Oxford University Hospitals
NHS Foundation Trust

Public Trust Board Meeting: Wednesday 10 March 2021

TB2021.20

Title:	**Maternity Incentive Scheme Update Report**

Status:	**For Discussion**
History:	**Maternity Clinical Governance Committee**

Board Lead:	**Chief Nursing Officer**
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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. The purpose of this paper is to provide an update on the current status of OUH compliance with the NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year Three.
2. It is also intended to highlight to the Board areas of risk to compliance, facilitating discussion as to how the Trust Board could most effectively support the Maternity and Neonatal units with proposed mitigations.

Recommendations

3. The Trust Board is asked to:
    - Note the contents of the update report;
    - In relation to Safety Action 4 and Appendix 2:
        - Formally record in the minutes the proportion of Obstetrics and Gynaecology Trainees in their trust who responded 'Disagreed' (27.49%) and 'Strongly disagreed' (24.14%) to the 2019 General Medical Council (GMC) National Trainees Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' (Appendix 2);
        - note the actions that have been undertaken in the Obstetrics and Gynaecology Directorate since 2019;
        - consider a live audit of rota changes for trainees so that more timely and objective evidence of this metric is available;
    - Consider how its organisation is complying with the Saving Babies' Lives Care Bundle Version 2 (SBLCBv2) and
    - Discuss how the Trust could support the Maternity and Neonatal units with overcoming the challenges that have been identified.

Contents

1. Purpose

1.1. The purpose of this paper is to provide an update on the current status of OUH compliance with the NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year Three.

1.2. It is also intended to highlight to the Board areas of risk to compliance, facilitating discussion as to how the Trust Board could most effectively support the Maternity and Neonatal units with proposed mitigations.

2. Background

2.1. The deadline for the Board declaration of compliance with all ten standards to reach NHSR was extended in light of the Covid-19 pandemic to noon on Thursday 15 July 2021. A twelve page revision guide and revised Scheme were circulated by NHSR on the 1st February 2021.

2.2. The ten safety actions for year three of the scheme were first published by NHSR on 23rd December 2019, however were subject to change as a direct result of the Covid-19 pandemic (see sections 3 and 5 below).

2.3. This paper outlines the required standards for each of the ten safety actions along with the current evaluation of the compliance status and perceived level of risk for each standard (see section 5 below).

3. October Re-launch and Revised Guidance from NHSR

3.1. After a pause on the scheme during the first wave of the pandemic, NHSR relaunched the Scheme on the 1st October 2020. This relaunched Scheme included the addition of elements aiming to ensure key learning from important emerging Covid-19 themes were considered and implemented.

3.2. A report against compliance with the October 2020 revised standards and relaunch was presented to Trust Board in November 2020 (TB2020.76) and in January 2021 (TB2020.07).

3.3. The following section outlines the two areas of high risk of non-compliance that the Board are asked to consider.

4. Overview of Areas with High Risk of Non-Compliance

4.1. These two Safety Actions are key areas of concern for the Maternity and Neonatal Directorates.

4.2. **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? **High risk on non-compliance**

4.2.1. OUH offer Transitional Care Services for parents to be with their newborn(s) across different locations within the Trust, the Postnatal

Ward being one of them. The Postnatal Ward arm was launched at the beginning of 2020, however current staffing levels, skills mix and capacity mean that the admission criteria for the provision of transitional care in this practice area do not currently consistently meet the minimum standards required by the Maternity Incentive Scheme, with infants receiving transitional care in the Low Dependency Unit of the Newborn Care Unit.

4.2.2. There is an action plan in place outlining the implementation of a Transitional Care Pathway which meets the requirements of the Maternity Incentive Scheme.

4.2.3. **Financial implications:** It is expected that work is needed to become compliant and this may require financial support.

4.3. **Safety Action 4**: Can you demonstrate an effective system of Clinical Workforce planning to the required standard? **High risk of non-compliance (Neonatal Nursing workforce is not currently compliant)**

4.3.1. **Financial implications:** It is expected that the work needed to become compliant will have a significant financial implications due to the need to extend the Neonatal Medical and Nursing Workforces. To be compliant the MIS asks for action plans to be approved at Board level to address any deficiencies.

4.3.2. To this end, a business case has been developed to address the issue with Neonatal Workforce and is to be presented at business planning group as soon as possible. At this time a business case number cannot be provided.

4.3.3. Whilst we are currently compliant with the Scheme's requirements for Neonatal Medical workforce, it is recognised that there is a high risk of non-compliance in the long term. This is because current compliance is due to temporary staff members. To mitigate this risk, a business plan to recruit four additional Neonatal Doctors is being developed a business case number will be provided in the next MIS update paper. The Board is asked for their support in reviewing and approving this business case in order to achieve compliance.

5. Overview of Areas with Demonstrated Compliance

5.1. **Safety Action 5**: Can you demonstrate an effective system of Midwifery Workforce Planning to the required standard? **Compliant**

5.1.1. Compliance has been evidenced with all required standards of this safety action. The submission of the second six monthly Midwifery staffing oversight report to the March Public Board this safety action will be complete with a plan to maintain compliance in place.

5.2. **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

Maternity Voices Partnership (MVP) to co-produce local maternity services? **Compliant**

5.2.1. Compliance has been evidenced with all required standards of this safety action. Work is ongoing and will continue to maintain compliance.

6. Year 3 Safety Actions: Detail of Current Status and Risk Level

6.1. **Safety Action 1**: Perinatal Mortality Review Tool (PMRT)

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance	Expected Evidence
a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.	**Expecting to be compliant** A Standard Operating Procedure is being drafted to ensure a more robust process exists within our Trust for reporting eligible deaths to MBRRACE-UK.	• Paper submitted to Confidential Trust Board November 11th 2020 • Paper submitted to Confidential Trust Board January 11th 2021 (paper number) • Paper to be submitted to May Board • CNST will check our PMRT data.
a) ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies suitable for review, using the PMRT from Friday 20 December 2019 to 15 March 2021, will have been started.	**Compliance already achieved for all deaths in this time period**	• As above
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 Friday 20 December 2019 to Monday 15 March 2021, will have been reviewed using the PMRT by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool.	**Expecting to be compliant**	• As above

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance	Expected Evidence
c) For 95% of all deaths of babies who were born and died in your trust from Friday 20 December 2019, the Parents were told that a review of their baby's death will take place, and that the Parents' perspectives and any 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. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trust 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 these actions.	**Expecting to be compliant**	• Paper submitted to Confidential Trust Board November 11th 2020 • Evidence in first section of the PMR tool. Data collected in bereavement checklists used in both maternity and the neonatal unit respectively. • At time of submission CNST pulled data from PMRT will be subsequent Trust Board Papers.
d)i Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust Maternity Safety Champion.	**Currently compliant** Trust Board meetings: • November 2020: Quarter 4 of 2019/20 and Quarters 1 and 2 of 2020/21 • March 2021: Quarter 3 of 2020/21 • May 2021: Quarter 4 of 2020/21	• Paper submitted to Confidential Trust Board November 11th 2020 • Paper submitted to Confidential Trust Board January 11th 2021 (paper number) • CNST will check our PMRT data.

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance	Expected Evidence
	All reports will be discussed with the Trust Maternity Safety Champion prior to being reviewed at the Board meeting.	

6.2. **Safety Action 2**: Maternity Services Data Set (MSDS)

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. It will help trusts understand the improvements needed in advance of the assessment months. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met. Criteria 1-13 will be assessed by NHS Digital and included in the scorecard.	See below for details of 13 mandatory criteria. OUH have had successful submissions every month so far. Further clarity was sought from the Scheme by Operational Services Manager for Maternity on standard 5 of this safety action surrounding data completeness and whether it would be acceptable to collect data in a number of clinics but not all community clinics. A Higher Information Analyst from NHS Digital confirmed that there is no threshold for the number of required records.	• CNST Criteria Scorecards • Full Scorecard meeting all 13 criteria submitted in November 2020
1. At least two people registered to submit MSDS data to SDCS Cloud and still working in the Trust on Saturday 31 October 2020.	**Compliant**	

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
2. MSDSv2 webinar attended by at least one colleague from each trust in January/February 2020	**Compliant**	
3. Trust Boards to confirm to NHS Resolution that they have fully conformed to the MSDSv2 Information Standards Notice, DCB1513 and 10/2018, which was expected for April 2019 data; or that a locally funded plan is in place to do this and agreed with the Maternity Safety Champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT.	**Compliant**	
4. Made a submission relating to August 2020 - December 2020 data, submitted to deadlines October 2020 - February 2021.	**Compliant**	• Evidence pulled from NHS Digital • Evidence of submission with Information Team.
5. December 2020 data included all following tables: MSD000 MSDS Header MSD001 Mother's Demographics MSD002 GP Practice Registration MSD101 Pregnancy and Booking Details MSD102 Maternity Care Plan MSD201 Care Contact (Pregnancy) MSD202 Care Activity (Pregnancy) MSD301 Labour and Delivery MSD302 Care Activity (Labour and Delivery) MSD401 Baby's Demographics and Birth Details MSD405 Care Activity (Baby)	**Expecting to be compliant**	• As above

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
MSD901 Staff Details		
6. December 2020 data contained at least 90% of the deliveries recorded in Hospital Episode Statistics (unless reason understood). (MSD401)	**Compliant**	• As above
7. December 2020 data contained at least as many women booked in the month as the number of deliveries submitted in the month (unless reason understood). (MSD101)	**Compliant**	• As above
8. December 2020 data contained Estimated Date of Delivery for 95% of women booked in the month. (MSD101)	**Compliant**	• As above
9. December 2020 data contained valid postcode for mother at booking in 95% of women booked in the month. (MSD001)	**Compliant**	• As above
10. December 2020 data contained valid ethnic category (Mother) for at least 80% 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)	**Expecting to be compliant**	• As above
11. December 2020 data contained antenatal Continuity of Carer Plan fields completed for 90% of women booked in the month. (MSD101/2)	**Expecting to be compliant**	• As above
12. December 2020 data contained antenatal personalised care plan fields completed for 90% of women booked in the month. (MSD101/2)	**Expecting to be compliant**	• As above

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
13. December 2020 data contained valid presentation at onset of delivery codes for 90% of births where this is applicable. (MSD401)	**Expecting to be compliant**	• As above

6.3. **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?

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
a) Pathways of care into transitional care have been jointly approved by Maternity and Neonatal Teams with neonatal involvement in decision making and planning care for all babies in transitional care.	**Partially compliant** The pathway into transitional care was jointly approved by 31 Jan 2020, however the admission criteria must meet a minimum of HRG XA04 (see gap analysis in section 6.3.1 below). The pathway does not always meet the required standard.	
b) The pathway of care into transitional care has been fully implemented and is audited every other month. Audit findings are shared with the neonatal safety champion.	**Partially compliant** Audits have now been completed by the Neonatal Safety Champion and a Neonatal colleague. The pathway has been partially implemented. Therefore this standard has been downgraded from red to amber.	• Audits (Appendix 1)
c) A data recording process for capturing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded.	**Compliant**	

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
d) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.	**Expecting to be compliant**	• Evidence to be requested from ODN minutes
e) Review of term admissions should be an ongoing process. The review of admissions during Covid-19 should be completed by the Friday 26 February 2021 is undertaken to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.	**Compliant**	
f) An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19 period as in point e) above has been agreed with the Maternity and Neonatal Safety Champions and Board Level Champion.	**Expecting to be compliant** Ongoing ATAIN reviews require a significant amount of investment of time, currently undertaken by a Band 7 Midwife and Obstetric Consultant. A strategy is currently being discussed as to how to modify the review process to be able to formulate and progress appropriate actions in a more sustainable way.	

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
G) Progress with the revised ATAIN action plan has been shared with the Maternity, Neonatal and Board level safety champions.	**Compliant**	

Gap analysis: Transitional Care (TC) requirements according to the MIS

MIS Requirements of TC	Current status of TC at OUH
A multidisciplinary approach between Maternity and Neonatal Teams	**Compliant**
An appropriately skilled and trained workforce	**Compliant** Staffing for TC at OUH includes Midwives, Maternity Support Workers, Advanced Neonatal Nurse Practitioners and Paediatricians/ Neonatologists. All babies receiving TC have a named Neonatal Consultant and are reviewed regularly by the ANNP team.
Data collection with regards to activity	**Awaiting confirmation of compliance status**
A link to community services.	**Compliant**
Appropriate admissions as per HRGXA04 criteria (Neonatal Critical Care, Special Care, Carer resident at cot-side and caring for baby)*: *The following list pertain to an otherwise well baby who therefore does not require intensive or high dependency care	**Partially compliant (see list below for details)**
• Presence of an indwelling urethral or suprapubic catheter	**Partially compliant** Babies with catheters or stomas who no longer require intensive/high dependency care have a 'Transitioning to Home' period on the Neonatal Unit. In these circumstances the parent/carer 'rooms in' and is supported by the Neonatal Team to learn how to care for their baby's needs prior to discharge home. There are plans to extend this service to the Transitional Care area on the Postnatal Ward as part of Stage 2 of the implementation plan outlined in
• Care of a Stoma	

MIS Requirements of TC	Current status of TC at OUH
	Appendix 5.
• Birth weight ≤2kg for first 48 hours after birth	**Compliant**
• Gestation at birth 35 weeks for first 48 hours after birth	**Compliant**
• Gestation at birth 34 weeks for first 7 days (168 hours) after birth	**Compliant**
• Gestation at birth <34 weeks until discharge from hospital	**Compliant**
• Intravenous medication not otherwise specified elsewhere	**Compliant**
• Feeding by orogastric, nasogastric, jejunal tube or gastrostomy	**Partially compliant** Babies requiring orogastric, nasogastric, jejunal tube or gastrostomy feeding who no longer require intensive/high dependency care have a 'Transitioning to Home' period on the Neonatal Unit. In these circumstances the parent/carer 'rooms in' and is supported by the Neonatal Team to learn how to care for their baby's needs prior to discharge home. There are plans to extend this service to the Transitional Care area on the Postnatal Ward as part of Stage 2 of the implementation plan outlined in Appendix 5.
• Oxygen by low flow nasal cannula	**Partially compliant** Babies requiring low flow oxygen who do not require intensive/high dependency care have a 'Transitioning to Home' period on the Neonatal Unit. In these circumstances the parent/carer 'rooms in' and is supported by the neonatal team to learn how to care for their baby's needs prior to discharge home. There are plans to extend this service to the Transitional Care area on the Postnatal Ward as part of Stage 2 of the implementation plan outlined in Appendix 5.

MIS Requirements of TC	Current status of TC at OUH
• Receiving Intravenous Sugar +/- electrolyte solutions	**Partially compliant** Babies requiring IV sugar +/- electrolyte solutions who do not require intensive/high dependency care have a 'Transitioning to Home' period on the Neonatal Unit. In these circumstances the parent/carer 'rooms in' and is supported by the Neonatal Team to learn how to care for their baby's needs prior to discharge home. There are plans to extend this service to the Transitional Care area on the Postnatal Ward as part of Stage 2 of the implementation plan outlined in Appendix 5.
• Receiving drug treatment for neonatal abstinence AND on an observations scoring regimen 4 hourly or more frequently	**Compliant**

6.4. **Safety Action 4**: Clinical work force planning

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
Obstetric Medical Workforce All boards should formally record in their minutes the proportion of Obstetrics and Gynaecology Trainees in their trust who responded 'Disagreed or /Strongly disagreed' to the 2019 General Medical Council (GMC) National Trainees Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' Furthermore, there should be an agreed strategy and an action plan with deadlines produced by the Trust to address these lost educational opportunities due to rota gaps. The Royal College of Obstetricians and	**Compliant** OUH was not an outlier for the GMC metric under review in 2019 so there was no formal action plan written at the time.	• See Appendix 2 for narrative and evidence of compliance. • Formally recorded in minutes at March Trust Board.

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
Gynaecologists (RCOG) has examples of trust level innovations that have successfully addressed rota gaps available to view at www.rcog.org.uk/workforce The action plan should be signed off by the trust Board and a copy (with evidence of Board approval) submitted to the RCOG at workforce@rcog.org.uk		
Anaesthetic medical workforce An action plan is in place and agreed at Trust Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6	**Compliant – awaiting evidence**	• Action plan & Trust Board formal minutes
Neonatal medical workforce The Neonatal Unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at Board level	**Compliant at present but with a high-risk of non-compliance** An action plan is being developed to address deficiencies and will be presented to Board.	• Action plan & Trust Board formal minutes
Neonatal nursing workforce The Neonatal Unit meets the service specification for neonatal nursing standards. If these are not met, an action plan is in place and agreed at Board level to meet these recommendations	**Not currently compliant**	• Action plan & Trust Board formal minutes

6.5. **Safety Action 5**: Midwifery Workforce Planning

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	**Compliant**	• Bi-annual paper submitted to Trust Board.
b) 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	**Compliant**	• As above.
c) All women in active labour receive one-to-one midwifery care	**Compliant**	As above.
d) Submit a six monthly midwifery staffing oversight report that covers staffing/safety issues to the Board.	**Compliant**	As above.

6.6. **Safety Action 6**: SBLCBv2

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
a) Trust Board level consideration of how its organisation is complying with the SBLCBv2, published in April 2019.	See below	• Referenced in Overarching Papers to Public Trust Board meetings in November, January, March & May
b) 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	**Expecting to be compliant by deadline**	• Scorecard • SBL dashboard • Action plan or exemption report

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network. The process metrics described in SBLCBv2 should be used by the Board to assess implementation with a threshold score of 80% compliance used to confirm successful implementation. If the process metric scores are less than 95% Trusts must also have an action plan for achieving >95%.		
c) The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including the data submission requirements. The corroborating evidence is the SBLCBv2 survey and MSDS data, availability of this depends on the COVID-19 status.	**Compliant**	
The following rows outline the assurance required to assess compliance with each element of the care bundle		
Element 1: • Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital* • Percentage of women where CO measurement at booking is recorded* • Percentage of women where CO measurement at 36 weeks is recorded* Recording that the test was offered and declined can be included in the numerator of the element 1 compliance metrics*	**Not currently compliant** EPR changes are now live and were implemented in mid-October 2020. However, an audit of OUH compliance for November 2020 demonstrates the need for work to be done in order to achieve 80% compliance. Awaiting an action plan, December and January audit data.	• Scorecards • SBL dashboard • Action plan or exemption report

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
The relevant data items for these indicators should be recorded on the provider's Maternity Information System (MIS) and included in the April 2020 MSDS submission to NHS Digital. If there is a delay in the provider trust MIS's ability to record these data at the time of submission an in-house audit of 40 consecutive cases using locally available data or case records should have been undertaken to assess compliance with this indicator. A threshold score of 80% compliance should be used to confirm successful implementation. If the process metric scores are less than 95% Trusts must also have an action plan for achieving >95%. *Interim August update from NHSR announced that this would be changed to: • Percentage of women where **smoking status** at booking is recorded • Percentage of women where **smoking status** at 36 weeks is recorded. If CO monitoring is suspended due to Covid 19 the audit described above will be based on the percentage of women asked whether they smoke at booking and at 36 weeks.		
Element 2: • Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking.	**Expecting to be compliant by deadline** Awaiting SMART action plan	Trust board specifically confirms 1, 2 & 3 of this element.

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
Note: The relevant data items for these metrics should be recorded on the provider's Maternity Information System (MIS) and included in the April MSDS submission to NHS Digital. If there is a delay in the provider trust MIS's ability to record these data at the time of submission an in-house audit of 40 consecutive cases using locally available data or case records should have been undertaken to assess compliance with this indicator. A threshold score of 80% compliance should be used to confirm successful implementation. 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: 1. women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards 2. in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 3. There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. If this is not the case the Trust Board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice.	As was the case for the Year 2 MIS, an exception report will be submitted for an alternative to offering ultrasound assessment from 32 weeks' gestation for women with BMI>35kg/m^2	

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
How should Trust board specifically confirm that within their organisation standard 1-2 above have been implemented? This should be confirmed as a minimum via inclusion in the Trust's standard operating procedure/guidelines.		
Element 3: • Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy. • Percentage of women who attend with RFM who have a computerised CTG. Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of 2 weeks' worth of cases or 20 cases whichever is the smaller to assess compliance with the element 3 indicators. A threshold score of 80% compliance should be used to confirm successful implementation. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.	**Expecting to be compliant**	Tommy's RFM Leaflet audit data received and awaiting audit report. RFM audit complete and awaiting audit report.
Element 4: • Percentage of staff who have received training on fetal monitoring in labour, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness. • Percentage of staff that have successfully completed mandatory annual competency assessment.	**Expecting to be compliant**	• Trajectory outlining plan to become compliant (Appendix 3)

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
Note: An in-house audit should have been undertaken to assess compliance with these indicators. The compliance required is the same as safety action 8 i.e. 90% of maternity staff which includes 90% of each of the following groups: • Obstetric Consultants • All other Obstetric Doctors (including staff grade Doctors, Obstetric Trainees (ST1-7), Sub Speciality Trainees, Obstetric Clinical Fellows and Foundation Year Doctors contributing to the Obstetric rota • Midwives (including Midwifery Managers and Matrons, Community Midwives; birth centre Midwives (working in co-located and standalone birth centres and bank/agency Midwives). Maternity theatre Midwives who also work outside of theatres.		
Element 5: • Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. • Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. • 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 indicators should be recorded on the provider's Maternity Information System	**Compliant**	

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
(MIS) and included in the April 2020 MSDS submission to NHS Digital. If there is a delay in the provider trust MIS's ability to record these data at the time of submission an in-house audit of a minimum of 4 weeks' worth of consecutive cases up to a maximum of 20 cases to assess compliance with the element 5 indicators. Completion of the audits should be used to confirm successful implementation. If the process indicator scores are less than 85% Trusts must also have an action plan for achieving >85%. In addition, the Trust Board should specifically confirm that within their organisation: • women at high risk of pre-term 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 has been completed to measure the percentage of singleton live births (less than 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids		

6.7. **Safety Action 7**: Service user feeding and coproducing maternity services with Maternity Voices Partnership (MVP)

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
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 to coproduce local maternity services?	See below for details of evidence required.	
Terms of Reference for your Maternity Voices Partnership	**Compliant**	
Minutes of regular Maternity Voices Partnership meetings demonstrating explicitly how a range of feedback is obtained and consistent involvement of trust staff in coproducing service developments based on this feedback	**Compliant**	
Evidence of service developments resulting from coproduction with service users	**Compliant**	
Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses	**Compliant**	
Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data.	**Compliant**	

6.8. **Safety Action 8**: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
a) Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	**Expecting to be compliant**	• See Trajectory of Compliance Tables in Appendix 4
b) Can you evidence that multi-professional training occurs at least twice a year with Anaesthetic/Maternity/Neonatal Teams in the clinical area, and that risks/issues identified are addressed.	**Expecting to be compliant**	
c) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since the launch of MIS year three in December 2019.	**Not currently compliant** There are plans for the Trust e-learning system to change providers in early 2021 and the new system will reflect the MIS NLS requirements. The risk of non-compliance by the deadline is now lower than previously thought as online NLS training can be counted towards compliance. Note also: There is a discrepancy between what OUH asks employees to complete and what the MIS requires. The Trust requirement for resuscitation training is once every 15 months, and the target for each directorate is 80%. The MIS requirement for neonatal resuscitation training is once every 12 months and to have 90% trained within	• See Trajectory of Compliance Tables (Appendix 4) • Still awaiting data from some staff groups.

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
	this period.	

6.9. **Safety Action 9**: Can you demonstrate that the Trust safety champions (obstetrician, midwife and neonatologist) are meeting bi-monthly with Board level champions to escalate locally identified issues?

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
a) A pathway has been developed that describes how frontline Midwifery, Neonatal, Obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks.	**Compliant**	
b) Board level safety champions are undertaking monthly feedback sessions for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to Covid-19 service changes and service user feedback and can demonstrate that progress with actioning named concerns are visible to staff.	**Expecting to be compliant**	
c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. Taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas, a revised action plan describes how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.	**Compliant**	

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
d) Together with their frontline safety champions, the Board safety champion and MatNeoSIP Patient Safety Networks has reviewed local outcomes in relation to: I. Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of Covid-19, drawing on resources and guidance to understand and address factors which led to these outcomes. II. The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK. III. The MBRRACE-UK SARS-Covid-19 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACEUK Maternal_Report_2020_v10_FINAL.pdf IV. The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups And considered the recommendations and requirements of II, III and IV on I.	**Compliant**	
e) The Board Level Safety Champion is actively supporting capacity (and capability) building for all staff to be actively involved in the following areas: - Maternity and neonatal quality and safety improvement activity within the Trust, including that determined in response to Covid-19 safety concerns - The Patient Safety Networks of which each Trust will be a member - Specific national improvement work and testing lead by	**Expecting to be compliant** as long as the following work is undertaken (details from the technical guidance document): 'the Board should support staff to: • identify key trust-level safety improvement priorities, including areas identified via the SCORE culture survey • develop a trust-level improvement	

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
MatNeoSIP that the Trust is directly involved with - The Patient Safety Network clinical leaders group where Trust staff are members	plan • implement the plan and engage in relevant improvement/capability building initiatives nationally, regionally or via the local learning systems • maintain oversight of improvement outcomes and learning'.	

6.10. **Safety Action 10**: NHSR Early Notification Scheme

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
a) Reporting of all outstanding qualifying cases for the year 2019/20 to NHSR's EN scheme.	**Expecting to be compliant**	• Note: an updated log including columns for Duty of Candour and Informing Parents will be included in a future update paper.
b) Reporting of all qualifying cases to the Healthcare Safety Investigation Branch (HSIB) for 2020/21.	**Expecting to be compliant**	
c) For qualifying cases which have occurred during the period 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. 1. the family have received information on the role of HSIB and the EN scheme; and 2. 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008	**Expecting to be compliant**	• Copy of letter and statement in overarching paper to Public Trust Board in May.

Required Standards following re-launch of MIS	December update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
(Regulated Activities) Regulations 2014 in respect of the duty of candour.		

7. Conclusion

7.1. This paper outlines the Trust's current level of compliance with the re-launched MIS requirements.

7.2. It is also highlight to the Board areas of risk to compliance, for the purpose of facilitating discussion as to how the Trust Board could most effectively support the Maternity and Neonatal units with proposed mitigations.

7.3. The information and grading of compliance in the report are accurate at the time of writing but are subject to change as work is ongoing.

8. Recommendations

The Trust Board is asked to:

- Note the contents of the update report;
- In relation to Safety Action 4 and Appendix 2:
    - Formally record in the minutes the proportion of Obstetrics and Gynaecology Trainees in their trust who responded 'Disagreed' (27.49%) and 'Strongly disagreed' (24.14%) to the 2019 General Medical Council (GMC) National Trainees Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' (Appendix 2);
    - note the actions that have been undertaken in the Obstetrics and Gynaecology Directorate since 2019;
    - consider a live audit of rota changes for trainees so that more timely and objective evidence of this metric is available;
- Consider how its organisation is complying with the Saving Babies' Lives Care Bundle Version 2 (SBLCBv2) and
- Discuss how the Trust could support the Maternity and Neonatal units with overcoming the challenges that have been identified.

Appendix A: Evidence

The evidence referred to in the table above is available to the Board and has been reviewed by the Trust Assurance Team.

The list of evidence is as follows:

- Transitional Care Audit Data
- Evidence and Discussion of Compliance with Safety Action 4 – Obstetric Medical Workforce
- Trajectory Outlining Plan For Compliance with SA 6 Element 4 (EFM)
- Tables Outlining Current Compliance with SA 8, Standard a) (PROMPT)
- Tables Outlining Current Compliance with SA 8, Standard c) (NLS)