Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 14 May 2025

TB2025.36

Title:	**Perinatal Quality Surveillance Summary Report – February and March 2025**
Status:	**For Discussion**
History:	**Maternity Clinical Governance Committee (MCGC) 14/04/2025** **Maternity and Neonatal Governance Operational Delivery Committee 24/04/2025**

Board Lead:	**Chief Nursing Officer**
Author:	**Milica Redfearn, Director of Midwifery** **Sharon Andrews, Head of Midwifery** **Claire Litchfield Maternity Clinical Governance Lead** **Joana Dias, Perinatal Clinical Governance Lead** **Nadine Purdy, Neonatal Matron** **Niamh Kelly, Maternity Safety, Risk and Compliance Lead**
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. The report provides a summary and overview of the perinatal quality surveillance at Oxford University Hospitals, based on the Ockenden report recommendations and the Maternity Perinatal Incentive Scheme (MPIS) Year 6 safety actions. The report covers the February 2025 and March 2025 reporting period.
2. **Perinatal Deaths Review**: The report summarises 7 perinatal deaths that were reviewed in February and March, using the Perinatal Mortality Review Tool (PMRT).
3. **Patient Safety Incidents**: In maternity, there were 230 safety incidents reported in February 2025, 55 of which were moderate harm. There were 229 safety incidents reported in March 2025, 53 of which were moderate harm. In Neonates, there were 60 safety incidents reported in February 2025, 2 of which were moderate harm. There were 71 safety incidents reported in March 2025, 1 of which was moderate harm.
4. **Avoiding Term Admissions**: Unplanned admissions to the neonatal unit were 4.0% in February and 3.7% in March 2025 remaining below the national target of 6%. The primary reason for admission and diagnosis on discharge is presumed sepsis in the neonates.
5. **Training compliance:** Training compliance for newborn life support remains at above 90% for neonatal/paediatric consultants, junior neonatal doctors (who attend births) and ANNP's apart the anaesthetic group attending PROMPT which is at 88% (improvement from previous month) and fetal monitoring training for consultant obstetricians which has decreased to 88% (with a trajectory to meet the 90% standard after April's training session) and from Neonatal nurses' compliance is currently 82%. A collaborative action plan has been developed to meet the >90% standard.
6. **Delivery Suite Care**: There were no occasions in February or March when 1:1 care in labour was not provided. There were no occasions when the Delivery Suite coordinator was not supernumerary.
7. **Maternity and Perinatal Incentive Scheme (MPIS):** Year 7 of the MPIS was published on the 02 April 2025. This is currently being reviewed and meetings set up for this year to monitor compliance against the safety actions.
8. **Service Users' Feedback**: An action plan has been co-produced with the OMNVP lead aligned to the Triangulation and Learning Committee (T.A.L.C) action plan. Daily walkarounds in inpatient areas with friends and family test (FFT) are being undertaken by volunteers and maternity staff to capture current inpatient feedback, supported by the Patient Experience team.
9. **Staff Feedback**: The Safety Champions Walk-around was conducted on the 24 March 2025 and their journey included the Transitional Care Unit (TCU) on Level 5 and the Neonatal Unit (NNU). Weekly safety walkabouts in line with the Trust Care Assurance framework were conducted by the senior leadership team during this

period. Staff continue to have access to the Say on the Day devices to rate their shift experiences.

Recommendations

10. The Trust Board is asked to:

Receive and note the contents of the Perinatal Quality Surveillance Mortality Report.

Contents

Perinatal Quality Surveillance Summary Report – February and March 2025

Purpose

1.1. The report provides an overview of the perinatal quality surveillance at Oxford University Hospitals, based on the Ockenden report recommendations and the Maternity Perinatal Incentive Scheme (MPIS) Year 6 safety actions.

1.2. The report covers the data from February and March 2025.The Trust is required to provide a PQSM report to the Berkshire West, Oxfordshire, Buckinghamshire (BOB) local maternity and neonatal services (LMNS) for perinatal quality oversight.

1.3. The monthly data on which this paper is based is presented within the maternity quality report at the Maternity Clinical Governance Committee (MCGC) meetings.

1.4. Provide an overview of compliance in relation to MPIS Year 6.

Perinatal Deaths

1.5. The table below summarises the total number of deaths by type and gestation reported through maternity services.

1.6. There were 6 perinatal deaths in February and 5 in March 2025.

Month		Feb 25	Mar 25
Total Number of Deaths		**6**	**5**
Type of Mortality	Antepartum Stillbirths	1	4
	Intrapartum Stillbirths	1	0
	Neonatal Deaths	4	1
Gestational Age	<24 weeks	1	2
	24-27 weeks	2	1
	28 - 31 weeks	2	0
	32 - 36 weeks	0	1
	37-41 weeks	1	1
	≥ 42 weeks	0	0
Number of Cases reviewed using PMRT		3	4
External Panel Member	Occasions present	3	3

Findings from Perinatal Deaths Reviews

1.7. During the month of February, 3 cases were reviewed using the Perinatal Mortality Review Tool (PMRT) and 4 cases were reviewed in March (see table 1). The care is graded using A, B, C and D categories during the review process, two grades are given, one for care up to the point of diagnosis of death, and one for care following the diagnosis of death. Definition of categories attached as appendix 1.

1.8. Two of the cases were graded A/A as there were no issues identified with the care.

1.9. Case 96498- Graded a B as OUH were unable to access any of her previous scan reports when she transferred trusts. The creation of new resident packs for patients moving to the Trust is being explored.

1.10. Case 96559- Graded a B due to IUD being confirmed, however there were signs of life when born and is recognised to have had a psychological impact on the parents. No learning was identified that would not have changed the outcome.

1.11. Case 97015 was graded B. No partogram was completed following confirmation of an IUD. A reminder for this to be completed has been circulated to staff.

1.12. Case 97158 was graded a B as there is no documentation regarding timings for recommending attendance at MAU with reduced fetal movements, and attendance was not until 4 hours after the call. This learning has been fed back to the staff on MAU to ensure a time frame is given to attend and to document this.

1.13. Case 97223 was graded a B as CO monitoring was not completed at booking. The care following was graded a B due to the neonatal bereavement paperwork not being completed. The Perinatal governance lead will review the paperwork with the neonatal and maternity bereavement teams to ensure that checklists are shared as appropriate and completed fully.

Ulysses No: or MBRRACE Ref.	Case	IUD - Grading of care of the mother and baby up to the point that the baby was confirmed as having died	Grading of care of the mother following the death of her baby
96498	P0 booked at Reading MLC moved house to OUH at 34+5 transferred to	B	A

	OUH. Attend MAU at 38+3 with reduced movements IUD confirmed.		
96559	P0 MLC 22+2 Attended MAU with bleed, found to having bulging membranes. 22+4 Preterm rupture of membranes and cord prolapse. Bedside scan IUD confirmed. Spontaneous labour and delivery, NND at 30mins of age.	B	A
97015	P0 under FMU for anhydramnios and talipes, planned palliative care. Attended MAU at 36+2 with reduced movements, IUD confirmed.	A	B
97119	P0 referred to OUH for congenital myotonic dystrophy. ELCS at 36+1 Compassionately extubated on D4	A	A
97158	P1 MLC Attended MAU with reduced movements at 27+0 IUD confirmed	B	A
97223	P1 Under FMU for IUGR, absent/ reversed EDF, EMCS at 27+2. NND at 20 hours old	B	B

Table 1: Reviews in February and March 2025

MNSI Referrals

1.14. No cases were reported to MNSI in February. In March 2025, two cases were reported (403892 and 404287). The first involved an intrauterine device where the patient attended in an advanced stage of labour, and the second was a case of therapeutic cooling with a normal MRI.

1.15. Final reports or finalised action plans received in February 2024 and March 2025 as follows:

MNSI No.	Description	Comment
Mi-037536	A baby was born on the Spires MLU and required resuscitation and cooling.	There were no safety recommendations, however an action plan has been developed to address safety prompts. These actions related to: 1.16. Role and expectations for second midwife attending birth – action: Included in annual mandatory training led by consultant midwives. • Update to guidance to ensure that the operational manager is not used as a second midwife.

		• Telephones in every birthing room to enable ease of communication for escalation/bleeps
MI 036869	A woman awaiting a planned emergency caesarean started to labour and required an emergency caesarean. The baby required resuscitation and cooling.	There was one safety recommendation relating to: • The development of a pathway for women who deviate from the standard caesarean pathway.

Patient Safety

1.17. The Trust adopted a standardised approach from October 2021, automatically grading Postpartum Haemorrhage (PPH) of more than 1.5 litres and Obstetric Anal Sphincter Injury (OASI) incidents as moderate harm to ensure thorough investigation and learning. In maternity there were 55 moderate and above harm incidents reported in February and 53 in March 2025. Of the PPH and OASI cases reviewed during this period all cases were graded A or B.

1.18. In Neonates there were 2 moderate harm incidents reported in February 2025 and 1 in March 2025. Joint learning identified following MDT reviews included endorsement of results within 7 days including urine toxicology. Ensuring baby's unique QR code is attached to the cot/incubator for correct ID selection and communication of antenatal plans.

Avoiding Term Admissions to the Neonatal Unit (ATAIN):

1.19. Unplanned admissions to the neonatal unit were 4% and 3.7% respectively in February and March remaining below the national target of 6%. The primary reason for admission and diagnosis on discharge is presumed sepsis in the neonate. See appendix 2 for a copy of the Action Plan.

1.20. The Quarter 4 data was reviewed at the ATAIN meeting on the 11 April 2025. Six of the cases reviewed were graded C and learning has been disseminated.

1.21. The Quality Improvement Red Hat project went live on the 27 January 2025 and is running until 30 April 2025.

Maternity Mandatory Training Attendance:

1.22. Training weeks that include PROMPT, fetal monitoring training, OxMUD and neonatal life support continue, and compliance is above the target of 90% for staff groups apart from the anaesthetic group attending PROMPT which

is at 88**%** (improvement from previous month). Fetal monitoring training for consultant obstetricians has decreased to 88**%** (with a trajectory to meet the 90% standard after April's training session).

1.23. At the end of March 2025, training compliance for newborn life support is above the target of 90% for neonatal/paediatric consultants, junior neonatal doctors (who attend births) and ANNP's. For neonatal nurses, compliance is 82%.

Minimum Staffing

1.24. There were no occasions in February or March when 1:1 care in labour was not provided for women and birthing people in established labour and there were no occasions when the Delivery Suite Co-ordinator was not working in a supernumerary capacity.

1.25. The midwife to birth ration was 1:22.32 in February and 1:23.77 in March.

1.26. During February in maternity services, 341.8 hours were provided by on-call staff, this was reduced to 202 in March 2025.

1.27. Neonatal Workforce: The neonatal team continues to work towards compliance with BAPM standards for the medical workforce. A business plan was approved at the Trust Management Executive meeting on the 28 November to increase medical staffing to meet BAPM standards. A locum consultant has been appointed since.

1.28. Prospective consultant hours on Delivery Suite are 109hrs per week.

1.29. The trust monitors compliance with regards to consultant attendance for clinical situations listed in the RCOG workforce document 'roles and responsibilities of the consultant providing acute clinical care in obstetrics and gynaecology,' via exception reporting. No episodes have been reported where a consultant did not attend in person in February or March.

Maternity and Perinatal Incentive Scheme (MPIS):

1.30. Year 7 of the Maternity and Perinatal Incentive Scheme (MPIS) was published on the 02 April 2025.

1.31. Safety Action 6: Quarterly reviews of the trusts Saving Babies Lives audits continue as business as usual with the BOB LMNS. The quarter 3 data have been reviewed by the BOB LMNS and has been presented to the April Maternity Clinical Governance Committee (MCGC). Overall, there have been improvements, and these are reflected in increased % compliance requirement.

1.32. Improvements have been noted with Element 1 in relation to carbon monoxide (CO) monitoring and smoking status.

1.33. Year 7 launched on the 02 April 2025. This is currently being reviewed and meetings set up for this year to monitor compliance against the safety actions. Following rapid review, the areas that may pose a compliance risk are:

1.34. Safety Action 1: “External panel member(s) should be relevant senior clinicians who are currently practicing clinically and work in a hospital external to the trust undertaking the review and external to any trust involved in the care at any stage”. This is an MBRRACE requirement and has been updated in year 7. Coordination to achieve with the LMNS and partnership Trusts is already in motion.

1.35. Safety Action 7: The Maternity and Neonatal Voices Partnership (MNVP) to be a quorate member of trust governance, quality and safety meetings at speciality/divisional/directorate level. There is currently no MNVP lead for OUH due to the recent resignation of the Chair, active recruitment is underway.

Service Users Feedback

1.36. The service has implemented a Triangulation and Learning Committee (TALC) which includes complaints, service user feedback, safety themes, legal/claims, patient experience and operational representation. The aim of the group is to triangulate feedback data from the multiple sources and develop and execute actions to address themes in a timely and systematic way.

1.37. An action plan has been co-produced with the Oxford Maternity and Neonatal Voices Partnership (OMNVP) lead aligned to the TALC action plan.

1.38. There was a quarterly OMNVP meeting in March 2025 where the quarter 1 responses were reviewed. Overall service user satisfaction has improved. The responses will feed into the TALC action plan.

1.39. The postnatal working group/task and finish group continues. This will develop, implement and measure the improvements to the postnatal ward.

1.40. Following the updated friends and family test (FFT) test that was launched via Microsoft Teams QR code in February, limited responses were noted following the initial 5 day period. Responses in February were 51, most of which were submitted in the first week. In March circa. 36 were achieved, which was due to the tactical mobilisation of face-to-face feedback gathering by volunteers and midwifery staff in the inpatient areas.

1.41. There are two areas that require immediate action: the continued development of the FFT questionnaire and the establishment of a consistent communication strategy.

1.42. The following plan is now in progress; volunteers that are supporting the activity have received training and support with FFT and have been signposted how to escalate any concerns that service users raise:

1.43. Bi-weekly walkarounds in inpatient areas with FFT being undertaken by volunteers and maternity staff to capture current inpatient feedback, supported by the Patient Experience team.

1.44. Discharge coordinators from postnatal ward are facilitating FFT on discharge and collecting any paper-based surveys.

1.45. Posters have been distributed within inpatient and community areas.

1.46. There is a plan for automated reports in progress – this will be enabled once all coding is complete.

1.47. Weekly reporting by area will be launched at the Maternity Leadership Team meeting (MLT) on 23 April 2025.

1.48. The Newborn Care Unit is working collaboratively with the Thames Valley and Wessex Neonatal Network to implement a Neonatal Family Experience Feedback Survey.

Feedback from Staff Engagement Sessions and the Safety Champions

1.49. On the 24 March, the Safety Champions Walk-around was conducted by Milica Redfearn, Director of Midwifery, Nadine Purdy, Children's and Neonatal Matron and Dr. Amit Gupta, Neonatal Unit (NNU) Clinical Lead. Their journey included the Transitional Care Unit (TCU) on Level 5 and the Neonatal Unit (NNU).

1.50. On TCU, they had the pleasure of speaking with a midwife and a student who both reported positive experiences. They highlighted the good communication and collaborative working environment with neonatal colleagues. The student midwife also mentioned that it had been a positive learning experience.

1.51. They also spoke with one of our internationally educated midwives (IEM) who has been working within the service for 12 months since arriving in the UK. She described her experience as good, noting that it was quite different and much busier than what she was used to.

1.52. They also had the opportunity to speak with a mother who had been cared for in the TCU who expressed high praise for the excellent care she received while having her baby. She specifically mentioned the red hat project,

explaining that she was well-informed about it and its benefits even before entering the service.

1.53. On NNU, they had the pleasure to speak to a parent whose baby had been in the unit for 5 days. The baby had been transferred due to complications and specific care requirements. The parent reported that both she and her baby had been well cared for. She appreciated the helpfulness of the staff and their support in caring for her baby and assisting with infant feeding, despite the baby being on a ventilator.

1.54. Throughout the walkabout, they were warmly welcomed by all staff members, and it was a pleasure to meet everyone. Overall, the feedback from staff, patients, and parents was overwhelmingly positive, highlighting the excellent care, communication, and support provided within both the TCU and NNU.

Conclusion

1.55. The report outlines the implementation of the Perinatal Quality Surveillance Model (PQSM) in alignment with the Ockenden report's recommendations and the Year 7 safety actions of the Maternity Perinatal Incentive Scheme (MPIS).

1.56. It details the number and types of perinatal deaths documented within the Trust, followed by a summary of the reviews conducted via the Perinatal Mortality Review Tool (PMRT).

1.57. The report also summarises prominent themes and actions derived from these reviews and incidents.

1.58. Additionally, the report indicates the percentage of term admissions to the Neonatal Unit (NNU) and includes an appended action plan.

Recommendations

1.59. The Trust Board is asked to:

- Receive and note the contents of the Perinatal Quality Surveillance Mortality Report.

Appendix 1: Categories used for grading of care for perinatal mortality reviews (PMR)

- A – The review group concluded that there were no issues with care identified.
- B – The review group identified care issues which they considered would have made no difference to the outcome.
- C – The review group identified care issues which they considered may have made a difference to the outcome.
- D – The review group identified care issues which they considered were likely to have made a difference to the outcome.

Appendix 2: ATAIN action plan

ATAIN action plan, Quarter 4 24-25

Action Owners: Perinatal Risk Coordinator and Neonatal Consultant

No.	Recommendation	Action	Evidence	Responsibility	Deadline	Progress Update
Patient Safety Incident Response Framework						
1	Compassionate Engagement	Creation of survey to ask parents/carers of babies who are unexpectedly admitted to the neonatal unit	Copy of survey/Copy of agenda	Perinatal Risk Coordinator/OMNVP/EDI Midwives	Completed 31st January 2025	**Ongoing:** FFT feedback commenced in March 2025.
Common Discharge Diagnosis						
2	**TTN**	Explore the resource needs for the high flow oxygen at the mother's bedside project	Resource planning, equipment/staffing needs	Consultant Neonatologist	31st July 2025	**Ongoing:** Further information is required in relation to the feasibility of this. There is a plan for an update to be given at the Q1 ATAIN meeting in July.
		Explore the training needs for the high flow oxygen at the mother's bedside project	Copy of Training Plan		31st July 2025	Not yet commenced
QI Projects						
3	**Red Hat QI Project**	Register QI project by 1/9/24 in line with MPIS.	QI Log	Perinatal Risk Coordinator	31/05/25	Project registered and red hats received. Launched 27 January 2025. The project is due to run until the 30 April 2025.

Appendix 3: Quarter 3 Saving Babies Lives Audit

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

Implementation Report

Trust		Oxford University Hospitals NHS Foundation Trust
Date of Report		21-Mar-25
ICB Accountable Officer		Rachael Corser
Trust Accountable Offi	00-Jan-00	Yvonne Christley
LMNS Peer Assessor Names		Nicky Galdeano, Zeshaan Mudassar

Background

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

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

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

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

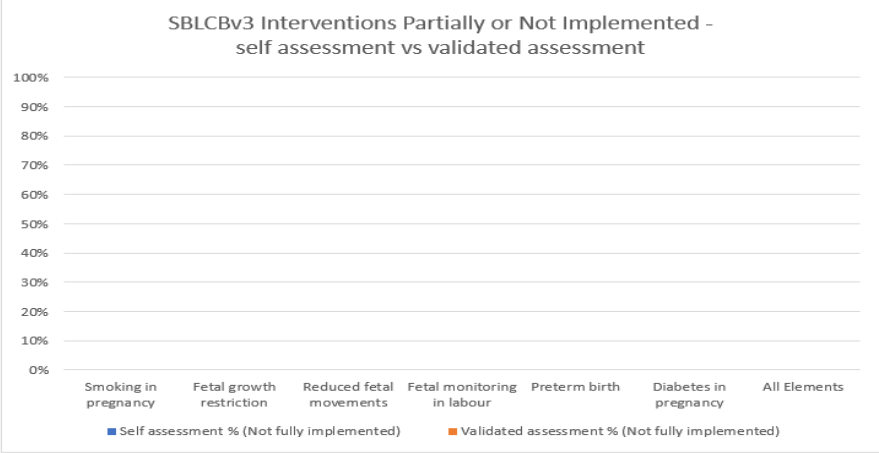
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

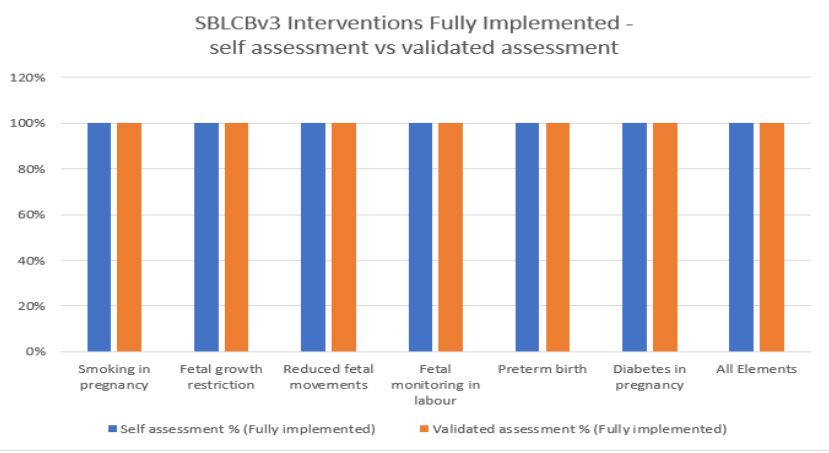
Implementation Grading

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

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Fully implemented	100%	Fully implemented	100%	CNST Met





	Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
	INTERVENTIONS				
Element 1	1.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	It is clear that Trust interventions are making a difference as clear improvement seen-to continue to observe
	1.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	As above, although improvement not as large as above-to maintain focus on this section of the element.
	1.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Improvements seen, although needs to remain focus of improvement.
	1.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Note Trust data collection issue related to Badgernet-hoping to see improvement as expected next quarter.
	1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	1.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Compliance improvement trajectory noted, therefore compliance increased for 1.6 E to reflect audit findings
	1.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard consistently met.
	1.8	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Standard met
	1.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Compliance Trajectory noted within audit findings- well done
	1.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met

INTERVENTIONS				
2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met-audit cycle to continue.
2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met, aware of data collection issues.
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	National % Compliance met and stretch ambition-well done
2.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
2.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
2.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard consistently met
2.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
2.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met

Element 2	2.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard being met
	2.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Look towards the national requirement, compliance improved, almost at National ambition-action plan in place
	2.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	2.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	2.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	2.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	2.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	2.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	2.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met, reflects level 3 related activity. MBRRACE data demonstrates position of OUH nationally compares favourably against other Level 3 units.
	2.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	LMNS requirement <1%, unable to enter into box. Standard met
	2.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
Element 3	INTERVENTIONS				
	3.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	3.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Aware of some documentation related issues with 3.2b-improvement noted, compliance % increased-robust action plan in place.

Element 4	INTERVENTIONS				
	4.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	4.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Reaching stretch ambition-well done.
	4.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Great improvement demonstrated here-standard met. Aware of some EPR related issues.
	4.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Reaching stretch ambition-standard met and exceeded.
	4.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met

INTERVENTIONS				
5.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met-PTB team in place
5.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Whilst trust aware to strive for low numbers-when MBRRACE data used are lower than other Level 3 units, thus no concerns. Standard being met.
5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Reaching the % Compliance as a stretch ambition for a high performing trust-great work-standard met and exceeded.
5.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
5.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
5.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
5.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
5.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
5.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Trust now have access to partosure, to undertake audit to reflect new guidance-see letter from NHSE-to ensure tool is being evidenced as in use.

Element 5	5.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	5.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit shows improvement, therefore compliance requirement increased to reflect that the standard being met-well done.
	5.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	5.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	5.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	5.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	5.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Improvement in evidence of compliance, % increased to reflect this. Great work by the MDT
	5.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Excellent improvement noted-audit demonstrates great work of the PTB team-standard met.
	5.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
	5.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	stretch ambition consistently met.

5.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Required standard consistently met.
5.21	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Aware of data issues for Q2 audit review. Trust to closely monitor to ensure audit reflects practice.
5.22	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met and audit demonstrates standard is embedded.
5.23	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Stretch ambition met-well done. Standard met and surpassed.
5.24	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met, % compliance adjusted to reflect audit findings.
5.25	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met, % compliance adjusted to reflect audit findings.
5.26	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Aware that data collection challenging here as the Neonatal Nurses do not input onto Badgernet. To work with the neonatal team to create a solution.
5.27	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	% compliance to reflect consistent compliance-well done.

Element 6

INTERVENTIONS				
6.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard Met
6.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met-Reaching stretch ambition of a high performing trust. To continue monitoring to maintain standard.
6.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met
6.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met, aware that may be occasional dips in compliance due to very small numbers of birthing people that this relates to.
6.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met.
6.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Standard met.