delivery, CT scan use, delayed intubation, Neonatal Life Support guidance not followed. **2. Fetal monitoring:** Misinterpretation, inappropriate modality, fresh eyes reviews. **3. Delayed care delivery:** Delayed delivery of baby, delayed obstetric review, delayed examination. **4. Delayed escalation:** Midwifery to medical staff, registrar to consultant. **5. Delayed transfer:** Both neonatal and maternal. **6. Lack of senior support:** Midwifery and neonatal. The identified themes were in line with improvement work already completed and underway. An action plan has been developed by the senior multidisciplinary team. The action plan will be shared with NHS Resolution and monitored monthly through the Care Group Governance Assurance Group (CGGAG) and shared with the Trust Board Safety Champions.

Prior Discussions	**Committee**	**Date**	**Recommendations/ Concerns**
	Trust Board	March 2022	Themes of review included in Maternity Report.
	Care Group Governance and Assurance Group	23rd August 2022	Report discussed

Action to be recommended to	To review this report for discussion and approve the action plan

the Committee/Board	

Link to Key Priorities	Delivering outstanding care and experience	Create the culture and conditions for colleagues to be the very best they can be	Make the best use of our physical and financial resources	Working in partnership
	x	x		x
	This report has a direct impact on patient safety			

Impact on Board Assurance Framework or Corporate Risk Register				
Risk Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Equality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Quality Impact Assessment	Is this required?	**N**	If Yes, Date Completed	
Environmental / Sustainability Impact Assessment	Is this required?	**N**	If Yes, Date Completed	

Acronyms	
NHS Resolution	National Health Service Resolution
NLS	Neonatal Life Support (a more advanced training than the minimal standard Newborn Life Support)
CNST	Clinical Negligence Scheme for Trusts

EN Scheme	Early Notification Scheme
CGGAG	Care Group Governance Assurance Group
CQC	Care Quality Commission

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

NHS RESOLUTION REPORT

INTRODUCTION

1. The Early Notification Scheme was introduced on the 1st April 2017, and reportable cases include babies born, following labour with a potentially severe brain injury diagnosed in the first seven days of life.

2. The aim of the Early Notification Scheme is to identify learning and share at a national, regional and local level. Secondly, improve the experience for both the families and staff affected. In addition, reduce formal litigation in the courts and the associated legal costs.

3. The number of reported cases between 2017 to 2019 is in line with the national average reported to the Early Notification Scheme. There is no comparable data between 2019-2021 however the case numbers are in keeping with previous reported years.

4. All maternity services that are rated as inadequate by the CQC are offered a thematic review of their qualifying cases by NHS Resolutions. This is a supportive measure to assist with learning and safety improvements. NHS Resolutions presented the findings of their review to University Hospitals Morecambe Bay Trust in March 2022. The review covers all cases referred to NHS Resolutions through the Early Notification Scheme and the Healthcare Safety Investigation Branch (HSIB).

5. The summary of the main themes are:

- **Neonatal factors:** Lack of presence at delivery, CT scan use, delayed intubation, Neonatal Life Support guidance not followed
- **Fetal monitoring:** Misinterpretation, inappropriate modality, fresh eyes reviews
- **Delayed care delivery:** Delayed delivery of baby, delayed obstetric review, delayed examination
- **Delayed escalation:** Midwifery to medical staff, registrar to consultant
- **Delayed transfer:** Both neonatal and maternal
- **Lack of senior support:** Midwifery and neonatal

6. NHS Resolution (NHSR) requested feedback on the below actions by the 29th July 2022.

DISCUSSION

1. The Trust should share the findings of the thematic review with wider maternity, neonatal and governance teams.

The findings were shared with the Trust Board in March 2022 and the Maternity and Neonatal Governance Meeting on the 2nd March 2022. The action plan will be shared at CGGAG on the 23rd August 2022 and with the Board Level Safety Champions at the Maternity Safety Champions meeting.

2. The Trust will feedback how their ongoing improvement work relates to the themes identified in the review

Please see action plan below.

3. Clarifications related to previous correspondence, which concerned feedback from an individual case.

- **Is a stethoscope included in the routine homebirth kit?**

The Trust has implemented the standardised Baby Lifeline Homebirth bags. These contain a stethoscope.

- **Are you satisfied that the safety of both women and staff is assured in your home birth protocol, and that this approach supports informed maternal choices?**

The Homebirth Guideline was updated to ensure practise is aligned to national recommendations and provides a safe framework to ensure safety for women and babies. A Consultant Midwife who commenced in post on the 4th July 2022 will be working with the Maternity Voice Partnership to ensure maternal choice is reflected.

4. Has the second midwife involved in the neonatal resuscitation had any additional training?

Both midwives attended NLS training courses immediately following the case in 2018. Neither midwife works in the community setting at the present time. We have since implemented in house NLS training and community midwives are prioritised to attend.

Monitoring of the Action Plan

1. An action plan has been developed by the senior multidisciplinary team. The action plan will be shared with NHS Resolutions and monitored monthly through the Care Group Governance Assurance Group (CGGAG) and shared with the Trust Board Safety Champions.

2. The identified themes were in line with improvement work already completed and underway.

Appendix 1 NHSR Action Plan

Other Identified Factors (Occurred 1/12)

Identified Factor	UHMB Actions undertaken
Mismanagement of fetal bradycardia	• Fetal monitoring guideline in-line with national guidance • Fetal monitoring leads perform quarterly audits • Weekly fetal monitoring training sessions
Impacted fetal head	• Incorporated within forward plan of PROMPT training • Fetal pillows in use
Incorrect diagnosis of full dilatation	• Additional support and training offered on an individual basis if concerns identified
Loss of situational awareness	• Included in mandatory training
Lack of 1:1 care in labour	• 1:1 care recorded and reported monthly at Trust Board and regional level • 100% 1:1 care maintained on all sites and monitored monthly
No obstetric review before second round of induction	• Induction of labour guideline updated • Induction of Labour audit
Prolonged instrumental with multiple instruments	• Operative birth guideline currently under review
Management of retained placenta	• Guideline reviewed and updated June 2021
Chosen place of birth not available	• Regional escalation policy developed and being implemented • Helme Chase Midwifery Led Unit has implemented a night shift to reduce unavailability of the service
Delay in evacuating pool	• Risk assessment stickers created with patient information for when they would be asked to leave the pool. Proforma now available on Badgernet • Skills drills
Signs of sepsis not recognised	• Modified Early Obstetric Warning scoring tool implemented on all sites and including homebirth

	• Sepsis included in rotational skills drill forward plan • Sepsis included in PROMPT training cycle • Sepsis Audit to be undertaken November 2023
Sliding scale not commenced when indicated	• Increased establishment of diabetic specialist midwives to increase teaching sessions in clinical areas and cross site presence for advice and guidance • Individual education provided for staff members • Guideline currently under review
Oxytocin mismanagement	• Guideline reviewed and updated Nov 2021
Prolonged induction of labour	• Change of guideline to ensure all women are offered caesarean section following 24 hrs of Propess • Included as a standard in the induction of labour audit
Prolonged use of Propess	• Guidance for use of Propess incorporated within guideline and audited for assurance
Fetal heart and pool temperature not checked prior to delivery	• Waterbirth guideline updated • In January 2022 the education theme of the month was waterbirth to share the learning • Audit to be completed in November 2022
Poor quality local RCA	• Trust training developed • Baby Lifeline training accessed • HSIB training accessed

NHSR Report
University Hospitals of Morecambe Bay NHS Foundation Trust
Quality Assurance Committee (26th September 2022)