Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 17 January 2024

TB2024.04

Title:	**Maternity Services Update Report**

Status:	**For Discussion**
History:	**Regular Reporting**
	Maternity Clinical Governance Committee (MCGC) 18/12/2023
	Reviewed at Divisional Level on 08/01/2024
	Previous paper presented to Trust Board 08/11/2023

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 to the Trust Board on the following maternity related activities:

    - Ockenden Assurance Visit
    - Midwifery Led Unit (MLU) status
    - Maternity Performance Dashboard
    - Perinatal Quality Surveillance Model Report
    - CQC inspection action plan update
    - Maternity Development Programme (MDP)
    - NHS Resolutions Response
    - Maternity Incentive Scheme Year 5
    - Maternity Safety Support Programme (MSSP)
    - Three-year delivery plan for maternity and neonatal services
    - Safeguarding
    - Antenatal Screening Quality Assurance visit

Recommendations

2. The Trust Board is asked to:

    - Receive and note the contents of the update report.
    - Consider how the Board may continue to support the Divisional Teams.
    - Note the contents of the Maternity Incentive Scheme Tracker (Appendix 2) detailing evidence of compliance with all ten Safety Actions.
    - Receive and note associated papers in support of the Maternity Incentive Scheme Year 5 (Available in Reading Room).
    - Consider and agree the local maternity training plan developed in line with the Core Competency Framework v2 (Available in the Reading Room).
    - Receive and note the LMNS Quarter 2 SBLCBv3 Trust Board report confirming that the Trust is on-track to fully implement all 6 elements of Safety Action 6 by March 2024 (Available in Reading Room).
    - Record in the Trust Board minutes that OUHT are currently non-compliant with BAPM Standards for the neonatal junior medical

workforce; and agree the action plan to address these deficiencies (Briefing note available in Reading Room).

- Record in the Trust Board minutes that OUHT are not compliant with the BAPM standards for the Neonatal Nursing Workforce action plan and acknowledge the progress against the action plan. (Available in Reading Room).
- Record in the Trust Board minutes that the Board Safety Champions are meeting with the Perinatal Quadrumvirate leadership team at least quarterly.
- Request Board approval for the CEO to sign the Board declaration form confirming that the Board is satisfied that the evidence provided to declare compliance with/achievement of the ten maternity safety actions meets the required safety standards as set out in the safety actions and technical guidance document.
- The declaration form is to be submitted to NHS resolution by the deadline of 1st February 2024.

Contents

Maternity Services Update Report

1. Purpose

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- Maternity performance dashboard
- Perinatal Quality Surveillance Model Report
- CQC inspection action plan update
- Maternity Development Programme
- NHS Resolutions Response
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- Maternity Safety Support Programme (MSSP)
- Three-year Single Delivery Plan for Maternity and Neonatal Services
- Safeguarding
- Antenatal Quality Assurance Screening visit

1.2. As part of the Trust's commitment to the provision of high quality safe and effective care to maternity service users, there are a variety of different maternity governance requirements that the Board are required to receive and discuss.

1.3. These requirements include reporting against regulatory and professional standards each of which have a range of different reporting deadlines.

2. Ockenden Assurance visit

2.1. The Ockenden Assurance insight visit took place on the 10 June 2022 and the Trust received the final report with associated recommendations.

2.2. The action plan is being monitored through the Maternity Clinical Governance Committee (MCGC) and then upward through existing governance processes. In relation to the specific immediate and essential actions (IEAs), please note the outstanding actions are:

- IEA 5 – Risk assessments in pregnancy. Work continues on the actions from the recent audit. The new digital system (BadgerNet) is on track for

implementation in January 2024, this will allow ongoing risk assessments to be undertaken.

- IEA 7 – Informed Consent. The outstanding action was to update the Trust website to ensure pathways of care are clearly described, in written information in formats consistent with NHS policy. This was reported as completed at MCGC on the 27 November 2023.
- Strengthening Midwifery Leadership –The substantive Director of Midwifery was appointed in November 2023 and will support the stabilisation of the midwifery leadership team. Recruitment continues within the midwifery leadership team with interim posts having been extended up to the 28 February 2024 to support this period and the continued stability for the Maternity service. A new Head of Midwifery role is currently out to national advert and will strengthen the leadership team, furthermore. In December 2023 both the inpatient services and delivery suite clinical matron posts were successfully appointed into. The business case to support the recommended Birthrate plus uplift was approved at the Trust Board in November 2023 and recruitment into these posts has commenced.

3. Midwifery Led Unit (MLU) Status

3.1. In October, one woman was affected by the closure of the homebirth service, she went on to give birth on the Spires MLU. No care concerns identified.

3.2. In November, the homebirth service was suspended on one occasion. However, at the time of the homebirth request and following a service review with the manager on-call, the woman was supported to give birth at home. No other women were affected that night.

4. Maternity Performance Dashboard

4.1. The maternity performance dashboard may be seen in Appendix 1 and there were no exceptions to report for the November data.

5. Perinatal Quality Surveillance Model Report

5.1. In part fulfilment of the requirements from Ockenden actions the Board is asked to note that the Perinatal Quality Surveillance Model (PQSM) report is reported monthly to MCGC.

5.2. The Perinatal Quality Surveillance Model (PQSM) report for October and November data 2023 is being received by the Trust Board and Private Trust Board meeting on 17 January 2024 (paper CTB2023.xx). Both months were

previously reported to MCGC in December 2023 and remains a standing agenda item at the monthly Maternity and Neonatal Safety Champions meetings.

6. CQC Inspection and Action Plan Update

6.1. Since the last report to the Trust Board, two actions remain overdue relating to Estates, the updates for which can be seen on the table below.

Should Do	Actions	Update
11	11.1 Long term major capital Investment estates plan required to design and build a new Women's centre - the layout of which would enable further prioritisation of the privacy and dignity of service users (all known risks to be reflected in the relevant risk registers)	**Overdue:** Estates plan is part of maternity development programme. There is currently no significant capital investment available to progress this for the foreseeable future.
12	12.4 Business plan to be developed and approved to enable two existing birthing rooms on the periphery of the delivery suite footprint to be converted into a bespoke bereavement suite, optimising the rebirth environment for women and their families.	**Overdue:** In November, Trust Management Executive (TME) have agreed additional funding of £76,772 to cover a whole project cost of £201,772+VAT. The project is due to commence in early 2024.

6.2. Progress against the CQC action plan is reported through existing governance processes, which include Maternity Clinical Governance Committee (MCGC), SuWOn Divisional Clinical Governance Committee and the Trust Clinical Governance Committee (CGC) as part of the quality reports.

7. Maternity Development Programme (MDP)

A sustainability plan to support the continuation of the MDP is underway and the service aim for this to be evident through the implementation of the clinical strategy.

The MDP celebration took place on the 03 November 2023 several members of the team were in attendance and showcased the projects that they had been working on and what had been achieved over the past 18 months.

8. NHS Resolution Response

8.1. The outstanding actions from the NHS Resolutions (NHSR) action plan have been added to Ulysses ‘Action Planning’ section.

8.2. There are currently 2 actions to complete (1 for Maternity and 1 for neonates). They are all being progressed and were completed by 31/12/2023.

8.3. Progress is monitored through MCGC.

9. Maternity Incentive Scheme (MIS)

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

9.2. Trusts must achieve all ten maternity safety actions.

9.3. The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services.

9.4. The Trust Board declaration form must be signed and dated by the Trust's Chief Executive Officer (CEO) to confirm that: The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions,' sub-requirements as set out in the safety actions and technical guidance document. That there are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before 1 February 2024.

9.5. The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

9.6. In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' 5 evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

9.7. The evidence has been collated against all ten Safety Actions and compliance has been achieved. This evidence has been cross checked through the Local Maternity and Neonatal System and through external review by the Maternity Improvement Advisor, NHS England. With regards to Safety Action 6, the Saving Babies Lives Care Bundle v3, it is confirmed that OUHT are 'on track' to meet all elements of the Bundle by 31 March 2024. This forms part of a separate workbook that is overseen by the BOB LMNS. A report outlining compliance with Safety Action 6 is available in the Reading Room.

9.8. The minimum requirements have been met for the purposes of the Maternity Incentive Scheme. The Safety Actions are detailed in Appendix 2.

10. Maternity Safety Support Programme (MSSP)

10.1. Maternity Services are currently working with the Maternity Improvement Advisor (MIA) and the Division to embed the MSSP exit criteria into the Maternity Development Programme.

10.2. The action plan from the Maternity Clinical Governance Deep Dive has been finalised and ratified at MCGC in November 2023. Project timeline and prioritisation of actions will be defined in the month of January and reported at MCGC.

11. Three Year delivery plan for maternity and neonatal services

11.1. The Three year delivery plan for maternity and neonatal services was published on the 30 March 2023 called the Single Delivery Plan. Work streams have commenced.

11.2. Theme 1: Listening to Women

- The Personalised Care and Support Plan (PSCP) developed in conjunction with the Berkshire, Oxfordshire and Buckinghamshire (BOB) Local Maternity and Neonatal System (LMNS) and the service was launched in September 2023. This has been distributed to the community teams to give to women and birthing people at booking. There is an opportunity for women and birthing people to give feedback on the PSCP at 17 weeks, 35 weeks and after the birth via a QR code which is collected by the BOB LMNS. The BOB LMNS are undertaking the initial audit of their usage and will report back we are awaiting the timeframe of this.
- The OUH has been chosen as a pilot site for Advance Communication for Personalised Care for Maternity and Neonatal Services. There is a 2-day course starting in March 2024.
- There is a neonatal representative as part of the MNVP who has begun a 3–6-month scoping exercise and further Neonatal representatives, these will be recruited with funding provided by the LMNS. Feedback and reporting of the Neonatal user voice will be separate to Maternity feedback. The NHS 15 Steps Challenge took place in November and is a ‘first impressions’ survey to assess clinical areas from a senses/instinctual perspective. Initial feedback was positive, and the full report is expected in January 2024.

- A workstream has commenced for achieving the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding. Progress of this project will be monitored through a task and finish group and will be reported through MCGC.

11.3. Theme 2 – Workforce

- The BirthRate+ midwifery staffing tool was recalculated in 2022 and an uplift of 22.38wte midwives, recommended. The business plan to support this was approved at the Trust Board in November 2023. A recruitment plan has commenced to achieve the uplift recommendation and includes both the additional Clinical Midwifery matron and Head of Midwifery post, clinical inpatient midwives and Maternity Support Workers.
- The Equity, Diversity and Inclusion (EDI) Midwives have been providing learning sessions for staff on assessing women, birthing people and babies with dark and brown skin tones. Feedback will be assessed and reported to MCGC in March 2024.

11.4. Theme 3 – Culture and Leadership

- Continue embedding and sustainability work from the Maternity Development Programme and future strategic direction of the maternity services.
- Maternity services to look at introducing a clear and structured role for the escalation of clinical concerns based on the framework such as the Each Baby Counts: Learn & Support escalation toolkit.
- A meeting has been held to review how the service triangulates the OMNVP feedback, feedback from the Friends and Family Test (FFT) and the themes from complaints. The embargoed results of the 2023 CQC Maternity survey have been received and an initial review undertaken by the service. They are due to be published in January 2024 where an action plan will be developed in collaboration with the OMNVP.

11.5. Theme 4 – Standards

- One of the deliverables of the SDP is to implement Saving Babies Lives Care Bundle version 3 (SBLCBv3) by March 2024. This also forms Safety Action 6 of Year 5 of the Maternity Incentive Scheme (MIS) and is overseen by the MIS Lead. The required evidence has been uploaded to the NHS Futures platform on the SBLCBv3 toolkit and progress meetings are held with the LMNS monthly. The LMNS have reviewed the evidence that has been submitted on the toolkit as part of the MIS compliance review. OUH are currently 73% compliant overall and at

least 50% compliant in each of the six elements. OUHT is on track to achieve full compliance by March 2024. Once implemented the plan is to build on the percentage compliance as agreed across the LMNS. Progress is reported monthly as part of the MIS update at MCGC. The next quarterly meeting with the LMNS is on the 24/01/2024 with a deadline to upload the evidence by the 31/01/2024.

- A meeting has been arranged in January 2024 to pilot the national Maternity Early Warning Score initially within the Observation Area. There is a working party looking at the implementation of NEWTT 2 tool is recommended to be in place by March 2025.
- The new Digital Maternity record goes live on the 23 January 2024 for antenatal care and on the 06 February for intrapartum and postnatal care.

12. Safeguarding

12.1. Maternity safeguarding continues to increase in volume and complexity which include the multiple vulnerabilities that women and birthing people experience. The main categories being domestic abuse, substance abuse and complex mental health. A new band 6 safeguarding midwife post is currently being advertised to support the team.

12.2. To increase specialist collaborative working within maternity, moves have been made to reduce overlap of support and focus more on specialisms working together to form effective, evidence-based plans for care of the woman and her unborn as well as the wider family. Not all women and birthing people who have mental health have a safeguarding element to it, but it is widely evidenced that multiple disadvantages exist within families and services need to work closely to improve the outcomes for these families. The mental health midwives are now located with the safeguarding team and are line managed by the Matron for Safeguarding and Mental Health. This is a model we hope to build on and extend further in the future.

12.3. Mental Health services in Oxfordshire are under significant pressure across adults and children's services. The Perinatal Mental Health Team (PNMHT), run by Oxford Health, are currently experiencing staffing shortages and their psychiatry support is on long term sick. If a pregnant woman is accepted into the PNMHT service, and not in crisis, the current wait for a care coordinator to be allocated is 4 months and the wait for psychology support within the PNMHT is 6 months. The OUH mental health midwifery team are supporting women who do not qualify for PNMH services and advising community midwives on where women can go for help with their mental health, including GPs, Oxford Parent and Infant Project (OXPIP) - 3 months wait, Infant Parent Perinatal Service (IPPS) - wait list of 4 months. A weekly multidisciplinary team (MDT) clinic is run

at both the Horton and JR sites which includes a Consultant Obstetrician, substance abuse services, maternity safeguarding team, mental health midwives and antenatal clinic midwives. The impact of the OUH mental health service during this staff shortage has been greatly valued by the community midwives.

12.4. A previous Audit (NICE CG110) undertaken in 2022 showed clear improvements in compliance on key indicators when considering pregnancy with complex social factors. The audit is being repeated in Jan 2024 following the introduction of the domestic abuse pathway and changes in documentation. The audit examines mental health, substance abuse, domestic abuse, asylum seeker, refugees and recent migrants, teenage pregnancies and language barriers.

12.5. In response to the Perinatal Mortality Review (PMR) cases reporting a lack of domestic abuse routine enquiry, the maternity safeguarding team are launching a monthly lunchtime learning forum for all maternity and neonatal staff to discuss complex cases with a commonly seen theme and an area of learning. The forum will be used for shared learning and the learning from these forums will be published on an 'At a Glance' and distributed widely. The hope is to launch in February 2024.

12.6. In addition, due to the rise in domestic abuse cases within maternity, Standing Together (national charity) with operational support from Oxfordshire County Council, BOB ICB, A2Dominion and maternity safeguarding at OUH, are going to fund a 12-month pilot for an IDVA (independent domestic violence advisor/advocate) role to be based in maternity. They will also be able to support with some specialised training within maternity, give specialised support to women including housing and legal matters as well as working in the emergency department to support any non-pregnant victims that present to the OUH. We are hopeful that if the pilot is successful that funding will be received for the post to become permanent.

12.7. Maternity Safeguarding and the PAUSE project continue to work closely together in regard to the increasing number of women and birthing people who have babies removed from their care shortly after birth within the hospital. The process which Maternity safeguarding and PAUSE developed has been reported by PAUSE to have shown an increase in engagement with this vital intervention.

12.8. The Local authority legal teams are requesting court reports and witness statements from the maternity safeguarding team for most court cases when care orders are being sought by the LA. This has been due to the high level of support and close working with all agencies during the pregnancy and postnatal period that LA legal team value the input from the maternity team for court purposes. The excellent documentation, in the majority of cases, enables the safeguarding teams to write a comprehensive statement without the need to

physically attend court – this feedback has been shared in the mandatory training which the safeguarding team facilitated during 22/23.

12.9. In response to the increase in babies being separated shortly after birth through care proceedings, the Matron for Safeguarding Maternity is participating in research with Oxford University who have submitted a stage one application for a NIHR grant. The funding will enable research into the trauma suffered by women and birthing people following a baby being removed by care proceedings and the assessment of current interventions. If the bid is successful, this research will begin in September 2024 and last for 18 months.

12.10. There have been no serious incidents within the last three years where a baby has been significantly injured or has died when there has been awareness, escalation, or a postnatal plan from Maternity Safeguarding. There have also been no reported actions on Child Safeguarding Partnership Reviews CSPRs) for OUH maternity safeguarding.

13. Antenatal Screening Quality Assurance Visit

13.1. The Screening Quality Assurance Service (SQAS) has planned a quality assurance (QA) visit to the Oxford University Hospitals NHS Foundation Trust antenatal and newborn screening programmes.

13.2. The Director of Midwifery received a letter on the 08 November 2023 which outlines the basic requirements for the QA visit. Further details, including a visit schedule, is being coordinated with the national team and Maternity Service.

13.3. The visit for the programme will take place on the 23 April 2024.

13.4. All screening pathways will be quality assured but due to the complexity of provision the following service areas will be considered as part of this QA process:

- all maternity and children's services provided by Oxford University Hospitals NHS Foundation Trust which deliver elements of the antenatal and newborn screening pathways (diagnostic services will not be quality assured but the efficiency and effectiveness of referral to diagnostic services and relevant failsafe processes are included)
- the hearing screening service which provides hearing screening for this maternity unit (diagnostic audiology will not be included)

13.5. The evidence should be submitted by the 13 February 2024 to allow the team sufficient time to review and assess the documentation provided.

13.6. Within 6 weeks of the visit a draft report is sent to the Trust to confirm factual accuracy. The final report is completed within 10 weeks of the visit and is shared with the organisation and the commissioners.

13.7. Team meetings have commenced in Maternity to collect the evidence prior to submission.

14. Recommendations

14.1. The Trust Board is asked to:

- Receive and note the contents of the update report.
- Consider how the Board may continue to support the Divisional Teams.
- Note the contents of the Maternity Incentive Scheme Tracker (Appendix 2) detailing evidence of compliance with all ten Safety Actions.
- Receive and note associated papers in support of the Maternity Incentive Scheme Year 5 (Available in Reading Room).
- Consider and agree the local maternity training plan developed in line with the Core Competency Framework v2 (Available in the Reading Room).
- Receive and note the LMNS Quarter 2 SBLCBv3 Trust Board report confirming that the Trust is on-track to fully implement all 6 elements of Safety Action 6 by March 2024 (Available in Reading Room).
- Record in the Trust Board minutes that OUHT are currently non-compliant with BAPM Standards for the neonatal junior medical workforce; and agree the action plan to address these deficiencies (Briefing note available in Reading Room).
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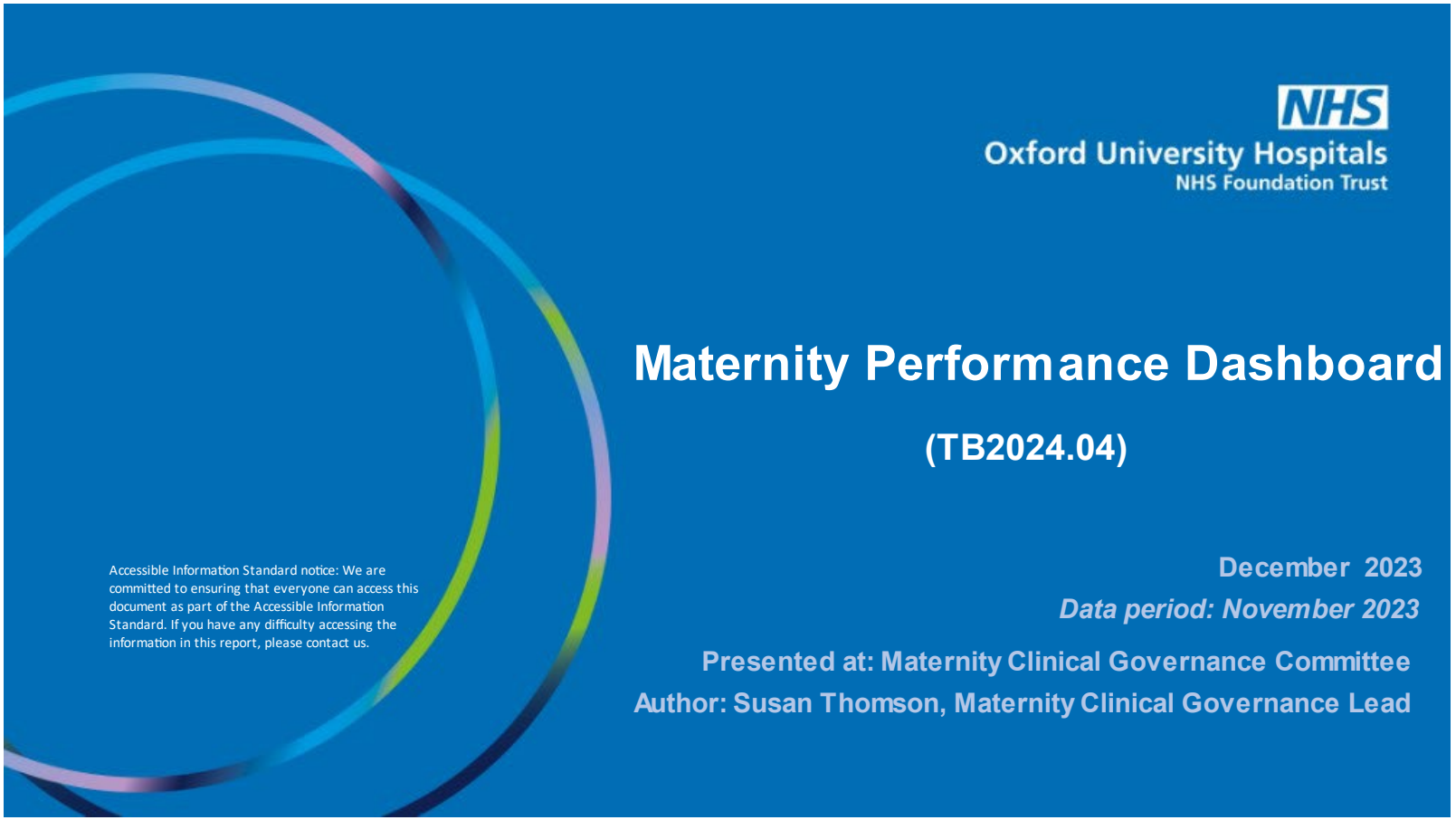
- The declaration form is to be submitted to NHS resolution by the deadline of 1st February 2024.

Appendix 1: Maternity Performance Dashboard December 2023 (November data)



Executive summary

Oxford University Hospitals
NHS Foundation Trust

Notable Successes

- The Maternity Development Day celebration event was held on the 03 November 2023. It was very well attended and brought together staff from across the MDT.
- Congratulations to Bronwen Eadie who was successful at interview for the substantive matron for inpatients and bereavement post.
- Welcome back to Bea Culligan who resumes her role as Deputy Head of Midwifery following her secondment to BOB LMNS. Her portfolio now includes Clinical Governance, and she will lead on the implementation of the 'deep-dive' project.
- A fantastic celebration day was held to thank all MSW's across the Trust for their hard work and dedication, with a gathering at the JR and mini celebrations across the MLU's.
- The vacancy rates are down for both midwives and MSW's. This is in part due to having a recruitment and retention team, and the PMA well-being team.
- Amanda Lee (Public Health matron) presented at the Equality Delivery System where the service were assessed against how they are providing the 9 protected characteristics. Initial feedback from the national team was very positive.

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Executive summary, continued

Oxford University Hospitals NHS Foundation Trust

Domain	Performance challenges, risks and interventions
Activity	In November there was a total of 598 mothers birthed and 700 scheduled booking undertaken which is a reduction from the previous month. The service received 182 referrals for elective caesarean section (ELCS) to be booked compared to 150 in April 2023. There were seven days with an extra case added. 25 women booked in November for ELCS had an emergency caesarean section (CS). In November 2020 there were 62 ELCS compared to November 2023 where there were 108.
Workforce	Midwife: birth ratio was 1:21.87. Consultant hours 109
Maternal Morbidity	The percentage of 3rd and 4th degree tears as a % of spontaneous/other vaginal delivery increased to 3.6% in November from 1.6% in October. There were 14 women affected – 11 were white British and 3 were from ethnic minorities. Four cases were occurred during a forceps delivery. Three women delivered in midwifery led units (MLU's) and were transferred to Delivery Suite for repair. At the daily maternity incident meeting there were no immediate care concerns identified. These will be reviewed There were 8 cases reviewed using the proformas in November – 4 were graded as an A – no care issues identified and 4 were graded as a B – care issues identified that did not impact care or management related to a delay in repair of the tear. The percentage of postpartum haemorrhages (PPH) of >1.5litres was 2.7% in November. There were 16 women affected. Nine women were white British, 4 were from ethnic minority backgrounds. Six women were multips which is a risk of having a PPH. Six cases were a forceps delivery. Four women were an induction of labour. There was a total of 23 cases reviewed using the proformas – 14 were graded as an A and 9 were graded as a B. The learning from these were to reinforce the importance of calculating shock index and calculation of MEOWs charts then appropriate escalation. There were 8 maternal postnatal readmissions. There were no mothers admitted to the intensive care unit.
Perinatal Morbidity and Mortality	There was sadly two neonatal deaths in November – 1 occurred at less than 24 weeks and one at between 24-27 week's gestation. There were five cases reviewed through the perinatal mortality review tool (PMRT). Two were graded as a C grade in relation to place of assessment and scan referral. Action plan in place in relation to these. There were no babies reported to MNSI (Previously HSIB). There was a decrease in the number of term admissions to SCBU to 4.4% in November (previous month 4.9%. The main reason for admission was respiratory distress with the main diagnosis at discharge being suspected sepsis. There was a total of 35 term admissions reviewed in November – 26 were graded as an A (no care issues identified) and 9 were graded as a B (care issues identified but they did not impact the care or management). The areas for improvement were to reinforce the importance of plotting symphysis fundal height (SFH) on growth chart. This is included as part of the mandatory training and the fetal monitoring multidisciplinary training. There were 19 readmissions of babies – 16 were related to jaundice and 3 were related to weight loss.
Maternity Safety	There was no PSII's declared in November 2023. There were 11 new complaints received in November and 6 complaints closed. Examples of issues raised were; communication x 3, clinical treatment x 3, appointments, consent, patient care, delayed discharge and values and behaviours of staff.
Test Endorsement	Test result endorsement increased to 79.6% in November which is a decrease from 83.65% in October. The target is 85%. An Endorsing Results checklist and Reference Index has been written and should assist staff in endorsing results contemporaneously in line with Trust safety incentives. Maternity continues to educate staff to improve results.
Public Health	The percentage of women initiating breastfeeding increased to 84% in November which was a significant improvement from 67% in September, The infant feeding team continue to monitor this through the Baby Friendly Initiative (BFI) Strategy working group which commenced in May 2023, and data validation is improving.
Exception reports	No exception reports identified.

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Indicator overview summary (SPC dashboard)

ER Exception report

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Mothers Birthed	Nov 23	598	625			628	556	700
Babies Born	Nov 23	608	-			639	566	712
Scheduled Bookings	Nov 23	700	750			711	575	848
Inductions of labour from iView	Nov 23	141	-			147	103	190
Inductions of labour from iView: as a % of mothers bi	Nov 23	24.0%	28.0%			23.4%	17.7%	29.0%
Spontaneous Vaginal Births (including breech)	Nov 23	302	-			313	224	401
Spontaneous Vaginal Births (including breech): as a %	Nov 23	51.0%	-			51.3%	44.1%	58.5%
Forceps & Ventouse	Nov 23	80	-			90	64	117
Forceps & Ventouse: as a % of mothers birthed	Nov 23	13.0%	-			14.4%	10.2%	18.5%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-Section	Nov 23	209	-			211	175	247
as % of mothers birthed	Nov 23	35.0%	-			35.2%	29.3%	41.0%
% Emergency c-sections	Nov 23	18.0%	-			19.8%	14.5%	25.1%
% Elective c-sections	Nov 23	17.0%	-			13.9%	9.6%	18.2%
Robson group 1 c-section with no previous births	Feb 23	15.5%	-			14.2%	11.0%	17.5%
Robson group 2 c-section with no previous births	Feb 23	57.0%	-			56.7%	48.9%	64.4%
Robson group 5 c-section with 1+ previous births	Feb 23	83.3%	-			83.4%	76.1%	90.8%
Elective CS <39 weeks no clinical indication	Nov 23	0	0			0	0	0
Prospective Consultant hours on Delivery Suite	Nov 23	109	109			109	109	109
Midwife:birth ratio (1 to X)	Nov 23	21.9	28.0			26.9	23.5	30.2
Maternal Postnatal Readmissions	Nov 23	8	-			8	-1	17
Readmission of babies	Nov 23	19	-			20	2	37

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
3rd/4th Degree Tear	Nov 23	14	-			12	0	24
3rd/4th Degree Tear as % of SVD+OVD	Nov 23	3.6%	3.5%			2.9%	0.0%	5.9%
3rd/4th Degree Tear with unassisted births (SVD)	Nov 23	3.3%	-			2.6%	-1.4%	6.6%
3rd/4th Degree Tear with assisted births (OVD)	Nov 23	5.0%	-			4.7%	-3.0%	12.3%
PPH 1.5L or greater, vaginal births	Nov 23	16	-			13	0	25
PPH 1.5L or greater, vaginal births as % of mothers bir	Nov 23	2.5%	2.4%			2.0%	0.3%	3.8%
PPH 1.5L or greater, caesarean births	Nov 23	1	-			7	-1	16
PPH 1.5L or greater, caesarean births as % of mothers	Nov 23	0.1%	4.3%			1.2%	-0.7%	3.2%
ICU/CCU Admissions	Nov 23	0	-			1	-1	3
% completed VTE admission assessments	Nov 23	96.6%	95.0%			97.1%	94.1%	100.0%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Maternal Deaths: all	Nov 23	0	0			0	0	1
Early Maternal Deaths: Direct	Nov 23	0	0			0	0	0
Early Maternal Deaths: Indirect	Nov 23	0	0			0	0	0
Late Maternal Deaths: Direct	Nov 23	0	0			0	0	0
Late Maternal Deaths: Indirect	Nov 23	0	0			0	0	0
Puerperal Sepsis	Nov 23	2	-			6	0	12
Puerperal Sepsis as % of mothers birthed	Nov 23	0.3%	1.5%			1.0%	0.0%	1.9%
Stillbirths (24+0/40 onwards; excludes TOPs)	Nov 23	0	0			2	-2	7
Stillbirths (24+0/40 onwards; excludes TOPs): as rate per	Nov 23	0	4			3	#N/A	#N/A
Late fetal losses (delivered 22+0 to 23+6/40; excludes TO	Nov 23	0	1			0	-2	3

5

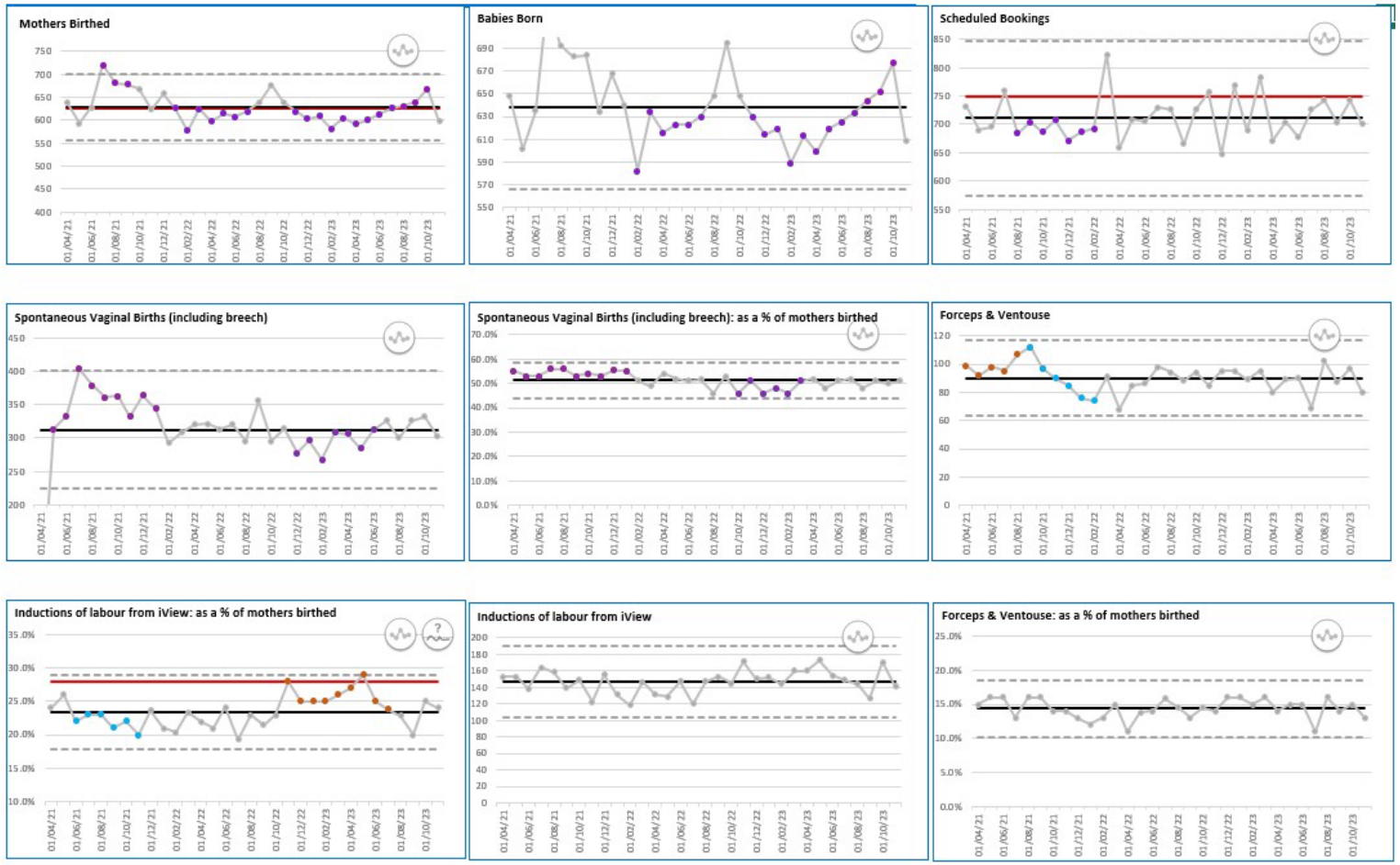
Indicator overview summary (SPC dashboard), *continued*

ER Exception report

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Neonatal Deaths (born in OUH, up to 28 days)	Nov 23	2.0	0.0			2.5	-2.0	7.0
Neonatal Deaths (born in OUH, up to 28 days): Early (bef	Nov 23	2	0			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): as rate pe	Nov 23	0	3			1	-3	5
HIE 2	Nov 23	0	0			0	0	0
HIE 3	Nov 23	0	0			0	0	1
Shoulder Dystocia	Nov 23	6	-			8	0	17
Shoulder Dystocia: as % of births	Nov 23	1.0%	1.5%			1.3%	0.1%	2.5%
Unexpected NNU admissions	Nov 23	27	-			26	10	43
Unexpected NNU admissions: as % of births	Nov 23	4.4%	4.0%			4.0%	1.5%	6.6%
Hospital Associated Thromboses	Nov 23	0	0			0	-1	1
Returns to Theatre	Nov 23	0	0			1	-2	4
Returns to Theatre: as % of caesarean section deliveries	Nov 23	0.0%	0.0%			0.7%	-0.8%	2.2%

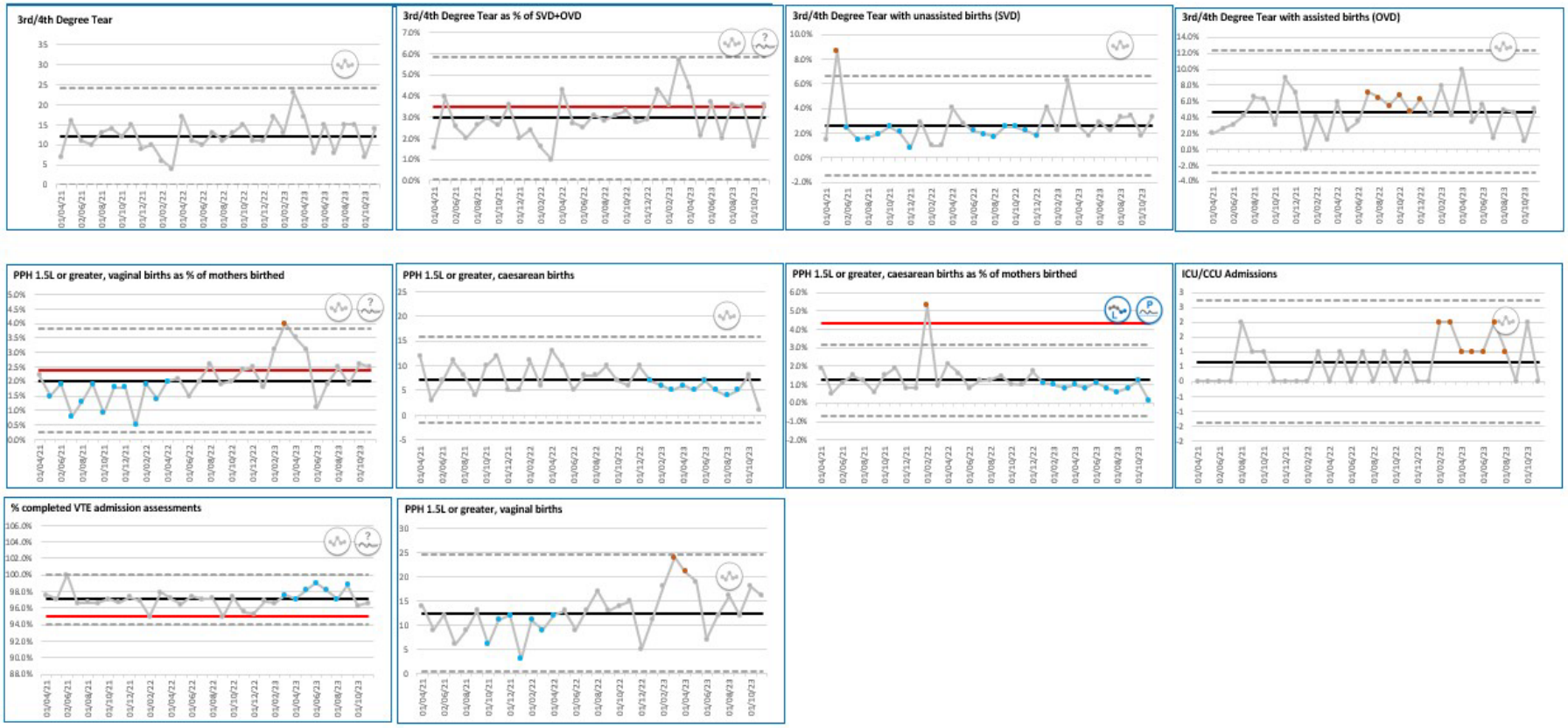
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Number of SIRI	Nov 23	0	0			1	-2	5
Number of Divisional Investigations	Nov 23	0	-			0	-1	1
Number of Complaints	Nov 23	11	-			8	-3	20
Born before arrival of midwife (BBA)	Nov 23	3	-			6	-3	15
Test Result Endorsement	Nov 23	79.6%	85.0%			74.4%	63.2%	85.7%
Number Of Women Booked This Month Who Currently S	Nov 23	54	-			53	32	74
Percentage Of Women Booked This Month Who Current	Nov 23	7.7%	-			7.5%	4.4%	10.6%
Number of Women Smoking at Delivery	Nov 23	29	-			36	20	51
Percentage of Women Smoking at Delivery	Nov 23	4.8%	8.0%			5.7%	3.1%	8.3%
Percentage of Women Initiating Breastfeeding	Nov 23	84.0%	80.0%			79.1%	69.7%	88.4%
Percentage of women booked by 10+0/40	Nov 23	72.4%	-			69.7%	64.4%	75.0%

Appendix 1. SPC charts (1)



Appendix 1. SPC charts (2)

Appendix 1. SPC charts (3)



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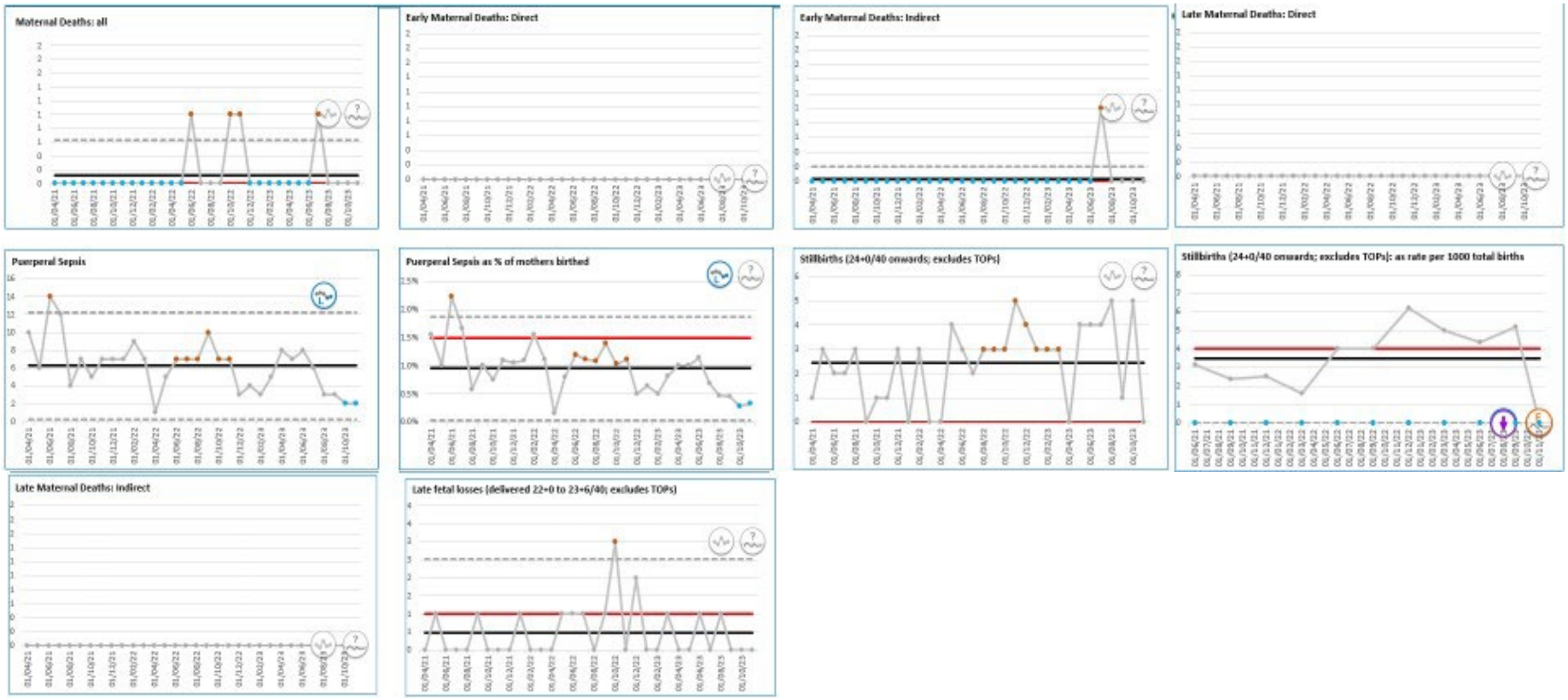

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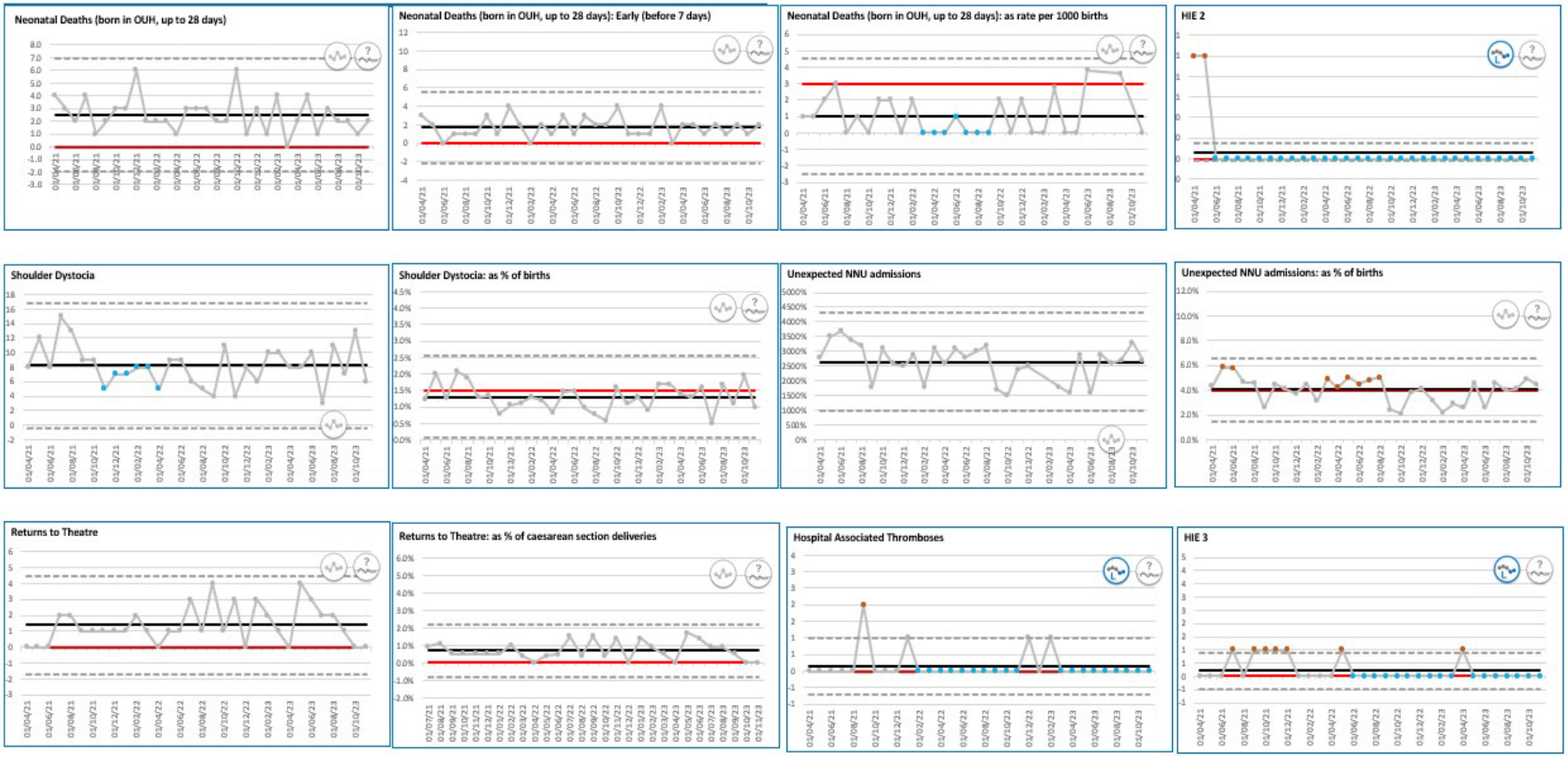

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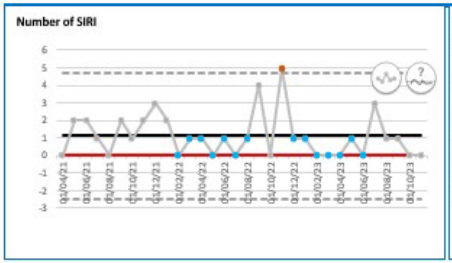

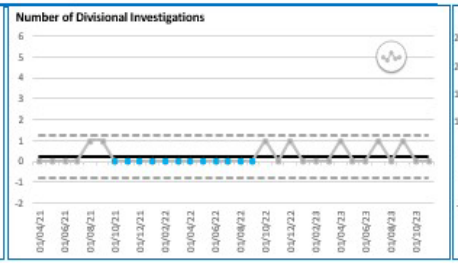

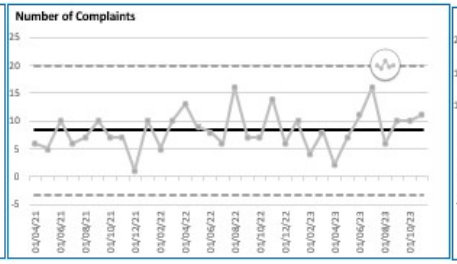

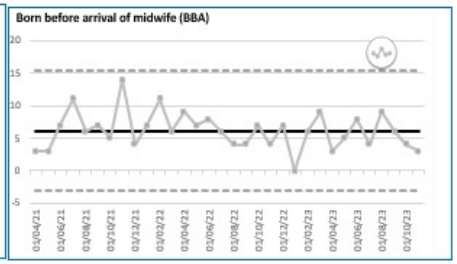

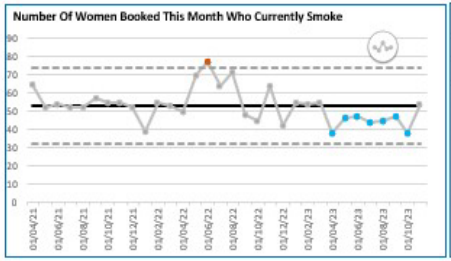

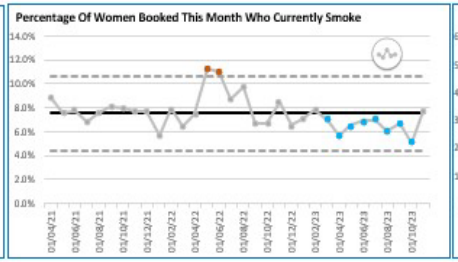

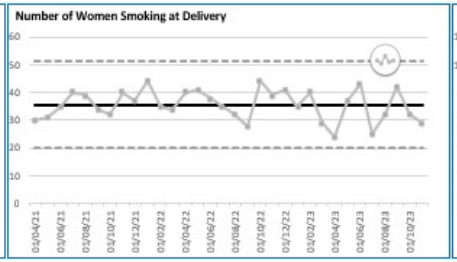

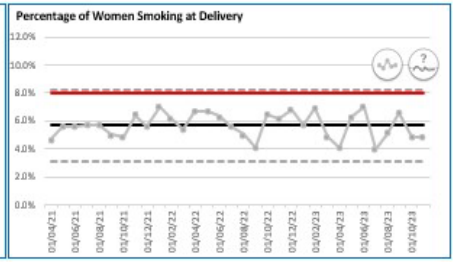

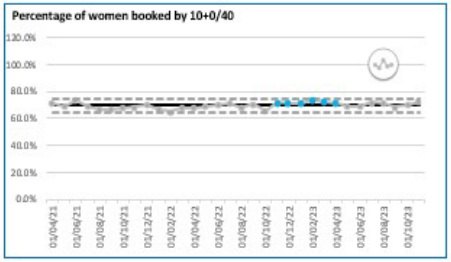

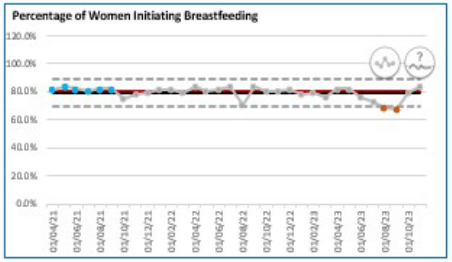

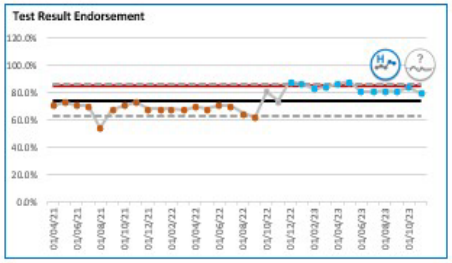

Gradings of Care for PMRT, Post partum haemorrhage (PPH), 3rd and 4th Degree Tears, Term Admissions to SCBU

A - No care issues identified; appropriate guidelines followed
B - Care issues identified - did not impact the care or management
C - Care issues identified - that may have impacted the care or management
D - Care issues identified - That did impact the care or management

Appendix 2: Maternity Incentive Scheme Compliance Tracker

Safety Action 1: National Perinatal Mortality Review Tool (PMRT)

Required Standards following re-launch of MIS	RAG rating for risk of non-compliance	Evidence and update on status
Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		
a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from **30 May 2023,** MBRRACE-UK surveillance information should be completed within one calendar month of the death.	**Compliant**	Copy of the job description for the Perinatal Mortality Review (PMR) Coordinator. Copy of the reporting Standard Operating Procedure (SOP) for PMR, Perinatal Death Reporting and Parental Involvement. PMRT quarterly reports. Minutes from Perinatal Mortality Review Tool meetings. Spreadsheet which shows eligible case list. As of the end of Quarter 2 we were 100% compliant. Due to staff sickness and unit acuity a notification and a surveillance were completed outside of the deadline within Quarter 3. This was identified PMR Panel Update Report for Confidential Trust Board, v0.1 Page 11 of 13 and the Trust liaised with the clinical lead for the Maternity Incentive Scheme (MIS) at NHS Resolution and NPEU (National Perinatal Epidemiology Unit). In view our excellent track

Required Standards following re-launch of MIS	RAG rating for risk of non-compliance	Evidence and update on status
		record with Safety Action 1 MIS, our mitigation was accepted.
b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.	**Compliant**	SOP on Parental Involvement in PMRT. The parental perspectives are discussed at PMR meetings and recorded in the minutes. The information is on the PMR tool.
c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from **30 May 2023.** 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.	**Compliant**	Perinatal Mortality Review SOP Spreadsheet list shows 96% compliance. One case not completed due to awaiting input from a different Trust – this does not impact on compliance for MIS: *'If you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the external validation process'.*
d) Quarterly reports should be submitted to the Trust Executive Board from **30 May 2023.**	**Compliant**	The Perinatal Mortality Review Meeting Quarterly reports are presented at confidential Trust Board. Relevant excerpts from Confidential Trust Board minutes.

Safety Action 2: Maternity Services Data Set (MSDS)

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		
This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023.	**Compliant**	Evidence of the Maternity Services Dataset Scorecard which shows a pass for each metric. Email evidence of submission of the data in July 2023. Screenshot of July 2023 data which formed the basis of submission.
2. July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	**Compliant**	Provisional data was submitted in July 2023. Flex data was shown in October 2023 which showed a failure in reporting 90% of ethnicities at booking. Ethnicities reported was 88% and the digital team worked with teams to correct this. Final submission resulted in a pass of 92.3% Screenshot of July 2023 data which formed the basis of submission.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: Midwifery Continuity of carer (MCoC) i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Final data for July 2023 will be published in October 2023.	**Compliant**	Screenshot of July 2023 result showing all metrics passed
i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.	**Compliant**	MSDS evidence of July data Final submission – Pass, 97.4%

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Final data for July 2023 will be published in October 2023.	**Compliant**	MSDS evidence of July data Final submission – Pass, 100%
Midwifery Continuity of Carer (MCoC) i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion. If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool	**Compliant**	All metrics of the MSDS passed for July 2023 data

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
supplied by NHS England (see technical guidance for further information).		
4. Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023. 5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.		All metrics of the MSDS passed for July 2023 data OUHT have 7 members of the information team working within the Trust who are registered to submit MSDS data.

Safety Action 3: Transitional Care & Avoiding Term Admissions into Neonatal Units Programme

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal Units Programme?		

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
a) Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: - There is evidence of neonatal involvement in care planning - Admission criteria meets a minimum of at least one element of HRG XA04 - There is an explicit staffing model - The policy is signed by maternity/neonatal clinical leads and should have auditable standards. - The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	**Compliant**	-Transitional care unit At a Glance. Shows admission criteria against HRG XA04. -Transitional care guideline which has been co-produced by maternity and neonatal leads and Safety Champions. This shows neonatal involvement in care planning and an explicit staffing model OUHT have been fully compliant with Transitional Care as a service. However, following consultation and funding from Year 4 MIS, a specific TC unit was launched 21st August 2023 to enhance services. -Patient information leaflet– Welcome to the Transitional Care Unit. -Geographical TC Policy to be audited January 2024 as per first Quarter since TC launch location August 2023. - Quarter 1 and 2 audits of admissions to TC (Quarter 3 being collected January 2023). These audits cover TC as a service, not as a location. -A multi-disciplinary symposium has been held involving Maternity & Neonatal leads to develop the geographical service, and fortnightly multi-disciplinary meetings are held.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies **equal to or greater than 37 weeks**. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB. Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks. - Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks. - Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan. - Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan.	**Compliant**	ATAIN Action plan has been approved by the BOB LMNS and ICB. It will go to Trust Board January 2024. It has been shared with safety champions. Evidence of minutes. Monthly ATAIN reports. Minutes of quarterly MDT meetings between maternity and neonatal to discuss thematic learning, review action plan and deep dive into potentially avoidable admissions. Copies of PQSM Papers Safety Champions minutes monthly Minutes of MCGC meetings monthly The ATAIN action plan is included each month as part of the ATAIN paper that goes to MCGC and to the Safety Champions meeting. The Safety Champions meeting is attended by the Maternity Safety Champions (DoM and CD) as well as the Board Safety Champion, NED and Neonatal Safety Champion. It is shared monthly with the LMNS and ICB. MCGC is attended by OSM, DoM and CD.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
C) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway. Evidence to include: • Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring OR • An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation.	**Compliant**	Evidence that TC location launched August 2023. TC guideline (see point a) TC raw data: Neonates going to TC spreadsheet evidences that TC is being used.

Safety Action 4: Clinical Workforce Planning

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Can you demonstrate an effective system of clinical workforce planning to the required standard?		
Obstetric medical workforce 1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.	**Compliant**	We do not employ external locums and therefore N/A - confirmation of this by email from the Obstetric Deputy Guardian of Safe Working Hours at OUH. Email confirming internal locum's work at OUH and are members of NHSP. Therefore, no need to use the RCOG guidance as they are not external. Confirmed by the Clinical Director for midwifery.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.	**Compliant**	We do not employ locums and therefore N/A - confirmation of this by email from the Obstetric Deputy Guardian of Safe Working Hours at OUH.
3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-compensatory-rest.pdf 4)Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as	**Compliant**	An SOP on Compensatory Rest for Consultants was ratified at MCGC in October 2023. MCGC Minutes October 2023 Trust Board minutes November 2023 Email from Clinical Director assuring implementation of SOP.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.		
3)Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working 28 as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.	**Compliant**	As above
5. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service	**Compliant**	QR code link to questionnaire for staff to submit data for consultant attendance. Consultant attendance compliance submitted as part of PQSM paper monthly.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.		Minutes of MCGC Meetings monthly. Minutes of Safety Champions Meetings monthly. Minutes of LMNS Meetings monthly.
b) Anaesthetic medical workforce A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) The rota should be used to evidence compliance with ACSA standard 1.7.2.1.	**Compliant**	Evidence of anaesthetic rotas for: On call and resident rota –Jan 2023 until Dec 2023 with no gaps in cover. Email from Anaesthetics lead assuring compliance.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
c) Neonatal medical workforce The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements **have not been met** in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements **had been met** previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN). **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).	**Compliant**	The junior neonatal medical workforce has previously been compliant. The BAPM standards now require more medical cover at night and weekends. An action plan has been developed to address the deficiencies. This includes the development of a business case to uplift the numbers of junior neonatal registrars. The action plan was ratified at Neonatal Clinical Governance Committee (NCGC) on 27 November 2023. Excerpt from TME minutes 14 Dec 2023. The Trust Board is required to formally record in Trust Board minutes that it does not meet the standard. Minutes of LMNS meeting regarding submission of action plan. Email from ODN confirming action plan received.
d) Neonatal nursing workforce The neonatal unit meets the BAPM neonatal nursing standards.	**Compliant**	The Neonatal workforce calculator went to the Trust Board reading room 8th November 2023.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
If the requirements **have not been met** in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies. If the requirements **had been met** previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN). **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN). Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form.		This shows funding is compliant in accordance with the BAPM Nurse Staffing Standards. An action plan has been developed to show progress with recruitment against funded establishment. The board is required to formally minute that OUHT are not compliant with this standard and acknowledge the progress against the action plan. Neonatal Nursing Workforce Action Plan Trust Board Minutes. LMNS Board meeting minutes. Email from ODN confirming action plan received.

Safety Action 5: Midwifery Workforce Planning

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Can you demonstrate an effective system of midwifery workforce planning to the required standard?		
a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.	**Currently compliant** Using Birthrate+	Since Dec 2022 we have been using Birthrate+ The Birthrate+ Paper was approved at Trust Board 8th November 2023 for an uplift in funded establishment of 22.38wte midwives. Trust Board minutes 8th November 2023 Excerpt of minutes from: Investment Committee Business Planning Group Trust Management Executive Staffing and Escalation SOP
b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in (a) above.	**Currently compliant**	Email with establishment review charts.
c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no	**Currently compliant**	Reported monthly as part of the Maternity performance dashboard as part of the workforce section.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.		The bi-annual Maternity Safe Staffing reports Red Flags Safe Staffing Paper Q3/Q4 Safe Staffing Paper Q1/Q2 Delivery Suite Staffing Policy
d) All women in active labour receive one-to-one midwifery care.	**Currently compliant**	The bi-annual Maternity Safe Staffing reports Red Flags Safe Staffing Paper Q3/Q4 Safe Staffing Paper Q1/Q2 Delivery Suite Staffing Policy Manager on call SOP Staffing and Escalation SOP
e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the MIS year four reporting period.	**Currently compliant**	Bi-annual report Maternity Safe Staffing for Quarter 3 and Quarter 4 2022/23 was reported to Trust Board July 2023. (TB2023.73) Quarter 1 and Quarter 2 went to MCGC 27th November 2023 and to Trust Board 17th Jan 2024.

Safety Action 6: Saving Babies Lives Care Bundle Version Three (SBLCBv3)

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Can you demonstrate compliance with all five elements of the Saving Babies Lives Care Bundle Version Two (SBLCBv3)?		
1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024. 2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available.	**Compliant**	SBL toolkit on NHS futures which is monitored by the LMNS for compliance.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
1) The Three Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024. **A new implementation tool is now available to help maternity services to track and evidence improvement and compliance with the requirements set out in version three. The tool is based on the interventions, key process and outcome measures identified within each element, and is available at https://future.nhs.uk/SavingBabiesLives** Providers should use the new national implementation tool to track and compliance with the care bundle once this is made available and share this with the Trust Board and ICB. To evidence adequate progress against this deliverable by the submission deadline in February, **providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.** These percentages will be calculated within the national implementation tool once available. 2) Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following:	**Compliant** **Using toolkit to evidence Compliance**	The SBLCBv3 Toolkit demonstrates over 50% compliance for each Element and over 70% compliance overall. OUHT are also on-track to meet all elements of SBLCBv3 by March 2024. Confirmation emails from ICB confirming progress and summary against each element of the tool. Reports: Q1 LMNS Review Q2 LMNS Review

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
- Use of the implementation tool once it is made available. Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. - Progress against locally agreed improvement aims. - Evidence of sustained improvement where high levels of reliability have already been achieved. - Regular review of local themes and trends with regard to potential harms in each of the six elements. Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.		

Safety Action 7: Maternity Voices Partnership (MNVP)

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Listen to women, parents and families using maternity and neonatal services and coproduce services with users		
1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.	**Compliant**	ARC Grant Application BOB LMNS Grant application OMNVP Workplan
2. Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.	**Compliant**	OMNVP Workplan Minutes of Safety Champions Meeting (OMNVP Chair is invited to these meetings to discuss plans/service user feedback etc). Minutes of LMNS Board Meetings
3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.	**Compliant**	OMNVP feedback survey, Annual report and workplan.
Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff.	**Compliant**	Meeting minutes of the OMNVP meetings 2023. Evidence of feedback from 15 Steps.

Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.	**Compliant**	Email confirming Microsoft office package in the budget. Email confirming training plan. Email confirming Team Leader and Parent rep training. Email confirming training on the 'Community and Cultures' project. ONMVP Workplan.
The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it.	**Compliant**	OMNVP workplan Meeting minutes of OMNVP meetings. LMNS meeting minutes 31st August 2023 (when plan was ratified).
Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses.	**Compliant**	Email evidence from Chair and Vice Chair of expenses that are funded.
Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.	**Compliant**	Evidence of events for bereavement and deprived areas. Links to Social media information. Email from Chair confirming that OMNVP are partners in the 'Early lives, equal start' project.

		'And Breathe' Digital magazine demonstrating ongoing work with the BAME community. Email confirming training on the 'Community and Cultures' project. You tube film shared with OMNVP promoting translation services. OMNVP Health Inequalities Action Plan

Safety action 8: Training

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?		
1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.	**Compliant**	Training Needs Analysis produced in line with the Core Competency Framework Version 2.
2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB	**Compliant**	LMNS and ICB sign off 19th December 2023. LMNS Meeting minutes. Email from ICB. Trust Board minutes 17th Jan 2024.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
3. The plan is developed based on the "How to" Guide developed by NHS England.	**Compliant**	TNA in line with the 'how to' guide and the CCFv2.
Module 1 – Saving Babies Lives Bundle, Version 3	**Compliant**	Training plan in place for the implementation of the CCFv2. Copy of SBLCB training programme.
Modules 2 – Fetal monitoring	**Compliant**	From Dec 2022 – Dec 2023: Midwives – 96% compliant Obstetric Consultants – 96% compliant Obstetric Registrars – 100% compliant Obstetric SHO's - 100% compliant
Module 3 – Multiprofessional training in emergencies (PROMPT)	**Compliant**	From Dec 2022 – Dec 2023: Anaesthetic Registrars – 100% compliant Anaesthetic Consultants – 94% compliant Midwives – 98% compliant Maternity Support Workers – 96% compliant Obstetric Consultants – 96% compliant Obstetric Registrars – 94% compliant Obstetric SHOs – 91% compliant Training compliance spreadsheet as evidence.
Module 4 – Equality, equity, and personalised care	**Compliant**	From Dec 2022 – Dec 2023: Midwives – 96%

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Module 5 – Care during labour and immediate postnatal period	**Compliant**	From Dec 2022 – Dec 2023: Midwives – 96%
Module 6 – Neonatal life support (NLS)	**Compliant**	From Dec 2022 – Dec 2023: Neonatal medical – 98% compliant Neonatal nursing – 93.3% compliant Midwives – 96% compliant

Safety Action 9: Maternity and Neonatal Safety and Quality

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?		
a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded. **Is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically:** -Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues. - Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs).	**Compliant**	Monthly Safety Champions meetings are chaired by the non-executive director. These meetings are attended by the OMNVP, maternity triumvirate, Governance lead, legal teams and the OMNVP. Copy of agenda from Safety Champions meetings.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
-To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.		Copy of minutes from Safety Champions meetings (and associated papers e.g. PMRT, PQSM, Trust Claims Scorecard) BOB LMNS SI panel meeting minutes. Minutes of Trust Board meetings.
B) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.	**Compliant**	Maternity PSIRF Action Plan Minutes from BOB LMNS meetings. Minutes from Trust Board SUWON Divisional meeting minutes PSIRF Slide 'And Breathe' Maternity bulletin outlining PSIRF.
C) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.	**Compliant**	Safety Champions meeting minutes. All of the Quadrumvirate have attended training.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
		Copy of Certificate – Perinatal Quadrumvirate Culture and Leadership Development Programme. Score Survey planned for Maternity and Neonatal Services early 2024. Email from director confirming timeline.

Safety Action 10: NHSR Early Notification Scheme

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?		
A) Reporting of all qualifying cases to HSIB/CQC//MNSI from **6 Dec 2022 to 7 December 2023.**	**Compliant**	All qualifying cases were reported within the relevant reporting period. 100% compliance. HSIB case log.
B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until 7 December 2023.	**Compliant**	Email confirmation that all relevant EN cases have been reported in this reporting period but declined. 100% compliance. HSIB case log.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
C) For all qualifying cases which have occurred during the period 6 Dec 2022 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB/CQC/MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	**Compliant**	Spreadsheet confirming that all families received information of the relevant scheme. Aso confirming that, where relevant, a DOC letter has been provided. Redacted letters as examples of compliance. PQSM reports go monthly to MCGC, bi-monthly to Trust Board and quarterly to BOB LMNS.
Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB/CQC/MNSI/EN incidents and numbers reported to HSIB/CQC/MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of HSIB/CQC/MNSI and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.	**Compliant**	Perinatal Quality Surveillance Model (PQSM) containing this information are discussed monthly at the Maternity Clinical Governance Committee and the Maternity and Neonatal Safety Champions meetings. They also go monthly to Trust Board and quarterly to BOB LMNS. Excerpts of relevant meeting minutes confirming receipt of PQSM reports.