Oxford University Hospitals
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 13 November 2019

TB2019.109

Title	**Maternity Incentive Scheme Update Report**

Status	For Information
History	Maternity Directorate Clinical Governance meeting 25th October 2019

Board Lead(s)	Sam Foster Chief Nurse			
Key purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

1. This paper is to give an update on the workstreams included in the NHS Resolution Maternity Incentive Scheme Year 2, and the additional workstream that is expected to be added in Year 3.
2. Lessons learned from the first two years of the Maternity Incentive Scheme workstreams are outlined, and opportunities for improvement are explored.
Recommendation The Board is asked to note the contents of the update report, and to discuss how the Trust could support the Maternity and Neonatal units with overcoming the challenges that have been identified.

Maternity Incentive Scheme Update Report

1. Context / Background

1.1. NHS Resolution (NHSR) runs the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care.

2. Safety Action 1: Perinatal Mortality Review Tool

2.1. The Perinatal Mortality Review (PMR) group was formed in 2016, with the aim of providing a process for carrying out comprehensive reviews of all perinatal deaths within the following national MBRRACE criteria:

Included:	**Excluded:**
· All perinatal deaths between 22+0 weeks gestation and 28 days after birth. · Babies who die after 28 days but who have been cared for on the Neonatal Unit	· Cases below 22+0 weeks. · Terminations/Feticides · Babies with a birthweight below 500g where an accurate gestation is not known

2.2. The table below shows the required standards for this Safety Action in MIS Year 2:

Required Standards
a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death. b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death. c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. d) Quarterly reports have been submitted to the Trust Board that includes details of all deaths reviewed and consequent action plans.

2.3. Due to the sensitive nature of the data, an update on the current progress with this workstream has been submitted as a separate paper to the Confidential Trust Board.

2.4. **National recommendations** – In October 2019 MBRRACE-UK/PMRT published the first annual report of the national findings from PMRT reviews ('Learning from standardised reviews when babies die'). The report contains seven recommendations; those that fall partially or fully under the remit of the PMRT review teams have been explored in more detail below. Aside possibly from the last recommendation, which focuses on prioritising research

using PMRT report findings, any of these recommendations could be added to NHS Resolution's Maternity Incentive Scheme in Year 3. The recommendations are:

2.4.1. Improve the recording of the staff involved in PMRT reviews

Action: PMRT review teams

2.4.2. Improve the engagement of parents in reviews making sure they have ample opportunities at different stages after their bereavement to discuss their views, ask questions and express any concerns they have about the care they received

Action: Staff caring for bereaved parents

2.4.3. Provide adequate resourcing of PMRT review teams

Action: Local Trust and Health Boards, Service Commissioners

2.4.4. Involve an external member as part of the PMRT review team

Action: Local Trust and Health Boards, regional support systems and organisations e.g. Local Maternity Systems in England

2.4.5. Improve the quality of actions planned to ensure that the majority of actions are 'strong' and result in system level changes

Action: PMRT review teams, local governance teams in Trusts and Health Boards

2.4.6. Use the local summary reports and this national report as the basis to prioritise resources towards the aspects of care identified as having issues

Action: Local Trusts and Health Boards, Service Commissioners, regional support systems, e.g. Local Maternity Systems in England, Governments and national service organisations

2.4.7. Conduct research into new interventions that may be required to address issues with care identified in the PMRT report

Action: Research funding organisations and researchers

2.5. **'Improve the recording of staff involved in PMRT reviews' and 'Involve an external member as part of the PMRT review team' (see 2.4.1 and 2.4.4 above):**

Staff members who attend the PMRT reviews are recorded in the minutes of the meeting but aren't always added to the PMR tool. This means that the national data does not reflect the reality of the multi-disciplinary nature of the reviews. The local PMR panel aims to improve this by checking on the tool at the beginning of each review that the full membership has been listed appropriately.

The routine core membership of the local PMR panel has also been reviewed. MBRRACE-UK/PMRT recommended and the actual OUH FT composition of the local PMR group is outlined below:

Recommended core membership	OUH FT PMR Panel core membership
Roles within the group: • Chair and Vice-Chair • Scribe/Admin support • PMRT/Maternity Safety Champion	Roles within the group: • Chair • Admin support
Minimum of two each of the following:	
Obstetrician	2-3 Obstetricians routinely attend

Midwife	See below for 4-7 midwives who routinely attend. Other clinical midwives, Professional Midwifery Advocates or the Director of Midwifery have also attended on an ad hoc basis
Neonatologist and Neonatal Nurse for: • All deaths where resuscitation was commenced • All neonatal deaths	1 Neonatologist routinely attends, bringing actions and shared learning identified by a large group of neonatologists who have previously discussed the case at their Morbidity and Mortality meeting
Bereavement team (1 acceptable)	Bereavement Specialist Midwife
Risk manager/governance team member (1 acceptable)	3 governance team members routinely attend: • Maternity Clinical Governance Manager (Midwife) • Perinatal Risk Coordinator (Midwife) • Quality Assurance and Improvement Midwife
External panel member (1 acceptable)	External panel members have been routinely invited – one has attended one meeting
Other members as appropriate to the organisation of care in the Trust/Health Board e.g. service manager	Up to 3 Clinical Midwifery Managers routinely attend
Additional members	
Named and invited to attend or contribute where applicable: • Pathologist • GP/Community healthcare staff • Anaesthetist • Sonographer/radiographer • Safeguarding team • Service manager • Any other relevant healthcare team members pertinent to death	

The table above shows that there is strong representation of obstetricians and midwives at the PMR group. Although there is only one neonatologist who routinely attends, all neonatal deaths are also reviewed at the Neonatal Unit Morbidity and Mortality Meeting, which has a much larger attendance, and the neonatologist brings the actions and learning points from that meeting to the PMR panel meeting. There is scope for improvement in having an external panel member – this has only been achieved once with a Clinical Governance Midwife from another Trust.

2.6. **"Improve the engagement of parents in reviews making sure they have ample opportunities at different stages after their bereavement to discuss their views, ask**

questions and express any concerns they have about the care they received" (see 2.4.2 above):

The October 2019 MBRRACE-UK/PMRT report highlights that nationally 84% of parents were told about the review and 75% of parental perspectives were sought. In the Maternity Incentive Scheme Year 2 in OUH FT there was an issue that the information about whether the parents had been informed wasn't always added to the PMRT as soon as the review was opened, but was instead added at the panel meeting within the four month timeframe. This meant that most of the deaths that occurred in June and July had not yet had this information added to the tool at the point the data were retrieved by NHSR from MBRRACE in August. Further, in some cases the information about parental involvement had been added to a freetext box on the tool that isn't captured as part of the MBRRACE data monitoring. The Clinical Governance Team has since modified the system so that the information about parental awareness will be gathered and added to the appropriate section of the tool as soon as the review is opened. Currently, parents who have had a perinatal bereavement are told about the review and offered the opportunity to present their perspectives on their care at three different time points: first before they leave the hospital, second when they are sent a letter and third if they choose to attend their Consultant follow-up appointment.

2.7. **'Improve the quality of actions planned to ensure that the majority of actions are 'strong' and result in system level changes' (see 2.4.5 above):**

Details of action plans are outlined in the Perinatal Mortality Review Paper being submitted to the Confidential Trust Board. However, the Maternity Clinical Governance team have identified that there is scope to further improve the system whereby actions are followed-up and completed in a timely manner. It is planned that the new Quality Assurance Coordinator, joining the team in December, will further help to ensure that these improvements are implemented.

2.8. **'Use the local summary reports and this national report as the basis to prioritise resources towards the aspects of care identified as having issues' (see 2.4.6 above):**

The Clinical Director, Director of Midwifery, Consultant Obstetric Lead for Quality Improvement (QI) and the Quality Assurance and Improvement Midwife are currently putting together an overview paper of national maternity QI priorities, such that the allocation of resources to both these and local QI priorities can be allocated/managed appropriately. The local summary reports and the national report from PMRT form part of this programme.

2.9. **Other factors that have impacted on the quality and/or timeliness of the reviews:**

2.9.1. Access to external notes

Conducting a robust review of cases where some/all of the antenatal care has been provided by another Trust presents significant difficulties. As a tertiary unit the OUH FT provides care to many pregnant women and/or their babies who began their antenatal care at another unit in the region. The Perinatal Mortality Review Panel has had limited success with requesting notes from other organisations, and has frequently come against barriers to getting these notes; this has taken up a significant amount of Clinical Governance time. It has been raised as an issue at Regional Governance Meeting and the Clinical Directors and Perinatal Mortality Review Leads at other regional units have been contacted to request help with this issue. On one occasion the Perinatal Risk Coordinator attended an external Trust that had a number of cases that needed to be reviewed, to directly review the notes of those cases and

add the relevant information to the PMRT; this was identified as a possible way to overcome the barriers but will not always be an appropriate use of resources. This is likely to be an issue that many tertiary units are contending with so it has also been highlighted to MBRRACE-UK, who are currently working on improving the electronic PMRT system so that data can be added to a case from multiple Trusts. In order to meet the deadlines required by the MIS there have been times when the review has had to be closed without having all the information from the external Trust; it has been highlighted in the report for these cases that the review was not as robust as it could have been if the external notes were available. A system has recently been set up so that when women attend with external notes, these will be scanned onto the Electronic Patient Record (EPR) system using 'Scan-It'; it is hoped that this will resolve this issue in the majority of cases and we will know whether this is the case once the process has had time to embed.

2.9.2. Access to internal notes

There are various factors and national requirements that have meant the Maternity Directorate have so far been unable to become fully digital. When there are incidents such as perinatal bereavement, there are often a number of different teams/individuals who need access to the handheld maternity records. This has meant that Perinatal Mortality Review (or the post-review report closure) is occasionally delayed because the panel have been unable to gain access to the notes. Furthermore, there are a number of different information sources required for conducting the reviews such as EPR, handheld records, post-mortem report and follow-up bereavement appointment letter (the latter two of which are not automatically accessible on EPR). This means that there is no streamlined system for having all the required information in one place.

2.9.3. Time taken for entering data

Once all the information is available, each case requires a minimum of one hour for stillbirths and 1.5 hours for neonatal deaths to enter the data onto the electronic PMRT before the meeting. This means that even if all the information is easily accessible, there is a minimum of 6-7 person-hours per month. This time expands significantly whenever a case is complex or there is more information to be reviewed such as when there has been an inpatient stay during the pregnancy.

2.9.4. Identifying cases

Antenatal/intrapartum bereavements are identified through Datix incident reporting, bereavement team reporting, and electronic discharges being forwarded to a 'bereavement pool' on EPR. All these systems rely on someone to recognise the need to report a case and take responsibility for doing so on a frequently very busy unit while at the same time focusing on giving excellent care to devastated parents. Although there are opportunities for a case to be identified if one reporting method is forgotten by a staff member, there is still the possibility that a case may slip through the net; however, this has not occurred for these types of cases over the past year. Neonatal deaths are identified through the Maternity Clinical Governance team checking the BadgerNet electronic system regularly and the team on the Newborn Care Unit sending an email to the Bereavement Specialist Midwife. There have been occasions over the past year where neonatal deaths have been reported to MBRRACE but have not been identified to the Maternity Clinical Governance Team who organise the panel meeting agendas, particularly when the baby was not born in OUH FT.

The Maternity and Neonatal Units are currently exploring how to improve the system further to minimise the risk of this occurring.

3. Safety Action 2: Maternity Services Data Set

3.1. The table below shows the required standards for this Safety Action in MIS Year 2:

Required Standards
NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria.

3.2. OUH FT continues to submit data to NHS Digital on all three mandatory tables:

- MSD001 Mother's Demographics
- MSD002 GP Practice Registration
- MSD101 Pregnancy and Booking Details

All data submissions to date have been successful, most recently for the August data. There have been no submission errors. However, it is expected that over the next year more of the tables are going to become mandatory, and some of these are going to be challenging to achieve with the data that is currently routinely collected. The Maternity EPR Gap Analysis project is ongoing and it is hoped that this will identify those areas that are key to helping OUH FT achieve the targets set out in the national Maternity Transformation Programme.

4. Safety Action 3: Supporting the Avoiding Term Admissions into Neonatal Units Programme

4.1. The table below shows the required standards for this Safety Action in MIS Year 2:

Required Standard
a) Pathways of care for admission into and out of 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. b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2. c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions into Neonatal units (ATAIN) reviews. d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN

4.2. In the second year of the MIS, OUH FT was compliant with all the above standards. The updated action plan can be found in Appendix 1.

4.3. In the most recent National Maternity and Neonatal Audit (NMPA 2019) 83% of sites reported having a transitional care service: 19% of these were staffed exclusively by Maternity; 17% staffed exclusively by Neonatology; 64% staffed by both Maternity and Neonatology. NHS Improvement's 'Interim People Plan' emphasises that in the future the NHS workforce needs to be increasingly multidisciplinary and non-linear – it is possible that the third year of the MIS may extend its requirements of transitional care services to ensure that all babies who meet the British Association of Perinatal Medicine's (BAPM) criteria for transitional care have access to a robust service that is staffed by a multidisciplinary, well-trained team. The Maternity and Neonatal Units are currently working together on how the OUH FT transitional care service can be improved. This forms part of the overarching 'Better Births' and Local Maternity Strategy action plan which was presented at Maternity Governance Committee in September, the action plan for which may be seen in appendix 2.

5. Safety Action 4: medical work force planning

5.1. The table below shows the required standards for this Safety Action in MIS Year 2:

Required Standard
a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: *'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'* In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps. b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.

5.2. The updated action plan for the 2018 General Medical Council National Training Survey findings can be viewed in Appendix 3.

6. Safety Action 5: midwifery workforce planning

6.1. The table below shows the required standards for this Safety Action in MIS Year 2:

Required Standard
a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done. b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on) d) A bi-annual report that covers staffing/safety issues is submitted to the Board

6.2. As reported to the Board in May and July, a systematic evidence based process to calculate midwifery staffing establishment has been undertaken using the BirthRate Plus® tool.

6.3. The agreed existing funding establishment for OUH midwife to birth ratio at the Trust is 1:29. The ratio is monitored every month via the Maternity Dashboard, which has a red flag when the ratio is over 1:29. So far in this financial year the midwife:birth ratio has highlighted red every month, and remains around 1:30 although it is gradually improving. As highlighted by the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists' (RCOG) recommendation is for a midwife:birth ratio of 1:28 – and it is recommended for tertiary units such as OUH FT to have a ratio of 1:25 due to the complex nature of the cases that are referred here. A business case has been prepared to address the immediate requirement for investment to improve the midwife:birth ratio and to ensure specialist posts, for example bereavement, are also funded adequately.

6.4. The Maternity Directorate continues to actively recruit new staff. In this financial year between October and December we have 36 new midwives commencing with a further 6 to start between January and March 2020. International obstetric nurses and maternity support workers have been recruited to join the Maternity team. However, there are 39.47 predicted leavers between October 2019 and January 2020.

6.5. Bi-annual reports with more information on this Safety Action will be provided for the Board in January and July 2020.

6.6. The updated action plan for this Safety Action can be viewed in Appendix 4.

7. Safety Action 6: Saving Babies' Lives Care Bundle

7.1. The table below shows the required standards for this Safety Action in MIS Year 2:

Required Standard
Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services. Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).

7.2. In 2019 NHS England launched version 2 of the SBL care bundle, and it is fully expected that implementation of this version will be a required standard in MIS Year 3.

7.3. The SBL care bundle elements are listed below, including the additional element introduced in version 2 this year:

- Reducing smoking in pregnancy
- Risk assessment and surveillance for fetal growth
- Raising awareness of reduced fetal movements
- Effective fetal monitoring during labour
- Reducing preterm birth

7.4. The Local Maternity System (LMS) is gathering data on the barriers to implementing the SBL care bundle across the Berkshire, Oxfordshire and Buckinghamshire region. OUH FT has

contributed to this gap analysis. They have also put in a bid for training monies in relation to the new saving babies lives care bundle.

7.5. Progress towards implementing this extended care bundle will be reported to the Board in the bi-annual reports in January and July.

8. Safety Action 7: A patient feedback mechanism for maternity services

8.1. The table below shows the required standards for this Safety Action in MIS Year 2:

Required Standard
User involvement has an impact on the development and/or improvement of maternity services

8.2. Representatives from the Maternity Voices Partnership (MVP) continue to be very valued members of both the Intrapartum Group and the Antenatal/Postnatal Group. Feedback from service users that are submitted to the MVP are discussed at the meetings and themes are identified so they can be prioritised in the Directorate quality improvement work.

8.3. This year the Healthcare Safety Investigation Branch (HSIB), which started taking Maternity cases in July 2018, has been closing its first cases. Following the investigations representatives from the HSIB and from the Maternity Directorate have offered joint closure meetings to the parents whose care was the subject of the investigation. In this way there can be direct communication, including discussion of the findings and improvement action plan, between the external investigators, OUH FT and the service users.

9. Safety Action 8: Multi-Professional Maternity Emergencies Training

9.1. The table below shows the required standards for this Safety Action in MIS Year 2:

Required Standard
90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year.

9.2. The Maternity Practice Development Team and PROMPT (**Pr**actical **O**bstetric **M**ulti-**P**rofessional **T**raining) faculty continue to ensure that OUH FT is compliant with this Safety Action.

9.3. The training database, kept by the Practice Development Team, allows easy monitoring of when staff members have last attended training to ensure they keep their mandatory attendance up to date.

9.4. The PROMPT curriculum includes a session on Human Factors and learning from recent incidents, which is supported by the Maternity Clinical Governance Team.

9.5. There are currently no concerns regarding this Safety Action for the coming year of the MIS.

10. Safety Action 9: Trust safety champions are meeting bi-monthly with Board level champions to escalate locally identified issues

10.1. The table below shows the required standards for this Safety Action in MIS Year 2:

Required Standard

a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within:
i. the Trust
ii. the Local Learning System (LLS)

b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues

c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff

10.2. Trust safety champions continue to meet bi-monthly with the Board level champion to discuss and escalate locally identified issues.

10.3. There is a monthly staff feedback session run by one or both of the safety champions to provide staff with a forum to escalate safety concerns quickly, and to hear directly about progress with improvement activity.

11. Safety Action 10: NHS Resolution's Early Notification Scheme

11.1. The table below shows the required standards for this Safety Action in MIS Year 2:

Required Standard
100% of qualifying 2018/19 incidents have been reported under NHS Resolution's Early Notification Scheme

11.2. Since April 2017, the NHS Resolution Early Notification Scheme (ENS) has required Trusts to report all maternity incidents of potentially severe neonatal brain injury diagnosed in the first seven days of life which meet the following criteria:

Term delivery (≥37+0 completed weeks of gestation)
Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) **[OR]**
Was therapeutically cooled (active cooling only) **[OR]**
Had decreased central tone **AND** was comatose **AND** had seizures of any kind.

11.3. The Maternity Clinical Governance Team and the OUH FT Legal Team continue to ensure that 100% of incidents are reported as per the Early Notification Scheme.

12. The Maternity Incentive Scheme Year 3

12.1. The Safety Actions for the third year of the MIS are expected to be launched in December 2019.

12.2. It is expected that NHS Resolution will include a new Safety Action that will require compliance with the Better Births standards. As such a separate paper detailing the OUH FT progress towards achieving the Better Births standards has been submitted separately to the Trust Board.

12.3. It is expected that most, if not all, the year 2 Safety Actions will be extended in year 3.

12.4. The Perinatal Mortality Review Safety Action is likely to be extended to reflect some of the recommendations included in the first annual national PMRT report, as outlined above.

12.5. The requirements for the Maternity Services Data Set have already been updated, although it's not yet clear how many more tables will become mandatory. It is likely that the national priority for interoperable maternity records will be reflected in this safety action, as the Maternity Record Standard becomes embedded in the requirements for the Maternity Services Data Set.

12.6. The ATAIN Safety Action may be extended in the requirements of a transitional care service, and/or the review requirements of unexpected term admissions to a Neonatal Unit (NNU). As stated above, the OUH FT transitional care service is currently being reviewed. Furthermore, the Maternity Directorate currently has a robust process of reviewing unexpected term admissions to a NNU that exceeds the current national requirements.

12.7. The medical and midwifery workforce planning Safety Actions are likely to reflect recommendations in the NHS People Plan, with themes that may include:

- Staff engagement
- Leadership culture
- Addressing urgent workforce shortages
- Multidisciplinary team working

12.8. The Saving Babies' Lives Safety Action will be extended to include compliance with version 2 of the care bundle.

12.9. The service user feedback Safety Action may be extended to require more patient and public involvement in service development, incident prevention and investigation.

12.10. Multi-professional training in obstetric emergencies will continue, and may be extended to require multiprofessional neonatal resuscitation training (including midwives, neonatal nurses and neonatologists) or multiprofessional obstetric emergencies in the community (including midwives, paramedics and ambulance technicians).

12.11. The role of Maternity, Neonatal and Board Safety Champions may be extended to have greater involvement with frontline maternity staff.

12.12. The NHS Resolution's Early Notification Scheme will continue and the requirement is likely to continue to be 100%.

12.13. In line with the Maternity Transformation Plan, and in response to the MBRRACE-UK reports that continue to list suicide as the leading cause of late maternal death, there may also be greater emphasis on Perinatal Mental Health Services.

12.14. Bi-annual reports giving updates on the Maternity Incentive Scheme Year 3 will be provided to the Board in January and July 2020. Quarterly updates on specific Safety Actions will also be provided where appropriate.

13. Recommendation

13.1. The Board is asked to:

- note the contents of the update report, including the action plans in Appendices 1-4
- discuss how the Trust could support the Maternity and Neonatal units with overcoming the challenges that have been identified.

Sam Foster
Chief Nursing Officer

Paper compiled by Annie Williams, Quality Assurance and Improvement Midwife, with contributions from:

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Kate Eadie, Perinatal Risk Coordinator and ATAIN lead midwife
Rosie Wright, Senior Clinical Midwifery Manager for Community
Jane Upham, Clinical Midwifery Manager and lead for midwifery staff recruitment
Sujay Chakravarti, Consultant Obstetrician and ATAIN lead obstetrician
Jane Hirst, Consultant Obstetrician and Chair of the Perinatal Mortality Review Panel
Rachel Chakravarti, Better Births Midwife
Emily Brace, Consultant Midwife and lead for Better Births
Ali Cuthbertson, Director of Midwifery
Catherine Greenwood, Clinical Director, Maternity

October 2019

List of Appendices – The following appendices are attached to support this document

1. Avoiding Term Admissions Into Neonatal Units Action Plan
2. Better Births Local Action Plan
3. Response to the findings of the 2018 General Medical Council Survey
4. Midwifery Workforce Planning Action Plan

Appendix 1 – Avoiding Term Admissions into Neonatal Units Action Plan

Issue	Specific Action Required to achieve standard	Lead	Timescale	Evidence	Update
In order to decrease the number of term babies admitted with respiratory issues there needs to be a reduction in the number of elective CS performed under 39 weeks unless there is a clear contraindication.	• Increase the number of CS lists by providing 3rd theatre on delivery suite. This increases the capacity to book women at 39 weeks and avoid earlier delivery.	CD/Intra partum lead	April 2020	Operational 3rd theatre	The business case has been approved, the funding confirmed by NHSE and the Trust has tendered with contractors. Contractor finalisation is in progress with Director of Capital Development. Preliminary works are due to begin December 2019 with work on the Delivery Suite theatre itself commencing January 2020. However, the recent condemnation of the Womens Centre fire dampers may affect these dates. We are awaiting update from Operational Estates.

There have been cases of HIE associated with delays in inductions of labour therefore a strategy is required to reduce the number of delays	Review flow of postnatal patients through wards allowing improved capacity to ensure timely induction of labour	Matron for inpatient care	July 2019	Patient flow review, appropriate actions to be implemented following review 1. Discharge planning on Delivery Suite and Observation Area ('Home project') 2. Beds on Level 7 allocated to low risk postnatal women 3. Level 5 Safety Huddle to identify and overcome potential barriers to timely safe discharge process 4. New discharge coordinator role 5. Postnatal ward to be split into two areas with multidisciplinary teams working in each area 6. Recruitment of nurses to work in recovery areas of Level 5 7. Recruitment of midwives 8. Additional safeguarding practitioner to support midwives with complex social cases 9. Development of recovery bays with oxygen to support post-operative transfer within 2 hours of delivery 10. Order new equipment to assist midwives in completing their tasks 11. Changes to the layout of areas in the ward to facilitate discharge documentation 12. Recruitment of ward clerks to allow midwives and maternity support workers to concentrate on delivering care 13. Update the Pre-labour Rupture of Membranes at	**Review completed**. Actions following review: 1. Completed 2. Completed 3. Completed 4. Completed – two in post 5. Completed 6. Completed - first nurses started in July 7. Completed - new midwives started in September 8. Completed 9. Ongoing 10. Ongoing – there have been delays in authorisation 11. Ongoing – there have been delays in authorisation 12. Completed 13. Completed

	• Job plan obstetric consultants to provide prospective cover for ward rounds. This improves the flow of patients through the unit, releasing further capacity for timely induction of labour.	CD	August 2019	SARD completed job plans	A consultation document regarding changes to consultant working (including on-calls) was circulated 22nd Oct 2019. There will be a 1 month consultation period and a notice period of up to 3 months (unless colleagues agree to waive this). This will provide increased cover and 'free up' some PAs for prospective cover for ward rounds if needed. New job plans will be uploaded to SARD in February 2020.
	• Review midwifery staffing and acuity levels on delivery suite and wards using birth rate plus in all clinical areas	DoM	June 2019	Staffing review paper	**Completed** and report reviewed. Recommendation for increase in midwifery establishment. Business case being written

Appendix 1 – Avoiding Term Admissions into Neonatal Units Action Plan

Improved management of Neonatal Hypoglycaemia	• Implement new guideline for management of hypoglycaemia	Governance lead	April 2019	Guideline on intranet	**Complete** - Ratified at April Maternity Governance meeting. Implementation on 1st May 2019
	• Purchase neonatal glucose monitoring system for free standing MLUs	Matron for postnatal ward	Dec 2018	Available	**Complete**
	• Train midwives and MSW in the use of new glucose monitoring equipment	PDM lead	30th March 2018	Roll out of new guideline	**Complete** - Training completed as part of implementation date of 1st May 2019

Appendix 1 – Avoiding Term Admissions into Neonatal Units Action Plan

Improve the management of babies with suspected jaundice	• Provide more bilimetrers in the community midwifery teams • Increase the number of centrifuge machines in community settings from 4 to 6.	Matron for Community	October 2020	Equipment in community	**Complete** - 4 Bilimeters have been provided to the community teams in; Witney, Banbury, Bicester and Vale. 2 centrifuges have been ordered and awaiting to receive them from the suppliers, one to be insitu at Florence Park (ISIS Team) 2nd to be confirmed but either Chipping Norton
ATAIN e-learning	• To increase the number of neonatal doctors and ANNPs completing the e learning package to above 75%	ATAIN neonatal lead	March 2020	Audit	E-learning package has been added to neonatal induction programme. Audit planned for later in the year.
	• To complete a training needs analysis for the midwifes and maternity support workers with regards to the ATAIN e learning package.	PDM lead	July 2020	TNA paper	In progress

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NHS ENGLAND					**Oxford LMS** Key (L) = LMS (B) BOB system wide				
Recommendation	**Action**	**Owner**	**Time scale/scale of ambition**	**How will we know?**	**Action**	**Owner**	**Time scale**	**Finance Implications**	**Measure/Evidence**
1. Personalised care centered on the woman her baby and her family based around their needs and their decisions where they have genuine choice informed by unbiased information	*Every woman should develop a personalized care plan, with their midwife and other health professionals, which sets out her decisions about her care, reflects her wider health needs and is kept up to date as her pregnancy progresses and after the birth.*	*Providers and CGGs*	*100% of women by 2020/21*	*Maternity survey e-referral data*	• All women to have the 'Mum & Baby' App. • All women to have personalized care plans In form of 'Mum and Baby App' •Website updated, co-designed with service user, with virtual tours of birth and women's birth journey videos •Informed choice for all women supported by enhanced digital technology.	•RC •RC •RC •RC	•May 2019 •May 2019 •May 2019 •On-going	•£32,000 for LMS, funded from pooled BOB LMS budget •£10,200 •K2 Electronic record system or equivalent system being reviewed. •Business case being currently develope	•Feedback from MVP •Feedback from MVP •Website live, analysis of usage from OMI department •Updated electronic system

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								d. This will have finance implications.	
	Unbiased information should be made available to all women to help them make their decisions and develop their care plan drawing on the latest evidence, and assessment of their individual needs, and what services are available locally. This should be through their digital maternity tool.	*National Information Board (NIB) and NHS England*	*By April 2017*	*Maternity survey and NIB monitoring*	• Digital access to local patient information leaflets • All women to have the 'Mum & Baby' App. •All women to have access to Postnatal IBook to enhance postnatal recovery and ensure consistent and accessible information	•RC •RC	•Available on current website •May 2019 •March 2019	•No additional cost •See above •4 I Pads purchased. Funding provided by HSN	•Currently on website. See website action plan docx for details on accessibility •See above •1 I Pad on Level 7 Post-natal ward •3 I Pads on Level 5 Post-natal ward
	Women should be able to choose the provider of their antenatal, intrapartum and postnatal care	*NHS England and CCGs*	*Pioneer sites in 2016/17. Potential full roll out from 2017/18*	*Maternity survey, e-referral data and CCG Assessment*	• All women should have access to a comprehensive package of localized care which offers	•RW	•On-going	•No additional cost	•OUHFT currently provides full maternity offer of 4 environments. •CQC report •Feedback from MVP

	and be in control of exercising those choices through their own NHS Personal Maternity Care Budget				options for alternative antenatal care provision. • Source local venues to develop community hubs. • To fully utilise the current facilities which includes the midwife led units.	• WR • RC	• March 2020 • March 2020	• Capital funding/lease costs for local venues will be required. This will be dependent on properties sourced.	• Local venues will have been considered • Break down of places of birth
	Women should be able to make decisions about the support they need during birth and where they would prefer to give birth, whether at home, in a midwifery unit or in an obstetric unit after full discussion of the benefits/risks	*CCGs*	*Most women should have access to three types of birthplace by 2020*	*Maternity survey, e-referral data and CCG Assessment*	• Shared criteria for midwifery led units across BOB network • To increase births at home and in our midwifery led units by 5% each year	• Consmws • DOMs • RW • WR • RC	• Dec 2019 • March 2020	• £13,750-Motivational Interviewing training for community staff • £3000-Homebir	• Developed shared criteria • Break down of place of birth – increase of homebirths, midwifery-led births will be apparent

	associated with each option.							th and MLU promotion evenings monthly throughout the county • £12,000 – 3 'Maternity Offer Big events' • £10,200 - Development of website which will include virtual tours of MLUs and the JRH.	

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2 Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions	*Every woman should have a midwife, who is part of a small team of 4 to 6 midwives based in the community who know the women and family, and can provide continuity throughout the pregnancy, birth and Postnatally.*	*Providers and CCGs*	*Early adopters to roll out from 2016/17. Across the country by 2020*	*Maternity survey*	• To develop smaller groups of midwives within the overall team alongside buddying system	•Comm ws •RC	•Complete d	•£55,000 - Better Birth Midwife funded from Transfor mational money •No additional cost	• Team Continuity Community Model for all community teams available. Team Continuity Community Model.doc
					• Modified case loading model for vulnerable women to be developed and implemented for specialist midwife teams	•RW •WR •RC	•March 2020		•Effective, sustainable modified case loading model will be operating
						•WR	•Complete d	• £47,408 – 1.0 WTE Band 7 midwife • £189,63 2- 4.0 WTE Band 6 Midwive s	•Data collection commenced 1/3/19
					• Preliminary audit of post-natal community midwifery care	•RC •VM	•Complete d •April		•Local Reportables will be available

					pathway and improve continuity with antenatal midwifery team •Devise data collection tool for continuity of carer •Set local KPIs •Set BOB wide measuring/reporting matrix with trajectory of 35% women receiving continuity of care •Improve antenatal continuity to 75% from 56% •Improve antenatal and postnatal to 50% from 28%	•RW •BOB BB mws	2019 •April 2019 •Jan 2020	• Pending results of Birth Rate plus acuity tool •No additional cost •No additional cost •No additional cost •No additional cost •Pending	•BOB wide LMS reportables available •Audit, CQC report

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								results of Birth Rate plus acuity tool	
	Each team of midwives should have an identified obstetrician who can get to know and understand their service and can advise on issues as appropriate.	*Providers and CCGs*	*By 2020*	*Staff feedback*	• Each community midwifery team to have named obstetrician link for advice for low risk women with no previously assigned consultant.	• RC	• April 2019	• No additional cost	• Effective working system
	Community hubs should enable them to access care in the community from their midwife and from a range of others services, particularly for antenatal and postnatal care.	*NHS England – national support and guidance; CCGs and providers – local implementation*	*Plans for community hubs to be in place and agreed by end 2016/17, for roll out by 2020*	*CCG Assessment*	• Work collaboratively with Trust estates department and third sector to scope potential venues for local community hubs	• RW	• Sept 2019	• Capital funding/lease costs for local venues will be required. This will be dependent on properties sourced.	
	The woman's midwife should liaise closely with obstetric, neonatal and other services ensuring that they get the care they need and that it is	*Providers*	*From now*	*Maternity survey, Local Maternity System Governance*	• Develop collaborative pathways across the ACS with key teams who provide care and support to women in families during and after pregnancy	• All	• March 2020 • March 2020		

	joined up with the care they are receiving in the community.				• Implement a new antenatal pathway whereby all women will be offered a very early medical risk assessment by their GP and community midwives will deliver **all** routine antenatal appointments in line with NICE guideline • Demand and capacity analysis of GP space for midwives conducting all appointments. To feed into community hubs • Increase the number of antenatal clinics at the Horton Hospital, Banbury delivered by OUHFT consultants. Including some specialist services such as diabetic, high risk fetal/maternal medicine and perinatal mental health clinics • Work with South Warwickshire CCG to ensure local delivery of consultant led clinics for high risk Oxfordshire women who choose to book with South	• VM • RW • RC • L McK • CCG • RW • VM • RW • VM	• March 2020 • March 2020 • March 2020	• This may have financial implications in regards to midwifery clinic space • Capital funding/lease costs for local venues will be required. This will be dependent on properties sourced • Develop a business case for further expansion of consultant cover for antenatal clinics and delivery suite 2019-20	• Effective pathway will be utilised, audit • Enhanced antenatal clinics available more locally for women North of Oxfordshire

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					Warwickshire NHS Foundation Trust				
3 Safer care, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.	*Provider organization boards should designate a board member as the board level lead for maternity services. The Board should routinely monitor information about quality, including safety and take necessary action to improve quality.*	*Providers*	*By April 1st 16/17*	*CQC inspection*	No local or system wide action required			• No additional costings	• Chief Nurse is board level lead and safety champion • DOM, Chief Nurse and Clinical Director meet monthly • Chief Nurse, Divisional Director and Lay Director represent maternity services at board level quality and safety meetings
	Boards should promote a culture of learning and continuous improvement to maximize quality and outcomes from their services, including multi professional training. *CQC should consider these issues during inspections.*	*Providers and CQC*	*By April 1st 16/17*	*CQC inspection*	• Introduction of PROMPT training to enhance multi-professional working • Introduce Early Medical Risk Assessment (EMRA) supported and enhanced by improved IT infrastructure • To achieve 'good' status at next CQC inspection. However working towards 'outstanding'	• VM • All	• Completed • On-going	• Business case being currently developed. This may have finance implications.	• Training schedules available • ATTAIN • 10 Key safety standards • Quarterly reports from Clinical Director • CQC report
	There should be rapid referral protocols in place between professionals and across organisations to ensure that the woman and her baby can access more	*Providers and CCG*	*Timetable to coincide with establishment of local maternity systems. Full roll out*	*Local maternity system governance*	• No local or system wide action required Always reviewing to improve referral pathways			• Funding in place	• Existing pathways for referral to antenatal clinics, which are timely and appropriate • Joint clinics in place for diabetes. • Named link consultants for maternal medicine

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	specialist care when they need it.		*by end 2018/19.*						specialties including FGM, Haematology, Blood borne infections and maternal/fetal medicine. • We are the tertiary unit for the area and clear referral process for fetal and maternal medicine are in place
	Teams should collect data on the quality and outcomes of their services routinely, to measure their own performance and to benchmark against others' to improve the quality and outcomes of their services.	*Providers and regional networks*	*From 1 April 2017, following publication of national guidance*	*Regional clinical network monitoring, CQC inspections*	• Exploring feasibility of recruiting a Data analyst (1.0 WTE band 6/7) • To improve the interface of current electronic data systems in use		• July 2019 • On-going	• £32,000 - £47,408 - 1.0 WTE Data analyst Band 6/7 • Business case (as above) to improve current electronic patient record or review other alternative	• OUHFT maternity dashboard, Thames Valley regional dashboard, RCOG maternity indicators, HES data, NMPA audits MBRRACE, HQIP. Monthly maternity dashboard reviewed at local and corporate governance meetings • Maternity information group • EPR midwifery lead in post (0.6 WTE) • Achieved maternity dataset requirements in all 10 fields
	There should be a national standardized investigation process when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence.	*Health Care Safety Investigation Branch, NHS Improvement Maternity Clinical Networks*	*By end 2016/17*	*DH / NHS Improvement / HCSIB monitoring*	• Review mechanisms for wider sharing of learning within OUHFT and within BOB region	• VM • RW	• completed	• No additional cost	• OUHFT agreed investigation process and reporting system • HSIB has been implemented • Regional per-natal governance committee is now in place across the BOB region and chaired by our clinical director
	There is already an expectation of	*DH and NHS Litigation*	*By 2020*	*DH implementati*	• No local action required		• Completed	• No	• Duty of candor adhered to

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	openness and honesty between professionals and families, which should be supported by a rapid redress and resolution scheme, encouraging rapid learning and to ensure that families receive the help they need quickly.	*Authority*		*on*	as compliant			additional cost	and OUHFT fully engaged in NHS resolution scheme • Birth Afterthoughts service provided for women who give birth within OUHFT Consultant led meetings to debrief following an unexpected outcome
4. ***Better postnatal and perinatal mental health care, to address the historic underfunding and provision in these two vital areas, which can have a significant Impact on the life chances and wellbeing of the woman, baby and family.***	*There should be significant investment in perinatal mental health services in the community and in specialist care.*	*Mental Health Implementation Board, NHS England and CCGs*	*By 2020*	*CCG Assessment Framework, Mental Health Minimum Dataset (MHMDS), MCMDS*	• Perinatal mental health bid successful in the 2nd wave of funding. • To create a specific community perinatal mental health service. It is envisaged that women with severe mental illness during the perinatal period will be managed by this team. It is expected this team could provide preconception advice. • To attend and participated in perinatal pathway mapping collaboration	• VM	• completed	• Funding secured – no additional costs • Perinatal mental health bid successful in the 2nd wave of funding.	• OUHFT have a team which includes a perinatal psychiatrist, specialist midwife and community mental health champions.
	Postnatal care must be resourced appropriately. Women should have	*CCGs and providers*	*By end of 2018/19*	*Maternity survey, MCMDS*	• To develop smaller groups of midwives within the overall team alongside buddying	• Commws • RC	• Completed		• Team Continuity Community Model for all community teams available.

	access to their midwife as they require after having had their baby				system • Modified case loading model for vulnerable women to be developed and implemented for specialist midwife teams • Piloting value of 'Face time' to improve continuity of contact from carer • To explore the role of the MSW and work in partnership with the midwife to improve continuity of care • Purchase billimeters for community teams	• RW • WR • RC • WR • WR • RC • RC	• March 2020 • August 2019 • March 2019 • March 2019	• 47,408 – 1.0 WTE Band 7 midwife • £189,632- 4.0 WTE Band 6 Midwives • Pending results of Birth Rate plus acuity tool • Financial implications- community midwives would require OUHFT smart phones • £5,000 per unit	• Effective, sustainable modified case loading model will be operating • Improved rate of continuity of carer • Post Natal visits not organized around small amounts of equipment

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	Maternity services should ensure smooth transition between midwife and obstetric and neonatal care, and when appropriate to ongoing care in the community from their GP and health visitor.	*CCGs and providers*	*By end 2017*	*Maternity survey*	• Local actions in place however continually reviewing pathways for potential improvement and to reflect any changes in National guidance • Analysis and agreement of managing out of area/cross boarder women within the BOB network	• RW • BOB BB mws	• completed • June 2019	• No additional funding required at present	• Current electronic discharges to GP/Health visitor • Current messages through electronic records between specialties • Seamless pathway for identified women
	A dedicated review of neonatal services should be taken forward in light of the findings of this review	*NHS England*	*By end 2017*	*NHS England reporting*	• Implement any recommendations from the recent external NNU review that relate to collaborative working with maternity		• On-going	• No additional funding required at present	
5. Multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies	*Those who work together should train together. The Nursing and Midwifery Council and the Royal College of Obstetricians and Gynecologists should review education to ensure that it promotes multi-professionalism and that there are shared elements where practical and sensible.*	*NMC, RCOG*	*Review to be complete by end 2016/17 NMC and RCOG to include in their education from now and from Sept 2017 at the latest*	*NMC and RCOG reporting*	• For 90% of all staff to attend PROMPT training each year which will include Obstetricians, Midwives and maternity support workers • EMRA supported and enhanced by improved IT infrastructure • Shared learning of investigations		• On-going • On-going • On-going	• Ongoing PROMPT train the trainer costs (covered by local funding) • Business case (as above) to improve current electronic patient record or review other alternative • No	• PROMPT training implemented in 2018 • NLS and Sick Newborn courses regularly run with neonatologists and midwives training together • Risk newsletter, sharing outcomes, multidisciplinary feedback

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								additional costs	
	Multi-professional training should be a standard part of professionals' continuous professional development, both in routine situations in emergencies.	*NHS England, HEE, RCM, RCOG, employers*	*DH and HEE fund post registration training in 2016/17 Thereafter responsibility of employers*	*HEE reporting CQC inspection Board reporting*	• No local action required as compliant		• Completed	• See above	• PROMPT training • Annual appraisals
	Use of electronic maternity records should be rolled out nationally, to support sharing of data and information between professionals, organisations and with the woman. Commissioners and providers should invest in the right software, equipment and infrastructure to collect data and share information.	*NHS England, providers*	*By 2020*	*Digital Maturity Self-Assessment will cover electronic records generally*	• Implementation of electronic patient record system that will enable the maternity service to become 'paper light'. If unsuccessful with securing funding, to continue to work towards improving current electronic system	• VM	• On-going	• Business case (as above) to improve current electronic patient record or review other alternative	• Improved IT package
	A nationally agreed set of indicators should be developed to help local maternity systems to track benchmark and improve the quality of maternity services. This should include	*NHS England, RCM, RCOG*	*Convene by Spring 2016, report by end 2016/17*	*NHS England reporting*	• Awaiting national PROMS/PREMS to commence reporting. Benchmarking against NMPA and HQIP audit published 2017.		• On-going	• No additional funding required at present	• Reporting will commence against quality indicators

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	the possible development of PROMS/PREMs measures for maternity.								
	Multi-professional peer review of services should be available to support and spread learning. Providers should actively seek out this support to help them improve, and they must release their staff to be part of these reviews. CQC should consider as part of inspections.	*RCOG and RCM to provide support, employers to release professionals*	*By end 2017/18*	*RCM and RCOG reporting CQC Inspection*	• Identify peer reviewers across wider LMS and establish process	• RW • VM	• July 2019	• No additional costs	
6. ***Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed***	*Providers and commissioners should come together in local maternity systems covering populations of 500,000 to 1.5 million, with shared standards and protocols agreed by all.*	*NHS England – national support and guidance; CCGs and providers – local implementation*	*Planning for working in this way 2016/17; begin to work in this way from 2017/18. Full roll out by end 2020*	*CCG Assessment*	• Shared criteria for midwifery led units across BOB network • Develop a shared vision for expanding pre-conceptual care for women with complex health needs, including post-partum family planning	• Cons • DOMs • VM • RW • WR	• Dec 2019 • May 2019 • March 2020	• No additional costs • £227 % £89 annual registration per person for training for implants • No additional costs for IUDs as within current tariff	• BOB LMS wide shared criteria

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					• Explore the feasibility to enable access to Breech team from across BOB			Draft discus paper OUH PPF • Funding to be agreed by commission ers • Cover for Breech team on-call rota	
	Professionals, providers and commissioners should come together on a larger geographical area through Clinical Networks, coterminous for both maternity and neonatal services, to share information, best practice and learning, to provide support and to advise about the commissioning of specialist services which support local maternity systems.	*NHS England national and regional funding and support; CCGs and providers are members*	*From now*	*NHS England assurance of Clinical Networks*	• Continue collaborative working through AHSN • To work closely with commissioners to support recommendations regarding developing initiatives to improve quality indicators/outcomes for women in the Region • Continue regular LMS meetings • Continue LMS representation at BOB LMS board • Joint governance meetings To share learning across the BOB region		• On-going	• No additional costs	• OUHFT midwifery and obstetrics represented at Academic Health Science Network • OUHFT fully engaged with Maternity Clinical Network and BOB LMS Board • Establishment of LMS • Currently Wave 1 of the Maternity and Neonatal Safety Collaborative

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	Commissioners should take greater responsibility for improving outcomes, by commissioning against clear outcome measures, empowering providers to make service improvements and monitoring progress regularly.	*CCGs*	*From now – with demonstrable progress by end 2020/2021*	*CCG Assessment*	• Ongoing data collection, review, monitoring and action as required in response to maternity quality, safety and performance indicators		• On- going	• No additional costs	• Regular meetings with CCG to review key performances and identify areas for improvement • Clinical dashboard shared monthly with CCG
	NHS England should seek volunteer localities to act as early adopter sites.	*NHS England*	*A two year programme to start in September 2016.*	*NHS England reporting*	• Not applicable, OUHFT not an early adopter		• n/a	• Not applicable	• Not applicable
7. A payment system that fairly and adequately compensates providers for delivering high quality care to all woman, whilst supporting commissioners to commission for personalisation, safety and choice	*The payment system for maternity services should be reformed. In particular, it should take into account:* *• The different cost structures different services have, i.e., a large proportion of the costs of obstetric units are fixed because they need to be available 24 hours a day, seven days a week regardless of the volume of services they provide.*	*NHS England and NHS Improvement*	*Develop proposals for reforming payment system 2016/17; pilot new system 2017/18; implement new system 2018/19*	*NHS England and NHS Improvement reporting*	• Awaiting national guidance • No action required at present			• No additional funding required at present	
	• The need to ensure that the money follows the woman and her baby as far				• Awaiting national guidance • No action required at present			• No additional funding required at	

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	as possible, so as to ensure women's choices drive the flow of money, whilst supporting organisations to work together.							present	
	• *The need to incentivise the delivery of high quality and efficient care for all women, regardless of where they live or their health needs.*				• Awaiting national guidance • No action required at present			• No additional funding required at present	
	• *The challenges of providing sustainable services in certain remote and rural areas.*				• To review current pathways to ensure it meets the needs of the women • Working with CCG in the strategic transformation programme to ensure sustainable services to all Users across the County	• All	• On-going	• No funding identified at this particular time	• Currently maintaining 4 free standing midwifery-led units • Localised antenatal and postnatal care

Appendix 3 – Response to the findings of the 2018 General Medical Council Survey

Issue	Specific Action Required to achieve standard	Lead	Timescale	Evidence	Outcome
Due to gaps in working rotas the Trainees are required to cover the out of hours Rota which impacts on their clinical workload and availability to attend elective clinical sessions with training opportunities	To recruit additional Trust Grade Doctors: • 4 Trust Grade Doctors • 2 long-term locum appointments	Clinical Director for Maternity and Clinical Director for Gynaecology	December 2018	Appointment of Medical Staff. Working Rotas	Complete
Trainees reported lack of equity in accessing training opportunities	• To ensure equitable training opportunities are allocated to Trainees when creating the rota	The designated Rota Coordinator	Ongoing	Rotas	Complete
	• Audit rotas and training opportunities from August 2018 to March 2019 to monitor compliance with equitable training opportunities being given to Trainees. To share audit findings with Trainees and implement further actions if required	College Tutors	June 2019	Audit presented at OXFOG in May 2019 POD Meeting in June 2019	Complete
	• To introduce a rolling audit of ST3 – ST5 rotas, with updated action plans as required. The first audit should start with the new Trainees, who start in August 2019, and cover the remainder of Q2 data.	College Tutors	November 2019	Quarterly reports presented at Maternity, Gynaecology Directorates and Divisional Meetings.	Ongoing

Appendix 3 – Response to the findings of the 2018 General Medical Council Survey

Theatre capacity has reduced on JR site which has led to reduction in Gynaecology training opportunities	To source training accreditation from Health Education England Thames Valley (HEETV) to provide additional training opportunities at the Churchill, Manor and Ramsay Theatres	Clinical Director for Gynaecology	December 2018	Letter of accreditation received from HEETV in December 2018	Complete
Reduction in training opportunities due to cancellation of theatre list due to lack of Surgical Assistants availability	To explore the roles of non-medical surgical assistants and identify 10 staff members that can be trained as First Surgical Assistants to facilitate training opportunities: ➢ 5 staff members to be trained by September 2018 ➢ A further 5 trained by October 2019	Clinical Director for Gynaecology Matron for Theatres	 September 2018 October 2019	Names and evidence of training completion	 Complete Ongoing

Appendix 4 – Midwifery Workforce Planning Action Plan

Issue	Specific Action Required to achieve standard	Lead	Timescale	Evidence	Outcome
To implement the Birthrate Plus Acuity Tool to monitor acuity and staffing levels throughout the 24 hour period	To purchase Birthrate Plus Acuity Tool for all Maternity clinical areas To cascade the tool to all inpatient areas, commencing with Delivery Suite, Observation Area and the Spires Alongside Midwifery Led Unit	 Delivery Suite Clinical Midwifery Manager	November 2018 October 2019	Tool purchased Acuity Reports	Complete Complete for Delivery Suite, Observation Area and Spires
To ensure that frontline staff are aware of the process for escalating staffing red flags	Email to all Maternity Operational Managers Area-specific training to match the red flags that would be associated with the specific clinical area To review current systems for frontline staff reporting any staffing red flags during their shift and identify any areas for improvement	 Clinical Midwifery Managers for Outpatients and Inpatients	March 2019 June 2019 June 2019	Email Training plan for individual clinical areas, and signed record of understanding Written report of recommendations to be submitted to Maternity Clinical Governance	Complete Ongoing Report of red flags submitted in May and now a standard agenda item at Clinical Governance.
Increase the midwifery establishment in line with Birthrate Plus Report	Submit a business case Continue with the recruitment and retention plan as outlined in TB2019.58B	Director of Midwifery Senior Midwifery Team	May 2019 Rolling programme	Business case to be submitted to Trust Board Minutes of Directorate Band 7 Meetings, with standard agenda item detailing recruitment and retention updates	Business case submitted to Divisional Board in July and resubmitted in October 2019 Continuous – agenda item in place since June 2019