NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC (MATERNITY APPENDICES)

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6 September 2023

09:00 GMT+1 Europe/London

AGENDA

1. BOARD OF DIRECTORS IN PUBLIC (MATERNITY APPENDICES)

REFERENCES

Only PDFs are attached

- Appendix 1 - MISyear5-update-July-2023.pdf
- Appendix 2 - MIS Year 5 compliance table August 2023 V2 SA1.pdf
- Appendix 2.1 - MIS Year 5 compliance table August 2023 V2 SA2.pdf
- Appendix 2.2 - MIS Year 5 compliance table August 2023 V2 SA3.pdf
- Appendix 2.3 - MIS Year 5 compliance table August 2023 V2 SA4.pdf
- Appendix 2.4 - MIS Year 5 compliance table August 2023 V2 SA5.pdf
- Appendix 2.5 - MIS Year 5 compliance table August 2023 V2 SA6.pdf
- Appendix 2.6 - MIS Year 5 compliance table August 2023 V2 SA7.pdf
- Appendix 2.7 - MIS Year 5 compliance table August 2023 V2 SA8.pdf
- Appendix 2.9 - MIS Year 5 compliance table August 2023 V2 SA10.pdf
- Appendix 3 - Saving-babies-lives-version-three-a-care-bundle-for-reducing-perinatal-mortality-June-2023.pdf
- Appendix 4 - Ockenden Gap Analysis V9 updated August 2023.pdf
- Appendix 5 - Gap Analysis Three Year delivery plan V1.pdf
- Appendix 6 - CQC Inspection Report APH.pdf
- Appendix 7 - CQC Inspection Report Seacombe Birth Centre.pdf
- Appendix 8.1 - Perinatal June 2023.pdf
- Appendix 8.2 - Perinatal July 2023.pdf
- Appendix 9 - PRN00610_NIPE training requirements_July 2023.pdf

Maternity Incentive Scheme – year five

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

V1.1 July 2023

Contents

Introduction

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Maternity incentive scheme year five: conditions

In order to be eligible for payment under the scheme, Trusts must 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:

- Trusts must achieve **all** ten maternity safety actions.
- 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
- 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 included in this document.
    - 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**.
- 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.
- 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'

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

- Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of
  MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions, then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution
  Website).

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested as explained above.
- Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.
- Trusts will need to report compliance with MIS by **1 February 2024** at **12 noon** using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/Integrated Care System.

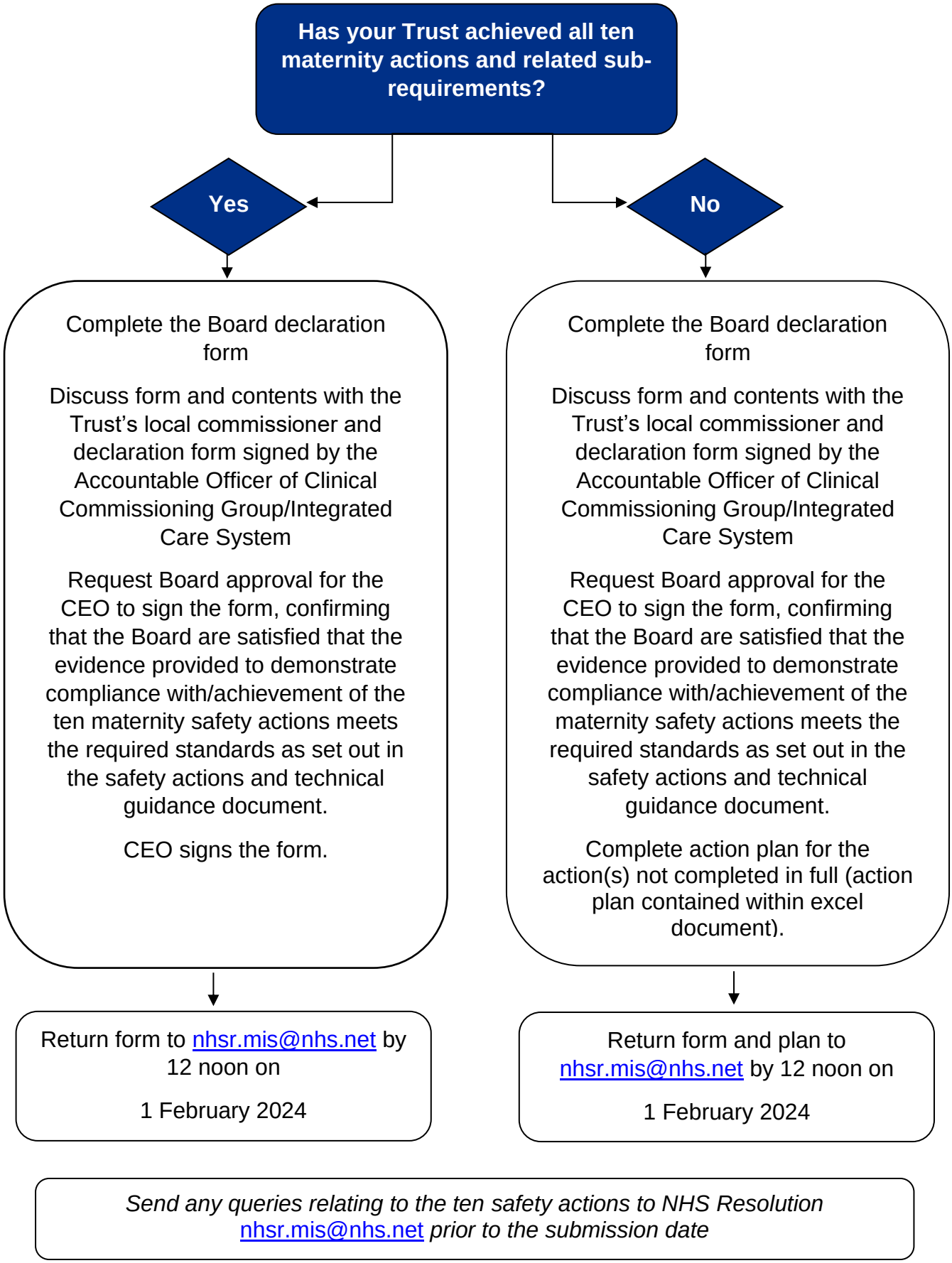
- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.
- The Board declaration form will be available on the MIS webpage at a later date.
- Trusts are reminded to retain all evidence used to support their position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described above) it must be made available as it was presented to support Board assurance at the time of submission.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution nhsr.mis@nhs.net prior to the submission date.
- The Board declaration form must be sent to NHS Resolution nhsr.mis@nhs.net between **25 January 2024** and **1 February 2024** at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from submission date.
- Submissions and any comments/corrections received after **12 noon** on **1 February 2024** will not be considered.
- The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.
- There are two possible grounds for appeal:
    - alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation
    - technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.
- NHS Resolution clinical advisors will review all appeals to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.
- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.
- Further detail on the results publication, appeals window dates and payments process will be communicated at a later date.

For Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 1 February 2024 to NHS Resolution nhsr.mis@nhs.net. The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form. Action plans should not be submitted for achieved safety actions.


Has your Trust achieved all ten maternity actions and related sub-requirements?
Yes
No
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
CEO signs the form.
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
Complete action plan for the action(s) not completed in full (action plan contained within excel document).
Return form to nhsr.mis@nhs.net by 12 noon on
1 February 2024
Return form and plan to nhsr.mis@nhs.net by 12 noon on
1 February 2024
Send any queries relating to the ten safety actions to NHS Resolution nhsr.mis@nhs.net prior to the submission date

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

Required standard	a) All eligible perinatal deaths 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. 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. 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. d) Quarterly reports should be submitted to the Trust Executive Board from **30 May 2023.**
Minimum evidential requirement for Trust Board	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal). The PMRT must be used to review the care and reports should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter from **30 May 2023** that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Verification process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.
What is the relevant time period?	From **30 May 2023** until **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**12 noon** on **1 February 2024**

Technical guidance for safety action 1

Further guidance and information is available on the PMRT website: Maternity Incentive Scheme FAQs. This includes information about how you can use the MBRRACE-UK/PMRT system to track your notifications and reviews: www.npeu.ox.ac.uk/pmrt/faqsmis; these FAQs are also available on the MBRRACE-UK/PMRT reporting website www.mbrrace.ox.ac.uk.

Technical Guidance **Guidance for SA 1(a) – notification and completion of surveillance information**	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal death must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
Where are perinatal deaths notified?	Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website. It is planned that a single notification portal (SNP) will be released by NHS England in 2024. Once this is released notifications of deaths must be made through the SNP and this information will be passed to MBRRACE-UK. It will then be necessary for reporters to log into the MBRRACE-UK surveillance system to provide the surveillance information and use the PMRT.
Should we notify babies who die at home?	Notification and surveillance information must be provided for babies who died after a home birth where care was provided by your Trust.
What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK from **30 May 2023** onwards must be notified to MBRRACE-UK within seven working days.
What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route of reporting for neonatal deaths that will be via MBRRACE-UK. Once this single route is established, MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP) and the NCMD. At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required mechanism for completing the local review for submission

	to CDOP. This will also be the required route for providing additional information about the death required by both CDOPs and the NCMD. Work is underway to provide this single route of reporting with plans to have this in place in the forthcoming months
Are there any exclusions from completing the surveillance information?	If the surveillance form needs to be assigned to another Trust for additional information, then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts, should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.
Guidance for SA1(b) – parent engagement	
We have informed parents that a local review will take place and they have been asked if they have any reflections or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order that parents' perspectives and questions can be considered during the review this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. The importance of parents' perspectives is highlighted by their inclusion as the first set of questions in the PMRT. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
We have contacted the parents of a baby who has died and they don't wish to have any involvement in the review process. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their perspective and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.

Parents have not responded to our messages and therefore we are unable to discuss the review. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will also be undertaken by the local CDOP. Verbal information can be supplemented by written information. If, for any reason, this does not happen and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process, ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of the role of key contact, are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
Guidance for SA1(c) – conducting reviews	
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: • All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) • All stillbirths (from 24+0 weeks' gestation) • Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth) While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet the safety action one standard.
What happens when an HSIB investigation takes place?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by HSIB. Your local review using the PMRT should be started but not completed until the HSIB report is complete. You should consider inviting the HSIB reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the HSIB review to be automatically incorporated into the PMRT review. Depending upon the timing of the HSIB report completion achieving the MIS standards for these babies may therefore be impacted by time frames beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an HSIB INVESTIGATION is taking place, and this will be accounted for in the external validation process.

What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session (which might be the first session of several) for that death. As an absolute minimum all the 'factual' questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review. The factual questions are highlighted within the PMRT with the symbol: FQ
What is meant by "reviews should be completed to the draft report stage"?	A multidisciplinary review team should have used the PMRT to review the death, then the review progressed to at least the stage of writing a draft report by pressing 'Complete review'. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details of assistance in using the PMRT to complete a review.
What does "multi-disciplinary reviews" mean?	To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include a member from a relevant professional group who is external to the unit who can provide 'a fresh pair of eyes' as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member. Bereavement care staff (midwives and nurses) should form part of the review team to provide their expertise in reviewing the bereavement and follow-up care, and advocate for parents. It should not be the responsibility of bereavement care staff to run the reviews, chair the panels nor provide administrative support. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details about multi-disciplinary review.
What should we do if our post-mortem service has a turn-around time in excess of four months?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than four months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death and complete it with the information you have available. When the post-mortem results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing earlier learning opportunities, especially if the turn-around time is considerably longer than four months. Where the post-mortem turn-around time is quicker, then the information from the post-mortem can be included in the original review.

What is review assignment?	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review, the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided.
How does 'assigning a review' impact on safety action 1, especially on starting a review?	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.
What should we do if we do not have any eligible perinatal deaths to review within the relevant time period?	If you do not have any babies that have died between **30 May 2023** and **7 December 2023** you should partner up with a Trust with which you have a referral relationship to participate in case reviews. This will ensure that you benefit from the learning that arises from conducting reviews.
What deaths should we review outside the relevant time period for the safety action validation process?	Trusts should review all eligible deaths using the PMRT as a routine process, irrespective of the MIS timeframe and validation process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 5 MIS requirements.
Guidance for SA1(d) – Quarterly reports to Trust Boards	
Can the PMRT help by providing a quarterly report that can be presented to the Trust Executive Board?	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews over a period, within the PMRT for user-defined time periods. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for quarterly Trust Board reports and should be discussed with Trust maternity safety champions.
Is the quarterly review of the Trust Executive Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for the Trust Executive Board summarising the results from reviews over a period time which have been completed can be generated within the PMRT by authorised PMRT users for a user-defined periods of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'.

	Please note that these reports will only show summaries, issues and action plans for reviews **that have been published** therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months.
Guidance – Technical issues and updates	
What should we do if we experience technical issues with using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk
If there are any updates on the PMRT for the maternity incentive scheme where will they be published?	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the maternity incentive scheme safety action 1, will be communicated via NHS Resolution email and will also be included in the PMRT 'message of the day'.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

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. 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) 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)** **Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable.** 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.

	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 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.
Minimum evidential requirement for Trust Board	The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.
Validation process	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
What is the relevant time period?	From **30 May 2023** until **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024** at 12 noon

Technical guidance for safety action 2

Technical guidance	
The following CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on these three months? • **Proportion of babies born at term with an Apgar score <7 at 5 minutes** • **Women who had a postpartum haemorrhage of 1,500ml or more** • **Women who were current smokers at delivery** • **Women delivering vaginally who had a 3rd or 4th degree tear** • **Women who gave birth to a single second baby vaginally at or after 37 weeks after a previous caesarean section** • **Caesarean section delivery rate in Robson group 1 women** • **Caesarean section delivery rate in Robson group 2 women** • **Caesarean section delivery rate in Robson group 5 women**	No. For the purposes of the CNST assessment Trusts will only be assessed on July 2023 data for these CQIMs. Due to this, Trusts are now directed to check whether they have passed the requisite data quality required for this safety action within the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts.
My maternity service has currently suspended Midwifery Continuity of Carer pathways. How does this affect my data submission for CNST safety action 2?	If maternity services have suspended Midwifery Continuity of Carer (MCoC) pathways, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102. This is a satisfactory response for safety action 2 criteria 3i. If your Trust has suspended all MCoC pathways, criteria 3ii is not applicable and does not need to be completed. If your Trust is continuing with some provision of MCoC pathways, then criteria 3ii does still apply.

Will my Trust fail this action if women choose not to receive continuity of carer?	No. This action is focussed on data quality only and therefore Trusts pass or fail it based upon record completeness for each metric and not on the proportion (%) recorded as the metric output. If women choose not to be placed onto a MCoC pathway, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102.
Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass CQIMs and other metrics specified above can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics
What is the Data Quality Submission Summary Tool? How does my Trust access this?	The Data Quality Submission Summary Tool has been developed by NHS England specifically to support this safety action. The tool provides an immediate report on potential gaps in data required for CQIMs and other metrics specified above after data submission, so Trusts can take action to rectify them. It is intended to be used alongside other existing reports and documentation in order for providers to be able to create a full and detailed picture of the quality of their data submissions. Further information on the tool and how to access it is available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/data-quality-submission-summary-tool
For the Data Quality Submission Summary Tool, what does "sustained engagement" mean for the purposes of passing criteria 3?	By "sustained engagement" we mean that Trusts must show evidence of using the tool for at least three consecutive months prior to the submission of evidence to the Trust Board. For example, for a submission made to the Board in November, engagement should be, as a minimum, in August, September and October. This is a minimum requirement, and we advise that engagement should start as soon as possible. To evidence this, Trusts should save the Excel output file after running the report for a given month. Three files representing each of the three consecutive months should be provided to your Trust Board as part of the assurance process for the scheme. Note – this only becomes a requirement in the event your Trust fails the requisite data quality for the continuity of carer metrics in criteria 3.

The monthly publications and Maternity Services DashBoard states that my Trusts' data has failed for a particular metric. Where can I find out further information on why this has happened?	Details of all the data quality criteria can be found in the "Meta Data" file (see 'CQIMDQ/CoCDQ Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics The scores for each data quality criteria can be found in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series
The monthly publications and national Maternity Services DashBoard states that my Trusts' data is 'suppressed'. What does this mean?	Where data is reported in low values for clinical events, the published data will appear 'suppressed' to ensure the anonymity of individuals. However, for the purposes of data quality within this action, 'suppressed' data will still count as a pass.
Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services DashBoard please contact maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

Required standard	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. 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. 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.
Minimum evidential requirement for Trust Board	**Evidence for standard a) to include:** 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.
	Evidence for standard b) to include: • 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.
	Evidence for standard c) 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.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	**30 May 2023** to **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024**

Technical guidance for safety action 3

Technical guidance	
Does the data recording process need to be available to the ODN/LMNS/ commissioner?	The requirement for a data recording process from years three and four of the maternity incentive scheme was to inform future capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review. This should be in place and maintained in order to inform ongoing capacity planning of transitional care to minimise separation of mothers and babies. This could be captured through existing systems such as BadgerNet or alternatives such as paper based or electronic systems. These returns do not need to be routinely shared with the Operational Delivery Network (ODN), LMNS and/or commissioner but must be readily available should it be requested.
What members of the MDT should be involved in ATAIN reviews?	The expectation is that this is a multi-professional review, as a minimum the care should be reviewed by representation from both maternity and neonatal staff groups. This should include as a minimum; a member of the maternity team (a midwife and / or obstetrician and /or trainee from maternity services) and a member of the neonatal team (neonatal nurse and / or neonatologist/paediatrician and/or trainee from neonatal services).
We have undertaken some reviews for term admissions to NICU, do we need to undertake more and do all babies admitted to the NNU need to be included?	Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the Avoiding Term Admissions into Neonatal Units (ATAIN) work to date. The expectation is that reviews have been continued from year 4 of the scheme. If for any reason, reviews have been paused, they should be recommenced using data from quarter 4 of the 2022/23 financial year (beginning January 2023). This may mean that some of the audit is completed retrospectively. We recommend ongoing reviews, at least quarterly of unanticipated admissions of babies **equal to or greater than 37 weeks** to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan. A high-level review of the primary reasons for all admissions should be included, with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed. For example, if 60% of babies are admitted for respiratory problems, then focus on this cohort of babies and complete a deep dive into identified themes or if 40% of babies were admitted with jaundice and 35% of babies were admitted with hypothermia then focus on these two cohorts of babies.

	In addition to this, the number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues and the number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on.
What do you mean by quarterly?	Occurring every three months. This would usually mirror the 4 quarters of the financial year and should cover the period of the MIS **30 May 2023 – 7 December 2023**.
What should the Transitional Care audit include and is there a standard audit tool?	An audit tool can be accessed below as a baseline template; however, the audit needs to include aspects of the local pathway. ATAIN-CASE-NOTE-REVIEW-PROFORMA-Revised-2022-converted.pdf We recommend that Trusts refer to the auditable standards included in their local TC pathway guideline/policy.
How long have the neonatal safety champions been in place for?	Trust Board champions were contacted in February 2019 and asked to nominate a neonatal safety champion. The identification of neonatal safety champions is a recommendation of the national neonatal critical care review and have been in place since February/March 2019.
What is the definition of transitional care?	Transitional care is not a place but a service (see BAPM guidance) and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/ https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/

	https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Illness-in-newborn-babies-leaflet-FINAL-070420.pdf Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk) Framework: Early Postnatal Care of the Moderate-Late Preterm Infant | British Association of Perinatal Medicine (bapm.org) B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk)

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required standard	a) **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 a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums. 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. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf 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 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 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. **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) **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). **d) Neonatal nursing workforce** The neonatal unit meets the BAPM neonatal nursing standards. 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).
Minimum evidential requirement for Trust Board	**Obstetric medical workforce** 1) Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses. Information on the certificate of eligibility (CEL) for short term locums is available here: www.rcog.org.uk/cel This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk 2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS. 3) 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 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. **NB**. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG 4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS. **Anaesthetic medical workforce** The rota should be used to evidence compliance with ACSA standard 1.7.2.1. **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). **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).

Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form.
What is the relevant time period?	**Obstetric medical workforce** 1. After February 2023 – Audit of 6 months activity 2. After February 2023 – Audit of 6 months activity 3. 30 May 2023 - 7 December 2023 4. 30 May 2023 - 7 December 2023 **Anaesthetic medical workforce** Trusts to evidence position by 7 December 2023 at 12 noon **Neonatal medical workforce** A review has been undertaken of any 6 month period between **30 May 2023 – 7 December 2023** **a) Neonatal nursing workforce** Nursing workforce review has been undertaken at least once during year 5 reporting period **30 May 2023 – 7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024**

Technical guidance for safety action 4

Technical guidance	
Obstetric workforce standard and action	
How can the Trust monitor adherence with the standard relating to short term locums?	Trusts should establish whether any short term (2 weeks or less) tier 2/3 locums have been undertaken between February and August 2023. Medical Human Resources (HR) or equivalent should confirm that all such locums met the required criteria.
What should a department do if there is non-compliance i.e. locums employed who do not meet the required criteria?	Trusts should review their approval processes and produce an action plan to ensure future compliance.
Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.
Where can I find the documents relating to short term locums?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to long term locums?	Trusts should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance for 6 months after February 2023 and prior to submission to the Trust Board and have a plan to address any shortfalls in compliance.
What should a department do if there is a lack of compliance demonstrated in the audit tool regarding the support and supervision of long term locums?	Trusts should review their audits and identify where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if long term locums are employed who are not fully supported/supervised?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.
Where can I find the documents relating to long term locums?	Safe staffing | RCOG

	All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to Standard operating procedures for consultants and SAS doctors acting down?	Trusts should provide documentary evidence of standard operating procedures and their implementation Evidence of implementation/compliance could be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.
What should a department do if there is a lack of compliance, either no Standard operating procedure or failure to implement such that senior medical staff are unable to access compensatory rest?	Trusts should produce a standard operating procedure document regarding compensatory rest. Trusts should identify any lapses in compliance and where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if we do not have a standard operating procedure or it is not fully implemented?	Trusts cannot self-certify if they have no evidence of any standard operating procedures by **October 2023**. They can self-certify if they have been unable to achieve appropriate compensatory rest in individual circumstances such as excessive staffing pressure have prevented the doctor accessing this. They should, however, demonstrate that they have an action plan to ensure future compliance and provide assurance to the Board that this is place.
Where can I find the documents relating to compensatory rest for consultants and SAS doctors?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to consultant attendance out of hours?	For example, departments can audit consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Departments may also wish to monitor adherence via incident reporting systems. Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	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.
Can we self-certify compliance with this element of safety action 4 if	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans

consultants have not attended clinical situations on the mandated list?	implemented to prevent subsequent non-attendances. These can be signed off by the Trust Board.
Where can I find the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/
For queries regarding this safety action please contact: nhsr.mis@nhs.net and RCOG	

Anaesthetic medical workforce

Technical guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard and action	
1.7.2.1	**A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.**

Neonatal medical workforce

Technical guidance	
Neonatal Workforce standards and action	
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If not, Trust Board should agree an action plan and outline progress against any previously agreed action plans. There should also be an indication whether the standards not met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap) alongside a record of the rota tier affected by the gaps. This action plan should be submitted to the LMNS and ODN.
BAPM **"Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021** **or** **"Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018**	

NICU **Neonatal Intensive Care Unit**	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff during office hours and out of hours. **Tier 1** Resident out of hours care should include a designated tier one clinician - Advanced Neonatal Nurse Practitioner (ANNP) or junior doctor ST1-3. NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice. **Tier 2** A designated experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP. NICUs with more than 2500 intensive care days should have an additional experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. (A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative) **Tier 3** Consultant staff in NICUs should be on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on the neonatal unit alone. NICUs undertaking more than 4000 intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day. NICUs undertaking more than 2500 intensive care days per annum should consider the presence of at least 2 consultant led teams during normal daytime hours. NICUs undertaking more than 4000 intensive care days per annum should consider the presence of three consultant led teams during normal daytime hours.

LNU **Local Neonatal Unit**	**Tier 1** At least one resident tier 1 practitioner immediately available dedicated to providing emergency care for the neonatal service 24/7. In large LNUs (>7000 births) there should be two dedicated tier 1 practitioners 24/7 to support emergency care, in keeping with the NICU framework. **Tier 2** An immediately available resident tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00 - 22.00, seven days a week. LNUs undertaking either >1500 Respiratory Care Days (RCDs) or >600 Intensive Care (IC) days annually should have immediately available a dedicated resident tier 2 practitioner separate from paediatrics 24/7. **Tier 3** Units designated as LNUs providing either >2000 RCDs or >750 IC days annually should provide a separate Tier 3 Consultant rota for the neonatal unit. LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs. All LNUs should ensure that all Consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system and no consultant should undertake fewer than 4 'consultant of the week' service weeks annually. No on-call rota should be more onerous than one in six and all new appointments to units with separate rotas should either have a SCCT in neonatal medicine or be a general paediatrician with a special interest in neonatology or have equivalent neonatal experience and training**.**

SCU **Special Care Unit**	**Tier 1** A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. **Tier 2** A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit. **Tier 3** In SCUs there should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology).
Our Trust do not meet the relevant neonatal medical standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.
When should the review take place?	The review should take place at least once during the MIS year 5 reporting period.
Please access the followings for further information on Standards	BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021). A BAPM Framework for Practice https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021 Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018). A BAPM Framework for Practice https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018

Neonatal nursing workforce

Technical guidance	
Neonatal nursing workforce standards and action	
Where can we find more information about the requirements for neonatal nursing workforce?	Neonatal nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here: https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf Access to the tool and more information will be available through your Neonatal ODN Education and Workforce lead nurse.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. d) All women in active labour receive one-to-one midwifery care. e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.
Minimum evidential requirement for Trust Board	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

	• Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.
	
	  ○ The midwife to birth ratio
	
	  ○ The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.
	
	• Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	30 May 2023 – 7 December 2023
What is the deadline for reporting to NHS Resolution?	**1 February 2023** at **12 noon**

Technical guidance for Safety action 5

Technical guidance	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice**.	• Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637 https://www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care or care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to

	midwives at birth when required, supporting junior midwives undertaking suturing etc. This should not be counted as losing supernumerary status.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. As stated above, completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 5 of MIS.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Required standard	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.
Minimum evidential requirement for Trust Board	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 compliance with the care bundle 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. 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 and includes the following: • 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.

Technical guidance for Safety action 6

Technical guidance	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: https://www.england.nhs.uk/publication/saving-babies-lives-version-three/ The implementation tool is available at https://future.nhs.uk/SavingBabiesLives and includes a technical glossary for all data items referred to in MSDS Additional resources are in production and will be advertised on this page. Any further queries regarding the tool, please email england.maternitytransformation@nhs.net Any queries related to the **digital aspects** of this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net Some data items are or will become available on the National Maternity Dashboard or from NNAP Online For any other queries, please email nhsr.mis@nhs.net
What is the rationale for the change in evidential requirements to SA6 in Year 5?	The broad principles that will apply to the implementation of the standards detailed in the Saving Babies' Lives Care Bundle (version 3) are: The use of the implementation tool will allow Trusts to track implementation and demonstrate local improvement using the process and outcome indicators within all six elements of the care bundle (for some elements this may only require evidence of a protocol, process, or appointed post). These data will form the basis of compliance with safety action 6 of this version of the maternity incentive scheme. This approach acknowledges the increased number and/or size of elements in this new version of the care bundle. The indicators for each of the six elements are set out below. Data relating to each of these indicators will need to be provided via the national implementation tool. ***Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and/or Neonatal System e.g Badgernet and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding.***

What are the indicators for Element 1	*Process Indicators* 1a. Percentage of women where there is a record of: 1.a.i. CO measurement at booking appointment 1.a.ii. CO measurement at 36-week appointment 1.a.iii. Smoking status** at booking appointment 1.a.iv. Smoking status** at 36-week appointment 1b. Percentage of smokers* that have an opt-out referral at booking to an in-house/in-reach tobacco dependence treatment service. 1c. Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date. *Outcome Indicators* 1d. Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks. 1e. Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks. *a "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). **Smoking status relates to the outcome of the CO test (>4ppm) and the enquiry about smoking habits.
What are the indicators for Element 2	*Process Indicators* 2a. Percentage of pregnancies where a risk status for Fetal Growth Restriction (FGR) is identified and recorded at booking. (This should be recorded on the provider's MIS and included in the MSDS submission to NHS Digital once the primary data standard is in place.) 2b. Percentage of pregnancies where a Small for Gestational Age (SGA) fetus (between 3rd to <10th centiles) is antenatally detected, and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital. 2c. Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT). *Outcome Indicators*

	2d. Percentage of babies <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR). 2e. Percentage of live births and stillbirths >3rd birthweight centile born <39+0 weeks gestation, where growth restriction was suspected.
What are the indicators for Element 3	*Process Indicators* 3a. Percentage of women who attend with Reduced Fetal Movements (RFM) who have a computerised Cardiotocograph (CTG). 3b. Proportion of women who attend with recurrent RFM* who had an ultrasound scan by the next working day to assess fetal growth. *Outcome Indicators* 3c. Percentage of stillbirths which had issues associated with RFM management identified using PMRT. 3d. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation. *There is no accepted definition of what recurrent RFM means; one region of the UK has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation.
What are the indicators for Element 4	*Process Indicators* 4a. Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors, and situational awareness. 4b. Percentage of staff who have successfully completed mandatory annual competency assessment. 4c. Fetal monitoring lead roles appointed. *Outcome Indicators* 4d. The percentage of intrapartum stillbirths, early neonatal deaths, and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. *Using the severe brain injury definition as used in Gale et al. 2018[48].

What are the indicators for Element 5	*Process Indicators* 5a. Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU). 5b. Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth. 5c. Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth. 5d. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive intravenous (IV) intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection. 5e. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth. 5f. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. 5g. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth. 5h. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (5a – 5g above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation). *To minimise the need for local data collection to support these improvements the formal collection of process measure data can be restricted to the seven interventions listed in this section, the use of volume targeted ventilation and caffeine is recommended but these data are not currently recorded or presented with national datasets. In addition, the gestational limits for some of the indicators and/or the groups studies have been adjusted to align with current nationally collected data (e.g., data on babies born only below 34 weeks or data on the number of babies*

	receiving antenatal corticosteroids rather than the number of mothers) *Outcome Indicators* **5i. Mortality to discharge in very preterm babies** (National Neonatal Audit Programme (NNAP) definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner). **5j. Preterm Brain Injury** (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: ✓ Germinal matrix/ intraventricular haemorrhage ✓ Post haemorrhagic ventricular dilatation ✓ Cystic periventricular leukomalacia 5k. Percentage of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation, or perinatal optimisation of preterm birth was a relevant issue. 5l. Maternity care providers will provide outcome data to the Trust Board and share this with the LMNS relating to the incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: ✓ In the late second trimester (from 16+0 to 23+6 weeks). ✓ Pre-term (from 24+0 to 36+6 weeks).
What are the indicators for Element 6	*Process Indicators* 6a. Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc). 6b. Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes.

	6c. Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets. 6d. Demonstrate compliance with Continuous Glucose Monitoring (CGM) training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes. 6e. Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with Diabetic Ketoacidosis (DKA) during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities, and availability of expertise. *Outcome Indicators* 6f. The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the National Pregnancy in Diabetes (NPID) dashboard (aiming for >95% of women). 6g. The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the start of the third trimester (aiming for >95% of women). Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.
What considerations need to be made to ensure timely submission of data to evidence implementation and compliance with locally agreed progress measures?	Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.
Is there a requirement on Trusts to evidence SBLCB process and outcome measures through their data submissions to Maternity Services Data Set?	Trusts should be capturing SBLCB data as far as possible in their Maternity Information Systems/Electronic Patient Records and submitted to the MSDS. MSDS does not capture all process and outcome indicators given in the care bundle. A summary of this appears in the technical appendix for version 2 of the care bundle, available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/tools-and-guidance

	Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.
Would a Trust be non-compliant if <60% of smokers set a quit date?	As stated in SA6, 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. The implementation tool will set out the evidence requirement for demonstrating compliance with each intervention. Where element process and outcome measures are listed in the evidence requirement, a performance threshold is recommended, but this is for agreement between a provider and their ICB in view of local circumstances.
The SBLCBv3 that was published on the 31st May 2023 included a typo in Appendix D Figure 6 with BMI as >18.5kg/m and it is not clear what "other features" mean	This has now been amended and states **<18.5kg/m** with further clarity provided regarding "other features".
How do we provide evidence for the interventions that have been implemented?	The evidence requirements for each intervention are set out within the implementation tool. You will need to verify that you have an implemented service locally.
Will the eLfH modules be updated in line with SBLCBv3?	The SBLCB eLearning for Health modules is currently being updated in line with the latest iteration, Version 3 of the Care Bundle and will include a new section to support implementation of element 6. We have asked for the ultrasound element to be reviewed for its relevance, this was developed separately, and we will make sure the completion of the e learning is focussed on elements 1-6.
What is the deadline for reporting to NHS Resolution?	**1 February 2024** at **12 noon**

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Required standard	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. 2. Ensuring 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. 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.
Minimum evidential requirement for Trust Board	**Evidence should include:** • Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff. • 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. • 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. • Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses. • 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.
Validation process	Self-certification to NHS Resolution using the Board declaration form.

What is the relevant time period?	Trusts should be evidencing the position as **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2023** at 12 noon

Technical guidance for Safety action 7

Technical guidance	
What is the Maternity and Neonatal Voices Partnership?	An MNVP listens to the experiences of women, birthing people, and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. MNVPs ensure that service user voice is at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the local maternity and neonatal system (LMNS). MNVPs ensure service user voice influences improvements in the safety, quality, and experience of maternity and neonatal care.
We are unsure about the funding for Maternity and Neonatal Voices Partnerships	It is the responsibility of ICBs to: Commission and fund MNVPs, to cover each Trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
What advice is there for Maternity and Neonatal Voices Partnership (MNVP) leads when engaging and prioritising hearing the voices of neonatal and bereaved service users, and what support or training is in place to support MNVP's?	MNVPs should work in partnership with local specialist voluntary, community, and social enterprise (VCSEs) with lived experience to gather feedback. Engagement needs to be accessible and appropriate, particularly for neonatal and bereaved families. It is essential that you consider how you will protect people from being retraumatised through giving feedback on their experience. Training for MNVPs to engage with seldom heard or vulnerable communities may be required to ensure unintentional harm is avoided. MNVPs can also work in collaboration with their trust bereavement leads to ensure adequate support is in place for themselves and the families they may engage with. Attendance at the trust training could be beneficial.
When will the MNVP guidance be published?	We are working with our stakeholders to publish the MNVP guidance as soon as possible. As it is not yet published, it is acknowledged that there may not be enough time ahead of the reporting period for full implementation of all the requirements of the MNVP guidance. Where an element of the guidance is not yet fully implemented, evidence must be presented that demonstrates progress towards full implementation within 12 months.

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Required standard and minimum evidential requirement	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework. 2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. 3. The plan is developed based on the "How to" Guide developed by NHS England.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	12 consecutive months should be considered from 1st December 2022 until 1st December 2023 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for trust boards to review. It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv1

Technical guidance for safety action 8

Technical guidance	
What training should be covered in the local training plan to cover the six modules of the Core Competency Framework?	A **training plan** should be in place to implement all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 2024. NHS England » Core competency framework version two Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework.
How will the 90% attendance compliance be calculated?	The training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups by the end of the 12 month period

Where can I find the Core Competencies Framework and other additional resources?	• https://www.england.nhs.uk/publication/core-competency-framework-version-two/
	• Includes links to the documents:
	  ○ Core competency framework version two: Minimum standards and stretch targets
	  ○ 'How to' guide - a resource pack to support implementing the Core Competency Framework version two
	  ○ Core competency framework: training needs analysis
	• NHS England V1 of the Core Competency Framework https://www.england.nhs.uk/publication/core-competency-framework/
	• https://www.resus.org.uk/library/2021-resuscitation-guidelines/newborn-resuscitation-and-support-transition-infants-birth

What training should be included to meet the requirements of the Core Competency Framework Version 2?	All 6 core modules in V2 of the Core Competency Framework (CCFv2) must be covered as detailed in the minimum standards. Trusts must be able to evidence the four key principles: 1. Service user involvement in developing and delivering training. 2. Training is based on learning from local findings from incidents, audit, service user feedback,

	and investigation reports. This should include reinforcing learning from what went well. 3. Promote learning as a multidisciplinary team. Promote shared learning across a Local Maternity and Neonatal System.
Which maternity staff should be included for Module 2: Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric consultants • All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor) • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • MSWs • GP trainees
Which maternity staff should be included for Module 3: Maternity emergencies and multiprofessional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric consultants. • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota. • Midwives (including midwifery managers and matrons), community midwives; birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) • Obstetric anaesthetic consultants. • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) **who contribute to the obstetric rota.**

	• Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS year 5 compliance assessment • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS year 5 compliance • At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff
Does the multidisciplinary emergency scenarios described in module 3 have to be conducted in the clinical area?	At least one emergency scenario needs to be conducted in the clinical area or at point of care. You need to ensure that 90% of your staff attend a minimum of one emergency scenario that is held in the clinical area, but not all of the scenarios have to be based in a clinical area.
Which staff should be included for Module 6: Neonatal basic life support?	Staff in attendance at births should be included for Module 6: Neonatal basic life support. This includes the staff listed below: • Neonatal Consultants or Paediatric consultants covering neonatal units • Neonatal junior doctors (who attend any births) • Neonatal nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. The staff groups below are not required to attend neonatal basic life support training: • All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit). • Local policy should determine whether maternity support workers are included in neonatal basic life support training.

I am a NLS instructor, do I still need to attend neonatal basic life support training?	No, if you have taught on a course within MIS year 5 you do **not** need to attend neonatal basic life support training
I have attended my NLS training, do I still need to attend neonatal basic life support training?	No, if you have attended a course within MIS year 5 you do **not** need to attend neonatal basic life support training as well.
Which members of the team can teach basic neonatal life support training and NLS training?	Registered RC-trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates. A detailed response to this can be found on the CCF NHS Futures page CCF NHS Futures page - FAQ
What do we do if we do not have enough instructors who are trained as an NLS instructor and hold the GIC qualification?	Your Neonatal Consultants and Advanced Neonatal Practitioners (ANNP) will be qualified to deliver the training. You can also liaise with your Local Maternity and Neonatal System (LMNS) to explore sharing of resources. There may be difficulty in resourcing qualified trainers. Units experiencing this must provide evidence to their trust board that they are seeking mitigation across their LMNS and an action plan to work towards NLS and GIC qualified status by 31st March 2024. As a minimum, training should be delivered by someone who is up to date with their NLS training.
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally determined.
How do we involve services users in developing and <u>delivering</u> training?	Please refer to the "How To" guide for ideas on how to involve service users in the developing and delivering of training. This is **Principle 1** of the CCFv2 that recommends MNVP leads could be a member of the multidisciplinary educational teams (MET) to support the planning and selection of themes/local learning requirements to reflect in the training. Ways in which service users and service user representatives can support the delivery of training include with video case studies, inviting service users to tell their story or inviting charitable/support organisations for example local Downs Syndrome groups; LGBTQIA+ Communities; or advocates for refugees.

	NHS England will be sharing examples of practice over the year and on their NHS Futures page.
The TNA suggests periods of time required for each element of training, for example 9 hours for fetal monitoring training. Is this a mandated amount of time?	The TNA has been inputted with **example** times to demonstrate how the calculations are made for the backfill of staff that is required to put a training plan in place. The hours for each element of training can be flexed by the individual trust in response to their own local learning needs.
Do all the modules within the CCF require a multidisciplinary attendance?	Multidisciplinary team working has an evidence-base and has been highlighted in The Kirkup Report (2022). Key Action 3 (Flawed Team working) was a significant finding with the recommendation to improve teamworking with reference to establishing common purpose, objectives, and training from the outset. It is therefore a requirement that there is a strong emphasis on multidisciplinary training throughout the modules in response to local incidents. The staff groups within the multidisciplinary teams being trained may also vary, depending on the incident/emergency being covered.

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Required standard	a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded. 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. 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.
Minimum evidential requirement for Trust Board	**Evidence for point a) 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). • 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. **Evidence for point b)** • Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaints data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. This should continue to be undertaken quarterly as detailed in MIS year 4. These discussions

	must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting. **Evidence for point c):** Evidence that the Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme. This will include: • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	**Time period for points a and b)** • Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action should be in place based on previous requirements. The expectation is that if work is still in progress, this will have been completed by 1st December 2023. • The expectation is that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance are continuing to take place at Board level monthly. If for any reason they have been paused, they should be reinstated no later than 1 July 2023. • The expectation is for ongoing engagement sessions with staff as per year 4 of the scheme. If for any reason these have been paused, they should be recommenced no later than 1 July 2023. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions. • Progress with actioning named concerns from staff engagement sessions are visible to both maternity

	and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than the 17th July 2023. • Evidence that a review of the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting by 17th July 2023. At least one additional meeting must have been undertaken before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review as part of the PSIRF plan. This should continue to be undertaken quarterly as detailed in MIS year 4. **Time period for points c)** • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have **registered** to the dedicated FutureNHS workspace to access the resources available no later than 1 August 2023. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of quarterly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 2 meetings held by 1 February 2024
What is the deadline for reporting to NHS Resolution?	By **1 February 2024** at 12 noon
Where can I find additional resources?	implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) Measuring culture in maternity services: Safety Culture Programme for Maternal and neonatal services: https://drive.google.com/file/d/1bzAqOcf5A5XHR8HWBZnLzH6qsG_SgXoa/view?usp=sharin Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme The Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace is a dedicated place for Non-Executive Director and Executive Director maternity and neonatal Board safety champions to access the culture and leadership

	programme, view wider resources and engage with a community of practice to support them in their roles. The Perinatal Culture and Leadership Programme - Maternity Local Transformation Hub - Maternity (future.nhs.uk) is a dedicated space for NHS England's Perinatal Culture and Leadership Programmes, with resources for senior leaders and their teams to support local safety culture work.

Technical guidance for safety action 9

Technical guidance	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local pathway for sharing intelligence updated. This revised pathway should: • Describe the local governance processes in place to demonstrate how intelligence is shared from the floor to Board. • Formalise how Trust-level intelligence will be shared with the LMNS/ICS quality group and regional quality groups involving the Regional Chief Midwife and Lead Obstetrician.
What do we need to include in the dashBoard presented to Board each month?	The dashboard can be locally produced, based on a minimum data set as set out in the Board level measures. It must include the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; SUV feedback; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. The dashboard can also include additional measures as agreed by the Trust.
We had not continued to undertake monthly feedback sessions with the Board safety champion what should we do?	Parts a) and b) of the required standards build on the year three and four requirement of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board safety champions to raise concerns relating to safety. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions as described above. Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three of the maternity incentive scheme and the expectation is that this should have been continued. If these have not been continued, this needs to be reinstated by no later than 1 July 2023.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.

What is the rationale for the Board level safety champion safety action?	It is important to ensure all staff are aware of who their frontline and Board safety champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names of the relevant leaders, will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here 2021 Scorecards launch - NHS Resolution https://resolution.nhs.uk/2020/10/27/claims-scorecards-for-2020/
What are the expectations of the Board safety champions in relation to quality improvement work undertaken by the maternity and neonatal quality improvement programme?	The Board safety Champions will be expected to continue their support for quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Networks. Trusts will be required to undertake improvement including data collection and testing work aligned to the national priorities.
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will be involved in the Perinatal Culture and Leadership Programme. As part of this programme every service will be undertaking work to meaningfully understand the culture of their services. This diagnostic will either be a SCORE culture survey or an alternative as agreed with the national NHSE team. It is expected that diagnostic findings are shared with the Trust Board to enable an understanding and garner support for the work to promote optimal safety cultures, based on the diagnostic findings.
What if our maternity and neonatal services are not undertaking the SCORE culture survey as part of the national programme?	The national offer to undertake a SCORE culture is a flexible, opt out offer. If your maternity and neonatal services demonstrated that they were already completing work to meaningfully understand local culture, and therefore opted out of the SCORE survey, the expectation is that the Board receives updates on this alternative work.
What are the expectations of the NED and Exec Board safety champion in relation to	As detailed in previous years MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provide an opportunity to share

their support for the Perinatal Culture and Leadership Programme (PCLP), culture surveys and ongoing support for the Perinatal 'Quad' Leadership teams? / What should be discussed at the bi-monthly meetings between the Board Safety Champion(s) and the Perinatal 'Quad' Leadership teams?	safety intelligence, examples of best practice and identified areas of challenge. The meetings should be conducted in an appreciative way, with the perinatal teams being open and transparent and the Board Safety Champions being curious and supportive. As a minimum the content should cover: - Learning from the Perinatal Culture and Leadership Development Programme so far - Plans to better understand their local culture. This will be use of the SCORE culture survey, or suitable alternative as agreed by the national NHS England team. - Updates on the SCORE survey, or alternative when undertaken. - Updates on identified areas for improvement following the local diagnostic, along with any identified support required from the Board. NB, a formal report following this work should be presented at Board by the Perinatal leadership team. Progress with interventions relating to culture improvement work, and any further support required from the Board
Clarification as to evidence required to meet the standard: *Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available.*	The NED and Exec Board Safety Champion will be able to evidence they have registered on the FutureNHS Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace through minutes of a trust board meeting providing confirmation of specific resources accessed and how this has been of benefit. This will be reported as part of the board submission to NHS Resolution.
How often should the Board Safety Champions be meeting and engaging with the perinatal 'Quad' team?	Meetings between the Board Safety Champion(s) and Quad member(s) should be occurring a minimum of quarterly. We would expect a minimum of two meetings during this reporting period.
Who is expected to have undertaken the Perinatal Culture and Leadership Quad programme?	The expectation is that the senior perinatal leadership team (the Quad) have undertaken the PCLP. This will be representation from the midwifery, obstetric, neonatal, and operational professional groups, usually consisting of the

	DoM/HoM, clinical lead / CD for obstetrics, clinical lead for neonates and the operational manager.
Is there an expectation that the board safety champions have undertaken the programme?	The Board Safety Champions should be supporting the Quad and their work as part of the PCLP, but there is no expectation for them to attend the programme.
Evidence that a monthly review – Most Trust meet bi-monthly (every other month) & are unable to meet this requirement	A review must be undertaken at every board meeting. If this is bi-monthly that will be sufficient, but this is the minimum requirement.
Examples have been requested for how to review the data from scorecards	The key to making this exercise meaningful is the triangulation of the data. Categorisation of the historic claims on the scorecard and any action taken, then presenting these alongside current incidents and complaints. This allows identification of potential themes or trends, identification of the impact of any learning, and allows you to act quickly if any historic themes re-emerged. An example is now available from the MIS team at NHS Resolution, and staff are happy to talk through this process if it is helpful.
The perinatal quality surveillance model requires review in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife to provide evidence of trust-level intelligence being shared and actions reported on areas of concern. This needs to happen before 1st July and therefore does not give trusts enough time to carry out this review	The expectation is that this process should already be in place as it was a requirement in previous years, with the year 4 requirement for this to be in place by 16th June 2022. However, in recognition of the challenges of embedding a new quality surveillance model the timeframe of the 1st July has been amended to 1st December 2023 to allow additional time for trusts.
Clarification as to what constitutes a trust board, can sub committees be categorised as a board?	This refers solely to the Board of the trust, and it is a requirement that the board oversees the quality of their perinatal services at every meeting.

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) *(known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023)* and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

Required standard	A) Reporting of all qualifying cases to HSIB/ MNSI from 6 December 2022 to **7 December 2023.** B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until **7 December 2023**. C) For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB//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.
Minimum evidential requirement for Trust Board	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB//MNSI/EN incidents and numbers reported to HSIB//MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of HSIB/MNSI and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Validation process	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against the HSIB/MNSI database and the National Neonatal Research Database (NNRD) and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard a) and b) have been met in the relevant reporting period. In addition, for standard C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's

	involvement, completion of this will also be monitored, and externally validated.
What is the relevant time period?	Reporting to HSIB – from 6 December 2022 to **7 December 2023** Reporting period to HSIB **and** to NHS Resolution – from 6 December 2022 to **7 December 2023**
What is the deadline for reporting to NHS Resolution?	By **1 February 2024** at 12 noon

Technical guidance for Safety action 10

Technical guidance	
Where can I find information on HSIB?	Information about HSIB/ MNSI and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/ From October 2023 this website will no longer be available and the HSIB maternity programme will be hosted by the CQC. Further details will be circulated once available.
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website: • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to HSIB/MNSI?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [or] • Was therapeutically cooled (active cooling only) [or] • Had decreased central tone AND was comatose AND had seizures of any kind. Once HSIB/MNSI have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury.
What is the definition of labour used by HSIB and EN?	The definition of labour used by HSIB includes: • Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation. • When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking). • Induction of labour (when labour is started artificially). • When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.
Changes in the EN reporting requirements for Trust from	With effect from 1 April 2022, Trusts have been required to continue to report their qualifying cases to HSIB via the electronic portal. In addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed

1 April 2022 going forward	they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must share the HSIB//MNSI report with the EN team within 30 days of receipt of the final report by uploading the HSIB/MNSI report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading HSIB/MNSI reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the HSIB/MNSI report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where HSIB are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury. • Where a family have declined a HSIB investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution. There is more information here: ENS Reporting Guide - July 2023 (for Member Trusts) - NHS Resolution
Cases that do not require to be reported to NHS Resolution	• Cases where families have requested a HSIB/MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a HSIB/MNSI investigation where the baby has a normal MRI. • Cases that HSIB/MNSI are not investigating.
What if we are unsure whether a case qualifies for referral to HSIB/MNSI or NHS Resolution?	For cases from 1 April 2022, if the baby has a clinical or MRI evidence of neurological injury and the case is being investigated by HSIB/MNSI because of this, then the case should also be reported to NHS Resolution via the claims wizard along with the HSIB/MNSI reference number (document the HSIB reference in the “any other comments box”). Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard. Should you have any queries, please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or HSIB/MNSI maternity team (maternity@hsib.org.uk).
How should we report cases to NHS Resolution?	Trusts’ will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once they have been confirmed by HSIB/ MNSI as under investigation. They must also complete the ***EN Report*** form and attach this to the Claims Reporting Wizard: https://resolution.nhs.uk/wp-content/uploads/2023/05/EN-Report-Form.pdf
What happens once we have	Following the HSIB/MNSI investigation, and on receipt of the HSIB/MNSI report and MRI report, following triage, NHS Resolution will overlay an

reported a case to NHS Resolution?	investigation into legal liability. Where families have declined an HSIB/MNSI investigation, no EN investigation will take place, unless the family requests this.
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by HSIB and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all incidents to HSIB/MNSI as soon as they occur and to NHS Resolution as soon as HSIB/MNSI have confirmed that they are taking forward an investigation. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to HSIBMNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and HSIB/MNSI and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme.

FAQs for year five of the maternity incentive scheme

Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice?	**We expect Trust Boards to self-certify the Trust's declarations following consideration of the evidence provided.** It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we will escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the Care Quality Commission for their consideration if any further action is required, and to the NHS England and NHS Improvement regional director, the Deputy Chief Midwifery Officer, regional chief midwife and Department of Health and Social Care (DHSC) for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the Accountable officer (AO) for their ICB is apprised of the MIS safety action 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 evidence to be submitted to NHS Resolution The declaration form must be signed by both CEO and the Accountable Officer of Clinical Commissioning Group/Integrated Care System before submission.
Our current commissioning systems are changing, what does this mean in terms of sign off?	There have been structural changes for NHS Commissioning as a result of 2022 Health and Care Act. Where this has caused significant reconfiguration and adjustment of commissioning systems, sign off by the accountable lead for commissioning maternity services can be considered
Will NHS Resolution cross check our results with external data sources?	Yes, we will cross reference results with external data sets from: MBRRACE-UK data (safety action 1 point a, b, c), NHS England& Improvement regarding submission to the Maternity Services Data Set (safety action 2, sub-requirements 2 and 3), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable to HSIB (safety action 10,

	standard a)). Your overall submission may also be sense checked with CQC maternity data, HSIB data etc. For more details, please refer to the conditions of the scheme.
What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the Trust CEO and Accountable Office (IBC). Where relevant, an action plan is completed for each action the Trust has not met. **Please do not send your evidence or any narrative related to your submission to NHS Resolution.** Any other documents you are collating should be used to inform your discussions with the Trust Board. These documents and any other evidence used to assure the Board of your position must be retained. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2023. **It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on 1 February 2024, NHS Resolution will treat that as a nil response.**
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on 1 February 2024**. If not returned to NHS Resolution by 12 noon on **1 February 2024**, NHS Resolution will treat that as a nil response.
What happens if we do not meet the ten actions?	Only Trusts that meet all ten maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet all ten safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.

Our Trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The maternity incentive scheme outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated link contacts via link on the NHS Resolution website. https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-Trusts/maternity-incentive-scheme/maternity-incentive-scheme/
What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process. Trusts will be allowed 14 days to appeal the decision following the communication of results. The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe. There are two possible grounds for appeal: • alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation • technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate. NHS Resolution clinical advisors will review all appeals to ensure validity, to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC. Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered. Further detail on the appeals window dates will be communicated at a later date.

Merging Trusts	Trusts that will be merging during the year four reporting period (30 May 2023 – 7 December 2023) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed. In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2022/23 and the reporting of claims and management of claims going forward.

Q&A regarding Maternity Safety Strategy and CNST maternity incentive scheme

Q1) What are the aims of the maternity incentive scheme?

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

Using CNST to incentivise safer care received strong support from respondents to our *2016 CNST consultation* where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our *Five year strategy: Delivering fair resolution and learning from harm.*

Q2) Why have these safety actions been chosen?

The ten actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with NHS Digital, NHS England, NHS Improvement, the Care Quality Commission (CQC), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Obstetric Anaesthetists Association, Royal College of Anaesthetists, HSIB, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

The Collaborative Advisory Group (CAG) previously established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme has also advised NHS Resolution on the safety actions.

Q3) Who has been involved in designing the scheme?

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England & Improvement
- NHS Digital
- MBRRACE-UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Anaesthetists
- Royal College of Paediatrics and Child Health
- Care Quality Commission
- Department of Health and Social Care
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff
- HSIB/CQC

Q4) How will Trusts be assessed against the safety actions and by when?

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.

Completed Board declaration forms must be discussed with the commissioner(s) of the Trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at nhsr.mis@nhs.net **by 12 noon on 1 February 2024**

Please note:

- Board declaration forms will be reviewed by NHS Resolution and discussed with the scheme's Collaborative Advisory Group.
- NHS Resolution will use external data sources to validate some of the Trust's responses, as detailed in the technical guidance above.
- If a completed Board declaration form is not returned to NHS Resolution by 12 noon on **1 February 2024**, NHS Resolution will treat that as a nil response.

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?			
	Year 5	**Compliance with Standards**	**Comments / Evidence**
Standard Required			
a)	a) All eligible perinatal deaths 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.		On review to date all deaths meeting the relevant criteria have been r eported to date.To ensure that the process is robust there is a need to introduce a failsafe/audit process to ensure compliance is consistently being met. Two cases require review (to confirm compliance) therefore need to look at cases 88579 and 88576 (DC to action)
b)	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.		To further evidence - DC to upload evidence of bereavement care presentation/evidence of parents involvement to MIS folder.
c)	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.		Standard is currently being met but process to be further improved. To introduce failsafe/audit process to ensure compliance being met (can pull data direct from MBRRACE system) JS - Analyst to action.
d)	d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.		Robust process established. To upload evidence of quarterly reports to the folder. These are sent to trust mortality group.
Minimum evidential requirement for Trust Board			
	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal). The PMRT must be used to review the care and reports should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter from 30 May 2023 that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.		Actions are added to the regional lessons learned templates. These templates are shared at audit meetings, added to CG Gems Newsletters and bereavement bulletin. Going forward -
Validation process			
	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.	No Change	Dates for Board paper/s and sign off reviewed. JL to update progress in BoD paper/s.
What is the relevant time period?			
	From 30 May 2023 until 7 December 2023	Note date	
What is the deadline for reporting to NHS Resolution?			
	12 noon on 1 February 2024	Note date	
Technical guidance - FOR INFORMATION PURPOSES ONLY			
Which perinatal deaths must be notified to MBRACE-UK?	Details of which perinatal death must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection		

Where are perinatal deaths notified?	Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website. It is planned that a single notification portal (SNP) will be released by NHS England in 2024. Once this is released notifications of deaths must be made through the SNP and this information will be passed to MBRRACE-UK. It will then be necessary for reporters to log into the MBRRACE-UK surveillance system to provide the surveillance information and use the PMRT.		
Should we notify babies who die at home?	Notification and surveillance information must be provided for babies who died after a home birth where care was provided by your Trust.		
What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK from 30 May 2023 onwards must be notified to MBRRACE-UK within seven working days.		
What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death.This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route of reporting for neonatal deaths that will be via MBRRACE-UK. Once this single route is established, MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP) and the NCMD. At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required mechanism for completing the local review for submission with plans to have this in place in the forthcoming months		
Are there any exclusions from completing the surveillance information?	If the surveillance form needs to be assigned to another Trust for additional information, then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts, should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.		
We have informed parents that a local review will take place and they have been asked if they have any reflections or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order that parents' perspectives and questions can be considered during the review this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. The importance of parents' perspectives is highlighted by their inclusion as the first set of questions in the PMRT. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials		

We have contacted the parents of a baby who has died and they don't wish to have any involvement in the review process. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their perspective and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.		
Parents have not responded to our messages and therefore we are unable to discuss the review. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will also be undertaken by the local CDOP. Verbal information can be supplemented by written information. If, for any reason, this does not happen and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process, ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of the role of key contact, are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.		
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: • All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) • All stillbirths (from 24+0 weeks' gestation) • Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth) While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet the safety action one standard.		
What happens when an HSIB investigation takes place?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by HSIB. Your local review using the PMRT should be started but not completed until the HSIB report is complete. You should consider inviting the HSIB reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the HSIB review to be automatically incorporated into the PMRT review. Depending upon the timing of the HSIB report completion achieving the MIS standards for these babies may therefore be impacted by time frames beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an HSIB INVESTIGATION is taking place, and this will be accounted for in the external validation process.		
What is meant by "reviews should be completed to the draft report stage"?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session (which might be the first session of several) for that death. As an absolute minimum all the 'factual' questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review. The factual questions are highlighted within the PMRT with the symbol:		
What is meant by "reviews should be completed to the draft report stage"?	A multidisciplinary review team should have used the PMRT to review the death, then the review progressed to at least the stage of writing a draft report by pressing 'Complete review'. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details of assistance in using the PMRT to complete a review.		

What does "multi-disciplinary reviews" mean?	To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include a member from a relevant professional group who is external to the unit who can provide 'a fresh pair of eyes' as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member. Bereavement care staff (midwives and nurses) should form part of the review team to provide their expertise in reviewing the bereavement and follow-up care, and advocate for parents. It should not be the responsibility of bereavement care staff to run the reviews, chair the panels nor provide administrative support. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details about multi-disciplinary review.		
What should we do if our post-mortem service has a turn-around time in excess of four months?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than four months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death and complete it with the information you have available. When the post-mortem results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing earlier learning opportunities, especially if the turn-around time is considerably longer than four months. Where the post-mortem turn-around time is quicker, then the information from the post-mortem can be included in the original review.		We recognise that there is a delay in PM results due to shortage of perinatal pathologists. This is a recognised issue nationally.
What is review assignment?	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review, the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided.		
How does 'assigning a review' impact on safety action 1, especially on starting a review?	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.		
What should we do if we do not have any eligible perinatal deaths to review within the relevant time period?	If you do not have any babies that have died between 30 May 2023 and 7 December 2023 you should partner up with a Trust with which you have a referral relationship to participate in case reviews. This will ensure that you benefit from the learning that arises from conducting reviews.		
What deaths should we review outside the relevant time period for the safety action validation process?	Trusts should review all eligible deaths using the PMRT as a routine process, irrespective of the MIS timeframe and validation process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 5 MIS requirements.		
Can the PMRT help by providing a quarterly report that can be presented to the Trust Executive Board?	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews over a period, within the PMRT for user-defined time periods. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for quarterly Trust Board reports and should be discussed with Trust maternity safety champions.		

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			
	Year 5	**Compliance with Standards**	**Comments / Evidence**
Standard Required			
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.		Meeting arranged with data analyst to review latest scorecard to confirm current compliance with data submission/s.
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)		Ethnicity confirmed as datafield evident in records.
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:		Await July scorecard review.
4)	Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.		Meeting arranged to conifrm same.
5)	Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.		Compliance evidenced
Continuity of carer (CoC)	Midwifery Continuity of carer (MCoC) Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable. 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.		Await review of July 2023 scorecard
	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		Await review of July 2023 scorecard
Personalised Care and Support Planning (PCSP)			
Minimum evidential requirement for Trust Board			
	The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.		
Validation process			
	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.		
What is the relevant time period?			
	From 30 May 2023 until 7 December 2023		
What is the deadline for reporting to NHS Resolution?		Note dates	
	1 February 2024 at 12 noon	Note dates	
Technical guidance - FOR INFORMATION ONLY			

The following CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on these three months? **• Proportion of babies born at term with an Apgar score <7 at 5 minutes** **• Women who had a postpartum haemorrhage of 1,500ml or more** **• Women who were current smokers at delivery** **• Women delivering vaginally who had a 3rd or 4th degree tear** **• Women who gave birth to a single second baby vaginally at or after 37 weeks after a previous caesarean section** **• Caesarean section delivery rate in Robson group 1 women** **• Caesarean section delivery rate in Robson group 2 women**	No. For the purposes of the CNST assessment Trusts will only be assessed on July 2023 data for these CQIMs. Due to this, Trusts are now directed to check whether they have passed the requisite data quality required for this safety action within the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts.		
My maternity service has currently suspended Midwifery Continuity of Carer pathways. How does this affect my data submission for CNST safety action 2?	If maternity services have suspended Midwifery Continuity of Carer (MCoC) pathways, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102. This is a satisfactory response for safety action 2 criteria 3i. If your Trust has suspended all MCoC pathways, criteria 3ii is not applicable and does not need to be completed. If your Trust is continuing with some provision of MCoC pathways, then criteria 3ii does still apply.		
Will my Trust fail this action if women choose not to receive continuity of carer?	No. This action is focussed on data quality only and therefore Trusts pass or fail it based upon record completeness for each metric and not on the proportion (%) recorded as the metric output. If women choose not to be placed onto a MCoC pathway, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102.		
Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass CQIMs and other metrics specified above can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics		

What is the Data Quality Submission Summary Tool? How does my Trust access this?	The Data Quality Submission Summary Tool has been developed by NHS England specifically to support this safety action. The tool provides an immediate report on potential gaps in data required for CQIMs and other metrics specified above after data submission, so Trusts can take action to rectify them. It is intended to be used alongside other existing reports and documentation in order for providers to be able to create a full and detailed picture of the quality of their data submissions. Further information on the tool and how to access it is available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/data-quality-submission-summary-tool		
For the Data Quality Submission Summary Tool, what does "sustained engagement" mean for the purposes of passing criteria 3?	By "sustained engagement" we mean that Trusts must show evidence of using the tool for at least three consecutive months prior to the submission of evidence to the Trust Board. For example, for a submission made to the Board in November, engagement should be, as a minimum, in August, September and October. This is a minimum requirement, and we advise that engagement should start as soon as possible. To evidence this, Trusts should save the Excel output file after running the report for a given month. Three files representing each of the three consecutive months should be provided to your Trust Board as part of the assurance process for the scheme. Note – this only becomes a requirement in the event your Trust fails the requisite data quality for the continuity of carer metrics in criteria 3.		
The monthly publications and Maternity Services DashBoard states that my Trusts' data has failed for a particular metric. Where can I find out further information on why this has happened?	Details of all the data quality criteria can be found in the "Meta Data" file (see 'CQIMDQ/CoCDQ Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics The scores for each data quality criteria can be found in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series		
The monthly publications and national Maternity Services DashBoard states that my Trusts' data is 'suppressed'. What does this mean?	Where data is reported in low values for clinical events, the published data will appear 'suppressed' to ensure the anonymity of individuals. However, for the purposes of data quality within this action, 'suppressed' data will still count as a pass.		
Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set		
Where should I send any queries?	On MSDS data For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services DashBoard please contact maternity.dq@nhs.net. For any other queries, please email nhsr.mis@nhs.net		

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?			
	Year 5	**Complaince with Standards**	**Comments / Evidence**
Standard Required			
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.		Revised pathway ratified.
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.		Atain meetings are multidisciplinary with input/leads from amternity and neonatal services. Action plan/s to be signed off by Director of Midwifery.
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.		Revised pathway ratified and is in use clinically.
Minimum evidential requirement for Trust Board			
standard a)	Evidence for standard a) to include: 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.		
Standard b)	Evidence for standard b) to include: • 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. 21 • 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.		
Standard c)	Evidence for standard c) 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.		
Validation process			
	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form	No Change	
What is the relevant time period?			
	30 May 2023 to 7 December 2023		

What is the deadline for reporting to NHS Resolution?			
	01-Feb-24	Note date	
Technical guidance - FOR INFORMATION ONLY			
Does the data recording process need to be available to the ODN/LMNS/ commissioner?	The requirement for a data recording process from years three and four of the maternity incentive scheme was to inform future capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review. This should be in place and maintained in order to inform ongoing capacity planning of transitional care to minimise separation of mothers and babies. This could be captured through existing systems such as BadgerNet or alternatives such as paper based or electronic systems. These returns do not need to be routinely shared with the Operational Delivery Network (ODN), LMNS and/or commissioner but must be readily available should it be requested.		
What members of the MDT should be involved in Atain reviews?	The expectation is that this is a multi-professional review, as a minimum the care should be reviewed by representation from both maternity and neonatal staff groups. This should include as a minimum; a member of the maternity team (a midwife and / or obstetrician and /or trainee from maternity services) and a member of the neonatal team (neonatal nurse and / or neonatologist/paediatrician and/or trainee from neonatal services).		
We have undertaken some reviews for term admissions to NICU, do we need to undertake more and do all babies admitted to the NNU need to be included?	Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the Avoiding Term Admissions into Neonatal Units (ATAIN) work to date. The expectation is that reviews have been continued from year 4 of the scheme. If for any reason, reviews have been paused, they should be recommenced using data from quarter 4 of the 2022/23 financial year (beginning January 2023). This may mean that some of the audit is completed retrospectively. We recommend ongoing reviews, at least quarterly of unanticipated admissions of babies equal to or greater than 37 weeks to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan. A high-level review of the primary reasons for all admissions should be included, with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed. For example, if 60% of babies are admitted for respiratory problems, then focus on this cohort of babies and complete a deep dive into identified themes or if 40% of babies were admitted with jaundice and 35% of babies were admitted with hypothermia then focus on these two cohorts of babies. In addition to this, the number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues and the number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on.		
What do mean by quarterly?	Occurring every three months. This would usually mirror the 4 quarters of the financial year and should cover the period of the MIS 30 May 2023 – 7 December 2023.		
TC audit – what should the audit include and is there a standard audit tool?	An audit tool can be accessed below as a baseline template; however, the audit needs to include aspects of the local pathway. ATAIN-CASE-NOTE-REVIEW-PROFORMA-Revised-2022-converted.pdf We recommend that Trusts refer to the auditable standards included in their local TC pathway guideline/policy.		
How long have the neonatal safety champions been in place for?	Trust Board champions were contacted in February 2019 and asked to nominate a neonatal safety champion. The identification of neonatal safety champions is a recommendation of the national neonatal critical care review and have been in place since February/March 2019.		
What is the definition of transitional care?	Transitional care is not a place but a service (see BAPM guidance) and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.		

Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/ https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Illness-in-newborn-babies-leaflet-FINAL-070420.pdf Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk) Framework: Early Postnatal Care of the Moderate-Late Preterm Infant | British Association of Perinatal Medicine (bapm.org) B1915-three-year-delivery-plan-for-maternity-		

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?			
	Year 5	**Compliance with Standards**	**Comments / Evidence**
Standard Required			
	a) 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 a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.		Meeting arranged to further review compliance against the standard.
	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. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf		Guidance in place but compliance against standard to be confirmed.
	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		Guidance in place but compliance against standard to be confirmed.
	4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 26 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ 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.		Policy detailing requirements reviewed, updated and ratified. Audit against standards to be undertaken September 2023.
	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)		Anaesthetic cover in place - audit against standard to confirm complaince awaited.

	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).		Gap analysis undertaken and service is partially compliant against standard - Neonatal ODN are aware and are working with service to support complaince. Action plan being developed to mitigate risk and to identify current shortfall in neonatal consultant cover. Action plan being developed and will be presented to Board in October 2023.
	d) Neonatal nursing workforce The neonatal unit meets the BAPM neonatal nursing standards. 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 27 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 nurse staffing reviewed with Neonatal ODN and additional funding has supported the recruitment of additional nursing staff. BAPM Guidance in November 2022 outlines severla roles required for the service. Gap analysis undertaken and paper identifying shortfall to be presented to Board in October 2023.
Minimum evidential requirement for Trust Board			
a)	Obstetric medical workforce 1) Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses. Information on the certificate of eligibility (CEL) for short term locums is available here: www.rcog.org.uk/cel This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk		
b)	2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS.		
c)	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. NB. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG		
d)	4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.		

	Anaesthetic medical workforce The rota should be used to evidence compliance with ACSA standard 1.7.2.1. 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). 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).		
Validation process			
	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form.		
What is the relevant time period?			
	Obstetric medical workforce 1. After February 2023 – Audit of 6 months activity 2. After February 2023 – Audit of 6 months activity 3. 30 May 2023 - 7 December 2023 4. 30 May 2023 - 7 December 2023 Anaesthetic medical workforce Trusts to evidence position by 7 December 2023 at 12 noon Neonatal medical workforce A review has been undertaken of any 6 month period between 30 May 2023 – 7 December 2023 a) Neonatal nursing workforce Nursing workforce review has been undertaken at least once during year 5 reporting period 30 May 2023 – 7 December 2023		
What is the deadline for reporting to NHS Resolution?			
	01-Feb-24		
Technical guidance - FOR INFORMATION ONLY			
	Obstetric workforce standard and action		
How can the Trust monitor adherence with the standard relating to short term locums?	Trusts should establish whether any short term (2 weeks or less) tier 2/3 locums have been undertaken between February and August 2023. Medical Human Resources (HR) or equivalent should confirm that all such locums met the required criteria.		
What should a department do if there is non-compliance i.e. locums employed who do not meet the required criteria?	Trusts should review their approval processes and produce an action plan to ensure future compliance.		
Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.		

Where can I find the documents relating to short term locums?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.	For Information	
How can the Trust monitor adherence with the standard relating to long term locums?	Trusts should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance for 6 months after February 2023 and prior to submission to the Trust Board and have a plan to address any shortfalls in compliance.	For Information	
What should a department do if there is a lack of compliance demonstrated in the audit tool regarding the support and supervision of long term locums?	Trusts should review their audits and identify where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.		
Can we self-certify compliance with this element of safety action 4 if long term locums are employed who are not fully supported/supervised?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.		
Where can I find the documents relating to long term locums?	https://rcog.org.uk/careers-and-training/starting-your-og-career/workforce/safe-staffing/#:~:text=RCOG%20updates%2C%20guidance%20and%20position%20statements%20on%20safe,indirect%20supervision%20from%20a%20consultant%20who%20is%20non-resident. All related documents are available on the RCOG safe staffing page.		
How can the Trust monitor adherence with the standard relating to Standard operating procedures for consultants and SAS doctors acting down?	Trusts should provide documentary evidence of standard operating procedures and their implementation Evidence of implementation/compliance could be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.		

What should a department do if there is a lack of compliance, either no Standard operating procedure or failure to implement such that senior medical staff are unable to access compensatory rest?	Trusts should produce a standard operating procedure document regarding compensatory rest. Trusts should identify any lapses in compliance and where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.		
Can we self-certify compliance with this element of safety action 4 if we do not have a standard operating procedure or it is not fully implemented?	Trusts cannot self-certify if they have no evidence of any standard operating procedures by October 2023. They can self-certify if they have been unable to achieve appropriate compensatory rest in individual circumstances such as excessive staffing pressure have prevented the doctor accessing this. They should, however, demonstrate that they have an action plan to ensure future compliance and provide assurance to the Board that this is place.		
Where can I find the documents relating to compensatory rest for consultants and SAS doctors?	https://rcog.org.uk/careers-and-training/starting-your-og-career/workforce/safe-staffing/#:~:text=RCOG%20updates%2C%20guidance%20and%20position%20statements%20on%20safe,indirect%20supervision%20from%20a%20consultant%20who%20is%20non-resident. All related documents are available on the RCOG safe staffing page.		
How can the Trust monitor adherence with the standard relating to consultant attendance out of hours?	For example, departments can audit consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Departments may also wish to monitor adherence via incident reporting systems. Feedback from departmental or other surveys may also be employed for triangulation of compliance.		
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	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.		
Can we self-certify compliance with this element of safety action 4 if consultants have not attended clinical situations on the mandated list?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non-attendances. These can be signed off by the Trust Board.		

Where can I find the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/		
	For queries regarding this safety action please contact: nhsr.mis@nhs.net and RCOG		
	Anaesthesia Clinical Services Accreditation (ACSA) standard and action		
	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.	For Information	
	Neonatal Workforce standards and action		
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If not, Trust Board should agree an action plan and outline progress against any previously agreed action plans. There should also be an indication whether the standards not met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap) alongside a record of the rota tier affected by the gaps. This action plan should be submitted to the LMNS and ODN.	For Information	
BAPM "Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021 or "Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018			

	Neonatal Intensive Care Unit (NICU) Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff during office hours and out of hours. Tier 1 Resident out of hours care should include a designated tier one clinician - Advanced Neonatal Nurse Practitioner (ANNP) or junior doctor ST1-3. NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice. Tier 2 A designated experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP. NICUs with more than 2500 intensive care days should have an additional experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. (A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative) Tier 3 Consultant staff in NICUs should be on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on the neonatal unit alone. NICUs undertaking more than 4000 intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day. NICUs undertaking more than 2500 intensive care days per annum should consider the presence of at least 2 consultant led teams during normal daytime hours. NICUs undertaking more than 4000 intensive care days per annum should consider the presence of three consultant led teams during normal daytime hours.	For Information	
	Local Neonatal Unit Tier 1 At least one resident tier 1 practitioner immediately available dedicated to providing emergency care for the neonatal service 24/7. In large LNUs (>7000 births) there should be two dedicated tier 1 practitioners 24/7 to support emergency care, in keeping with the NICU framework. Tier 2 An immediately available resident tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00 - 22.00, seven days a week. LNUs undertaking either >1500 Respiratory Care Days (RCDs) or >600 Intensive Care (IC) days annually should have immediately available a dedicated resident tier 2 practitioner separate from paediatrics 24/7. Tier 3 Units designated as LNUs providing either >2000 RCDs or >750 IC days annually should provide a separate Tier 3 Consultant rota for the neonatal unit. LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs. All LNUs should ensure that all Consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system and no consultant should undertake fewer than 4 'consultant of the week' service weeks annually. No on-call rota should be more onerous than one in six and all new appointments to units with separate rotas should either have a SCCT in neonatal medicine or be a general paediatrician with a special interest in neonatology or have equivalent neonatal experience and training.	For Information	

	Special Care Unit Tier 1 A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. Tier 2 A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit. Tier 3 In SCUs there should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology).	For Information	
Our Trust do not meet the relevant neonatal medical standards and in view of this an action plan, ratified by the Board has been developed. Can we declared compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.	For Information	
When should the review take place?	The review should take place at least once during the MIS year 5 reporting period.		
Please access the followings for further information on Standards	BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021). A BAPM Framework for Practice https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021 Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018). A BAPM Framework for Practice https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018	For Information	
	Neonatal Workforce standards and action		
Where can we find more information about the requirements for neonatal nursing workforce?	**Neonatal nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk** **The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here: https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf** **Access to the tool and more information will be available through your Neonatal ODN Education and Workforce lead nurse.**		

Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to meet the recommendations. The action plan and related progress, signed off by the Trust Board, should be shared with the Royal College of Nursing (doreen@crawfordmckenzie.co.uk) and Neonatal ODN Lead. This will enable Trusts to declare compliance with this sub-requirement.	For Information	

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?			
	Year 5	**Compliance with Standards**	**Comments / Evidence**
Standard Required			
a)	A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	No Change	Updated review of midwifery staffing completed in 2022 using Birthrate+.
b)	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.		Budget partially identifies budgetary requirements.
c)	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.		Compliance evidenced.
d)	All women in active labour receive one-to-one midwifery care.		1:1 midwifery care calculated monthly demonstrating compliance.
e)	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.		Midwifery staffing paper to be presented to Board in September 2023. This will demonstrate shortfall in meeting staffing requirements for continuity of carer.
Minimum evidential requirement for Trust Board			
	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.		
	Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.		
	The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.		
	Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. o The midwife to birth ratio o The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.		
	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.		
Validation process			
	Self-certification to NHS Resolution using the Board declaration form		
What is the relevant time period?			
	30 May 2023 – 7 December 2023	Note dates	
What is the deadline for reporting to NHS Resolution?			
	1 February 2023 at 12 noon	Note dates	
Technical guidance - FOR INFORMATION PURPOSE ONLY			

What midwifery red flag events could be included in six monthly staffing report (examples only)? We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice.	•Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637 https://www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637	For Information	
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care or care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to 40 midwives at birth when required, supporting junior midwives undertaking suturing etc. This should not be counted as losing supernumerary status.		
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. As stated above, completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 5 of MIS.	For Information	
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.	For Information	

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?										
	Year 5	**Compliance with Standards**	**Comments / Evidence**							
Standard Required										
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.		implementation plan agreed within the Division and work ongoing to implement all required standards. Partial complaince met. Detailed report to next Board meeting							
2	Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool.		No formal arrangement regarding meeting structure with ICB in place. Meeting with LMNS and ICB to be arranged to confirm. DoM has requested detail to implement							
Minimum evidential requirement for Trust Board										
1	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 compliance with the care bundle 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.		Previous presentation at Board of 3 Year Single Delivery plan.							
2	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 and includes the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. 42 • 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.		See narrative above							
Validation process										
1	Self-certification to NHS Resolution using the Board declaration form.	For information								
2										
3										
What is the relevant time period?										
		Note date								
What is the deadline for reporting to NHS Resolution?										
Technical guidance - FOR INFO ONLY		Note date								
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: https://www.england.nhs.uk/publication/saving-babies-lives-version-three/ The implementation tool is available at https://future.nhs.uk/SavingBabiesLives and includes a technical glossary for all data items referred to in MSDS Additional resources are in production and will be advertised on this page. Any further queries regarding the tool, please email england.maternitytransformation@nhs.net Any queries related to the digital aspects of this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net Some data items are or will become available on the National Maternity Dashboard or from NNAP Online For any other queries, please email nhsr.mis@nhs.net	For information								
What is the rationale for the change in evidential requirements to SA6 in Year 5?	The broad principles that will apply to the implementation of the standards detailed in the Saving Babies' Lives Care Bundle (version 3) are: The use of the implementation tool will allow Trusts to track implementation and demonstrate local improvement using the process and outcome indicators within all six elements of the care bundle (for some elements this may only require evidence of a protocol, process, or appointed post). These data will form the basis of compliance with safety action 6 of this version of the maternity incentive scheme. This approach acknowledges the increased number and/or size of elements in this new version of the care bundle.	For information								

What are the indicators for Element 1	Process Indicators 1a. Percentage of women where there is a record of: 1.a.i. CO measurement at booking appointment 1.a.ii. CO measurement at 36-week appointment 1.a.iii. Smoking status** at booking appointment 1.a.iv. Smoking status** at 36-week appointment 1b. Percentage of smokers* that have an opt-out referral at booking to an in-house/in-reach tobacco dependence treatment service. 1c. Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date. Outcome Indicators 1d. Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks. 1e. Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks. *a “smoker” is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). **Smoking status relates to the outcome of the CO test (>4ppm) and the enquiry about smoking habits.								
What are the indicators for Element 2	Process Indicators 2a. Percentage of pregnancies where a risk status for Fetal Growth Restriction (FGR) is identified and recorded at booking. (This should be recorded on the provider’s MIS and included in the MSDS submission to NHS Digital once the primary data standard is in place.) 2b. Percentage of pregnancies where a Small for Gestational Age (SGA) fetus (between 3rd to <10th centiles) is antenatally detected, and this is recorded on the provider’s MIS and included in their MSDS submission to NHS Digital. 2c. Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT). Outcome Indicators 2d. Percentage of babies <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR). 2e. Percentage of live births and stillbirths >3rd birthweight centile born <39+0 weeks gestation, where growth restriction was suspected.								
What are the indicators for Element 3	Process Indicators 3a. Percentage of women who attend with Reduced Fetal Movements (RFM) who have a computerised Cardiotocograph (CTG). 3b. Proportion of women who attend with recurrent RFM* who had an ultrasound scan by the next working day to assess fetal growth. Outcome Indicators 3c. Percentage of stillbirths which had issues associated with RFM management identified using PMRT. 3d. Rate of induction of labour when RFM is the only indication before 39+0 weeks’ gestation. *There is no accepted definition of what recurrent RFM means; one region of the UK has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks’ gestation.								
What are the indicators for Element 4	Process Indicators 4a. Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors, and situational awareness. 4b. Percentage of staff who have successfully completed mandatory annual competency assessment. 4c. Fetal monitoring lead roles appointed. Outcome Indicators 4d. The percentage of intrapartum stillbirths, early neonatal deaths, and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. *Using the severe brain injury definition as used in Gale et al. 201848.								

What are the indicators for Element 5	Process Indicators 5a. Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU). 5b. Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth. 5c. Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth. 5d. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive intravenous (IV) intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection. 5e. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth. 5f. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. 5g. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth. 5h. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (5a – 5g above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation). To minimise the need for local data collection to support these improvements the formal collection of process measure data can be restricted to the seven interventions listed in this section, the use of volume targeted ventilation and caffeine is recommended but these data are not currently recorded or presented with national datasets. In addition, the gestational limits for some of the indicators and/or the groups studies have been adjusted to align with current nationally collected data (e.g., data on babies born only below 34 weeks or data on the number of babiesreceiving antenatal corticosteroids rather than the number of mothers) Outcome Indicators 5i. Mortality to discharge in very preterm babies (National Neonatal Audit Programme (NNAP) definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner). 5j. Preterm Brain Injury (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: ✓ Germinal matrix/ intraventricular haemorrhage ✓ Post haemorrhagic ventricular dilatation ✓ Cystic periventricular leukomalacia 5k. Percentage of perinatal mortality cases annually (using PMRT for analysis) where								
What are the indicators for Element 6	Process Indicators 6a. Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc). 6b. Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes. 6c. Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets. 6d. Demonstrate compliance with Continuous Glucose Monitoring (CGM) training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes. 6e. Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with Diabetic Ketoacidosis (DKA) during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities, and availability of expertise. Outcome Indicators 6f. The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the National Pregnancy in Diabetes (NPID) dashboard (aiming for >95% of women). 6g. The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the start of the third trimester (aiming for >95% of women). Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.								

What considerations need to be made to ensure timely submission of data to evidence implementation and compliance with locally agreed progress measures?	Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.								
Is there a requirement on Trusts to evidence SBLCB process and outcome measures through their data submissions to Maternity Services Data Set?	Trusts should be capturing SBLCB data as far as possible in their Maternity Information Systems/Electronic Patient Records and submitted to the MSDS. MSDS does not capture all process and outcome indicators given in the care bundle. A summary of this appears in the technical appendix for version 2 of the care bundle, available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/tools-and-guidance 49 Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.								
Would a Trust be non-compliant if <60% of smokers set a quit date?	As stated in SA6, 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. The implementation tool will set out the evidence requirement for demonstrating compliance with each intervention. Where element process and outcome measures are listed in the evidence requirement, a performance threshold is recommended, but this is for agreement between a provider and their ICB in view of local circumstances.								
The SBLCBv3 that was published on the 31st May 2023 included a typo in Appendix D Figure 6 with BMI as >18.5kg/m and it is not clear what "other features" mean	This has now been amended and states <18.5kg/m with further clarity provided regarding "other features".								
How do we provide evidence for the interventions that have been implemented?	The evidence requirements for each intervention are set out within the implementation tool. You will need to verify that you have an implemented service locally.								
Will the eLfH modules be updated in line with SBLCBv3?	The SBLCB eLearning for Health modules is currently being updated in line with the latest iteration, Version 3 of the Care Bundle and will include a new section to support implementation of element 6. We have asked for the ultrasound element to be reviewed for its relevance, this was developed separately, and we will make sure the completion of the e learning is focussed on elements 1-6.								

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users			
	Year 5	**Complaince with Standards**	**Comments / Evidence**
Standard Required			
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.		Fully complaint and work ongoing to further improve partnership
2	Ensuring 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.		Action plan in place and recent CQC result has hilighted the outstanding work that is ongoing with the MNVP.
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.		MNVP Chair is a safety champion and attends all meetings.
Minimum evidential requirement for Trust Board			
	Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff. • 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. • 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. • Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses. • 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.		
Validation process			
	Self-certification to NHS Resolution using the Board declaration form		
What is the relevant time period?			
	Trusts should be evidencing the position as 7 December 2023		
What is the deadline for reporting to NHS Resolution?			
	1 February 2023 at 12 noon		
Technical guidance - FOR INFORMATION ONLY			
What is the Maternity and Neonatal Voices Partnership?	An MNVP listens to the experiences of women, birthing people, and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. MNVPs ensure that service user voice is at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the local maternity and neonatal system (LMNS). MNVPs ensure service user voice influences improvements in the safety, quality, and experience of maternity and neonatal care.		

We are unsure about the funding for Maternity and Neonatal Voices Partnerships	It is the responsibility of ICBs to: Commission and fund MNVPs, to cover each Trust within their footprint, reflecting the diversity of the local population in line with the ambition above.		
What advice is there for Maternity and Neonatal Voices Partnership (MNVP) leads when engaging and prioritising hearing the voices of neonatal and bereaved service users, and what support or training is in place to support MNVP's?	MNVPs should work in partnership with local specialist voluntary, community, and social enterprise (VCSEs) with lived experience to gather feedback. Engagement needs to be accessible and appropriate, particularly for neonatal and bereaved families. It is essential that you consider how you will protect people from being retraumatised through giving feedback on their experience. Training for MNVPs to engage with seldom heard or vulnerable communities may be required to ensure unintentional harm is avoided. MNVPs can also work in collaboration with their trust bereavement leads to ensure adequate support is in place for themselves and the families they may engage with. Attendance at the trust training could be beneficial.		
When will the MNVP guidance be published?	We are working with our stakeholders to publish the MNVP guidance as soon as possible. As it is not yet published, it is acknowledged that there may not be enough time ahead of the reporting period for full implementation of all the requirements of the MNVP guidance. Where an element of the guidance is not yet fully implemented, evidence must be presented that demonstrates progress towards full implementation within 12 months.		

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?			
	Year 5	**Complaince with Standards**	**Comments / Evidence**
Standard Required and minimum evidential requirement			
1	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.		Training Needs Analysis in place and follows national guidance set out on NHSE Future Platform. Training compliance trajectory on track to meet target.
2	The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.		Sign off to be discussed and agreed at Maternity and Neonatal Assurance Board
3	The plan is developed based on the "How to" Guide developed by NHS England.		See above narrative
Validation process			
	Self-certification to NHS Resolution using the Board declaration form.		
What is the relevant time period?			
	12 consecutive months should be considered from 1st December 2022 until 1st December 2023 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for trust boards to review. It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv1		
What is the deadline for reporting to NHS Resolution?			
Technical guidance - FOR INFORMATION ONLY			
What training should be covered in the local training plan to cover the six modules of the Core Competency Framework?	A training plan should be in place to implement all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 2024. NHS England » Core competency framework version two Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework.		
How will the 90% attendance compliance be calculated?	The training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups by the end of the 12 month period.		
Where can I find the Core Competencies Framework and other additional resources?	https://www.england.nhs.uk/publication/core-competency-framework-version-two/ • Includes links to the documents: o Core competency framework version two: Minimum standards and stretch targets o 'How to' guide - a resource pack to support implementing the Core Competency Framework version two o Core competency framework: training needs analysis • NHS England V1 of the Core Competency Framework https://www.england.nhs.uk/publication/core-competency-framework/ • https://www.resus.org.uk/library/2021-resuscitation-guidelines/newborn-resuscitation-and-support-transition-infants-birth		

What training should be included to meet the requirements of the Core Competency Framework Version 2?	All 6 core modules in V2 of the Core Competency Framework (CCFv2) must be covered as detailed in the minimum standards. Trusts must be able to evidence the four key principles: 1. Service user involvement in developing and delivering training. 2. Training is based on learning from local findings from incidents, audit, service user feedback, 55 and investigation reports. This should include reinforcing learning from what went well. 3. Promote learning as a multidisciplinary team. Promote shared learning across a Local Maternity and Neonatal System.		
Which maternity staff should be included for Module 2: Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric consultants • All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor) • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • MSWs • GP trainees		

Which maternity staff should be included for Module 3: Maternity emergencies and multiprofessional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric consultants. • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota. • Midwives (including midwifery managers and matrons), community midwives; birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) • Obstetric anaesthetic consultants. • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota. 56 • Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS year 5 compliance assessment • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS year 5 compliance • At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff		
Does the multidisciplinary emergency scenarios described in module 3 have to be conducted in the clinical area?	At least one emergency scenario needs to be conducted in the clinical area or at point of care. You need to ensure that 90% of your staff attend a minimum of one emergency scenario that is held in the clinical area, but not all of the scenarios have to be based in a clinical area.		
Which staff should be included for Module 6: Neonatal basic life support?	Staff in attendance at births should be included for Module 6: Neonatal basic life support. This includes the staff listed below: • Neonatal Consultants or Paediatric consultants covering neonatal units • Neonatal junior doctors (who attend any births) • Neonatal nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. The staff groups below are not required to attend neonatal basic life support training: • All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit). • Local policy should determine whether maternity support workers are included in neonatal basic life support training.		

I am a NLS instructor, do I still need to attend neonatal basic life support training?	No, if you have taught on a course within MIS year 5 you do not need to attend neonatal basic life support training		
I have attended my NLS training, do I still need to attend neonatal basic life support training?	No, if you have attended a course within MIS year 5 you do not need to attend neonatal basic life support training as well.		
Which members of the team can teach basic neonatal life support training and NLS training?	Registered RC-trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates. A detailed response to this can be found on the CCF futures page.		
What do we do if we do not have enough instructors who are trained as an NLS instructor and hold the GIC qualification?	Your Neonatal Consultants and Advanced Neonatal Practitioners (ANNP) will be qualified to deliver the training. You can also liaise with your Local Maternity and Neonatal System (LMNS) to explore sharing of resources. There may be difficulty in resourcing qualified trainers. Units experiencing this must provide evidence to their trust board that they are seeking mitigation across their LMNS and an action plan to work towards NLS and GIC qualified status by 31st March 2024. As a minimum, training should be delivered by someone who is up to date with their NLS training.		
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally determined.		
How do we involve services users in developing and delivering training?	Please refer to the "How To" guide for ideas on how to involve service users in the developing and delivering of training. This is Principle 1 of the CCFv2 that recommends MNVP leads could be a member of the multidisciplinary educational teams (MET) to support the planning and selection of themes/local learning requirements to reflect in the training. Ways in which service users and service user representatives can support the delivery of training include with video case studies, inviting service users to tell their story or inviting charitable/support organisations for example local Downs Syndrome groups; LGBTQIA+ Communities; or advocates for refugees. NHS England will be sharing examples of practice over the year and on their NHS Futures page.		

The TNA suggests periods of time required for each element of training, for example 9 hours for fetal monitoring training. Is this a mandated amount of time?	The TNA has been inputted with example times to demonstrate how the calculations are made for the backfill of staff that is required to put a training plan in place. The hours for each element of training can be flexed by the individual trust in response to their own local learning needs.		
Do all the modules within the CCF require a multidisciplinary attendance?	Multidisciplinary team working has an evidence-base and has been highlighted in The Kirkup Report (2022). Key Action 3 (Flawed Team working) was a significant finding with the recommendation to improve teamworking with reference to establishing common purpose, objectives, and training from the outset. It is therefore a requirement that there is a strong emphasis on multidisciplinary training throughout the modules in response to local incidents. The staff groups within the multidisciplinary teams being trained may also vary, depending on the incident/emergency being covered.		

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?			
	Year 5	**Compliance with standard**	**Comments / evidence**
Standard Required			
a)	Reporting of all qualifying cases to HSIB/ MNSI from 6 December 2022 to 7 December 2023.		Compliance evidenced to date.
b)	Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until 7 December 2023.		Compliance evidenced to date.
c)	For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:		
i	the family have received information on the role of HSIB//MNSI and NHS Resolution's EN scheme; and		Compliance evidenced to date.
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.		Compliance evidenced to date.
Minimum evidential requirement for Trust Board			
	Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB//MNSI/EN incidents and numbers reported to HSIB//MNSI and NHS Resolution.		
	Trust Board sight of evidence that the families have received information on the role of HSIB/MNSI and EN scheme.		
	Trust Board sight of evidence of compliance with the statutory duty of candour.		
Validation process			
	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against the HSIB/MNSI database and the National Neonatal Research Database (NNRD) and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard a) and b) have been met in the relevant reporting period. In addition, for standard C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.		
What is the relevant time period?			
	Reporting to HSIB – from 6 December 2022 to 7 December 2023 Reporting period to HSIB and to NHS Resolution – from 6 Decembe		
What is the deadline for reporting the NHS Resolution?			
	By 1 February 2024 at 12 noon		
Technical guidance - FOR INFORMATION			
Where can I find information on HSIB	Information about HSIB and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/ From October 2023 this website will no longer be available and the HSIB maternity programme will be hosted by the CQC. Further details will be circulated once available.		
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website: • EN main page • Trusts page • Families page		

What are qualifying incidents that need to be reported to HSIB/MNSI?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [or] • Was therapeutically cooled (active cooling only) [or] • Had decreased central tone AND was comatose AND had seizures of any kind. Once HSIB/MNSI have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury.		
What is the definition of labour used by HSIB and EN?	The definition of labour used by HSIB includes: • Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation. • When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking). • Induction of labour (when labour is started artificially). • When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.		
Changes in the EN Reporting requirements for Trusts from 1 April 2022 going forward	With effect from 1 April 2022, Trusts have been required to continue to report their qualifying cases to HSIB via the electronic portal. In addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed 1 April 2022 going forward they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must share the HSIB//MNSI report with the EN team within 30 days of receipt of the final report by uploading the HSIB/MNSI report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading HSIB/MNSI reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the HSIB/MNSI report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.		
What qualifying EN cases need to be reported to NHS Resolution?	Trusts are required to report cases to NHS Resolution where HSIB are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury. • Where a family have declined a HSIB investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution. There is more information here: ENS Reporting Guide - July 2023 (for Member Trusts) - NHS Resolution		
Cases that do not require to be reported to NHS Resolution	Cases where families have requested a HSIB/MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a HSIB/MNSI investigation where the baby has a normal MRI. • Cases that HSIB/MNSI are not investigating.		

What if we are unsure whether a case qualifies for referral to HSIB/MNSI or NHS Resolution?	For cases from 1 April 2022, if the baby has a clinical or MRI evidence of neurological injury and the case is being investigated by HSIB/MNSI because of this, then the case should also be reported to NHS Resolution via the claims wizard along with the HSIB/MNSI reference number (document the HSIB reference in the "any other comments box"). Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard. Should you have any queries, please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or HSIB/MNSI maternity team (maternity@hsib.org.uk).		
How should we report cases to NHS Resolution?	Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once they have been confirmed by HSIB/ MNSI as under investigation. They must also complete the EN Report form and attach this to the Claims Reporting Wizard: https://resolution.nhs.uk/wp-content/uploads/2023/05/EN-Report-Form.pdf		
What happens once we have reported a case to NHS resolution?	Following the HSIB/MNSI investigation, and on receipt of the HSIB/MNSI report and MRI report, following triage, NHS Resolution will overlay an reported a case to NHS Resolution investigation into legal liability. Where families have declined an HSIB/MNSI investigation, no EN investigation will take place, unless the family requests this.		
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by HSIB and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.		
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all incidents to HSIB/MNSI as soon as they occur and to NHS Resolution as soon as HSIB/MNSI have confirmed that they are taking forward an investigation. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to HSIBMNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and HSIB/MNSI and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme.		

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Saving Babies' Lives Version Three

A care bundle for reducing perinatal mortality

Version 3, 1 June 2023

Contents

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Executive summary

The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality.

The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025, and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there is more to do to achieve the Ambition in 2025.

Version 3 of the Care Bundle (SBLCBv3) has been co-developed with clinical experts including front-line clinicians, Royal Colleges, and professional societies; service users and Maternity Voices Partnerships; and national organisations including charities, the Department of Health and Social Care and a number of arm's length bodies (See Appendix A: Acknowledgements).

Building on the achievements of previous iterations, Version 3 includes a refresh of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. There are now 6 elements of care:

- **Element 1** focuses on **Reducing smoking in pregnancy** by implementing NHS-funded tobacco dependence treatment services within maternity settings, in line with the NHS Long Term Plan and NICE guidance. This includes carbon monoxide testing and asking women about their smoking status at the antenatal booking appointment, as appropriate, throughout pregnancy. Women who smoke should receive an opt-out referral for in-house support from a trained Tobacco Dependence Adviser who will offer a personalised care plan and support throughout pregnancy.

- **Element 2** covers **Fetal Growth: Risk assessment, surveillance, and management.** Building on the widespread adoption of mid-trimester uterine artery Doppler screening for early onset fetal growth restriction (FGR) and placental dysfunction, Element 2 seeks to further improve FGR risk assessment by mandating the use of digital blood pressure measurement. It recommends a more nuanced approach to late FGR management to improve the assessment and care of mothers at risk of FGR, and lower rates of iatrogenic late preterm birth.

- **Element 3** is focused on **raising awareness of reduced fetal movement (RFM).** This updated element encourages awareness amongst pregnant women of the importance of detecting and reporting RFM, and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM. Induction of labour prior to 39 weeks gestation is only recommended where there is evidence of fetal compromise or other concerns in addition to the history of RFM.

- **Element 4** promotes **Effective fetal monitoring during labour** through ensuring all staff responsible for monitoring the fetus are competent in the techniques they use (IA and/or CTG) in relation to the clinical situation, use the buddy system, and escalate accordingly when concerns arise, or risks develop. This includes staff that are brought in to support a busy service from other clinical areas, as well as locum, agency of bank staff**.**

- **Element 5** on **reducing preterm birth** recommends three intervention areas to reduce adverse fetal and neonatal outcomes: improving the **prediction** and **prevention** of preterm birth and **optimising perinatal care** when preterm birth cannot be prevented. All providers are encouraged to draw upon the learning from the existing BAPM toolkits and the wide range of resources from other successful regional programmes (e.g. PERIPrem resources, MCQIC).

- The new **Element 6** covers the **management of pre-existing diabetes in pregnancy** for women with Type 1 or Type 2 diabetes, as the most significant modifiable risk factor for poor pregnancy outcomes. It recommends multidisciplinary team pathways and an intensified focus on glucose management within maternity settings, in line with the NHS Long Term Plan and NICE guidance. It includes clear documentation of assessing glucose control digitally; using HbA1c to risk stratify and provide additional support/surveillance (National Diabetes Audit data); and offering consistent access to evidence based Continuous Glucose Monitoring (CGM) technology to improve glucose control (NICE and NHS plan).

In addition to the provision of safe and personalised care, achieving equity and reducing health inequalities is a key aim for all Maternity and Neonatal services and is essential to achieving the National Safety Ambition. Each element in SBLCB v3 has been reviewed to include actions to improve equity, including for babies from Black, Asian and mixed ethnic groups and for those born to mothers living in the most deprived areas, in accordance with the NHS equity and equality guidance.

As part of the Three Year Delivery Plan for Maternity and Neonatal Services, NHS Trusts are responsible for implementing SBLCBv3 by March 2024 and Integrated Care Boards

(ICBs) are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery.

SBLCBv3 also sets out a number of important wider principles to consider during implementation. These are not mandated by the care bundle but reflect best practice care and are recommended to be followed in conjunction with the 6 elements.

Forewords

ONS data suggests that because of the improvement in the perinatal mortality rate since 2010, at least 900 more babies will return home alive with their families this year. That is a great achievement, and all those who work in Maternity and Neonatal services should be incredibly proud of our progress towards the National Safety Ambition.

The recent rise in the perinatal mortality rate is likely to be related to the direct and indirect effects of the COVID-19 pandemic and is a stark reminder that there will always be challenges to reducing stillbirths and neonatal deaths. The trajectory to meet the National Ambition was unlikely to ever be a simple linear progression, particularly as the factors that lead to avoidable perinatal mortality are many and varied. We should all acknowledge that while we have reduced avoidable deaths, there is more to be done.

If we are to meet the National ambition for a 50% reduction in the stillbirth and neonatal mortality rates by 2025, we need to address longstanding inequitable outcomes associated with ethnicity and levels of deprivation. While it is clear that some solutions lie beyond the control of the health sector, our services must do everything possible to mitigate against the wider social determinants of health to continue to drive down the perinatal mortality rate.

The need to continuously iterate and improve care is why we have developed Version 3 of the care bundle at pace. Clinical experts, professional bodies, charities, service users and national regulators have collaborated to develop national best practice. It is important to remember that the care bundle is just one of a series of interventions to help reduce perinatal mortality and pre-term birth and shouldn't be implemented in isolation. The Three year delivery plan for maternity and neonatal services describes more broadly how providers should continue to implement best practice care wherever possible and a set of wider principles are included in this version of the Care Bundle.

Despite the recent set back in perinatal mortality rates the stillbirth rate was still 19% lower in 2021 than in 2010, and the neonatal mortality rate 30% lower. Thank you to all those who have worked tirelessly to drive improvement in our maternity services, whether they be NHS employees, parents or charities. I am confident that the collaborative approach modelled by the Saving Babies' Lives Care Bundle will continue to deliver improvements in outcomes and reduce the number of parents who have to face the tragedy of perinatal bereavement.

Matthew Jolly National Clinical Director for Maternity and Women's Health, NHS England

NHS England

On behalf of the Royal College of Midwives, I welcome the publication of this third version of the Saving Babies' Lives Care Bundle. We continue to support the ambition to achieve a 50% reduction in stillbirths and maternal and neonatal deaths by 2025. The care bundle to date has made a vital contribution to achieving this.

The RCM know that the relationships that professionals form in the workplace, in their teams and with women, are key to safety and preventing the avoidable tragedies of stillbirth and the death of babies. We are therefore pleased to see continued emphasis on professionals working together and with women to help them to make choices about their care and reduce the risks to their baby.

Gill Walton
Chief Executive, Royal College of Midwives

As Saving Babies' Lives Care Bundle (SBLCBv3) enters its third edition and its 7th year, it continues to innovate and drive forward quality improvement in key areas of maternity care. We welcome the addition of an element covering diabetes in pregnancy and the continued development of the other successful five elements. This version builds on versions 1 and 2, to focus on supporting those caring for pregnant women and to help support women to make choices about their care and reduce unnecessary intervention. Whenever a new guideline is introduced, it will always have limitations and there will be compromises to be made influenced by lack of current evidence and resource requirements to support successful implementation. However, the premise of the bundle is to reduce variation and provide a framework for continuous improvement. This will be supported by ongoing learning from evaluation of the bundle and is key to its success and value.

The Saving Babies' Lives Care Bundle is part of a number of initiatives to improve maternity care and safety. However, there are areas that we urgently need to address if we are to ensure a continued reduction in perinatal mortality for all women and babies. We must, therefore, harness the expertise and experience of obstetricians and specialists in fetal and maternal medicine, frontline maternity teams, academics and policymakers to tackle inequality and the social determinants of health in the pregnant population.

BMFMS is honoured to have worked closely on all three versions of SBLCB and fully supports the initiatives within this new version and the opportunity to work to deliver improvements in maternity care.

Katie Morris
President, British Maternal and Fetal Medicine Society

British Maternal & Fetal Medicine Society

Every day, maternity services support thousands of women and their families through pregnancy and childbirth. The majority of those using maternity services have good outcomes and report a positive experience of care but maternity care is complex and, unfortunately, adverse events occur.

Recent public inquiries into maternity care have emphasised the importance of continued learning and action on improving safety. The Royal College of Obstetricians and Gynaecologists warmly welcomes the publication of the third version of the Saving Babies' Lives Care Bundle, which will support further progress towards a 50% reduction in the rate of stillbirths, neonatal mortality and serious brain injury and a reduction of pre term births from 8% to 6% in the UK by 2025, as set in the NHS Long Term Plan.

Maternity care is delivered through multi-professional teams working together to support all women, requiring a wide range of skills, knowledge and expertise, and a supportive context in which these can be applied. By implementing the evidence-based, best practice elements of the Saving Babies' Lives Care Bundle, local maternity teams can ensure women receive personalised care that will continue to reduce perinatal mortality.

Importantly, each element of the care bundle includes action to improve equity, including for babies from Black, Asian and mixed ethnic groups and for those born to mothers living in the most deprived areas. Maternity systems must continue work to embed these into their local action plans.

The care bundle aligns with and complements a range of other important maternity safety initiatives and tools, including wider work being taken forward through the Maternity Transformation Programme as well as initiatives such as the Avoiding Brain Injury in Childbirth (ABC) programme.

The Royal College of Obstetricians and Gynaecologists will continue to work with partners, including other Royal Colleges, national policymakers and safety leaders, to support the NHS to implement these together, to improve the quality and safety of care that women and babies receive in the UK.

Dr Ranee Thakar
President, Royal College of Obstetricians and Gynaecologists

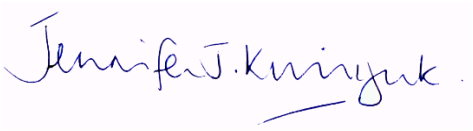
Royal College of Obstetricians & Gynaecologists

Having achieved the first national ambition milestone of reducing by 20% the perinatal mortality rate by 2020 the focus is now on achieving the further 30% reduction by 2025. This will require accelerated progress in the face of having probably dealt with the 'easier' problems to prevent and manage.

Activities on multiple fronts are going to be required which is why, amongst other actions, the full implementation in all trusts of the Saving Babies' Lives Care Bundle is needed. This, the third version of the Care Bundle, is a welcome reminder of the five elements from version two and the introduction of a sixth new element to improve diabetic management in pregnancy for women with type 1 and type 2 diabetes.

As demonstrated in the National Diabetes in Pregnancy Audit, monitoring and managing tight glycaemic control from pre-pregnancy and throughout pregnancy is key to reducing the risks of adverse outcomes including congenital anomalies and perinatal death. The 2022 MBRRACE-UK maternal confidential enquiry illustrated the risks to both diabetic pregnant women and their babies of poorly managed diabetic ketoacidosis.

The steps outlined in element six of the new version of the Care Bundle provide practical advice for service delivery to support improved management for this high-risk group of mothers and babies. Achieving the improvements that could be realised from the full implementation of all six elements of the new version of the Care Bundle will provide some of the essential pieces of the jigsaw of activities still needed to further reduce the national rate of perinatal deaths.



Professor Jenny Kurinczuk, Professor of Perinatal Epidemiology,
Director, National Perinatal Epidemiology Unit,
National Programme Lead MBRRACE-UK/PMRT,
University of Oxford

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Despite falls in perinatal mortality in recent years, too many parents and families are still devastated by the death of their baby. The exact impact of Covid 19 is as yet unclear but it's very possible that the pandemic has had a significant negative impact not just on women and pregnant people's experiences of maternity, but crucially on outcomes for both them and their babies. Importantly, the government is unlikely to meet the National Ambition to halve stillbirths and neonatal baby deaths by 2025.

Coming in the wake of further investigations into poor care such as the Ockenden and East Kent reports, this third version of the Saving Babies' Lives Care Bundle has urgency towards ensuring better, safer care. This new version maintains the focus of version two but adds another crucially important element around caring for women with Type 1 and Type 2 Diabetes who we know to be at 4-5 times increased risk of losing their baby. This version also encourages awareness among those who are pregnant of the importance of early warning signals that something may be wrong, such as noticing and reporting reduced fetal movements (RFM).

An innovation in this version is an assurance tool to help Trusts track their progress in implementation, thereby removing the need to have regular implementation surveys.

Listening to bereaved parents' experiences is vital in understanding why babies die, and learning from every baby's death is essential part of the continual improvement that underpins this Care Bundle. Parents tell us that if lessons can be learned from the death of their baby it can help them live with their grief, providing an important and lasting legacy.

This updated, third version of the Saving Babies' Lives Care Bundle carries essential knowledge for every healthcare professional who supports and works with those who are pregnant. It helps address inequalities with the same emphasis of continuity of carer, especially for those from black and minority ethnic backgrounds and those living in areas of social deprivation. When the worst happens, it ensures standards in bereavement care, in line with the National Bereavement Care Pathway.

We welcome its implementation and believe that it provides an opportunity to protect babies' lives in the future

Clea Harmer
Chief Executive, Sands

Sands
Stillbirth & neonatal death charity

Tommy's work is dedicated to reducing rates of pregnancy complications and baby loss as we know the heartbreak and devastation this causes far too many parents and families. Despite ambitious targets, the rates of stillbirth and preterm birth are not falling as quickly as we would have hoped, and indeed the stillbirth rates sadly rose in 2021. It is also clear that variation in care continues, and not all women and birthing people have the same chance of taking home a healthy baby – the outcome every family deserves. So, we warmly welcome Version 3 of the Saving Babies' Lives Care Bundle as a vital resource for all professionals involved in supporting people to have a safe and healthy pregnancy and birth.

Research is continually advancing understanding and growing evidence and it is vital this is translated into improvements in care. While this guidance has been produced before the evaluation of Version 2, we support the fast tracking of new evidence so that everyone can benefit as quickly as possible, and potentially more babies' lives can be saved.

We know from the MBRRACE data that some communities continue to experience much poorer outcomes than others. This is unacceptable and we're therefore particularly pleased that Version 3 has been reviewed from an inequity standpoint and highlights the promotion of equity and equality as an important principle to apply when implementing the care bundle. It is also positive to see that continuity of carer is explicitly noted as a key intervention to improve equitable outcomes.

A key addition to Version 3 is the management of diabetes in pregnancy. The number of women and birthing people with diabetes is on the rise and perinatal mortality rates for pregnant people with Type 1 and Type 2 diabetes have remained very high for the last five years. This practical guidance should standardise pathways and join these up with other aspects of maternity care to reduce risk.
The care bundle also contains a renewed focus on reduced fetal movement (RFM). This is such an important message given the relationship between episodes of RFM and stillbirth, and the vital role of timely hospital attendance and fetal monitoring. Everyone must feel they can and should contact their hospital if they are worried that their baby's movements have changed.

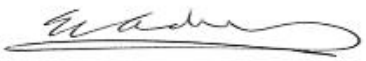
This version of the bundle is another important step on the journey to safer pregnancy and birth. We know that when all maternity units follow these actions, fewer families will face the heartbreak and devastation of pregnancy complications and loss.

Kath Abrahams, Chief Executive, Tommy's

Tommy's
Together, for every baby

*Preterm birth causes 78% of deaths in the neonatal period (first 28 days of life)*and is also a major contributor to childhood disability and poorer neurodevelopmental outcome. Interventions to reduce the impact of prematurity on morbidity and mortality must therefore be a major focus to move towards the national ambition to halve the rate of stillbirth, neonatal death, maternal death and serious intrapartum brain injury by 2025.*

BAPM therefore welcomes expansion of element 5 in the SBLCB v3 which aims to reduce preterm birth where possible and optimise perinatal care where preterm birth cannot be prevented. Given the importance of the interventions in improving outcomes, BAPM strongly encourages trusts to ensure that appropriate time is allocated to the neonatal medical and nursing leads of the preterm birth team, in addition to the maternity and obstetric leads, to allow rapid implementation.
**National Child Mortality Database Thematic Report: The contribution of Newborn Health to Child Mortality across England. July 2022*



Eleri Adams, BAPM President

British Association of Perinatal Medicine

Introduction

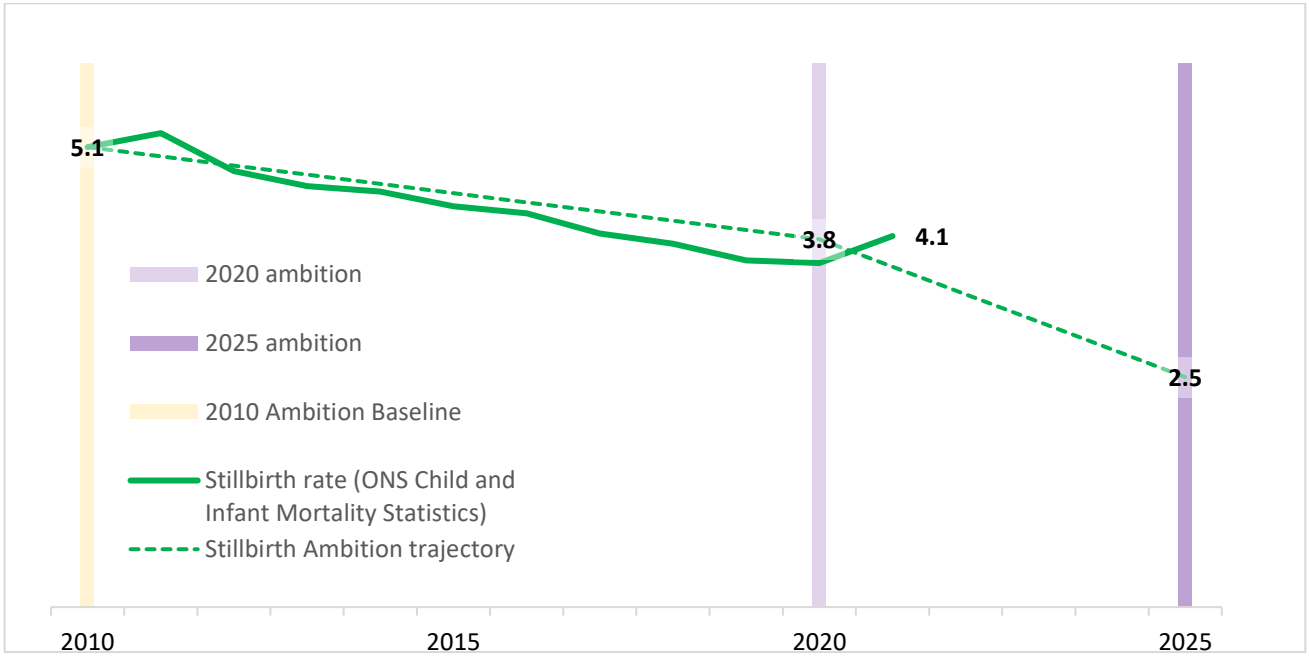
Progress towards the National Safety Ambition

In 2015, the Secretary of State for Health announced a national safety ambition, to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030, with a 20% reduction by 2020. In 2017, the ambition was extended to include a reduction in the rate of preterm births from 8% to 6%, while the date to achieve the ambition was also brought forward to 2025.

Office for National Statistics (ONS) data (shown in **Figure 1**, below) demonstrated a 25% reduction in stillbirths between 2010 and 2020 from 5.1 to 3.8 per thousand births, showing the 2020 milestone had been exceeded for stillbirths. It is not absolutely clear why stillbirth rates increased during the Covid pandemic, but it is likely that the direct effects of the Covid virus as well as the indirect impact of the pandemic on accessing maternity services played a part in the increase of the stillbirth rate from 3.8 per 1000 births in 2020 to 4.1 in 2021. The neonatal mortality rate also increased between 2020 and 2021 from 1.3 to 1.4 per 1000 live births at 24 weeks gestation and over. Despite the significant challenges faced by the NHS, these rates remain 19% and 30% lower (respectively) than in 2010. This equates to more than 900 families returning home with a healthy baby in 2021, than if the rates had remained unchanged from 2010.

The latest data on serious brain injury shows that rate of occurrence during or soon after birth fell by 9% between 2014 and 2019 to 4.25 per 1000 live births. Further reduction in the rate is needed to meet the 2025 ambition, a rate of 2.16 per 1000 live births.

Figure 1: National Maternity Safety Ambition – Summary of progress on stillbirths



Despite the achievements of the past few years and in light of the recent setbacks, there is clearly much more to be done to achieve the ambition by 2025. In particular, there is a need to address inequitable outcomes associated with ethnicity and levels of deprivation. MBRRACE-UK Perinatal Mortality Surveillance data show that the lowest stillbirth rates were for babies of White ethnicity from the least deprived areas, at 2.78 per 1,000 total births. The highest stillbirth rates were for babies of Black African and Black Caribbean ethnicity from the most deprived areas, at around 8 per 1,000 total births. The pattern is similar for neonatal deaths. Maternity services must do everything possible to mitigate against the wider social determinants of health in order toto continue to drive down the perinatal mortality rate.

Progress of the Saving Babies' Lives Care Bundle

The first version of the Saving Babies' Lives Care Bundle (SBLCBv1) was published in March 2016, and focused predominantly on reducing the stillbirth rate. An independent evaluation in 2018 showed a decrease in stillbirths in participating Trusts, concluding that despite being one of many concurrent interventions, it was highly plausible that SBLCBv1 had contributed to the reduction.

The evaluation helped inform the development of version 2 of the SBLCB (SBLCBv2). Launched in March 2019, SBLCBv2 aimed to go further in reducing stillbirth while also minimising unnecessary intervention. In answer to the expansion of the national safety ambition in 2017, it introduced Element 5 on reducing pre-term birth, and further decreasing perinatal mortality.

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. Published 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.

While SBLCBv3 would ideally be informed by the evaluation of SBLCBv2, this has been delayed due to the pandemic. Stakeholders agreed that improvements to best

practice couldn't be delayed when evidence is readily available for improvements to several elements. The evaluation of SBLCBv2 remains a priority and will be published in 2023. Findings will help inform the next iteration of SBLCB, which will also include important innovations from the Avoiding Brain Injury in Childbirth (ABC) collaboration along with anticipated updates to Green Top Guidance.
SBLCBv3 should not be implemented in isolation, but as one of a series of important interventions to help reduce perinatal mortality and preterm birth. It is important that providers continue to implement best practice care whenever possible, including by following NICE guidance and using the National Maternity and Neonatal Recommendations Register to assess their organisations' compliance with recommendations from confidential enquiries and other key national reports.

Implementing Version 3 of the Care Bundle

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.

Overseeing implementation

An implementation tool is being developed and will be available by May on the Maternity Transformation Programme's Future NHS platform. This tool will support providers to baseline current practice against SBLCBv3, agree a local improvement trajectory with their ICB, and track progress locally in accordance with that trajectory.

To reduce assurance burdens, national implementation surveys are being stepped down. Instead, trusts will be asked to use the implementation tool in 2 ways to ensure local oversight:

1. Track and demonstrate compliance to the Trust Board and ICBs. 'Full implementation' of the care bundle means completing all interventions for all 6 elements. Compliance will therefore be expressed as a percentage of completed interventions for each element, and across all elements.

2. Holding quarterly quality improvement discussions with the ICB. These provider-commissioner discussions should include, at a minimum:
   - 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.

While there will be no routine, deadline-based submissions of data to the national NHS England team for the purposes of assurance, the maternity team will review data stored on trust implementation tools on an ad-hoc basis to assess national progress in implementation.

Organisational roles and responsibilities

Successful implementation of SBLCBv3 requires providers, commissioners, and networks to collaborate successfully. National levers including NHS Planning Guidance, the NHS Standard Contract, and Safety Action 6 in the CNST Maternity Incentive Scheme will be updated in due course to reflect the following organisational responsibilities:

- **Providers** are responsible for implementing SBLCBv3, including baselining current compliance, developing an improvement trajectory, and reporting on implementation with their ICB as agreed locally. They are also responsible for submitting data nationally relating to key process and outcome measures for each element.
- **ICBs** are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery. Where there is unresolved clinical debate about a pathway, providers may wish to agree a variation to an element of the care bundle with their integrated care board. An integral part of ICSs, **LMNSs** are accountable to ICBs and have the system's maternity and neonatal expertise to support planning and provide leadership for improvement, facilitating peer support, and ensuring that learning from implementation and ongoing provision of SBLCBv3 is shared across the System footprint.
- **Clinical Networks and Regional Maternity teams** are responsible for providing support to providers, ICBs and LMNSs to enable delivery and achieve expected outcomes. It is important that specific variations from the pathways described within SBLCBv3 are agreed as acceptable clinical practice by their Clinical Network.

Principles to be applied when implementing Version Three

It has been necessary to restrict the scope of the SBLCBv3 to ensure it is deliverable. Nevertheless, it is just one of a series of important interventions to help reduce perinatal mortality and preterm birth. The following principles should be considered alongside implementing the Care Bundle.

Promoting Equity and Equality

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Equity in maternity and neonatal care means that all mothers and babies have a fair and just opportunity to attain the best health outcomes. To achieve equity and reduce inequalities, action must be universal, but with a scale and intensity proportionate to the level of disadvantage; this is known as 'proportionate universalism' (Marmot 2010).

England is one of the safest countries in the world to give birth. However, stillbirth rates and neonatal death rates are higher for some groups, such as women who are Black, Asian and those living in the most deprived areas. This emphasises the need for a continued focus to address these inequalities when implementing the care bundle. This includes ensuring that services reflect the needs of different groups, with support increasing as health inequalities increase. This requires use of quantitative and qualitative data on the local population and their health needs, along with co-production, to inform pathways and processes during implementation. Maternity and neonatal services also need to respond to each person's unique health and social situation — so that care is safe and personal for all.

Continuous improvement activity related to each element of the care bundle will routinely require consideration of access, experience, and outcomes in relation to protected characteristics and other variables influencing inequalities, such as factors related to deprivation. Pathways and processes should be changed, or additional supportive activity carried out, to address any inequity or inequalities identified.

While most people using maternity and perinatal services are women, the CQC Maternity Survey (2022) found that 0.65% of respondents stated that their gender was not the same as their sex registered at birth. Intersex, transgender, and non-binary people experiencing pregnancy and birth can experience particular health inequalities including poorer access and a lack of information and support in relation to their specific clinical and care needs within maternity services.

The role of Midwifery Continuity of Carer

Evidence shows that continuity models improve safety and outcomes; women who receive Midwifery Continuity of Carer (MCoC) are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to

experience preterm birth[1]. It is widely acknowledged that it is beneficial for women to know and form a relationship with the professionals caring for them[2]. It is a recurring theme within confidential enquiries that some groups in society struggle to access health care, and/or raise concerns.

The implementation of MCoC has been challenging particularly in the context of the pandemic and staffing shortages. Whilst the ambition remains for MCoC to be the default model of care for all women, currently there is not a national target timeframe for this to be achieved. In September 2022, NHS England published a letter asking trusts to review their safe staffing levels and decide to either: continue existing MCoC provision and continue to roll out; cease further rollout and continue with current levels of provision; or immediately suspend existing MCoC provision. MCoC remains an important intervention to address higher perinatal mortality rates in Black and Asian women and women from economically disadvantaged groups. In line with the CORE20PLUS5 strategy, Local Maternity and Neonatal Systems, regional and national colleagues will continue to support Trusts with sufficient staffing to focus rollout of MCoC to neighbourhoods with high numbers of women from Black, Asian, and Mixed ethnic groups, and women living in deprived areas, for whom CoC is linked to significant improvements in clinical outcomes[3] .

Informed choice and personalised care

Evidence shows that better outcomes and experiences, as well as reduced health inequalities, are possible when pregnant women can actively shape their care and support. Personalised care means pregnant women have choice and control over the way their care is planned and delivered, based on best available evidence, 'what matters' to them and their individual strengths, needs and preferences. Pregnant women receiving maternity care make informed decisions. They and their maternity professionals discuss evidence-based options together exploring preferences, benefits, risks, and consequences to enable a safe and positive experience.

For any given situation where a decision needs to be made, women are supported by their maternity professionals to understand their options, the benefits, harms and consequences of each. They have all the information they need for shared decision making and give consent, in line with the Montgomery ruling.

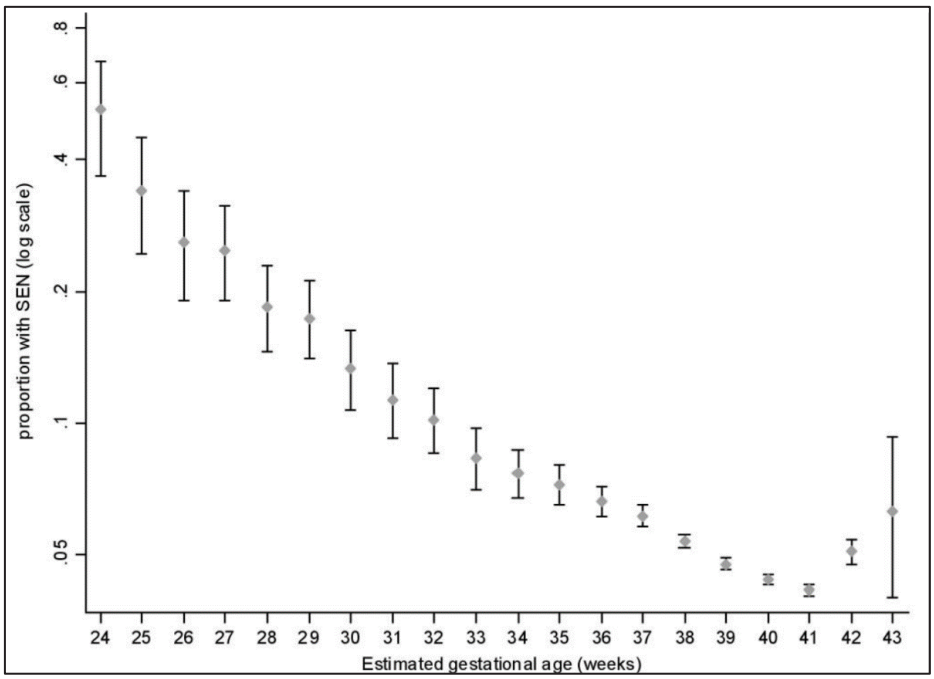
Linked to this principle, the following areas are of particular relevance to implementing a number of Elements in Version 3:

Informing women of the long-term outcomes of early term birth

One of the key interventions in elements 2 and 3 of the SBLCBv3 is offering early birth for women at risk of stillbirth. It is important that this intervention is not extended to pregnancies not at risk. The Avoiding Term Admissions Into Neonatal units (Atain) programme has identified that babies born at 37 – 38 weeks gestation were twice as likely to be admitted to a neonatal unit than babies born at later gestations. There are also concerns about long term outcomes following early term birth (defined as 37 and 38 weeks). These concerns relate to potential long term

adverse effects on the baby due to birth prior to reaching maturity, for example, the baby's brain continues to develop at term [4] Birth results in huge changes to the baby's physiology, for example, the arterial partial pressure of oxygen increases by a factor of three to four within minutes following birth and it is plausible that earlier exposure to these changes could alter long term development of the child's brain and data exist to support this possibility[4]. One example is the risk that the child will subsequently have a record of special educational needs (SEN). The risk of this outcome is about 50% among infants born at 24 weeks of gestational age and it progressively falls with increasing gestational age at birth, only to bottom out at around 40 – 41 weeks.

Figure 2: Prevalence of special educational needs by gestation at birth[4].



After adjusting for maternal and obstetric characteristics and expressed relative to birth at 40 weeks, the risk of SEN was increased by 36% (95% CI (confidence interval)) 27 – 45) at 37 weeks, by 19% (95% CI 14 – 25) at 38 weeks and by 9% (95% CI 4 – 14) at 39 weeks. The risk of subsequent SEN was 4.4% at 40 weeks. Hence, assuming causality, there would be one additional child with SEN for every 60 inductions at 37 weeks, for every 120 inductions at 38 weeks, and for every 250 inductions at 39 weeks compared with the assumption that they would otherwise have delivered at 40 weeks[4]. Recent data from the UK Millennium Cohort Study confirmed the finding that children born at early term gestational ages (37 to 38 weeks) were more likely to fail to achieve the expected level of attainment in primary school but, interestingly, there was no association between early term birth and poorer attainment at secondary school [5.] Moreover, as the current data are based on the observed gestational age at birth, the negative associations with later outcome may be explained by the factors that determined early term birth rather than a direct effect of gestational age. However, induction of labour prior to 39 weeks should continue to be considered as a significant medical intervention which requires appropriate justification.

Considering how the risks of induction of labour change with gestational age

For uncomplicated pregnancies NICE guidance on induction of labour should be followed. In all cases of induction, it is important women receive a clear explanation about why they are being offered induction and that the risks, benefits and alternatives are discussed.

At 39+0 weeks gestation and beyond, induction of labour is not associated with an increase in caesarean section, instrumental vaginal birth, fetal morbidity or admission to the neonatal intensive care unit[6]. The NICE guidance and data from the ARRIVE study[6] provide contradictory evidence as to whether induced labours are associated with a longer hospital stay or more painful labours. Induction of labour may also increase the workload of the maternity service which has the potential to impact the care of other women.

Safe and Healthy Pregnancy Information' to enable women and their families to make informed choices regarding their health and reducing risks to their babies.

It is important that women have access to high quality information before and during their pregnancy to enable them to reduce risks to their baby. The Office for Health Inequalities and Disparities and Sands have developed some key messages:

Figure 2: Summary of Safe and Healthy Pregnancy key messages

Pre-pregnancy:

- Choose when to start or grow your family by using contraception.
- Consult with your GP if taking medication for long-term conditions (e.g., diabetes, hypertension, epilepsy) as your medication may have to change prior to pregnancy.
- Eat a healthy balanced diet and be physically active to enter pregnancy at a healthy weight.
- Take a daily supplement of 400 micrograms (400 µg) folic acid before conception (some women will require a higher dose of 5mg as advised by a healthcare professional).
- Ensure that you are up to date with routine vaccinations e.g., measles, rubella, Coronavirus (Covid 19), flu.
- Find out if you think you or your partner could be a carrier for a genetic disorder.
- Stop smoking and/or exposure to second hand smoke.
- Reduce/stop alcohol consumption.

During pregnancy:

- Continue to take 400 micrograms (400 µg) folic acid until the 12th week of pregnancy (some women will require a higher dose of 5mg as advised by a healthcare professional).
- Pregnant women should have 10µg of vitamin D a day.
- You may be advised to take aspirin from 12 weeks of pregnancy.
- Alcohol – the safest advice is to not drink alcohol, if you are concerned, talk to your midwife, or doctor and help and advice is available for you.
- Don't smoke and avoid second hand smoke; support is available to help with this.
- Do tell your midwife if you use illegal street drugs or other substances, help is available for you.
- Eat healthily and be physically active to maintain a healthy weight while pregnant.
- Maintain oral hygiene. Free dental care is available to all pregnant women and up to a year after the birth.
- Recommended vaccinations and boosters: seasonal flu; pertussis (whooping cough); Coronavirus (Covid-19)
- Always check with your pharmacist, midwife of doctor about medicines and therapies used in pregnancy, even if you have taken them for a long time on prescription or think they are harmless.
- Avoid contact with people who have infectious illnesses, including diarrhoea, sickness, childhood illnesses or any rash-like illness.
- Reduce the risk of Cytomegalovirus (CMV) Toxoplasmosis, Monkeypox infections etc.,
- Attend all antenatal appointments.
- Contact the maternity service promptly if you are worried about reduced fetal movements, vaginal bleeding, watery or unusual discharge, signs of pre-eclampsia or itching. Don't wait!
- In later pregnancy (after 28 weeks), it is safer to go to sleep on your side than on your back.

Appendix B provides more detailed information on how women can plan, prepare, and look after themselves before and during pregnancy. This information is also available at NHS.uk and the Safer Pregnancy website developed by Sands.

Working within Networks for more specialist care

In a number of specialist fields, Maternity services are working within networks so that women and babies with complex needs have consistent access to the most specialist care, while also encouraging local expertise, and ensuring that care remains as close as possible to home.

While a networked model has been in place for a number of years in fetal medicine and in neonatal care, NHS England announced the creation of 14 Maternal Medicine Networks, which are now in operation across England.

All providers should be engaging in these networks and contributing to the development of joint protocols and ways of working. In this vein, new elements of

best practice shouldn't be implemented in isolation locally. Providers should consider what implications or opportunities this presents for ways of working agreed within wider Maternal Medicine, Fetal Medicine, or Neonatal Operational Delivery Networks.

Implementing relevant NICE guidance

Integrated Care Systems/ Boards (ICS/ICBs) are under an obligation in public law to have regard for NICE guidance and to provide clear reasons for any general policy that does not follow NICE guidance.

Providers and commissioners are encouraged to implement NICE guidance relating to antenatal, intrapartum and postnatal care. In particular, implementation of the NICE guidance on the management of diabetes in pregnancy, hypertension in pregnancy and multiple pregnancy, along with service provision for women with complex social factors are key to addressing some of the most significant contributors to perinatal mortality.

Best practice care in the event of a stillbirth or neonatal death

Despite the reduction in stillbirth rates sadly thousands of parents each year will experience the devastation of their baby dying before, during or shortly after birth. A best practice pathway for the clinical management of women experiencing stillbirth is available on the North West Coast (NWC) Strategic Clinical Network website.

Sands have developed a National Bereavement Care Pathway (NBCP) to help ensure that all bereaved parents are offered equal, high quality, individualised, safe and sensitive bereavement care when they experience pregnancy loss or the death of a baby. The NBCP is available at www.nbcpathway.org.uk.

The national Perinatal Mortality Review Tool (PMRT) is used to support hospital reviews by providing a standardised, structured process so that what happened at every stage of the pregnancy, birth and after, from booking through to bereavement care is carefully considered by staff reviewing care. This online tool may help staff understand why a baby has died and whether there are any lessons to be learned to saves future lives.

Continuous improvement and Maternity and Neonatal Services

As part of the update of SBLCBv3, we are maintaining an approach of continuous improvement. Within each element the focus is on a small number of outcomes with fewer process measures. Implementation of the elements will require a more comprehensive evaluation of each organisation's processes and pathways and an understanding of where improvements can be made.

Each organisation will be expected to look at their performance against the outcome measures for each element with a view to understanding where improvement may be required. We have provided suggested areas for improvement within each element, but these lists are not meant to be exhaustive.

There is an expectation that as well as reporting on the organisation's implementation of each element, there will be complimentary reporting of ongoing improvement work (with associated detail of interventions, and improvement in process measures and outcomes) within each element. An integral component of this improvement work will be a focus on learning from incidents or enquiry. Harm may have occurred in relation to implementation of or non-compliance with an element described in the care bundle. The use of the Perinatal Mortality Review Tool will complement the investigation and learning in this context.

Element 1: Reducing smoking in pregnancy.

Element description
Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing and ensuring in-house treatment from a trained tobacco dependence adviser[a] is offered to all pregnant women who smoke, using an opt-out referral process.

Interventions	
1.1	CO testing offered to all pregnant women at the antenatal booking and 36-week antenatal appointment.
1.2	CO testing offered at all other antenatal appointments to groups identified within NICE Guidance NG209.
1.3	Whenever CO testing is offered, it should be followed up by an enquiry about smoking status with the CO result and smoking status recorded.
1.4	Instigate an opt-out referral for all women who have an elevated CO level (4ppm or above), who identify themselves as smokers or have quit in the last 2 weeks for treatment by a trained tobacco dependence treatment adviser (TDA) within an in-house tobacco dependence treatment service.
1.5	Nicotine replacement therapy (NRT) should be offered to all smokers and provision ensured as soon as possible.
1.6	The tobacco dependence treatment includes behavioural support and NRT, initially 4 weekly sessions following the setting of the quit date then regularly (as required, however as a minimum monthly) throughout pregnancy to support the woman to remain smokefree.
1.7	Feedback is provided to the pregnant woman's named maternity health care professional regarding the treatment plan and progress with their quit attempt (including relapse). Where a woman does not book or attend appointments there should immediate notification back to the named maternity health care professional.
1.8	Any staff member using a CO monitor, should have appropriate training on its use and discussion of the result.
1.9	All staff providing maternity care to pregnant women should receive training in the delivery of Very Brief Advice (VBA) about smoking, making an opt-out referral and the processes within their maternity pathway (e.g., referral, feedback, data collection).
1.10	Individuals delivering tobacco dependence treatment interventions should be fully trained to NCSCT standards
Continuous learning	
1.11	When analysing patient safety incidents, maternity care providers should review smoking status throughout pregnancy and determine whether the appropriate pathway of care for this was followed.
1.12	Maternity providers should regularly review (a minimum of quarterly) their smoking-related data to understand performance and develop improvement plans (this list is designed to provide a steer and is not exhaustive): A. Identification of women who smoke – Determine any factors that would optimise CO testing rates and enquiry about smoking status, from both the provider/pathway and

[a] The role of tobacco dependence adviser (TDA) is also known under alternative names, including smoking cessation adviser, stop smoking adviser and smoking cessation practitioner. Irrespective of role name or grade, these roles are underpinned by appropriate training to deliver tobacco dependence treatment interventions (see 1.10).

service-user perspective and make changes to pathways and processes as appropriate.

B. Training of staff – Ensure all staff involved in identification, referral and treatment of women who smoke, and provision of VBA are appropriately trained.
C. Engagement – Determine and address any barriers to engagement with treatment services or compliance with treatment interventions from both the provider/pathway and service-user perspective.
D. Referral – Determine and address any factors that are influencing opt-out referral, from both the provider/pathway perspective and service-user perspective.
E. Quit rates – Consider the pathway holistically to determine which steps can be optimised to facilitate quit attempts and successful quits.
F. Relapse – Determine factors that are contributing to relapse and whether additional support or changes to pathways may address these.
G. Inequalities – Consider all the above by protected characteristics and other variables influencing inequalities, such as factors related to deprivation. Make changes to pathways and processes, or carry out additional supportive activity, to address any inequity or inequalities identified.

1.13 In order to monitor quality and effectiveness of pathways, maternity services should set ambitions for their pathway with regular review (a minimum of quarterly) of data and targeted quality improvement work to ensure they are being achieved.

1.14 Based on highly performing areas, stretching ambitions to achieve effective implementation of the full Element may include:

A. 95% of women where CO measurement and smoking status is recorded at their booking appointment.
B. 95% of women where CO measurement and smoking status is recorded at their 36-week appointment.
C. 95% of smokers have an opt-out referral at booking for treatment by a TDA within an in-house service.
D. 85% of all women referred for tobacco dependence treatment engage with the programme (have at least one session and receive a treatment plan).
E. 60% of those referred for tobacco dependence treatment set a quit date.
F. 60% of those setting a quit date successfully quit at 4 weeks.
G. At least 85% of quitters should be CO verified.

1.15 Individual providers should examine their outcomes in relation to other providers or systems with similar smoking prevalence or populations. National benchmarking is available through the Maternity Services Dashboard and will be available to ICS/LMS as the Tobacco dependence patient level collection is established.

Process Indicators	Outcome indicators
1a. Percentage of women where there is a recorded of: 1.a.i. CO measurement at booking appointment 1.a.ii. CO measurement at 36-week appointment 1.a.iii. Smoking status** at booking appointment 1.a.iv. Smoking status** at 36-week appointment 1b. Percentage of smokers* that have an opt-out referral at booking to an in-house tobacco dependence treatment service.	1d. Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks. 1e. Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks.

1c. Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date.	
* a “smoker” is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). ** Smoking status relates to the outcome of the CO test (>4ppm) and the enquiry about smoking habits.	

Rationale

Smoking increases the risk of pregnancy complications, such as stillbirth, preterm birth, miscarriage, low birthweight and sudden infant death syndrome (SIDS). Whether or not a woman smokes during her pregnancy has a far-reaching impact on the health of a child throughout their life. Whilst a number of studies have found that the risk of a number of poor pregnancy outcomes can be reduced to that of a non-smoker if a successful quit is achieved early in pregnancy. Others show increased risk with any smoking in pregnancy, and increasing risk with continued smoking. This reinforces the need to support women to quit smoking as early as possible in pregnancy to reduce the risk of poor pregnancy outcomes.

Smoking at time of delivery (SATOD) rates have declined since the release of previous versions of the care bundle, albeit at a slower rate than required to meet the government’s 2022 national ambition of 6% (and ultimately a smokefree generation by 2030). Although there is significant variation, the national SATOD rate was 9.1% in 2021/22, demonstrating that further work to reduce smoking during pregnancy is required.

This element is evidence-based and provides a practical approach incorporating the NHS Long Term Plan pathway for a smokefree pregnancy and core elements of NICE guidance. It builds on the previous version of the care bundle’s focus on CO testing to support identification of smokers, with referral to in-house tobacco dependence treatment services and ensuring that effective treatment is available to all pregnant women who smoke. Research indicates that pregnant women expect to be asked about smoking by their maternity care provider and if the issue is not raised it can be incorrectly interpreted that smoking is not a problem for the pregnancy. Learning from front line services demonstrates a need for a treatment offer that is part of the maternity pathway and the woman’s maternity journey. This should include processes for referral, treatment, and feedback that are timely and optimise engagement, with dedicated leadership within the maternity service that has oversight of the full pathway. To support this, consistent messages should be given from all clinicians who the woman comes into contact with during pregnancy.

This element impacts positively on the other care bundle elements. Reducing smoking in pregnancy will reduce instances of fetal growth restriction, intrapartum complications and preterm birth. This demonstrates the complementary and

cumulative nature of the care bundle approach.

This element also reflects the wider prevention agenda, impacting positively on the health of babies and the long-term outcomes for families and society.

Implementation guidance

Key factors for effective implementation include:

In-house pathways: Clinical leadership, delivery and oversight of the service and its outcomes remains with maternity. Services are considered as in-house when the woman's care for treating their tobacco dependence remains within the maternity service i.e., is not referred out to another provider like a local authority stop smoking service[b].

Opt-out referral pathways: Effective pathways are in place to ensure that as soon as a smoker is identified there is rapid referral to the tobacco dependence adviser on an opt-out basis. Immediate referral and consultation with the tobacco dependence adviser is the ideal, but as a minimum the woman should be contacted within 1 working day and seen (ideally face-to-face) by a TDA within 5 working days.

Nicotine Replacement Therapy: Pathways should ensure provision of long and short acting nicotine replacement therapy at the earliest opportunity to facilitate quitting at an optimal time to improve perinatal outcomes and maximise engagement with referral and treatment services. Ideally this should be at the earliest opportunity when maternity care has commenced, even if prior to a formal booking appointment.

Recent Quitters: The definition of a smoker includes those who have smoked within the past 2 weeks. However, it is good clinical practice to offer support to all women who have quit smoking since conception given that changes in first trimester pregnancy symptoms may affect smoking habits.

CO testing: All pregnant women should be offered CO testing at the antenatal booking and 36-week antenatal appointment, with testing offered at all other antenatal appointments after booking to groups identified within NICE guidance NG209. All staff providing antenatal care should have access to a CO monitor and training in how to use it and interpretation of results. Appropriate procurement processes should be in place for obtaining CO monitors and associated consumables (for example, tubes and batteries).

CO verified non-smokers at 4 weeks: this corresponds to the 4-week quit that is regularly captured by stop smoking services and is a comparable indicator that can be used to assess the quality of the intervention.

[b] In-reach services where a third party, such as the local authority stop smoking service, provide services as part of the maternity team with the patient staying under the care and management of the maternity service would count as in-house.

CO Levels: The most common reason for a raised CO level is smoking, however exposure may come from other sources such as second-hand smoke, faulty boilers, faulty heating/cooking appliances or car exhausts (and can happen at home or at the workplace). If women have raised CO levels and are non-smokers environmental exposure from a source in the home should be considered and the women should be advised to contact the Gas Emergency Line on 0800 111 999 for further advice. Referral for further medical advice should be sought if symptoms are consistent with CO poisoning. For NICE guidance on air pollution and vulnerable groups see recommendation 1.7.7. in NICE guidance NG70.

Tobacco dependence treatment: Following an initial appointment where a quit is initiated, weekly face-to-face appointments with the tobacco dependence adviser should take place for at least four weeks after the quit date is set followed by regular appointments (as required, but as a minimum monthly) throughout the pregnancy. Treatment includes behavioural support and a combination of long and short acting NRT. A recommended delivery model pathway is available on the Prevention Programme's NHS Futures webpages.

Recording data: There should be routine recording of the CO test result and smoking status for each pregnant woman on maternity information systems (MIS), reporting through to the tobacco dependence patient level collection and, where appropriate, the Maternity Service Data Set (MSDS).

Review and act upon local data: Use tools available (for example, the Maternity Services Dashboard's Clinical Quality Improvement Metrics) to review the current situation with smoking and data quality, compare with other nearby or demographically similar Trusts and identify if your Trust is an outlier and/or where improvements can be made.

Vaping: The Royal College of Midwives states that "If a pregnant woman who has been smoking chooses to use an e-cigarette (vaping) and it helps her to quit smoking and stay smokefree, she should be supported to do so". There is also more information available via the Smoking in Pregnancy Challenge Group.

Systemwide action: Action to help pregnant women stop smoking should be supplemented by wider activity across the local system to reduce smoking rates among women, partners and other household or family members. This includes reducing smoking rates in women pre-conception, in addition to working with neonatal care and health visiting services to ensure there are links with local stop smoking services to support quitting postnatally. Local tobacco control networks alongside LMNSs, ICSs and regional teams should be able to support with integrating activity to reduce smoking prevalence in all population groups which can impact on reducing maternal smoking.

Implementation resources

Resources: The NHS Long Term Plan delivery model for smokefree pregnancy provides details of the pathway and treatment programme that should be delivered in this element. This can be found on the NHS Futures webpages with additional resources and shared materials.

Information and links to further resources are also available from the Maternal and Neonatal Health Safety Collaborative. Action on Smoking and Health (ASH) produce annual briefings for Integrated Care Systems showing the impact of smoking, using data at ICS level. The briefings include national data on maternal smoking and other clinical areas broken down to ICS level, and signpost to current resources and information.

The Smoking in Pregnancy Challenge Group produces a range of resources and information for health professionals working to reduce maternal smoking. Those with an interest can also join the Smokefree Pregnancy Information Network administered by ASH, which will provide up to date information throughout the year. For more information contact admin@smokefreeaction.org.uk.

Training - tobacco dependence adviser: Those providing tobacco dependence treatment interventions are specialist advisers and should have successfully completed NCSCT stop smoking practitioner training (or local training to the to the required NCSCT Standard) and a speciality course for smoking in pregnancy (requires registration and log-in) including opportunities to observe good practice; to ensure they have the knowledge and skills to deliver the treatment. Tobacco dependence advisers should receive annual refresher training. NCSCT derived competency frameworks are also available on NHS Futures.

Training - all maternity health professionals: All multidisciplinary staff providing maternity care for pregnant women should receive training on how to use a CO monitor (see CO testing section), the delivery of Very Brief Advice (VBA) about smoking, making an opt-out referral and the processes within their maternity pathway (e.g., referral, feedback, data collection). Annual refresher training should align with the Core Competency Framework. Very Brief Advice on smoking in pregnancy training can be accessed via NCSCT e-learning or HEE eLearning for Health Hub.

Element 2: Fetal Growth: Risk assessment, surveillance, and management

Element description
Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).
Interventions
Reduce the risk FGR where possible. 2.1 Assess all women at booking to determine if prescription of Aspirin is needed using an appropriate algorithm agreed with the local ICSs. 2.2 Recommend vitamin D supplementation to all pregnant women using an appropriate algorithm agreed with the local ICS. 2.3 Assess smoking status and manage findings as per Element 1. **Monitor and review the risk of FGR throughout pregnancy.** 2.4 Perform a risk assessment for FGR by 14 weeks gestation using an agreed pathway (for example, Appendix D). In multiparous women risk assessment should include the calculation of previous birthweight centiles. The pathway and centile calculator used should be agreed by both the local ICSs and the regional maternity team. 2.5 During risk assessment trusts are encouraged to use information technology platforms to facilitate accurate recording and correct classification of risk by staff. No single provider is recommended, but technology platforms should not prevent compliance with Element 2 guidance and should follow national recommendations on the use of fundal height and fetal growth charts. 2.6 As part of the risk assessment for FGR blood pressure should be recorded using a digital monitor that has been validated for use in pregnancy 2.7 Women who are designated as high risk for FGR (for example see Appendix D) should undergo uterine artery Doppler assessment between 18+0 to 23+6 weeks gestation. 2.8 The risk of FGR should be reviewed throughout pregnancy and maternity providers should ensure that processes are in place to enable the movement of women between risk pathways dependent on current risk. 2.9 When an ultrasound-based assessment of fetal growth is performed Trusts should ensure that robust processes are in place to review which risk pathway a woman is on and agree a plan of ongoing care. 2.10 Women who are at low risk of FGR following risk assessment should have surveillance using antenatal fundal height (FH) measurement before 28+6 weeks gestation. Measurements should be plotted or recorded on charts by clinicians trained in their use. 2.11 Staff who perform FH measurement should be competent in measuring, plotting (or recording), interpreting appropriately and referring when indicated. Only staff who perform FH measurement need to undergo training in FH measurement. 2.12 Women who are undergoing planned serial scan surveillance should cease FH measurement after serial surveillance begins. FH measurement should also cease if women are moved onto a scan surveillance pathway in later pregnancy for a developing pregnancy risk (e.g., recurrent reduced fetal movements). 2.13 Women who are at increased risk of FGR should have ultrasound surveillance of fetal growth at 3-4 weekly intervals until delivery (see RCOG guidance and Appendix D)

Provide the correct surveillance when FGR is suspected and delivery at the right time.

2.14 When FGR is suspected an assessment of fetal wellbeing should be made including a discussion regarding fetal movements (see Element 3) and if required computerised CTG (cCTG). A maternal assessment should be performed at each contact this should include blood pressure measurement using a digital monitor that has been validated for use in pregnancy and a urine dipstick assessment for proteinuria. In the presence of hypertension NICE guidance on the use of PlGF/sflt1 testing should be followed.

2.15 Umbilical artery Doppler is the primary surveillance tool for FGR identified prior to 34+0 weeks and should be performed as a minimum every 2 weeks. Maternity care providers caring for women with early FGR identified prior to 34+0 weeks should have an agreed pathway for management which includes fetal medicine network input (for example, through referral or case discussion by phone). Further information is provided in Appendix D.

2.16 When FGR is suspected, the frequency of review of estimated fetal weight (EFW) should follow the guidance in Appendix D or an alternative which has been agreed with local ICSs following advice from the provider's Clinical Network and/or regional team.

2.17 Risk assessment and management of growth disorders in multiple pregnancy should comply with NICE guidance or a variant that has been agreed with local ICSs following advice from the provider's Clinical Network

2.18 All management decisions regarding the timing of FGR infants and the relative risks and benefits of iatrogenic delivery should be discussed and agreed with the mother. When the estimated fetal weight (EFW) is <3rd centile and there are no other risk factors (see 2.20), initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation.

2.19 In fetuses with an EFW between the 3rd and <10th centile, delivery should be considered at 39+0 weeks. Birth should be achieved by 39+6 weeks. Other risk factors should be present for birth to be recommended prior to 39 weeks (see 2.20)

2.20 Fetuses who demonstrate declining growth velocity from 32 weeks' gestation are at increased risk of stillbirth from late onset FGR. Declining growth velocity can occur in fetuses with an EFW >10th centile. Evidence to guide practise is limited and guidance (see Appendix D) is currently based on consensus opinion. In fetuses with declining growth velocity and EFW >10th centile the risk of stillbirth from late onset FGR should be balanced against the risk of late preterm delivery. In infants where declining growth velocity meets criteria (see Appendix D) delivery should be planned from 37+0 weeks unless other risk factors are present. Risk factors that should trigger review of timing of birth are: reduced fetal movements, any umbilical artery or middle cerebral artery Doppler abnormality, cCTG that does not meet criteria, maternal hypertensive disease, abnormal sFlt1: PlGF ratio/free PlGF or reduced liquor volume. Opinion on timing of birth for these infants should be made in consultation with specialist fetal growth services or fetal medicine services depending on Trust availability.

Continuous learning
Learning from excellence and error, or incidents 2.21 Trusts should determine and act upon all themes related to FGR that are identified from investigation of incidents, perinatal reviews, and examples of excellence. 2.22 Trusts should provide data to their Boards and share this with their ICS in relation to the following: a) Percentage of babies born <3rd birthweight centile >37+6 weeks' gestation. b) Ongoing case-note audit of <3rd birthweight centile babies not detected antenatally and born after 38+0 weeks, to identify areas for future improvement (at least 20 cases per year, or all cases if less than 20 occur). c) Percentage of babies born >39+6 and <10th birthweight centile to provide an indication of detection rates and management of SGA babies. d) Percentage of babies >3rd birthweight centile born <39+0 weeks gestation 2.23 Use the PMRT to calculate the percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue. Trusts should review their annual MBRRACE perinatal mortality report and report to their ICS on actions taken to address any deficiencies identified. 2.24 Individual Trusts should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements. 2.25 Individual Trusts should provide data on the distribution of FGR outcomes with relation to maternal reported ethnicity. 2.26 Maternity providers are encouraged to focus improvement in the following areas: a) Appropriate risk assessment for FGR and other conditions associated with placental dysfunction and robust referral processes to appropriate care pathways following this. b) Appropriate prescribing of aspirin in line with this risk assessment in women at risk of placental dysfunction. c) Review of ultrasound measurement quality control. Trusts are encouraged to comply with BMUS guidance on audit and continuous learning with relation third trimester assessment of fetal wellbeing d) Trusts will share evidence of these improvements with their Trust Board and ICS and demonstrate continuous improvement in relation to process and outcome measures.

Process indicators	Outcome indicators
2a. Percentage of pregnancies where a risk status for FGR is identified and recorded at booking. (This should be recorded on the provider's MIS and included in the MSDS submission to NHS Digital once the primary data standard is in place.) 2b. Percentage of pregnancies where an SGA fetus is antenatally detected, and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital.	2d. Percentage of babies <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR). 2e. Percentage of babies >3rd birthweight centile born <39+0 weeks gestation

2c. Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT).	

Rationale

There is strong evidence linking undiagnosed FGR to stillbirth [7] [8] . Therefore, antenatal detection of growth restricted babies is vital and has been shown to reduce stillbirth risk significantly because it gives the option to consider timely delivery of the

Update for version 3

The previous versions of this element have made a measurable difference to antenatal detection of FGR across England. The last version resulted in the widespread uptake of uterine artery Doppler screening for the first time outside of tertiary centres in England and a significant improvement in the quality of care provided to pregnant women in all types of maternity setting. By introducing more nuanced risk assessment we have sought to reduce intervention whilst maintaining the focus on delivering babies at risk. In this version we seek to clarify this further so that all members of staff caring for women have clear, practical guidance. Our new title **"Fetal Growth: Risk assessment, surveillance, and management."** reflects this.

Important changes in this update

- Following a review by the Chief Scientific Office only digital measurement of blood pressure is now recommended for risk assessment and monitoring of FGR.
- The previous definition of suboptimal fetal growth of <20g/day in the late third trimester has been too didactically interpreted and has therefore been removed. A prospectively tested method of identifying suboptimal fetal growth in babies >10th centile remains elusive so suggestion for replacement is contained within Appendix D.
- National guidance from RCOG on FH and EFW charts remains awaited so Trusts may continue to use a range of charts. However, charts that are appropriate for plotting EFW and birthweight are recommended for reporting to reduce discrepancies.

The risks and benefits of early term delivery

It is well recognised that preterm birth is associated with both short and long-term sequelae for the infant. The distinction between preterm and term birth is based on the 37+0-week threshold. However, like any threshold on a continuous scale, the separation into two groups is arbitrary. Some of the risks associated with preterm birth are still apparent at 'early term' gestation, defined as 37 and 38 weeks. The

association with short term morbidity can be captured by analysing the risk of admission of the infant to the neonatal unit. One of the best UK analyses was published by Stock et al[9] where they compared the risk of neonatal unit admission associated with induction of labour at the given week with the comparison group of all women delivered at a later week of gestation.

Figure 3: Neonatal unit admission according to week of gestational age, comparing induction of labour versus expectant management[10].

• Week of gestational age	• Neonatal admission • per 1,000		• Adjusted odds ratio (95% CI)
•	• Induction of labour	• Delivered later	•
• **37**	• 176	• 78	• 2.01 (1.80-2.25)
• **38**	• 113	• 74	• 1.53 (1.41-1.67)
• **39**	• 93	• 73	• 1.17 (1.07-1.20)
• **40**	• 80	• 73	• 1.14 (1.09-1.20)
• **41**	• 66	• 84	• 0.99 (0.93-1.05)

However, delivery of the baby early prevents the subsequent risk of antepartum stillbirth. As antepartum stillbirth is the major single cause of perinatal death at term, earlier delivery will prevent perinatal death. The same paper also reported data on the risk of extended perinatal mortality associated with earlier induction.

Figure 4: Extended perinatal mortality according to week of gestational age, comparing induction of labour versus expectant management[11].

• Week of gestational age	• Extended perinatal mortality • per 1,000		• Adjusted odds ratio (95% CI)
•	• Induction of labour	• Delivered later	•
• **37**	• 0.9	• 2.3	• 0.15 (0.03-0.68)
• **38**	• 0.8	• 2.0	• 0.23 (0.09-0.58)
• **39**	• 0.6	• 1.9	• 0.26 (0.11-0.62)

• **40**	• 0.8	• 1.8	• 0.39 (0.24-0.63)
• **41**	• 0.7	• 2.2	• 0.31 (0.19-0.49)

The dilemma is that early term delivery reduces the risk of a very rare but serious adverse event (stillbirth or neonatal death) while increasing the risk of much more common but less severe adverse events. Decision-making balances the risks of causing mild harm to relatively large numbers of infants in order to prevent serious harm to a relatively small number. For example, using the data above, at 37 weeks, 10 inductions will lead to one additional baby being admitted for neonatal care, but it will require more than 700 inductions to prevent each perinatal death. Hence, current care is aimed at targeting early term induction to those who are at increased risk of perinatal death.

Implementation

Element 2 recognises that there remains a range of expert opinions on some interventions and allows some flexibility in the choice of pathways. The pathways in Appendix D have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed with local ICSs following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care.

To implement this element effectively Trusts should:

- ensure that all pregnant women are assessed for their risk of placental dysfunction with the associated potential for FGR in early pregnancy.
- ensure that a robust training programme and competency assessment is included in any processes designed to detect an FGR fetus, for example measurement of FH, use and interpretation of charts, ultrasound scanning for growth and uterine artery Doppler measurement to detect early onset FGR.
- agree which charts will be used antenatally to measure fetal growth and ensure that these charts are based on EFW reference ranges.
- Electronic ultrasound database and MIS suppliers should provide EFW centile charts and birthweight centile charts with reference curves for the 3rd and 10th centiles. Providers using paper EFW centile charts and birthweight centile charts should ensure that the charts have reference curves for the 3rd and 10th centiles. Actual birthweight of the baby should be assessed using the same methodology used antenatally i.e., based on EFW reference, not a birthweight reference scale to ensure consistency.

Although overdue for revision the RCOG SGA guideline[12] advises that fetal biometry surveillance scans need not be performed more frequently than every three weeks unless potential abnormalities in fetal growth are identified, in which case scans may need to be performed more frequently (see intervention 2.7) and it is not anticipated that this will change in planned updates. Ultrasound surveillance of biometry in at risk fetuses should continue until delivery.

Providers with capacity may wish to use assessment of Middle Cerebral Artery (MCA) Doppler pulsatility indices (PI) in addition to umbilical artery Doppler to help identify and act upon potential fetal compromise in later pregnancy (after 34+0 weeks), but evidence to guide practise is due in the next 12-24 months and Trusts may wish to consider waiting for this before implementation.

Version two of the MSDS enables the recording of antenatally detected SGA using local criteria and the recording of fetal biometry, EFW and birthweight. Providers who submit these data via MSDS will be able to compare their performance with peer organisations using metrics developed by NHS Digital and available as part of the Maternity Data Viewer's Data Access Environment, which is being developed during 2019.

Trusts submitting data to the MSDS will be able to view the percentage of <10th centile and <3rd centile births in each gestational week of the third trimester in their unit annually. These data will allow Trusts to compare outcomes with similar units and to monitor the performance of their SGA and FGR detection programmes over time.

Element 3: Raising awareness of reduced fetal movement.

Element description
Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.
Interventions
3.1 Information from practitioners, accompanied by an advice leaflet (for example, RCOG or Tommy's leaflet available in multiple languages) on RFM, based on current evidence, best practice and clinical guidelines, to be available to all pregnant women by 28+0 weeks of pregnancy and FM discussed at every subsequent contact. 3.2 Use provided checklist (on page 33) to manage care of pregnant women who report RFM, in line with national evidence-based guidance (for example, RCOG Green-Top Guideline 57).
Continuous learning
3.3 Maternity care providers should examine their outcomes in relation to the interventions and trends and themes within their own incidents where the presentation and/or management of RFM is felt to have been a contributory factor. 3.4 Maternity care providers should ensure whether inequalities (particularly relating to ethnicity and deprivation) are being adequately addressed when there are incidents relating to presentation with or management of RFM. 3.5 Individual Trusts should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements. 3.6 Maternity providers are encouraged to focus improvement in the following areas: a) Signposting to information regarding RFM to pregnant women by 28+0 weeks of pregnancy. b) Appropriate care according to local guidance in relation to risk stratification and ongoing care for women presenting with RFM. c) Ensuring appropriate use of induction of labour when RFM is the only indication (for example, induction of labour for RFM alone is not recommended prior to 39+0 weeks).

Process indicators	Outcome indicators
3a. Percentage of women who attend with RFM who have a computerised CTG.	3c. Percentage of stillbirths which had issues associated with RFM management identified using PMRT.

3b. Proportion of women who attend with recurrent RFM* who had an ultrasound scan to assess fetal growth.	3d. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation.

Rationale

Enquiries into stillbirth have consistently described a relationship between episodes of RFM and stillbirth, ranging from the 8th CESDI report published in 2001[13] to the MBRRACE-UK reports into antepartum and intrapartum stillbirths respectively[14 15] . In all these case reviews unrecognised or poorly managed episodes of RFM have been highlighted as contributory factors to avoidable stillbirths. In addition, a growing number of studies, including an individual patient data meta-analysis have confirmed a correlation between episodes of RFM and stillbirth [16 17]. This relationship increases in strength when women have multiple episodes of RFM in late pregnancy (after 28 weeks' gestation). There is no accepted definition of what recurrent RFM means; one region of the UK has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation*. The relationship between RFM and stillbirth appears to be mediated by placental insufficiency [18,19,20].

This element and its interventions are aligned with the RCOG Green-Top Guideline 57 which is the best evidence summary and set of recommendations to date. A revision of the Green-Top Guideline will be completed in 2023.

Implementation

A systematic review found that interventions for encouraging awareness of fetal movement were associated with a reduction in perinatal death, neonatal intensive care unit admissions and Apgar scores of <7 at 5 minutes of age and were not associated with increases in caesarean births or induction of labour. The effect of encouraging fetal movement awareness or clinical management of RFM on stillbirth is uncertain.

It is possible that altering *clinical management after RFM* will cause an increase in ultrasound scans and obstetric intervention, such as induction of labour and Caesarean birth. The AFFIRM study found that a care package which recommended all women have an ultrasound assessment of fetal biometry, liquor volume and umbilical artery Doppler following presentation with RFM after 26 weeks' gestation and offered induction of labour for recurrent episodes of RFM after 37 weeks' gestation did not significantly reduce stillbirths but was associated with an increase in induction of labour and Caesarean births. However, this care pathway reduced the number of SGA babies born at or after 40 weeks' gestation.[21] Other studies found raised awareness of fetal movements, with no mandated management package, did

not increase Caesarean births.[22 23]

There are no trials of computerised CTG (cCTG) following presentation with RFM. However, cCTG is recommended as this provides an objective assessment of fetal wellbeing and may be completed more quickly than conventional CTG. If a cCTG has been performed and is normal and there are no other indications for an ultrasound scan, then a scan is not required for a *first* presentation of RFM but should be offered for women reporting recurrent RFM*. As stated on page 21 of this document, computerised CTGs are recommended over and above visualised CTG due to the potential to reduce the risks of human error.[24] If an appropriate scan has been performed within the previous two weeks and was normal a repeat scan is not required.

Prior to 39 weeks' gestation, induction of labour or Caesarean birth is associated with small increases in perinatal morbidity and neurodevelopmental delay. Thus, a recommendation for birth needs to be individualised and based upon evidence of fetal compromise (for example, abnormal CTG, EFW <10th centile or oligohydramnios) or other concerns (for example, concomitant maternal medical disease, such as hypertension or diabetes, or associated symptoms such as antepartum haemorrhage).

At 39 weeks' gestation and beyond, induction of labour is not associated with an increase in caesarean birth, birth with forceps or ventouse, fetal morbidity or admission to the neonatal intensive care unit. Therefore, expediting birth by induction of labour (to women for whom this is not contraindicated) could be discussed (risks, benefits and mother's wishes) with women presenting with a single episode of RFM after 38+6 weeks gestation. The patient decision aid for timing of induction of labour should be used.

It is important that women presenting with <u>recurrent</u> RFM* are additionally informed of the association with an increased risk of stillbirth and given the option of expediting birth (by the most appropriate route for them) for RFM alone after 39+0 weeks. Decision to offer birth should consider the timing as to whether this can be achieved within the safe capacity of the unit.

Suggested Checklist for the Management of Reduced Fetal Movements (RFM)	
1. Ask	
Confirm there is maternal perception of RFM? How long has there been RFM? Is this the first episode? When were movements last felt?	
2. Act	
Auscultate fetal heart (hand-held Doppler/Pinnard) to confirm fetal viability.	
Assess fetal growth by reviewing growth chart, perform SFH if not performed within last 2 weeks (if not on an ultrasound surveillance pathway already).	
Perform CTG to assess fetal heart rate in accordance with national guidelines (ideally computerised CTG should be used).	
Ultrasound scan for fetal growth, liquor volume and umbilical artery Doppler only need to be offered on first presentation of RFM if there is an indication for scan (e.g., the baby is SGA on clinical assessment). Ultrasound scan for fetal growth, liquor volume and umbilical artery Doppler should be offered to women presenting with recurrent RFM after 28+0 weeks' gestation. Scans are not required if there has been a growth scan in the previous two weeks.	
In cases of RFM after 38+6 weeks discuss induction of labour with all women and offer birth to women with recurrent RFM after 38+6 weeks.	
3. Advise	
Convey results of investigations to the mother. Mother should be encouraged to re-attend if she has further concerns about RFM.	
IN THE EVENT OF BEING UNABLE TO AUSCULTATE THE FETAL HEART, ARRANGE IMMEDIATE ULTRASOUND ASSESSMENT	

Element 4: Effective fetal monitoring during labour

Element description
Effective fetal monitoring during labour.
Interventions
4.1 All staff who care for women in labour are required to undertake annual training and competency assessment on knowledge and skills required for effective fetal monitoring via Intermittent auscultation (IA) [Midwives] and electronic fetal monitoring [Midwives and Obstetricians]. 4.2 At the onset of every labour, there is a structured risk assessment undertaken which informs the clinicians recommendation of the most appropriate fetal monitoring method at the start of labour. This risk assessment should be revisited throughout labour as part of a holistic review. 4.3 Regular (at least hourly) systematic review of maternal and fetal wellbeing should be agreed and implemented. This should be accompanied by a clear guideline for escalation if concerns are raised using this structured process. All staff to be trained in the review system and escalation protocol. 4.4 A buddy system should be used to help provide an objective holistic review for example 'Fresh Eyes' – this should be undertaken at least hourly when CTG monitoring is used and at least four hourly when IA is utilised, unless there is a trigger to provide a holistic review earlier. 4.5 Identify a dedicated lead midwife (minimum of 0.4 WTE) and lead obstetrician (minimum 0.1WTE) with demonstrated fetal monitoring expertise to focus on and champion best practice in fetal monitoring.
Continuous learning
4.6 Maternity care providers should examine their outcomes in relation to the interventions, trends and themes within their own incidents where fetal monitoring was likely to have been a contributory factor. 4.7 Individual Trusts should examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements. 4.8 Maternity providers are encouraged to focus improvement in the following areas: a) Risk assessment of the woman/fetus at the beginning and regularly during labour. b) Interpretation and escalation of concerns over fetal wellbeing in labour.

Process indicators	Outcome indicators
4a. Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors and situational awareness. 4b. Percentage of staff who have successfully completed mandatory annual competency assessment. 4c. Fetal monitoring lead roles appointed	4d. The percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. *Using the severe brain injury definition as used in Gale et al. 2018[25].

Rationale

As well as reducing stillbirth rates, there is a need to reduce avoidable fetal morbidity related to brain injury causing conditions such as hypoxic-ischemic encephalopathy (HIE) and cerebral palsy. These conditions have a huge emotional and financial impact upon families. They also have significant economic consequences for the health and social care system through the costs of care needed to support those with an avoidable brain injury throughout their lives and litigation understandably brought by families when something goes wrong during labour.

The importance of good fetal monitoring during labour, in achieving birth of a healthy baby, is underlined by data from the RCOG's Each Baby Counts report, showing that fetal monitoring was identified in 74% of babies as a critical contributory factor where improvement in care may have prevented the outcome.

The report identified problems with fetal monitoring using IA, including inappropriate assignment of women to 'low risk', delays in responding to abnormalities and switching to CTG monitoring when appropriate. There was also a failure to follow national guidelines about technique and frequency of IA and a failure to recognise transition between the stages of labour.

In the case of a high-risk labour where continuous monitoring is needed, CTG is the best clinical tool available to carry this out as it is a well-established method of confirming fetal wellbeing and identification of potential fetal hypoxia. However, CTG interpretation is a high-level skill and is susceptible to variation in judgement between clinicians and by the same clinician over time[26] . These variations can lead to inappropriate care planning and subsequently impact on perinatal outcomes[27].

The RCOG's Each Baby Counts report failure to initiate CTG when indicated, failure to record a good-quality CTG, inadequate CTG interpretation and failure to

communicate the findings to senior staff in a timely manner. The conclusions resulting from these findings included recommendations for:

- a regular/rolling programme of training in the use of electronic fetal monitoring.
- simple guidelines on the interpretation of electronic fetal monitoring
- clear lines of communication when an abnormal CTG is suspected.
- guidelines on appropriate management in situations where the CTG is.

  abnormal

Many of the findings and recommendations from the Each Baby Counts report are echoed in the 2017 MBRRACE-UK Perinatal Confidential Enquiry that focused on term, singleton, intrapartum stillbirth and intrapartum-related neonatal death. Recommendations that have now been incorporated into this element of the care bundle include the use of a risk assessment tool on admission and then throughout labour to guide the nature, frequency and interpretation of fetal monitoring, as well as determining the optimal form of training and competency assessment. In addition, both reports identify that CTG or IA monitoring cannot be used in isolation and are only part of a complex assessment of fetal wellbeing – “Failure to recognise an evolving problem, or the transition from normal to abnormal, was a common theme. It was rarely due to a single issue, more commonly appearing to arise from a more complex failure of situational awareness and ability to maintain an objective overview of a changing situation” (MBRRACE-UK Perinatal Confidential Enquiry). There is, therefore, a real need for all staff to undertake multidisciplinary training that includes situational awareness, human factors, and communication. The importance of ensuring situational awareness is present in teams performing complex tasks is also highlighted in the Each Baby Counts report from 2015.

Implementation

Trusts should be able to demonstrate that all qualified staff who care for women in labour are competent to interpret IA [Midwives] and CTG [Midwives and Obstetricians] in relation to the clinical situation, use the Buddy system and escalate accordingly when concerns arise, or risks develop. This includes staff that are brought in to support a busy service from other clinical areas such as the postnatal ward and the community, as well as locum, agency or bank staff (medical or midwifery)

Intervention 4.1: Owing to a lack of validated packages it is not possible to be prescriptive about the exact nature of either training packages or competency assessment. Principles for training packages are included in Appendix E.

However, it is recommended that all trusts mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, and ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed within the LMNS, Ockenden, 2022

Intervention 4.2: The MBRRACE-UK Perinatal Confidential Enquiry report recommended the national development of a standardised risk assessment tool. As this is not yet available the procedure should comply with fetal monitoring guidelines.

Intervention 4.3: The principle underlying this intervention is that fetal wellbeing is assessed regularly (at least hourly) during labour and documented using a structured proforma. This review should be more than recording the fetal heart rate via IA or categorisation of the CTG (Appendix E).

Intervention 4.4: A discussion between the midwife caring for the woman and another midwife or doctor should occur at least 4 hourly when undertaking IA and at least hourly when using CTG monitoring. The discussion should include the FHR (IA or CTG), review of antenatal risk factors such as concurrent reduced fetal movements, fetal growth restriction, previous caesarean section; and intrapartum risk factors such as meconium, suspected infection, vaginal bleeding or prolonged labour and should lead to escalation if indicated (Appendix E).

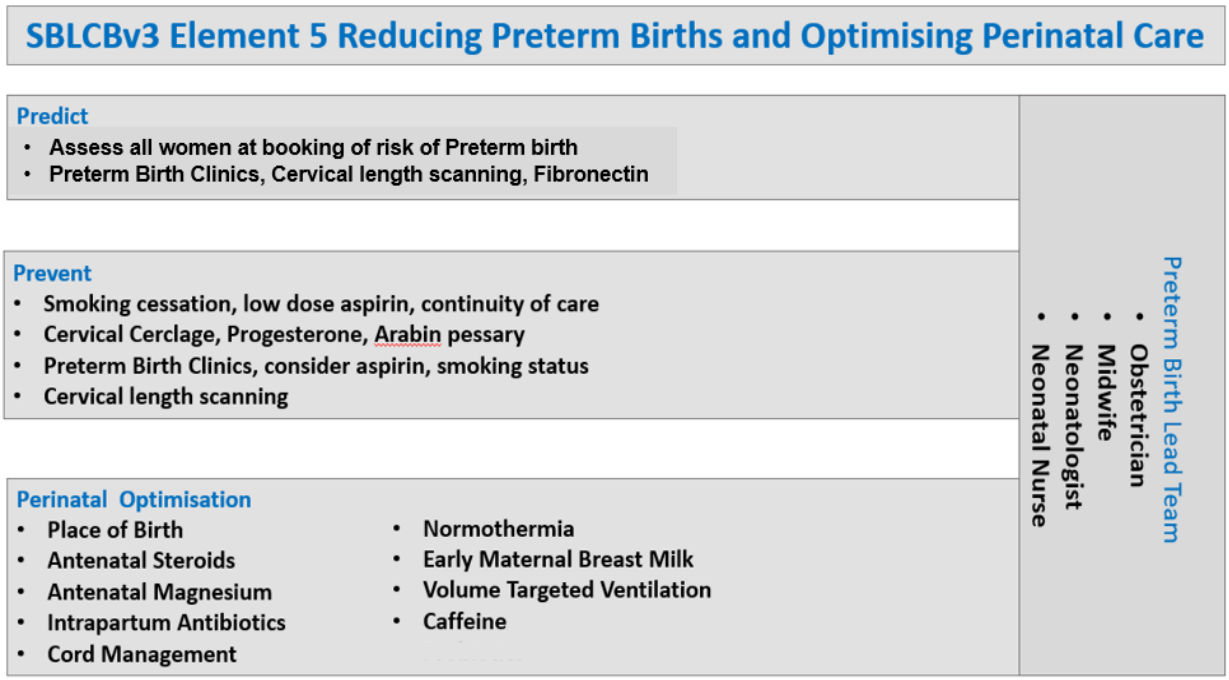
Introduce a Buddy system to pair up more and less experienced midwives during shifts to provide accessible senior advice with protocol for escalation of any concerns.

Intervention 4.5: Some Trusts may choose to extend the remit of the Practice Development Midwife to fulfil the role of Fetal Monitoring Lead, whereas others may wish to appoint a separate clinician. The critical principle is that the Fetal Monitoring Leads have dedicated time within their remit to support staff working in intrapartum care to provide high quality intrapartum risk assessments and accurate fetal heart rate interpretation using either IA or CTG. The role should contribute to building and sustaining a safety culture in intrapartum care with all staff committed to continuous improvement.

Element 5: Reducing preterm births and optimising perinatal care.

Element description

Reducing the number of preterm births and optimising perinatal care when preterm birth cannot be prevented.



Interventions

Preterm Birth Lead Team

5.1 Each provider trust should have.

a) An Obstetric Consultant lead for preterm birth, delivering care through a specific preterm birth clinic, or within an existing fetal medicine service.
b) An identified local preterm birth/perinatal optimisation Midwife Lead
c) A Neonatal Consultant lead for preterm perinatal optimisation
d) An identified Neonatal Nursing lead for preterm perinatal optimisation

5.2 Each Preterm Birth Lead team should have clear audit and QI pathways for preterm birth prevention, prediction and perinatal optimisation, and should engage in shared learning and QI with local preterm birth clinical networks, LMNSs and neonatal ODNs.

Prediction

5.3 Assessment of all women at booking for their risk of preterm birth and stratification to low, intermediate and high-risk pathways using the criteria in Appendix F. It is recognised that there are imperfections in the predictability of preterm birth on the basis of history; the use of digital algorithms & tools (for example the Tommy's app) may also be useful to support assessment.

5.4 In the assessment of women presenting in suspected preterm labour, evaluated digital tools are now available (QUIDS, QUiPP) to improve predictive accuracy of triage and enable collaborative decision making.

5.5 Networked Trusts should agree on the use of these tools within their ICS/LMNS.

5.6 Multiple pregnancy - risk assessment and management in multiple pregnancy should comply with NICE guidance or a variant that has been agreed with the local network or ICS following advice from the provider's clinical network.

Prevention

All women:

5.7 Assess smoking status (see Element 1) and implement appropriate intervention to ensure the pregnancy is smoke free before 15 weeks.

5.8 Assess all women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C or an alternative which has been agreed with the local network or ICS following advice from the provider's clinical network.

5.9 Symptomatic women require assessment using quantitative fetal fibronectin (qfFN) measurements (and use of decision-assist tools such as the QUiPP and QUIDS apps). The use of TVCS may also be used with or without qfFN. Further advice may be sought from UK Preterm Clinical Network, BAPM, or NICE guidance55).

Women at intermediate or high risk (Appendix F):

5.10 Assess each woman with a history of preterm birth to determine whether this was associated with placental disease and discuss prescribing aspirin with her.

5.11 Test for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking. Following any positive culture and treatment, a repeat MSU to confirm clearance is recommended54.

5.12 Asymptomatic women should have access to transvaginal cervix scanning (TVCS) to assess the need for further interventions such as cervical cerclage and progesterone supplementation (Appendix F).

5.13 Every provider should have referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories. This should include access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage. These procedures are performed relatively infrequently and therefore are best provided on a supra-regional basis in order to maintain expertise.

5.14 Midwifery Continuity of Carer (CoC) models, with a focus on individualised risk assessment and care pathways, may prevent preterm birth and save babies' lives. Ref B0961_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf

(england.nhs.uk). Local implementation plans for midwifery CoC models should ensure prioritisation of women from the most deprived groups in line with Core20+5. However, Midwifery CoC must be supported by safe staffing levels to preserve the safety of all pregnant women and families https://www.gov.uk/government/publications/final-report-of-the-ockenden-review

Perinatal Optimisation

5.15 Women identified to be at increased risk of preterm birth should be made aware of the signs/symptoms of preterm labour and encouraged to attend their local maternity unit early if these occur.

5.16 Ensure the neonatal team are involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with parents prior to birth. This is especially important at earlier gestational ages.
In the case of extreme prematurity where complex decision making is required (active survival focused care or comfort care), management should be as outlined in the 2019 BAPM Framework for Practice regarding Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation: *"Conversations with parents should be clearly documented and care taken to ensure that the agreed management plan is communicated between perinatal professionals and staff shifts. Decisions and management should be regularly reviewed before and after birth in conjunction with the parents; plans may be reconsidered if the risk for the fetus/baby changes, or if parental wishes change."*
https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019

5.17 Women identified to be potentially at increased risk of imminent preterm birth, where active survival focused care is planned, should be made aware of optimisation interventions that may be offered. Families should also be offered information and support for families from charities such as Bliss.

5.18 Acute tocolysis may be used when short term delay is desirable i.e., in utero transfer, and probably to ensure adequate antenatal exposure to corticosteroid/magnesium sulphate (i.e. no longer than 48 hours). There is no evidence that maintenance tocolysis is beneficial when compared with no tocolysis treatment, oxytocin antagonist and calcium channel blockers appear effective in delaying birth for more than 48 hours. In the absence of any contraindications nifedipine is the preferred agent for tocolysis[2].

5.19 **Place of birth** – Women who have symptoms suggestive of preterm labour or who are having a planned preterm birth:

a) less than 27 weeks gestational age (in a singleton pregnancy)
b) less than 28 weeks gestational age (in a multiple pregnancy)
c) any gestation with an estimated fetal weight of less than 800g

should be managed in a maternity service on the same site as a neonatal intensive care unit (NICU). Maternity services must operate in close perinatal collaboration with neonatal networks to ensure that babies predicted to require a higher level of neonatal care than can be provided in the local delivery unit are moved in utero whenever possible. https://www.bapm.org/pages/194-antenatal-optimisation-toolkit

5.20 **Antenatal corticosteroids** should be offered to women between 22+0 (where active management is agreed) and 33+6 weeks of pregnancy, optimally at 48 hours prior to birth. A steroid-to-birth interval of greater than seven days should be avoided if possible. and repeat courses of steroids should be avoided where possible. https://www.bapm.org/pages/194-antenatal-optimisation-toolkit

5.21 **Magnesium sulphate** to be offered to women between 22+0 (where active management is agreed) and 29+6 weeks of pregnancy - and considered for women between 30+0 and 33+6 weeks of pregnancy - who are in established labour or are having a planned preterm birth within 24 hours. https://www.bapm.org/pages/194-antenatal-optimisation-toolkit

5.22 **Intrapartum antibiotics** All women in preterm labour at less than 37 weeks of gestation should receive intravenous intrapartum antibiotic prophylaxis (Benzylpenicillin, where not contraindicated) to prevent early onset neonatal Group B Streptococcal (GBS) infection irrespective of whether they have ruptured amniotic membranes. This excludes planned caesarean births without labour. NB – this intervention should be considered up to 36+6 weeks.

5.23 **Cord Management** Babies born at less than 37 weeks gestational age should have their umbilical cord clamped at or after one minute after birth – this can have benefits for all babies. Perinatal multidisciplinary teams should work together to ensure this can reliably be delivered at all births.
https://www.bapm.org/pages/197-optimal-cord-management-toolkit

5.24 **Normothermia** Babies born at less than 37 weeks gestational age should have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. Neonatal normothermia can have benefits for all babies.
https://www.bapm.org/pages/105-normothermia-toolkit

5.25 **Early maternal breast milk** (MBM) Babies born below 37 weeks gestational age should receive their own mother's milk, ideally within 6 hours, but aiming always within 24 hours of birth (except in rare situations where there are contraindications to MBM). Perinatal teams should work together to ensure consistent delivery of antenatal advice about MBM, with support (equipment, education, help) for mothers to express within two hours of birth. https://www.bapm.org/pages/196-maternal-breast-milk-toolkit

5.26 **Volume-Targeted Ventilation** For babies born below 34 weeks' gestation who need invasive ventilation, use volume-targeted ventilation (VTV) in combination with synchronised ventilation as the primary mode of respiratory support. This reduces the chance of death or bronchopulmonary dysplasia by 27% and intraventricular haemorrhage (grades 3–4) by 47% compared with pressure-limited ventilation modes.
**NB – For preterm babies who do not need invasive ventilation, consider nasal CPAP or nasal high-flow therapy as the primary mode of respiratory support.*
https://www.nice.org.uk/guidance/qs193/chapter/Quality-statements

https://www.gettingitrightfirsttime.co.uk/medical-specialties/neonatal-intensive-care/

5.27 **Caffeine** For babies born below 30 weeks' gestation, caffeine reduces the chance of death or disability. Caffeine should be started within 24 hours of birth
https://www.nice.org.uk/guidance/qs193/chapter/Quality-statements
https://www.gettingitrightfirsttime.co.uk/medical-specialties/neonatal-intensive-care/

Continuous learning & improvement

5.28 All providers are encouraged to draw upon the learning from the four BAPM toolkits and a range of resources from other successful regional current programmes (e.g., PERIPrem resources, MCQIC)

a) https://www.bapm.org/pages/104-qi-toolkits
b) https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/
c) https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/spsp-programmes-of-work/maternity-and-children-quality-improvement-collaborative-mcqic/neonatal-care/
d) https://www.weahsn.net/our-work/transforming-services-and-systems/periprem/

5.29 Maternity & Neonatal care providers should determine and act upon all themes related to preterm birth that are identified from investigation of incidents, perinatal reviews and examples of excellence, particularly focusing on prediction, prevention, preparation and perinatal optimisation, including:

a) Risk assessment of women in their first pregnancy for the risk of preterm birth and timely triage to the appropriate care pathway.
b) Management of women at high risk of preterm birth, including appropriate cervical length surveillance and use of cervical cerclage.
c) Implementation of optimisation interventions as a whole **preterm perinatal optimisation** pathway, including measurement and reporting of overall optimisation pathway compliance

5.30 Maternity & Neonatal care providers should demonstrate continuing improvement by regular reassessment of the process and outcome indicators below. These data can be accessed through a number of national and network level data sources including the National Neonatal Audit Programme (NNAP) and Neonatal ODN data. Data completeness via electronic maternity and neonatal record systems is vitally important, and data quality should be monitored frequently. Provider Trusts should seek to support data quality assurance, including support for data clerk or data manager time.

5.31 **Benchmarking:** Maternity & Neonatal care providers should examine their process and outcome indicators in relation to similar provider Trusts to understand variation and inform potential improvements.

5.32 **Sharing learning & improvement:** The preterm birth teams (see 5.1) within each Maternity & Neonatal care provider setting should:

a) Review and share their process and outcome indicator data across the perinatal team on a regular basis (at least quarterly) to drive continual improvement.
b) Share process and outcome indicator data, and evidence of improvement with their Maternity & Neonatal Board level safety champions, LMNS (Local Maternity & Neonatal System) and ICS (Integrated Care System) quality surveillance teams on a quarterly basis.

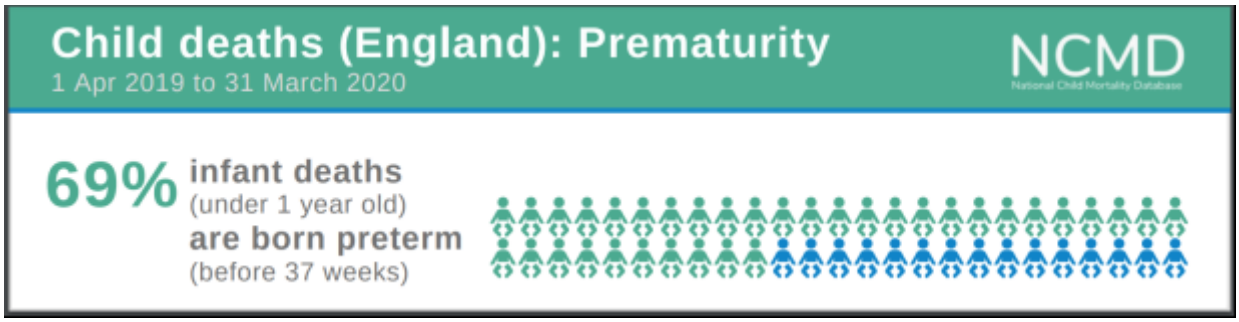
Process indicators	Outcome indicators
5a. Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU) 5b. Percentage of women giving birth before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth. 5c. Percentage of women giving birth before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth. 5d. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection. 5e. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth. 5f. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. 5g. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth. 5h. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (1 to 7 above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation) *To minimise the need for local data collection to support these improvements the forma collection of process measure data can be restricted to the seven interventions listed in this section the use*	5i. **Mortality to discharge in very preterm babies** (NNAP definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner) 5j. **Preterm Brain Injury** (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: a) Germinal matrix/ intraventricular haemorrhage b) Post haemorrhagic ventricular dilatation. c) Cystic periventricular leukomalacia 5k. Percentage of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue. 5l. Maternity care providers will provide outcome data to the Trust Board and share this with the LMNS relating to the incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a) in the late second trimester (from 16+0 to 23+6 weeks). b) preterm (from 24+0 to 36+6 weeks).

of volume targeted ventilation and caffeine is recommended but these data are not currently recorded or presented with national datasets	

Rationale

- Preterm birth (PTB), defined as birth at less than 37+0 week's gestation, is a common complication of pregnancy, comprising around 8% of births in England and Wales[28]. Prematurity is the most significant cause of mortality in children under five and is associated with significant morbidity in surviving infants. PTB is estimated to cost health services in England and Wales £3.4bn per year[29] .

Figure 5: https://www.ncmd.info/wp-content/uploads/2021/06/NCMD_2nd_Annual_Report_June-2021_web-FINAL.pdf



- The NHS Long Term Plan has an ambitious goal to reduce stillbirth, neonatal mortality and serious brain injury by 25% by 2020, and 50% by 2025 *NHS Long Term Plan. NHS England January 2019. [available from https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf* This has been further developed in *'Safer Maternity Care: The National Maternity Safety Strategy – Progress and Next Steps'* where the Government made it clear that 'we will not achieve the national Maternity Safety Ambition [to halve the rates of stillbirths, neonatal and brain injuries that occur during or soon after birth by 2030] unless the rate of preterm births is reduced' and set an additional ambition to reduce the national rate of preterm births from 8% to 6%. The current scope of NICE preterm guidelines is limited to principally to acute presentation[30 31], and this document specifies those at-risk populations

who should be targeted for additional referral and management to meet this ambition. It is anticipated that the rapidly expanding evidence base in this field will contribute to these evolving guidelines, and the UK Preterm Clinical Network guidance document will be updated periodically and this will be an open access document.

- There are evidence-based perinatal interventions to reduce the risk of preterm mortality or serious brain injury. Perinatal optimisation refers to the process of reliably delivering these evidence-based interventions in the antenatal, intrapartum and neonatal period to improve preterm outcomes.
- UK audit data show there is variable uptake in these interventions with wide variability between units and networks [Ref NNAP 2020 *National Neonatal Audit Programme. 2022. Annual Report on 2020 Data: Royal College for Paediatrics and Child Health; 2022 [Available from: https://www.rcpch.ac.uk/resources/national-neonatal-audit-programme-annual-report-2020*] .
- The British Association of Perinatal Medicine has released a series of QI toolkits to support implementation of this perinatal optimisation pathway. *https://www.bapm.org/pages/104-qi-toolkits*

Implementation

All the elements within SBLCBv3 address iatrogenic preterm and early term birth, recognising the need to ensure that any decision for birth is based on evidence of maternal and/or fetal compromise. This element focuses on reducing spontaneous preterm birth via prediction, prevention, and preparation. This will need to be done in the context of a strong perinatal team including neonatology, obstetrics and midwifery. https://www.bapm.org/resources/building-successful-perinatal-teams-doc

- The Preterm Birth Lead Team (see 5.1) should provide leadership and oversight of the implementation of Element 5 of SBLCBv3.
- Providers should have provision for care for women at risk of preterm birth ideally within a preterm birth prevention clinic with midwifery support and access to risk assessment tests, including transvaginal cervix scanning and quantitative fetal fibronectin and potential interventions, for example, cervical cerclage, pessary and progesterone. Where preterm birth prevention clinics are not available providers should ensure that women are able to access care that guarantees that they are given evidence-based information, access to risk assessment tests and interventions as appropriate and can actively

participate in decisions regarding their management.

- Providers should have access to supra-regional prevention services within their care pathways and networks, which include access to high vaginal and transabdominal cerclage.

Further guidance regarding the implementation of this Element, and care of women and their babies at risk of preterm birth can be found at:

- https://www.bapm.org/pages/104-qi-toolkits
- https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/
- https://ihub.scot/improvement-programmes/scottish-patient-safety-programme-spsp/spsp-programmes-of-work/maternity-and-children-quality-improvement-collaborative-mcqic/neonatal-care/
- https://www.weahsn.net/our-work/transforming-services-and-systems/periprem/
- https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019.
- NICE Guideline NG25 'Preterm labour and birth'
- NICE Diagnostics Guidance DG33 'Biomarker tests to help diagnose preterm labour in women with intact membranes'
- Ockenden Report (2022) Element 9 accessible at https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions
- UK Preterm Clinical Network 'Reducing Preterm Birth: Guidelines for Commissioners and Providers'

Appendix F includes a suggested risk assessment and management algorithm that providers may wish to adopt.

Element 6: Management of Pre-existing Diabetes in Pregnancy

Background and rationale for introducing management of Diabetes in pregnancy into the SBLCB.

Women with Type 1 and Type 2 diabetes have persistently high perinatal mortality with no improvement over the past 5 years. Contemporary annual data from the mandatory National Pregnancy in Diabetes audit (NHS Digital) (Lancet D&E 2021) in England & Wales shows that perinatal loss in diabetes is 4-5 times higher than the background population: In women with Type 1 diabetes, stillbirth occurs in 10·4 per 1000 livebirths and stillbirths, with neonatal death occurring in 7·4 per 1000 livebirths; In women with Type 2 diabetes it is even higher - stillbirth occurs in 13·5 per 1000 livebirths and stillbirths, with neonatal death occurring in 11·2 per 1000 livebirths. The risk of perinatal mortality is highest in women who are the most socioeconomically deprived (increased 2-fold) and those who have suboptimal glucose control in the third trimester (increased 3 fold). As women with diabetes are more socioeconomically deprived and more likely to be of South Asian and Black ethnicity than pregnant women without diabetes, there is an urgent need to address these inequalities.
Introducing management of Diabetes into the SBLCB allows us to do this in two keyways:

- Ensuring there are standard pathways of care for MDT management of these women throughout pregnancy, with increased access to expert and 'joined-up' support for their complex care needs.
- Improving management of glucose control during pregnancy by focusing support on high-risk women who are not achieving safe pregnancy glycaemic targets and by ensuring consistent and high levels of uptake of digital glucose monitoring technology to facilitate this.

The recent Ockenden report has highlighted the need for continuity of experienced staff within Diabetes in Pregnancy teams to reduce poor outcomes in women with diabetes.

The recent MBBRACE report has highlighted the very high risk of fetal death (stillbirth rate 160 per 1,000 births) associated with diabetic ketoacidosis (DKA).

Element description

Providing multidisciplinary care in a joined-up way for women with type 1 and type 2 diabetes during pregnancy and harnessing technology (e.g. continuous glucose monitoring) to reduce maternal complications of diabetes, including perinatal morbidity and mortality.

Interventions

6.1 Women with a diagnosis of pre-existing diabetes in pregnancy should be offered care in a one stop clinic, providing care to pre-existing diabetes only, which routinely offers multidisciplinary review and has the resource and skill set to address all antenatal care requirements. The multidisciplinary team should consist, as a minimum, of: Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife.

6.2 Women with type 1 diabetes should be offered real time continuous glucose monitoring (CGM) and be provided with appropriate education and support to use this.

6.3 Women with type 2 diabetes should have an objective record of their blood glucose recorded in their hospital records/EPR and be offered alternatives (e.g., intermittently scanned CGM) to blood glucose monitoring if glycaemic targets are not achieved

6.4 Women with diabetes should have an HbA1c measured at the start of the third trimester and those with an HbA1c above 48mmol/mmol should be offered increased surveillance including additional diabetes nurse/dietetic support, more frequent face to face review and input from their named, specialist Consultant to plan ongoing care and timing of birth decisions.

Green	HbA1c 43 mmol/mol or less	Continue current care
Amber	HbA1c 44-48 mmol/mol	Consider additional input to improve glucose management
Red	HbA1c more than 48 mmol/mol	MDT discussion required. Offer additional input to improve glucose management including alternative methods of monitoring treatment. Offer increased fetal surveillance, and re-discuss increased risk of stillbirth, birth and neonatal complications.

6.5	Women with diabetes and retinopathy requiring treatment during pregnancy and/or kidney impairment (CKD 2 with significant proteinuria i.e. PCR>30; or CKD 3 or more) should be managed in a regional maternal medicine centre where care can be delivered in a single MDT clinic. In circumstances where regular travel to a tertiary clinic is not possible, ongoing care should be planned via regular (4-6 weekly) MDT discussion with the MMC centre throughout the pregnancy.
6.6	Recognising the very high risk of fetal death (stillbirth rate 160 per 1,000 births) associated with diabetic ketoacidosis (DKA), all pregnant women presenting to secondary care with DKA should have ongoing multidisciplinary Consultant input and be cared for in line with the jointly agreed trust policy.
Continuous learning	
6.7	Maternity care providers involved in the care of women with type 1 and type 2 diabetes should examine their outcomes in relation to all themes related to these women. These include risk assessment and management in the antenatal and intrapartum period.
6.8	Maternity care providers who look after women with type 1 and type 2 diabetes in pregnancy should submit data to the NPID audit, review their submissions and develop an action plan to address ongoing challenges.
6.9	Individual Trusts should examine their outcomes in relation to other Trusts caring for women in pregnancy with type 1 and type 2 diabetes and engage with wider regional and national Diabetes Clinical networks to share examples of good practice and work collaboratively to address challenges.
6.10	Individual Trusts should actively gather feedback from service users about their care, and co-produce guidance and proposed care pathways with Maternity Voices Partnerships (MVP) members with ‘lived experience’.
6.11	All cases of perinatal death in women with diabetes, or where diabetes is considered to be a possible contributory factor, should be reviewed by a multidisciplinary team which includes members with expertise in the care of women with diabetes in pregnancy. Learning from these case reviews should be disseminated as appropriate and an action plan developed to reduce the risk of recurrence.
6.12	Any pregnancies where CGM or HbA1C was not offered in line with the recommendations should be subject to case review to determine service-level issues which could be addressed.

Process indicators	Outcome indicators
6a. Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc). 6b. Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes. 6c. Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets. 6d. Demonstrate compliance with CGM training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes. 6e. Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with DKA during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities and availability of expertise.	6f. The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the NPID dashboard (aiming for >95% of women) 6g. The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the start of the third trimester (aiming for >95% of women) *Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.*

Reducing perinatal mortality in pregnancies complicated by diabetes.

This element provides a practical approach to reducing perinatal mortality in pregnancy affected by Type 1 or Type 2 diabetes, by implementing multidisciplinary team pathways and an intensified focus on glucose management within maternity settings in line with the NHS Long Term Plan and NICE guidance. It focuses on demonstrating clear multidisciplinary pathways to provide a dedicated, integrated service for addressing complex needs (and thereby mitigate risk for poor pregnancy outcome). Furthermore, as glucose is the most significant modifiable risk factor for poor pregnancy outcome in pregnancies complicated by diabetes, the element includes: clear documentation of assessing glucose control digitally; using HbA1c to risk stratify and provide additional support/surveillance (National Diabetes Audit data); and offering consistent access to evidence based Continuous Glucose Monitoring (CGM) technology to improve glucose control (NICE and NHS plan).

Appendix A: Acknowledgments

NHS England would like to thank the following contributors to the development of the elements of this care bundle:

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Element 3: Raising awareness of reduced fetal movement (acknowledgments TBC)

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Appendix B: Detailed safe and healthy pregnancy messages

There are numerous causes of stillbirth, many of which are poorly understood. *MBRRACE-UK* highlights that stillbirth and neonatal mortality rates are higher in women from Black, Asian and minority ethnic backgrounds, those living in areas of deprivation and twin pregnancies. Almost three-quarters of both stillbirths and neonatal deaths occur preterm therefore maternity advice and care should be focused on mitigating risk. Other at-risk groups are women with pre-existing medical conditions especially cardio-vascular disorders; diabetes, psychiatric disorders and maternal age (teenage and older women) and women living with obesity. Health professionals should consider these risk factors (as well as smoking, drinking, recreational drug-taking, oral hygiene and diet) and take appropriate action for individual women. Providing information as 'safe and healthy pregnancy' messages for all women presents an opportunity to raise awareness of pre-term birth as well as stillbirth as an uncommon but possible outcome.

This section looks at how women can help themselves and their baby. It also includes some pre-pregnancy advice, and a note on whooping cough and Covid 19 vaccination.

Background

It is unhelpful to make women feel unnecessarily anxious or judged. Key messages need to be shared sensitively with women to enable them to know what they can do to help themselves and their baby stay safer in pregnancy.

For women who are at increased risk of stillbirth, communication may be a barrier. It is important to provide information in a format and/or language that is easily accessible and understood. For non-English speaking women, it is imperative that an interpreter/translation service is utilised and family members and/or friends are not used as an alternative.

Safer Pregnancy is a website developed by Sands that carries safer pregnancy messages with links to national guidance and further information.

Safe and healthy pregnancy messages

The section below contains additional information which may support conversations with women around these safe and healthy pregnancy messages.

Pre-pregnancy

Advice point: Choose when to start or grow your family by using contraception.
Why is this important? Worse outcomes are linked to unplanned pregnancies. Also, getting pregnant again after a baby is born can happen sooner than many people realise, and too short a gap between babies is known to cause problems. Planning your pregnancy facilitates accessing pregnancy care at the right time and early booking is associated with better outcomes.
Tip: Encourage women to speak to a health professional about the range of contraception options available. Some maternity services are now offering contraception from birth (IUCD at Caesarean birth) and/or on the postnatal wards.

Advice point: Consult with your GP if taking medication for long-term conditions (e.g., diabetes, hypertension, epilepsy)
Why is this important? Some medications may have to change prior to pregnancy e.g. Sodium Valporate is not recommended in pregnancy as it can cause birth defects as well as problems with baby's learning and behaviour. Outcomes are better if conditions such as diabetes; epilepsy; hypertension for example are optimised prior to conception.
Tip: GPs to ensure women of childbearing age are aware of their personal status regarding medications and pregnancy as part of medication review appointments.

Advice point: Eat healthily and be physically active to enter pregnancy at a healthy weight and maintain a healthy weight while pregnant.
Why is this important? Women who are overweight or obese before they conceive have an increased risk of complications during pregnancy and birth including an increased risk that their baby will be stillborn.
Tips: Encourage women who are overweight or have obesity to:
speak to a health professional about how to lose weight and sustain the weight loss to enter pregnancy at a healthy weight.
eat a balanced diet, control portion sizes and swap unhealthy food for healthier options (the Eatwell Guide may be helpful)
be fit and healthy, try to be active daily and do at least 150 minutes of weekly physical activity, including both aerobic and strength exercises.

Advice point: Take a daily supplement of 400 micrograms (400 µg) folic acid before conception and until the 12th week of pregnancy (some women will require a higher dose of 5mg as advised by a healthcare professional).
Why is this important? Folic acid (also known as vitamin B9) is very important for the development of a healthy fetus, as it can significantly reduce the risk of neural tube defects (NTDs), such as spina bifida. A high proportion of women are still unaware of the recommendation to take folic acid and do not take supplements.
Tips: Encourage women to take folic acid in preparation for pregnancy

Advice point: Before pregnancy, ensure that you are protected from measles, rubella, Coronavirus (Covid 19) and Flu. Check you are vaccinated if you're thinking of becoming pregnant.

Why is this important? Maternal rubella and maternal measles infection in pregnancy may result in fetal loss or congenital rubella syndrome. Coronavirus in pregnancy is associated with a 2-3 times greater risk of pre-term birth and increased risk of stillbirth therefore vaccinations in preparation for pregnancy are strongly recommended. Coronavirus and Flu are also associated with severe illness in pregnant women causing hospital admission.

Tips: Encourage women to check with their GP that they have had two documented doses of MMR vaccine. If not, they can catch up on missing doses before becoming pregnant but should take steps to avoid pregnancy for one month following the MMR vaccination. Coronavirus vaccinations can be given at the same time as seasonal flu vaccines. There are no published studies that demonstrate an increased risk of miscarriage or problems with fertility associated with COVID-19 vaccinations.

Advice point: Find out about screening if you think you or your partner could be a carrier for a genetic disorder.

Why is this important? Some disorders can be passed from parents to their children through their genes, and these can be more common in some groups of people.

Tip: Encourage women to speak to their GP to see if they and/or their partners should be screened before becoming pregnant. Women at risk should be referred for pre-pregnancy counselling with genetic specialist.

Advice point: Stop smoking and/or exposure to second hand smoke.

Why is this important? Smoking and second-hand smoke can impact on fertility. It can take time to stop smoking so leaving it until pregnancy will be less immediate and can be less successful thus exposing the baby to greater risk. Tobacco smoke contains thousands of chemicals, and many are toxic. They can pass through the placenta to the baby and affect their development. A small baby who doesn't grow healthily has an increased chance of being stillborn. Smoking or exposure to second hand smoke also increases the likelihood of a baby being born prematurely, and that they will have health and development problems in childhood and later life.

Tips: The best thing a woman who smokes can do is stop. Find out about local stop smoking support available for women and families in your area and adopt an opt out approach to smoking cessation.

Advice point: Reduce/stop alcohol consumption in preparation for pregnancy.

Why is this important? Drinking to excess can be associated with unplanned pregnancy. Alcohol passes from the mother's blood across the placenta to the developing baby. Alcohol in the baby's blood has a direct effect on the baby and can lead to birth defects, reduced growth and effects on brain and nervous system with long-term learning and behaviour problems. It can also affect the placenta and interfere with the baby's oxygen and nutrient supply. Stillbirths are also more common in women who drink heavily. Drinking alcohol at critical times in the baby's

development, heavy ('binge') drinking and frequent drinking increase the likelihood that the baby will be affected.
Tips: The simplest and safest advice for women is not to drink alcohol at all while planning to become pregnant. There are free and confidential helplines for people concerned about their, or a relative's, drinking. Drinkline 0300 123 1110. NHS UK (formerly NHS Choices) has additional options.

During Pregnancy

Advice point: Continue to take Folic Acid until the 12th week of pregnancy.
Why is this important? Folic acid (also known as vitamin B9) is very important for the development of a healthy fetus, as it can significantly reduce the risk of neural tube defects (NTDs), such as spina bifida. A high proportion of women are still unaware of the recommendation to take folic acid and do not take supplements.
Tips: Encourage women to continue to take folic acid until the 12th week of pregnancy

Advice point: Pregnant women should take 10µg of Vitamin D a day.
Why is this important? Pregnant women (and all adults, including breastfeeding women) are also recommended to have 10 µg of vitamin D a day. Vitamin D regulates the amount of calcium and phosphate in the body, which keeps bones, teeth and muscles healthy. Women with BMI >25 have decreased bioavailability of vitamin D which makes these women and their babies at greater risk. Some women are more likely to need vitamin D than others, those who rarely go outside; always cover their skin; use high-factor sun block; have darker skin; have a BMI above 25.
Tips: Encourage women to take Vitamin D in pregnancy; particularly women with a greater risk of a deficiency, as above

Advice point: You may be advised to take aspirin from 12 weeks of pregnancy.
Why is this important? Low dose aspirin (150mg) from 12 weeks of pregnancy is recommended for women who are at high risk of pre-eclampsia. Aspirin is a cyclooxygenase inhibitor with anti-inflammatory and antiplatelet properties. There is no increased risk of adverse fetal or neonatal effects associated with low-dose aspirin exposure.
Tips: An accurate risk assessment is required at booking to identify women at increased risk of pre-eclampsia and ensure Aspirin prescribed from 12th Week of pregnancy.

Advice point: The safest way to ensure baby is not damaged by alcohol is not to drink while pregnant. Advice about alcohol in pregnancy can get confusing – the simplest line is to not drink alcohol at all when pregnant.
Why is this important? Alcohol passes from the mother's blood across the placenta to the developing baby. Alcohol in the baby's blood has a direct effect on the baby and can lead to birth defects, reduced growth and effects on brain and nervous system with long-term learning and behaviour problems. It can also affect the placenta and interfere with the baby's oxygen and nutrient supply. Stillbirths are

also more common in women who drink heavily. Drinking alcohol at critical times in the baby's development, heavy ('binge') drinking and frequent drinking increase the likelihood that the baby will be affected.
Tips: The simplest and safest advice for women is not to drink alcohol at all while pregnant. There are free and confidential helplines for people concerned about their, or a relative's, drinking. Drinkline is a national advice line and can be contacted on 0300 123 1110.

Advice point: Stop smoking and/or exposure to second hand smoke. NHS UK (formerly NHS Choices) has additional options.
Why is this important? Smoking and exposure to second hand smoke affects the development of the baby and is associated with complications in pregnancy and poor outcomes. Smoking or exposure to second hand smoke also increases the likelihood of a baby being born prematurely. Also, smoking in pregnancy increases the risk of Sudden Infant Death (SID) https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/sleep-and-night-time-resources/co-sleeping-and-sids/ .Tobacco smoke contains thousands of chemicals, and many are toxic. They can pass through the placenta to the baby and affect their development. A small baby who doesn't grow healthily has an increased chance of being stillborn or having health and development problems in childhood and later life.
Tips: The best way for women to protect themselves and their baby is to stop smoking completely and/or reduce/stop exposure to second hand smoke. Stopping at any time in pregnancy will help, although the sooner the better as it may contribute to a low-birth weight baby. Stopping smoking early in pregnancy can almost entirely prevent any damage to the baby. Stopping smoking in early pregnancy, prior to 15 weeks, can reverse the risk of some adverse perinatal outcomes. If her partner or other household members smoke, they can support her by making efforts to give up smoking too and have a smoke-free home. Find out about local stop smoking support available for women and families in your area and adopt an opt-out approach to smoking cessation.

Advice point: If you currently use or have used illegal street drugs or other substances, it is important to tell your midwife.
Why is this important? Street drugs and other substances can be harmful to the baby during pregnancy.
Tips: A woman may be worried about sharing this information – reassure her that it will be treated in strict confidence and will only be shared with relevant health professionals if that's in the best interest of the baby. Women can contact FRANK for friendly and confidential drugs advice, including information on the different types of help available. The FRANK helpline 0300 123 6600 is open every day, 24 hours a day or Text 82111 and FRANK will text back. Healthcare professionals should support and manage the care of pregnant women who use drugs, alcohol or other substances in conjunction with referral to specialist teams (drug and alcohol) where required.

Advice point: Eat healthily and be physically active to maintain a healthy weight while pregnant.
Why is this important? Women who are overweight or are living with obesity have an increased risk of complications during pregnancy and birth including an

increased risk that their baby will be stillborn. Due to the increased risks associated with obesity, birth is recommended in an obstetric unit which affects choice regarding place of birth.

Tips: While pregnancy isn't the time for a weight-loss diet, it is a good time to adopt a healthy diet, so encourage women to swap unhealthy foods for healthier options and try to keep active. Reassure women that, even during the last few months of pregnancy, they only need an extra 200 calories a day (for example, two slices of wholemeal toast or an apple and a banana). Also encourage women to do 30 minutes or more of moderate physical activity, such as walking, every day right up until the baby is born. If they are not used to exercise, then they can build up to daily exercise. If there are health reasons why they shouldn't exercise, advise them to talk to their midwife or GP.

Advice point: Maintain oral hygiene.

Why is this important? Hormone changes can increase blood flow to gum tissues, causing sensitivity, bleeding or swollen gums. This is known as pregnancy gingivitis, which has been linked to poor pregnancy outcomes, including pre-term birth and low birth weight babies.

Tips: Free dental care is available to all pregnant women and up to a year after the birth

Advice point: Have the seasonal Flu vaccination, it's safe, effective and free of charge to pregnant women.

Why is this important? Influenza is more likely to cause severe illness in pregnant women than in women of reproductive age who are not pregnant. Changes to the immune system, heart, and lungs during pregnancy make women more susceptible to influenza severe enough to cause hospitalisation throughout pregnancy and up to two weeks postpartum. A common influenza symptom, e.g., fever, may be associated with neural tube defects and other adverse outcomes for a developing baby such as perinatal mortality, prematurity and lower birth weight. Parental vaccination also can help protect a baby from influenza after birth (because antibodies are passed to a developing baby during pregnancy)

Tips: Getting an influenza (flu) vaccine is the first and most important step in protecting against flu. Vaccination has been shown to reduce the risk of flu-associated acute respiratory infection in pregnant women by up to one-half and reduces a pregnant person's risk of being hospitalized with flu by an average of 40 percent. Pregnant women who get a flu vaccine also are helping to protect their babies from flu illness for the first several months after their birth, when they are too young to get vaccinated. Reassure women and their families that Flu vaccinations have been given to millions of people over many years with an excellent safety record.

Advice point: Have the pertussis (whooping cough) vaccination.

Why is this important? It's safe, effective and free of charge to pregnant women. Pertussis can lead to the death of a young baby. Pregnant women can have a pertussis vaccine from 16 weeks gestation – the best time is at 16 to 32 weeks. Women may still be immunised after week 32 of pregnancy but this may not offer as high a level of passive protection to the baby. The aim of the maternal pertussis

immunisation programme is to provide the baby with passive immunity to pertussis until the baby starts routine immunisations from 8 weeks of age.
Tips: You can be reassuring that vaccine containing pertussis can be safely given to pregnant women from 16 weeks gestation. It gives 90% protection against the disease and is 97% effective in preventing death from pertussis in babies less than 3 months. The mother's antibodies that are generated in response to the vaccine help protect the baby until they have their immunisations from 8 weeks of age. The baby should also complete their routine childhood immunisations on time at 8, 12 and 16 weeks of age.

Advice point: Have the Coronavirus (COVID-19 vaccination/booster
Why is this important? Women who are pregnant or were recently pregnant, are more likely to get severely ill from COVID-19 compared to people who are not pregnant. Pregnancy causes changes in the body that can make it easier to get very sick leading to increase hospital admissions, the need for ventilation in intensive care units and the requirement of extracorporeal membrane oxygenation (ECMO). There is also a higher rate of stillbirth in infected women and an increase in babies born pre-term with its associated complications. Other factors can further increase the risk of getting very sick with COVID-19: women from Black Asian and Mixed Ethnic Groups with underlying medical conditions; being older than 25 years; and living/working in communities with high numbers of COVID-19 cases/low levels of COVID-19 vaccination.
Tips: Getting a COVID-19 vaccination/ booster is the first and most important step in protecting against COVID-19. Vaccination has been shown to reduce the risk to babies born to vaccinated women of admission to neonatal units and intrauterine fetal death. There are no published studies that demonstrate an increased risk of miscarriage or problems with fertility.

Advice point: Always check with your pharmacist, midwife of doctor about medicines and therapies used in pregnancy, even if you have taken them for a long time on prescription or think they are harmless.
Why is this important? A medicine or therapy may have different effects on your body if you're pregnant. As a result, familiar medicines and therapies may not always be safe for pregnant women or their developing baby.

Tips: If medications are via prescription they should be checked by the pharmacists or doctor who prescribed it. If they are over-the-counter medications, then they should be checked with the pharmacist or midwife. If it's a complimentary or alternative therapy, check with the therapist. Not all therapies are considered safe in pregnancy e.g., some essential oils are not recommended for use while pregnant.

Advice point: Wherever possible, avoid contact with people who have infectious illnesses, including diarrhoea, sickness and childhood illnesses, such as chickenpox or parvovirus (slapped cheek) or any rash-like illness.
Why is this important? The immune system becomes weaker in pregnancy, so pregnant women are more at risk of infections. Some infections can increase the risk of stillbirth and/or maternal and perinatal complications.

Tips: Encourage women to:

- be strict about good hygiene – washing hands before and after handling food, after going to the toilet and after sneezing and blowing their nose.
- know which foods to avoid
- urgently seek advice from their GP or midwife if they have been in contact with someone who has rash-like illnesses, or if they develop a rash-like illness themselves.

Advice point: Reduce the risk of CMV (cytomegalovirus) and Toxoplasmosis infections.

Why is this important? CMV is a common virus, similar to the herpes virus that causes cold sores and chickenpox. Infection can be dangerous during pregnancy as it can cause problems for unborn babies, such as hearing loss, visual impairment or blindness, learning difficulties and epilepsy. CMV is particularly dangerous to the baby if the pregnant mother has not had the infection before. Toxoplasmosis is a common infection that is usually harmless. However, if pregnant women get toxoplasmosis for the first time when they are pregnant, or a few months before they conceive, there's a small risk the infections could cause miscarriage or stillbirth.

Tips: it is not always possible to prevent a CMV infection, but you can reduce the risk by:

- washing your hands regularly with soap and hot water, particularly if you have been changing nappies, or work in a nursery or day care centre.
- not kissing young children on the face – it is better to kiss them on the head or give them a hug.
- regularly wash toys or other items that get young children's saliva or urine on them.
- not sharing food or cutlery with young children, and not drinking from the same glass as them.

These precautions are particularly important if you have a job that brings you into close contact with young children. In this case, you can have a blood test to find out whether you have previously been infected with CMV. Find out more about CMV on the CMV Action website.

To prevent toxoplasmosis, it is recommended that gloves are worn during gardening and when emptying cat litter trays/dealing with excrement.

Advice point: Attend all antenatal appointments.

Why is this important? Some of the tests and measurements have to be done at specific times, and the midwife needs to share information as the pregnancy progresses.

Tips: The first midwife appointment (sometimes called 'booking appointment') should happen before 10 weeks. Make sure women know where the dates and times of appointments are written and what to do if they miss an appointment or can't attend.

There's an animation that describes antenatal and newborn screening for pregnant women, new mums and their families on the government website

https://youtu.be/_afr5oIlpTM** and there are leaflets also available in 12 languages http://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief

Tip: Maternity services are staffed 24/7, and there is always someone who can speak to women on the phone.

Advice point: Contact the maternity service promptly if you are worried. Don't wait!

Tip: Maternity services are staffed 24/7, and there is always someone who can speak to women on the phone

Leaflets are also available in 12 languages http://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief

Why is this important? Timely action is sometimes needed (see below). Women should be aware of who to contact/when if they have concerns as it may be an acute issue that requires a prompt response for the wellbeing of the woman and/or baby. Leaflets are also available in 12 languages http://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief

Reasons to get in touch promptly include:

- Baby's movements have reduced, slowed down or changed.
- Bleeding from the vagina
- Watery, clear or coloured discharge from the vagina which seems different to usual.
- Signs of pre-eclampsia, such as obvious swelling, especially affecting the hands and face or upper body; severe headache that won't go away, sometimes with vomiting; problems with vision (blurring, flashing lights or spots, difficulty in focusing); and severe pain just below the ribs in the middle of the abdomen.
- Itching, particularly on the hands and feet, can be a sign of the liver disorder called intrahepatic cholestasis of pregnancy (ICP); women should contact a midwife within 24 hours if they experience itching.

Advice point: In later pregnancy (after 28 weeks), it is safer to go to sleep on your side than on your back.

Why is this important? For pregnant women, the blood flow going to the baby may be reduced or interrupted if they spend a long time lying on their back. Research has linked this with an increased risk of stillbirth.

Tips: Encourage women to settle on their side when they go to sleep or have a day-time nap, rather than on their back. A woman who wakes up on her back shouldn't worry but should settle to sleep again on her side. Find out more information about sleep positions on the Tommy's website.

Advice point: Talk to your midwife about the benefits of breastfeeding.

Why is this important? There is overwhelming evidence on the benefits of breastfeeding for babies for a wide range of different health outcomes. https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/breastfeeding-resources/off-to-the-best-start/

Tips: Maternity services have specially trained staff to provide you with advice and support with any questions, there is always someone to talk to

Appendix C: Medication to reduce the risk of pregnancy complications.

All women should take a daily supplement of 400 micrograms (400 µg) folic acid before conception and until the 12th week of pregnancy (some women will require a higher dose as advised by a healthcare professional). Women (and all adults, including breastfeeding women) are also recommended to have 10 µg of vitamin D a day.

Elements 2 and 5 of this care bundle include the assessment of pregnant women for treatment with aspirin. NICE recommends Aspirin[c] reduces the risk of pregnancy complications related to placental dysfunction, particularly preeclampsia[32]. Thus, it is important to take a full history from pregnant women who have had a previous baby with FGR and/or a preterm birth to determine whether placental dysfunction was a contributory factor. Aspirin as a preventative medication appears to be safe in pregnancy and therefore there is a substantial net benefit of daily aspirin use to reduce the risk for preeclampsia and associated preterm birth. Aspirin is therefore recommended from the first to the third trimester of pregnancy in women, following risk assessment at their pregnancy booking visit.

Dosage

There is evidence from randomised controlled trials that the dose of aspirin should be 150mg[33] from 12 weeks' gestation and may be more effective if taken at night[34]. In some circumstances this may not be appropriate and lower doses (60-75mg) may be used (for example, pregnant women with hepatic or renal disease).

[c] Although this use is common in UK clinical practice, at the time of publication, aspirin did not have a UK marketing authorisation for this indication. Community pharmacies cannot legally sell aspirin as a Pharmacy Only Medicine for prevention of pre-eclampsia in pregnancy in England. Aspirin for this indication must be prescribed. The prescriber should see the Summary of Product Characteristics for the manufacturer's advice on use in pregnancy. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

Predictive algorithms that combine a variety of risk factors to identify pregnant women at risk for preeclampsia are available. Providers should use an algorithm such as the one included in Table 1 which is based on the NICE pregnancy hypertension guideline[35]. Any other algorithm must be agreed with local commissioners (ICBs) following advice from the provider's Clinical Network.

Table 1: Clinical risk assessment for preeclampsia as indications for aspirin in pregnancy

Risk level	Risk factors	Recommendation
High	• Hypertensive disease during a previous pregnancy • Chronic kidney disease • Autoimmune disease such as systemic lupus erythematosus or antiphospholipid syndrome • Type 1 or type 2 diabetes • Chronic hypertension • Placental histology confirming placental dysfunction in a previous pregnancy	Recommend low dosage aspirin if the woman has ≥1 of these high-risk factors
Moderate	• First pregnancy • Are 40 years or older at booking. • Pregnancy interval of more than 10 years • Body mass index (BMI) of 35kg/m² or more at first visit • Family history of preeclampsia in a first degree relative • Multiple pregnancy	Consider aspirin if the woman has two or more moderate risk factors

There are a few absolute contraindications to aspirin therapy[36]. Pregnant Women with a history of aspirin allergy (for example, urticaria) or hypersensitivity to other salicylates are at risk of anaphylaxis and should not receive aspirin. There is significant cross-sensitivity between aspirin and other nonsteroidal (NSAIDS) drugs, thus aspirin is contraindicated in pregnant women with known hypersensitivity to NSAIDs. Relative contraindications to aspirin include a history of gastrointestinal bleeding, active peptic ulcer disease, other sources of gastrointestinal or genitourinary bleeding, and severe hepatic dysfunction. The decision to continue

aspirin in the presence of obstetric bleeding or risk factors for obstetric bleeding should be considered on a case-by-case basis.

Appendix D: Risk assessment, surveillance pathway and management of FGR

This appendix describes a risk assessment and surveillance pathway for pregnant women at increased risk of FGR and a management pathway when a fetus has been found to be growth restricted, recognising that prior to 34 weeks this will require input from fetal medicine services. It has been designed to optimise effectiveness and minimise the scan burden on providers and recognise the potential harm caused by increased intervention in infants at only marginally increased risk of stillbirth. Trusts may wish to follow other pathways, but these should be agreed with their local ICSs and for some deviations specified in the guidance the regional maternity team.

Definition of FGR within SBLCBv3
FGR is difficult to diagnose representing those fetuses that have failed to reach their growth potential. A Delphi consensus-based definition has been used in research for both early (defined in the Delphi consensus as <32 weeks) and late onset FGR[37], but has not yet been shown to be useful in improving outcomes through intervention. Diagnosing FGR in a current pregnancy and risk assessing whether FGR existed in a previous pregnancy also present different challenge.

The following definitions are suggested to address these challenges and remain practical for most providers. It highlights that absent or reversed end diastolic flow in the umbilical artery is a feature of early onset FGR, importantly even in the absence of this feature (for example, a normal umbilical artery Doppler) after 32 weeks of gestation does not exclude growth restricted or fetal compromise.

Definition of FGR in a previous pregnancy as a risk factor: defined as any of the following:

- birthweight <3rd centile
- early onset placental dysfunction necessitating birth <34 weeks.
- birthweight <10th centile with evidence of placental dysfunction as defined below for current pregnancy.

Definition of FGR in a current pregnancy: defined as either of the following:

- EFW or abdominal circumference (AC) <3rd centile
- EFW or AC <10th centile with evidence of placental dysfunction (either):
- Abnormal uterine artery Doppler (mean pulsatility index >95th centile[38]) earlier in pregnancy (20 – 24 weeks) and/or
- Abnormal umbilical artery Doppler (absent or reversed end diastolic flow or pulsatility index >95th centile).

Suboptimal fetal growth:

- EFW or AC crossing declining by >50 centiles between two scans 14-21 days apart, >/=34 weeks gestation.

Risk assessment and screening

Early onset FGR is rare (~0.5%[73]). Most cases are associated with abnormal uterine artery Doppler indices or already present estimated fetal weight (EFW) <10th centile
in the early third trimester. Thus, uterine artery Doppler can be used in the second trimester (18+0 – 24+0 weeks) to facilitate determining the risk of placental dysfunction and risk of hypertensive disorders or early onset FGR.

For pregnant women with a normal uterine artery Doppler pulsatility index (mean measurement ≤95th centile) the risk of these disorders is low and thus serial scanning for fetal biometry can be routinely planned from 32 weeks gestation.

Pregnant Women at moderate risk of FGR do not require uterine artery Doppler assessment but are still at risk of later onset FGR so require serial ultrasound assessment of fetal growth from 32 weeks.

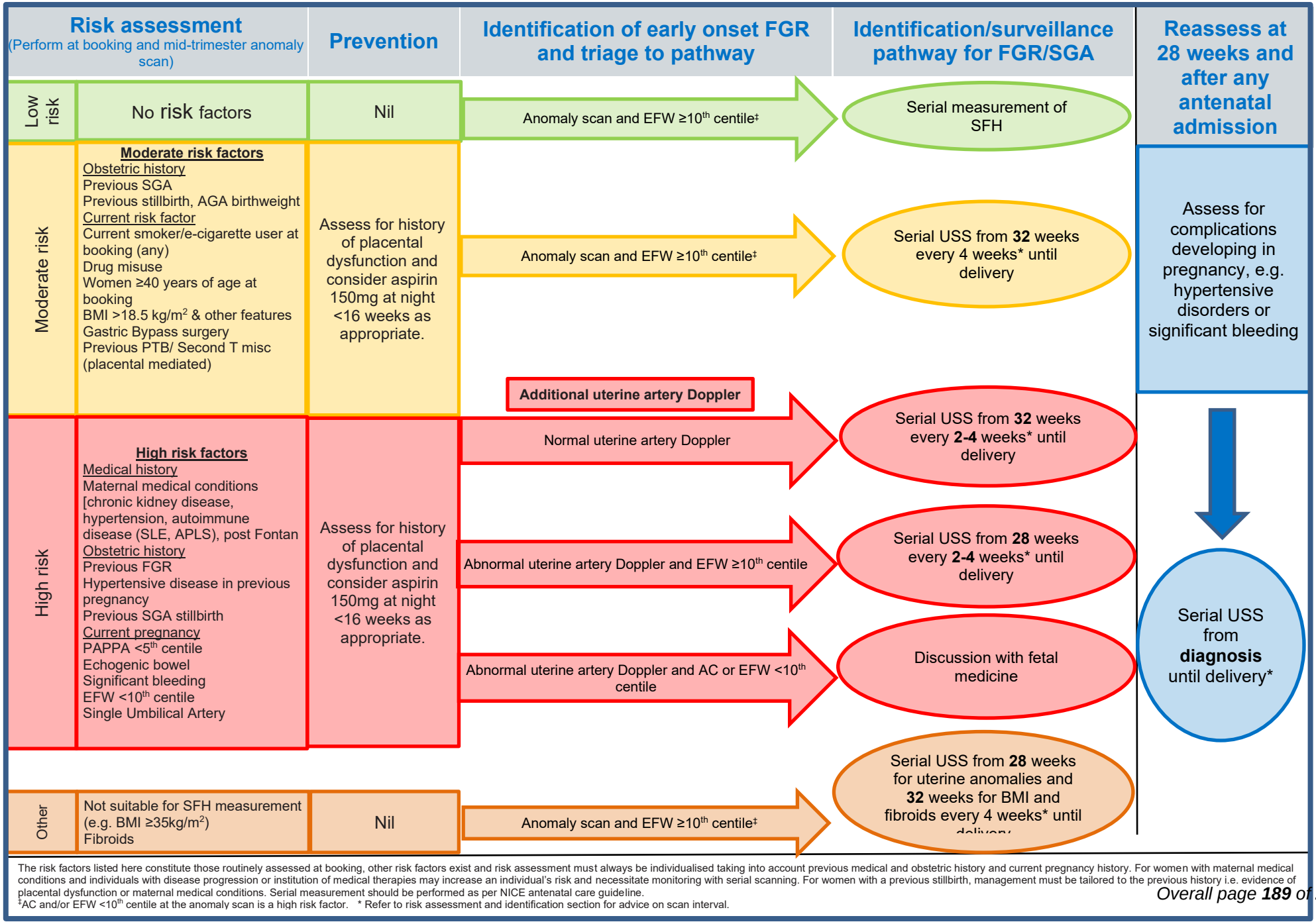
Ongoing surveillance of fetal growth should be performed at intervals between 21 – 28 days whilst fetal growth remains >10th centile. For many pregnancies in the moderate risk category or in those unsuitable for SFH measurements, an interval of four weeks is appropriate. For pregnant women in the high-risk category the scan interval should be confirmed following the first assessment for fetal growth, but routine growth assessment should not occur <14 days.

Trusts are encouraged to invest in training of Ultra sonographers to perform uterine artery Doppler alongside the fetal anomaly scan with the opportunity to reduce the number of serial scans for growth that a woman would require during the pregnancy.

It should be noted that there are reference ranges available for uterine artery Doppler PI throughout pregnancy[39] and thus while offering at the time of the fetal anomaly scan is appropriate (for resource use and convenience), the measurement may be performed at any time during pregnancy [40].

Figure 6 provides an algorithm for using uterine artery Doppler as a screening tool for risk of early onset FGR. Note the use of <10th centile EFW calculated at the time of the routine anomaly scan is preferred over <10th centile AC.

Figure 6: Algorithm for using uterine artery Doppler as a screening tool for risk of early onset FGR.



The risk factors listed here constitute those routinely assessed at booking, other risk factors exist and risk assessment must always be individualised taking into account previous medical and obstetric history and current pregnancy history. For women with maternal medical conditions and individuals with disease progression or institution of medical therapies may increase an individual's risk and necessitate monitoring with serial scanning. For women with a previous stillbirth, management must be tailored to the previous history i.e. evidence of placental dysfunction or maternal medical conditions. Serial measurement should be performed as per NICE antenatal care guideline.

‡AC and/or EFW <10th centile at the anomaly scan is a high risk factor. * Refer to risk assessment and identification section for advice on scan interval.

Management of FGR

The RCOG[41] provides detailed recommendations for the monitoring of SGA when EFW is <10th centile and Trusts should either follow this guidance or a similar protocol which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network as to whether the variation is acceptable.

This appendix describes further recommendations for management of fetuses with FGR supported by randomised controlled trial evidence and highlights important features for management:

- Absent or reversed end diastolic flow in the umbilical artery is a feature of FGR prior to 32 weeks.
- Ductus venosus (DV) Doppler is less predictive after 32 weeks in the management of the FGR fetus.
- A normal umbilical artery Doppler after 32 weeks of gestation does not mean that the fetus is not growth restricted, nor that there is no evidence of fetal compromise.
- After 34 weeks providers with capacity may wish to use assessment of Middle Cerebral Artery (MCA) Doppler pulsatility indices (PI) to help identify and act upon potential fetal compromise in later pregnancy.

FGR diagnosed before 34 weeks' gestation.

Prior to 34+0 weeks, management of the FGR fetus requires regional network specialist fetal medicine input to determine the most appropriate monitoring for fetal wellbeing and timing of birth where fetal compromise is demonstrated.

Trusts caring for such pregnant women should have access to personnel who can carry out DV Doppler assessment and computerised CTG. If Trusts do not have access to DV Doppler or access that is intermittent (i.e., not 365 days/year), then computerised CTG must be provided for monitoring and a pre-established referral pathway should be present to enable assessment of pregnant women by a specialist fetal medicine service within 72 hours.

Pregnant women with early onset FGR should give birth in a unit with neonatal facilities able to deal with the increased risks of FGR preterm infants. Timing should be determined in collaboration with neonatal colleagues, sub-speciality fetal medicine input, steroid administration and magnesium sulphate administration and be guided by current RCOG guidance and findings from the Truffle 2 study [42]

FGR diagnosed after 34 weeks' gestation.

For fetuses with an EFW <3rd centile diagnosed later in pregnancy birth should be initiated at 37+0 weeks' gestation. If other risk factors are present, then involvement of a specialist fetal growth service or fetal medicine service is required to plan birth.

In fetuses with an EFW between the 3rd and <10th centile, other risk factors must be present for birth to be recommended prior to 39 weeks. These are reduced fetal movements, any umbilical artery or MCA Doppler abnormality, cCTG that does not meet criteria, maternal hypertensive disease, abnormal sFlt1: PlGF ratio/free PlGF or reduced liquor volume. If FGR cannot be excluded, then birth after 37 weeks should be discussed with the mother and an ongoing management plan individualised.

For all fetuses with an EFW or AC <10th centile, birth or the initiation of induction of labour should be offered at 39+0 weeks after discussion with the mother.

Evidence on the use of MCA Doppler in the management of late onset FGR is awaited and this is not mandated for use in the management of FGR in this version of SBLCB.

For pregnant women who decline induction of labour or birth after 39+0 weeks, counselling must include a discussion regarding evidence that there is no increase in risk for the baby or for the mother from birth/induction at this gestation (REF) and that there is no evidence to determine how fetuses with SGA/FGR should be monitored if pregnancy continues

Appendix E: Risk assessment at the onset of labour

4.1 Multidisciplinary Training – Principles:
Include multidisciplinary and scenario-based training – this should involve all medical and midwifery staff who care for pregnant women in birth settings.
All staff to be competent in the use of fetal monitoring equipment.
Teaching about fetal responses to labour including changes in fetal heart rate (FHR). In addition, the impact of factors antenatal risk factors such as fetal growth restriction and intrapartum risk factors such as maternal pyrexia.
Effective fetal monitoring in low-risk pregnancies using IA, the role of IA in initial assessment, in established labour and indications for changing from IA to CTG.
Interpretation of CTG including:

- normal FHR parameters
- impact of intrapartum fetal hypoxia on the FHR
- classification of CTG
- holistic interpretation of fetal monitoring in specific clinical circumstances (such as previous caesarean sections, breech and multiple pregnancy).

Channels of communication to follow in response to a deteriorating CTG trace, and escalation.
Application of local fetal monitoring guideline (NICE, FIGO or Physiological)
Multi-disciplinary training must integrate the local handover tool (such as SBAR) into teaching programme at all trusts (IEA 7, Ockenden Report)
Provision of adequate training is a Trust priority – as a minimum all staff should receive a full day of multidisciplinary training (including the principles outlined above) each year with reinforcement from regular attendance at fetal monitoring review events.
The training and assessment should be agreed with local commissioners (CCG) based on the advice of the Clinical Network.

Competency assessment: all staff will have to pass an annual competency assessment that has been agreed by the local commissioner (CCG) based on the advice of the Clinical Network. The assessment should include demonstrating a clear understanding of the areas covered in training (see principles above). Trusts should agree a procedure with their CCG for how to manage staff who fail this assessment.
No member of staff should care for pregnant women in a birth setting without evidence of training and assessment within the last year.

4.2 Start of labour risk assessment.
All pregnant women should undergo a full clinical assessment when presenting in early or established labour. This should include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. This assessment should be agreed with local commissioners (CCG) based on the advice of the Clinical Network and reflect fetal monitoring guidelines. This should be shared with woman and her birth partner to enable an informed decision re place of birth.

4.3 Ongoing labour risk assessments
To include: start of labour risk assessment; intrapartum risk factors; consideration of fetal heart rate parameters when using Intermittent auscultation (IA) or cardiotocograph (CTG),

and whether the woman and her birth partner have any concerns. This information is used to inform the whole clinical picture and inform care and escalation if required.

4.4 Buddy system/Fresh Eyes

There is no evidence to inform the optimal frequency of a buddy system for IA or CTG and/or its effectiveness. However, the concept was introduced to enable a fresh eyes perspective of maternal and fetal wellbeing therefore has the potential to be beneficial and supportive.

IA is predominantly used in low-risk labours where the incidence of hypoxia is very low and therefore an hourly fresh eyes process can be distracting from care in labour without conferring benefit. A four hourly review may be more beneficial*

CTG is predominantly used in labour where there are risk factors and therefore the risk of sepsis and fetal hypoxia is greater; therefore, fresh eyes review at least hourly may be more beneficial*

*Timeframe for Fresh Eyes should be decided within maternity services should be agreed with local commissioners (CCG) based on the advice of the Clinical Network.

4.5 Fetal monitoring expertise

The dedicated hours for midwifery and obstetric fetal monitoring leads will be dependent on the size of the maternity unit and agreed with local commissioners (CCG) based on the advice of the Clinical Network.

Appendix F: Risk assessment, surveillance pathway and management of women at risk of preterm birth

This appendix describes a risk assessment, surveillance and management pathway for pregnant women at risk of preterm birth. It has been designed with reference to NICE guidance[43] and the UK Preterm Clinical Network guidance. It does not address administration of corticosteroids, magnesium sulphate and use of tocolytics for which there is evidence based guidance[44 45 46] .

Prevention

All pregnant women should be assessed at booking for risk factors for preterm birth. This assessment should include modification of population-based risk factors acknowledging that the majority of preterm births occur in pregnant women not appropriate for care in a preterm prevention clinic.

Smoking cessation: Smoking doubles the risk of preterm birth[47] and therefore all pregnant women should be asked about smoking, and cessation advice and/or referral should be provided. Women who have experienced a previous preterm birth, who stopped smoking early in the pregnancy, modify their risk back to that of a non-smoker. If smoking cessation is delayed until the third trimester this modifiable benefit is lost. The importance of promoting smoking cessation is therefore one of the most important prevention strategies to implement (see Element 1 for more detail).

Maternal age: Young women (<18 years) have an increased risk of preterm birth[48]. Appropriate referral to teenage pregnancy teams should be offered to provide adequate support and advice throughout the pregnancy and may help prevent preterm birth.

Domestic violence: Women experiencing domestic violence and/or other social pressure should be directly counselled and referred for specific support through local pathways.

Urinary tract infection (UTI): A midstream urine sample (MSU) should be taken and sent for culture and sensitivity in all high or intermediate risk pregnant women at booking. Culture positive samples, even in symptom-free pregnant women (asymptomatic bacteriuria), should be promptly treated. Following any positive culture and treatment, a repeat MSU to confirm clearance is recommended. Those who have a recurrent episode require review in secondary care.

Vaginal infection: Pathogens such as *Neisseria Gonorrhoeae* and *Chlamydia Trachomatis* are associated with preterm birth, and screening should be offered to at-risk pregnant women. In particular, healthcare professionals should inform pregnant women under the age of 25 years about the high prevalence of chlamydial infection in their age group and give details of their local National Chlamydia Screening Programme.

The role of organisms found in bacterial vaginosis (BV) remains controversial; the presence of BV is linked with preterm birth, but the varying methods used to ascertain its presence, and the timing and means of treatment in several studies have meant that no consensus currently exists as to its identification and treatment in at-risk pregnant women. The presence of Group B Streptococci in a vaginal swab is not an indication to treat until in labour unless also isolated from a midstream urine specimen.

Risk assessment

The risk assessment should identify a group of high-risk pregnant women who require management in a preterm birth prevention clinic where further tests may be offered as part of the surveillance pathway. This assessment should take place at the booking appointment with referral by 12 weeks.

Table 2 is a suggested risk assessment and management tool.

Table 2: Risk assessment and management tool for pregnant women at risk of preterm birth

Risk factor	Pathway
High risk • Previous preterm birth or mid-trimester loss (16 to 34 weeks gestation). • Previous preterm prelabour rupture of membranes <34/40. • Previous use of cervical cerclage. • Known uterine variant (i.e., unicornuate, bicornuate uterus or uterine septum). • Intrauterine adhesions (Ashermann's syndrome). • History of trachelectomy (for cervical cancer).	**Surveillance** 1. Referral to local or tertiary Preterm Prevention (PP) clinic by 12 weeks. 2. Further risk assessment based on history +/- examination as appropriate in secondary care with identification of pregnant women needing referral to tertiary services. 3. All pregnant women to be offered transvaginal cervix scanning every 2-4 weeks between 16 and 24 weeks as a secondary test to more accurately quantify the risk of preterm birth. 4. Additional use of quantitative fetal fibronectin in asymptomatic pregnant women may be considered where centres have this expertise. **Management** 5. Interventions should be offered to pregnant women as appropriate, based on either history or additional risk assessment tests by clinicians able to discuss the relevant risks and benefits according to up to date evidence and

	relevant guidance, for example, UK Preterm Clinical Network guidance and NICE[49] guidance. These interventions should include cervical cerclage, pessary and progesterone as appropriate.
Intermediate risk • Previous birth by caesarean section at full dilatation. • History of significant cervical excisional event i.e., LLETZ where >15mm depth removed, or >1 LLETZ procedure carried out or cone biopsy (knife or laser, typically carried out under general anaesthetic).	**Surveillance** 1) Refer to preterm birth prevention clinic by 12 weeks. 2) Further risk assessment based on history +/- examination as appropriate in secondary care with discussion of option of additional risk assessment tests, including: a) A single transvaginal cervix scan between 18-22 weeks as a minimum. b) Additional use of quantitative fetal fibronectin in asymptomatic pregnant women can be considered where centres have this expertise. **Management** 3) Interventions should be discussed with pregnant women as appropriate based on either history or additional risk assessment tests by clinicians able to discuss the relevant risks and benefits according to up-to-date evidence and relevant guidance. These interventions should include cervical cerclage, pessary and progesterone as appropriate. 4) Pregnant women at intermediate risk should be reassessed at 24 weeks for consideration of transfer back to a low-risk pathway.

Risk assessment

Pregnant women with any of the additional high-risk factors should be reviewed in a preterm birth prevention clinic where a detailed history should be obtained and an individualised plan made. Additional tests for ascertaining risk should be offered; as a minimum this should include transvaginal cervix scan between 18 and 22 weeks. Some providers may wish to schedule this as part of the anomaly scan. Additional cervical length scans should be performed at the discretion of the lead clinician and are likely to be more frequent than the minimum outlined above.

The addition of a second risk assessment tool, quantitative fetal fibronectin, is currently being evaluated in symptomatic pregnant women in clinical studies. In asymptomatic

pregnant women, this additional tool may be used from 18 weeks to ascertain risk of second trimester miscarriage or preterm birth in conjunction with cervical length measurement and support discussions of potential interventions with pregnant women. It can also be used in high-risk pregnant women in late second/early third trimester to determine timing of preparation for preterm birth, for example, administration of steroids and magnesium sulphate. In current clinical practice the use of additional risk assessment tools in asymptomatic pregnant women should be at the discretion of the lead clinicians and where there is expertise and clear guidance for use.

The use of other near-patient tests, such as placental alpha macroglobulin-1 (PAMG-1, PartoSure) and insulin-like growth factor binding protein-1 (IGFBP-1, Actim Partus), has recently been examined by NICE and these are currently not recommended for routine use outside research settings[50].

Prevention

After assessment within the preterm birth prevention clinic, pregnant women on the basis of history and/or additional risk assessment tools should be offered treatment to prevent second trimester miscarriage and preterm birth.

Several interventions have been assessed for pregnant women at high risk of preterm birth: cervical cerclage, progesterone and pessaries. Cervical cerclage is an established procedure, progesterone is recommended in certain situations by NICE, and there are randomised trials suggesting benefit in the use of Arabin pessaries in at-risk pregnant women [51]. At present the evidence base cannot determine precisely in which pregnant women, and in what circumstances, each intervention will be most effective. Care should, therefore, always be individualised, taking into account the pregnant women's wishes, and following a discussion with a clinician able to discuss the potential risks and benefits of each intervention. The following evidence and guidance should be discussed:

Pregnant women with a history of spontaneous preterm birth or late miscarriage (16-34 weeks):

- Offer a history-indicated (planned, prophylactic, elective) cervical cerclage or transvaginal ultrasound surveillance of the cervix within the second trimester.
- History-indicated cerclage should be placed by the end of the first trimester where possible, however often it may be prudent to wait until after the dating scan and aneuploidy screening has been performed, so that significant fetal malformations can be excluded.
- For pregnant women having ultrasound surveillance, discuss intervention when cervix is <25mm, either cervical cerclage[52], Arabin pessary or prophylactic progesterone (vaginal or intramuscular).
- **Pregnant women with a previous failed transvaginal suture**:
- The circumstances of the failed suture and other clinical factors should be considered prior to placement, and appropriately experienced clinicians should be involved in the decision making and surgery. High vaginal or transabdominal

cerclage may be considered. Transabdominal placement during pregnancy should be undertaken prior to 14 weeks. Guidelines regarding laparoscopic placement have previously been published by NICE[53].

- **Pregnant Women with no history of spontaneous preterm birth or midtrimester loss in whom a transvaginal cervix scan has been carried out between 16+0 and 26+0 weeks of pregnancy and the cervix is less than 25mm***:*
- Care for these pregnant women should be individualised. Counselling should include options of continued surveillance or intervention with clinicians able to discuss the relevant risks and benefits according to up to date evidence and relevant guidance. These interventions should include cervical cerclage, pessary and progesterone as appropriate.

Pregnant women with an intervention (cerclage, pessary or progesterone) should remain under the care of the preterm birth prevention clinic until birth. Pregnant women undergoing transvaginal cervix scanning risk assessment should continue this until 24 weeks, when this monitoring pathway is complete and if no intervention is recommended, pregnant women may be transferred to routine pathways of care. Midwifery-led care is appropriate if no other additional risk factors are identified.

Abbreviations

AC – Abdominal circumference
BME – Black and Minority Ethnic
CCG – Clinical Commissioning Group
CI – Confidence interval
CO – Carbon monoxide
CTG – Cardiotocograph
DV – Ductus venosus
EFW – Estimated fetal weight.
FGR – Fetal growth restriction
FHR – Fetal heart rate
HCP – Healthcare professional
HEE – Health Education England
IA – Intermittent auscultation
LLETZ - Large loop excision of the transformation zone
LTP – NHS Long Term Plan
LMNS – Local maternity and neonatal system
MCA – Middle Cerebral Artery
MIS – Maternity information system
MSDS – Maternity services data set
MSU – Midstream urine
MSW – Maternity Support Worker
NSAIDS – Nonsteroidal anti-inflammatory drugs
NHS – National Health Service
NICE – National Institute for Health and Care Excellence
ODN – Operational delivery networks
ONS – Office for National Statistics
PI – Pulsatility index
PMRT – Perinatal mortality review tool
PHE – Public Health England
RCM – Royal College of Midwives
RCOG – Royal College of Obstetricians and Gynaecologists
RFM – Reduced fetal movements.
SBLCB – Saving Babies' Lives Care Bundle
SEN – Special educational needs
SFH – Symphysis fundal height
SGA – Small for gestational age
SIDS – sudden infant death syndrome
TVCS – Transvaginal cervix scanning
VBA – Very brief advice
WHO – World Health Organisation

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Ockenden Essential Actions - August 2023

			1: WORKFORCE PLANNING AND SUSTAINABILITY	RAG Rating	Lead	Review Date	Comments / Lead Progress
			Full workforce review required in 2022 - Priority to Neonatal and Obstetric Workforce with focus on additional governance related work and training. Neonatal nursing workforce reviewed and additional funding via NODN secured. Midwifery staffing reviewed with BR+ however as per ask re increased uplift for additional training PER HEAD COUNT not wte sme to be reviewed as a priority.				
1: WORKFORCE PLANNING AND SUSTAINABILITY	The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	**1**	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.		JL	31/3/23	Neonatal service Staffing Review undertaken and bid for national monies successful.: Adam Brown with Angela MacDonald. Anaesthetic staffing review to be undertaken :Medical & Anaesthetic staffing review to be undertaken: Alice Arch. Libby Shaw and Mustafa Sadiq. Midwifery Staffing review undertaken but same to be reviewed and updated pending CoC model: Debbie Edwards and Jo Lavery. Deadline - July 2022. Staffing review given reduction in substantive NHSE funding indicates that with further implementation of Continuity of Carer there will be a small deficit circa 5wte midwives/MSWs).
		2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.		JL	31/3/23	Dependant on midwifery model which will dictate the staffing required. From the last BR+ review staffing was identified as appropriate with the additional funding from NHSE to support complaince with BR+ findings. Workforce paper being produced to outline the deficit in staffing should continuity of carer be delivered at 100%. This will also go to Board of Directoprs to update.
		3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.		JL	31/3/23	Local uplift to be calculated and compared to BR+ staffing requirements. The uplift of 24% is in keeping with national guidance/local LMNS calculation.
		4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.				Recommendation reviewed - WUTH to await Regional / National review which is currently ongoing.
			Essential Action : Training				
			Work to update orientation packages for |Band 7 staff with process to allocate a mentor. Decision re NQM with NHSE as moreof a risk. Additional work re support for senior leaders.				
	We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	**5**	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.		SW/JL	31/3/23	National programme being developed however robust preceptorship in place currently. For review once national work completed and recommendation made. Current robust programme in palce and embedded.
		6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.		TBC	31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
		7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.		TBC	31/3/23	Shift Coordinators have attended development Programmes including Hiuman Factors training however National Programme awaited. Completion of any national prohramme to be agreed. D
		8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.		JL/SW	31/3/23	Orientation pack currently in use but same to be reviewed nationally and to include study time for profrssional development. To continue with current process in the interim.
		9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.		JL	30/8/22	EMC Team based on DS and all midwives have undergone recognised specific HDU training.
		10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience		JL	31/3/23	Workforce strategy in place however this will be reviewed and include reference to leadership roles. Compl;eltion date - September 2022; leadership programmes and initiiatves in place
		11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.		JL/MS/LMNS	31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
			2: SAFE STAFFING				
			Escalation policy to be further reviewed re risk assessment specifically for medical Process re assessing staffing in place but review will provide further assurance. This includes review of rotas for Obs and Gynae. RCOG tool to be used once introduced to assess medical staffing. Progress with the roll out of the				
2: SAFE STAFFING	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	**1**	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.		JL	31/3/23	Escalation processes in place and the number of diverts is included on the maternity dashboard. Staffing related incident forms reviewed and reported monthly. Staffing reviewed and reported monthly with Chief Nurse oversight.
		2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.		JL,MS & LS	30/4/23	Escalation in-house at present therefore formal process - SOP to be developed and agreed at Board to formalise process.Leads: Mustafa Sadiq and Libby Shaw. Completion date - TBA following further national guidance. Relevant policies - P2 & P3 ureviewed and updated with risk assessment completed and included in the next Board of Directors quarterly maternity update.
		3	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.				Specific job description in place with personal specification. JD has been through matching process.
		4	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.		JL/DF	31/3/23	Debbie Edwards and Jo Lavery have reviewed staffing establishments as detailed above - staffing previously has supported CoC - withold complete roll out but continue with partial roll out pending staffing review. Further team to go out in January 2023. Review of national guidance in Febryary 2023 re next steps.
		5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction		JL	30/6/24	Final position statement on this to be formalised nationally - completion date awaited. Locally MCofC is not withheld - meeting compliance as per staffing numbers.
		6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.		JL/NP/JL	31/3/23	Job plans review in progress Natalie Park, Jon Lund, Mustafa Sadiq and Libby Shaw.to finalise. Review 31/3/23.
		7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.				Facilitators in post to support - guidance awaited re what should be included. Date TBCSarah Weston, Ali Campion, Jo Allen and Karen Cullen
		8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.		JL/DF	31/3/23	Process to be reviewed and agreed with L&D Team within the Trust. Also include specific requirements for appraisals and support for leadership training eg Top Leaders; 4 C's
		9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.				CoC - Engagement, listening events, one-to-one meetings, Block C update, Senior midwife meeting joint with all leads.
		10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.		JL/MS/LS	31/3/23	Locum pack developed and shared across C&M- Libby Shaw and Mustafa Sadiq to check RCOG guidance for locum guidance to further support current process. Locum pack and Gapa analysis required with assurance mechanisms. Review following any additional NHSE recomendations.
			3: ESCALATION AND ACCOUNTABILITY				
			Processes in place - same to be auditted with clear SOPs.				
3: ESCALATION AND ACCOUNTABILITY	Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	**1**	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals		JL/LS/MS	31/12/22	Guidance in place but standalone policy with flowcharts required. Libby Shaw developing SOP as per EBC Guidance. Completion date July 2022.
		2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role		JL/LS/MS	31/3/23	Mustafa Sadiq and Libby Shaw to lead on embedding the Locum package being embedded and evidence of assurance
		3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable		JL/MS/LS	31/3/23	Ward round take place at weekend, twice daily however resident consultant presence not in place 24/7; Added to Risk Register inview of non-compliance but review completed by WUTH therefore no further action required at present.
		4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit				Guidance in place / in policy
		5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.		JL/MS/LS/NP	31/3/23	Partial guidance in place and currently no dedicated maternity on call rota in place as Trust on call provides OOH cover. Specific Maternity on call put on hold pending further advice and guidance from NHSE in February 2023.
			4. Clinical governance and leadership				
			Review of additional resource as detailed above to support. Training in place but to be formalised/auditted.				

4 : CLINICAL GOVERNANCE-LEADERSHIP	Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	**1**	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans			31/3/23	Mat Neo agenda is in place and other QI work is reported in Governance meetings but there is limited Board oversight - same to be reviewed. Maternty safety champions and regular board meetings. Processes embedded - review in March 2023.
		2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board			31/3/23	Self-assessment tool completed with actons in place and presented to Board. However same to be reviewed following Ockenden and an updated self assessment to go to Board in January 2023
		3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services				In place. Structure organogram required
		4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities		MS/LS	31/3/23	In self-assessment tool to include neonates and anaesthetists. Only obstetric time currently supported. Completion date - July 2022; reviwing additional PA's and funding to achieve
		5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		JL	31/3/23	Staff currently trained however review of staff group required and additional training to be identified. For further review in March 2023.
		6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.				Multi-discipinary leads in place. Consultant Midwife coleads with audit/research.
		7	All maternity services must ensure they have midwifery and obstetric co-leads for audits		MS/LS/JL	31/3/23	Audit plan in place - same to be strengthened for Maternity and Neonates.Obstetric leads in place but midwifery leads for the audit plan to be agreed with Mustafa Sadiq Completion date - June 2022.
5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATING AND COMPLAINTS							
			Robust governance processes in place - same to be reviewed with MVP Chair				
5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	**1**	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.				In place and evidenced. Robust process for reviewing documents before they are sent to families.
		2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.				In place in various forums both internal and external to the Trust
		3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.		CC/JL	31/12/22	Implementation of actions recorded and monitored however audit of same to be reviewed.Link with audit plan
		4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.		JL/CC	31/12/22	Learning put in place immediately. - evidenced on individual reports.
		5	All trusts must ensure that complaints which meet SI threshold must be investigated as such				Clear MDT process in place - SI Panel. Process embedded.
		6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent				Complaint response processes in place however MVP to review and to identify improvements to further strengthen the process
		7	Complaints themes and trends must be monitored by the maternity governance team.				Processes currently in place to incorportae all patient feedback - LEAP to include Feedback Friday - positive and negative feedback and trends to be communicated to all staff.
6: LEARNING FROM MATERNAL DEATHS							
6: LEARNING FROM MATERNAL DEATHS	Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	**1**	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.		TBC	31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
		2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.		TBC	31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
		3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.		TBC	31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
7: MULTIDISCIPLANRY TRAINING							
			MDT in place - same to be extended and recorded (ad hoc drills)				
7: MULTIDISCIPLINARY TRAINING	Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	**1**	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.		JL/CC/MS/LS	31/3/23	Midwifery and middle grades involved in audit - need to expand to neonatal evidence of same and allocated time to be evidenced.
		2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.				SBAR in all training including neonates. Audit of same to be further improved.
		3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.				For all staff attend human factors training however guidance re content awaited from LMNS
		4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.		JL/SW	31/3/23	PROMPT includes all of these topics however all staff groups including neonatal staff to be included in PROMPT - same to be reviewed after national recommendation/s.
		5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.				Jo Allen support for NQM. PMAs. NWAS has toolkit for staff Contact Steph Heyes. Discussed psychological support that was available in ITUs during Covid pandemic - that there was psychological support present at work.This helped staff to attend work becuase they knew the support would be there.
		6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.				Karen Cullen in post for CTG / Fetal Physiology in addition to Ali Campion and Libby Shaw.
		7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory				PROMPT, K2, fetal physiology, CIF meetings, Pass mark for CTG assessment is mandated and reviewed monthly.
8: COMPLEX ANTENATAL CARE							
			Review of High Risk team and support to implement MMN links. Review of preconceptual care and further progress in secondary care.				
8: COMPLEX ANTENATAL CARE	Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	**1**	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.		JL	31/3/23	Do not currently offer routine pre conception care. Will discuss regionally at what can be offered - will look at what high risk team could provide. Completion date - July 2022; Plan to be developed; Two consultants currently have pre-conception clinics and any referrals sent are accommodated from a specialist referral; Pre-conception counselling education with GP's
		2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019		JL	31/3/23	Twins Trust coming in multi-pregnacy clinic - Mustafa Sadiq is lead.
		3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.			31/3/23	Guidance in place - to link wth Rachel Tildesley and Lauren Evertts. Need to look at audit to support compliance. For FAAP 2023
		4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.			31/3/23	In place but could be subject to audit to demonstrate compliance. For FAAP 2023
		5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).			31/3/23	Guidance in place to support this practice - specific clinic to be reviewed. Audit compliance in March 2023. For FAAP 2023
9: PRETERM BIRTH							
			Both 9 + 10 are in place - audit of processes needed				
9: PRETERM BIRTH	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	**1**	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.				Policy in place with clear guidance.
		2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.				Guidance discussed at time dependant on individual situation. Guidance in place re type of monitoring as per gestation of pregnancy.
		3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.				Regional policy - link in with Angela MacDonald and Sanjeev Rath re any further update
		4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.				Current review of Level 3 neonatal services however as WUTH Level 3 currently this is not applicable.
10: LABOUR AND BIRTH							
10: LABOUR AND BIRTH	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.	**1**	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made				Practice in place - Demonstrated in care metrics
		2	Midwifery-led units must complete yearly operational risk assessments.		JL/DF	31/3/23	In place however annual check for 2023 to be undertaken for Deacombe and Eden Suite.
		3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan		JL/DF	31/3/23	All staff included in PROMPT training however schedule of drills to be recorded and ad-hoc taken forward

	Centralised CTG monitoring systems should be mandatory in obstetric units	4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust		DE/JL	31/3/23	Transfer policy in place regionally and adopted locally - same reviewed and updated with NWAS.
		5	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.				Pathways in place - same being reviewed regionally.
		6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs		DE	31/3/23	Purchase of system currently being undertaken. Procurement In progress once approved at CMG meeting. IT support required and request for same requested. Review March 2023.
11: OBSTETRIC ANAESTHESIA							
			Close links with Anaesthetic leads with compliance to standards - same to be auditted				
11: OBSTETRIC ANAESTHESIA	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	1	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia		JL/NP/JL	31/3/23	Alice Arch overview: If a post-operative debrief would be useful these can be arranged to be purely or involve a Consultant Anaesthetist and we do this for lots of patients already - we usually offer this at 6-8 weeks post event unless the patient requests it to be earlier or later - and these patients can be referred to the Obstetric Anaesthetic Assessment clinic if they present in subsequent pregnancies; Assurance process developing
		2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.		JL/NP/JL	31/3/23	Currently being undertaken but need to review guidance to ensure all criteria included with audit of same. Completion date - July 2022; part of assurance process 11.1
		3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC		NP/JL/JL	31/3/23	Documentation is recorded in maternity record hwoever need to review audit process. Completion date - July 2022; part of assurance process 11.1; part of assurance process 11.1
		4	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional / National review
	Obstetric anaesthesia staffing guidance to include:	5	The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.		NP/JL/JL	31/3/23	Staff who do not do regular Obstetric Anaesthesia sessions want to do a Consultant Accompanied CPD session in Obstetric Anaesthesia to keep skills up to date we are more than happy to facilitate this - and several people have already taken up this opportunity. Process to be reviewed. Completion date - July 2022; assurance process to be developed
		6	• The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.		JL/JL/NP	31/3/23	Staffing of same to be reviewed. Completion date - July 2022; assurance process to be developed
		7	• The competency required for consultant staff who cover obstetric services out-of hours, but who have no regular obstetric commitments.		JL/JL/NP	31/3/23	As point 5; assurance process to be developed
		8	• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		JL/JL/NP	31/3/23	All anaesthetists attend PROMPT MDT training; assurance process to be developed
12: POSTNATAL CARE							
			Audit and review of processes / policies re postnatal care				
12: POSTNATAL CARE	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.Postnatal wards must be adequately staffed at all times	1	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non maternity ward		JL	31/3/23	Process in place - document to be developed to support process
		2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum		JL	31/3/23	Process in place - document to be developed to support process
		3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary		JL	31/3/23	Process in place - document to be developed to support process
		4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.				Acuity tool used and effective
13: BEREAVEMENT CARE							
13. BEREAVEMENT CARE	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	1	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.				Bereavement midwife in post but works Monday to Friday. EMC team upskilled and shift coordinators. With development of bereavement champions in teams. Cover available 24/7
		2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.				EMC staff and coordinators - can be inlcuded in development package for coordinators
		3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome				In place - dual with obstetrics and neonates
		4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway				Pathway in place and in use.
14: NEONATAL CARE							
			Close links with NODN to progress - this links in with the regional transformational work with Exec input to support				
14: NEONATAL CARE	There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	1	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.				Guidance in place
		2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.			31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
		3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.				This is a unit with onsite Level 3 NICU
		4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.			31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance
		5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.			31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance
		6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required		JL	31/3/23	Evidence of this happening in practice to be confirmed and to be followed up with Angela McDonald, Adam Brown and Sanjeev Rath
		7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.		JL	31/3/23	NLS Guidance followed - action to be followed up with neonatal team
		8	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.		AB/ AK	31/3/23	Staffing review undertaken as above -Adam Brown and Anand to feedback to DMB.
15: SUPPORTING FAMILIES							
			Ensure support covers maternity and neonatal care/services				
15: SUPPORTING FAMILIES	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provisionMaternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	1	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.		AK	31/3/23	Perinatal mental health team in post. GIRFT identified need for neonatal support. This is in place regionally
		2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.		AK	31/3/23	Perinatal mental health team in post with further support from Psychiatric Liason team..
		3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care		AK	31/3/23	Psychiatric liaison team and dedicated psychologist to support. WUTH also involved in regional project to further enhance PMH support.

Recommendation reviewed - WUTH ready however awaiting Regional / National Guidance
Fully Embedded
On target to achieve; no risks
Partially Compliant
Non Compliant/risk identified on risk register
NOTE: Completion dates are provisional pending detailed improvement plan.

	Three Year Single Delivery Plan for Maternity and Neonatal Services - June 2023							
	Theme1: Listening to and working with women and their families with compassion				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 1: Care that is personalised	Personalised care gives people choice and control over how their care is planned and delivered. It is based on evidence, what matters to them, and their individual risk factors and needs	**1**	Women experience care that is always kind and compassionate. They are listened and responded to. Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected. All women are offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices. Plans consider inequalities in the broadest sense, including protected characteristics and Core20PLUS5. The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.		JL	No further action	CQC Patient survey Debrief clinics to go through pregnancy outcomes. Birth Options clinic to evidence discussion of women's preferences Examples of care plans; PMH plans; Risk assessment audits Look at further improving inequalities as per equity and equality plan – Consultant Midwife to support with MNVP involvement.
			2	Women receive care that has a life course approach and preventative perspective, to ensure holistic care for women and the best start in life for babies. This includes NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers, and evidence-based information about screening and vaccination		AK/ER	31/5/23	Evidence of smoking cessation midwife/work with ABL. Use of NRT. ANNB Screening Programme QA; ANNB Screening action plan to further review screening information
			3	Women have clear choices, supported by unbiased information and evidence- based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Rebirth report, and is co-produced.		AK/ER	31/12/23	No specific work done with Rebirth report – review of same. Clear choices and information is in place including the updated/revamped website. Continue to work with MNVP re equity and equality to ensure all people
			4	All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and foetal medicine networks, and neonatal care, when needed		JKL	31/10/23	All services with guidelines are in place except perinatal pelvic health services – same being introduced; Set up a perinatal pelvic health service and work closely with LMNS re guidance/requirements; funding secured and JD to be matched; initial discuss with PPHS lead and service to be set up at WUTH
			5	Women experience personalised, joined-up, high-quality care right through to the postnatal period with handover to health visiting services and a GP check 6-8 weeks after birth. They are provided with practical support and information that reflects how they choose to feed their babies		DF	31/10/23	Processes in place although clarity needed regarding 6-8week GP check post pandemic; Check with HV team re GP follow up check
			6	Parents are partners in their baby's care in the neonatal unit through individualised care plans utilising a family integrated care approach, together with appropriate parental accommodation.		ST/AMC	No further action	FI Care review undertaken with action plan developed following feedback positive in May 2022; repeated in May 2023 and GREEN accreditation achieved
			7	Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units		AK/ER	No further action	Bereavement midwife in post. Bereavement Suite on site. Use of Ron McDonald House is also an option that is used
	Objective 2: Improve equity for mother and babies	The NHS approach to improving equity (Core20PLUS5) involves implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived area It is the responsibility of trusts to: Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal	**8**	To reduce inequalities for all in access, experience and outcomes		JL	30/4/24	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed; Further work re equality to be undertaken
			9	Targeted support where health inequalities exist in line with the principles of proportionate universalism		JL	30/6/24	MCoC teams to be set up as a wraparound service but the support is already in place from these Leads; MCoC teams in place and embedded in the identified areas; plan for McCoy to be the default model by June 2024 and subject to safe staffing and additional funding
			10	Services listen to and work with women from all backgrounds to improve access, plan and deliver personalized care. Maternity and Neonatal voice partnerships ensure all groups are heard, including those most at risk of experiencing health inequalities.		JL	No further action	
			11	The NHS collaborates with local authority services, other public sector organisations (NHS Constitution Principle 5, 2021) to address the social determinants of health, which are a significant driver of health inequalities (WHO, 2022)		JL/DF	30/6/24	Maternity services to work with PLACE; LMNS and ICB leads to progress
			12	In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services		JL/MB	30/6/24	To achieve requirement to work with the LMNS to meet and no local prisons feed into WUTH; consider a SoP with safeguarding midwife involvement
	Objective 3: Work with service users to improve care	Acting on the insights of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through maternity and neonatal voices partnerships (MNVPs) and by	**13**	MVNPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.		JL	No further action	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed; Further work re equality to be undertaken as detailed above
			14	MNVPs have strategic influence and are embedded in decision making		JL	No further action	MIS evidence supports work and undertaken and co-production
			15	MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formally MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.		JL	31/1/24	MNVP embedded; full funding of post with agreed workplan from ICB awaited
	Theme 2: Growing, retaining and supporting workforce				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 4: Grow our workforce	The maternity and neonatal workforce encompasses a wide range of professions, including midwives, maternity support workers, obstetricians, anaesthetists, neonatologists, neonatal nurses, sonographers, allied health professionals, and psychologists. Growing our workforce requires the tailoring of interventions to professional groups, career stage, and local requirements	**16**	Workforce capacity to grow as quickly as possible to meet local needs.		JL	No further action	Workforce plan in place with report to Board every 6 months
			17	Local and national workforce planning to utilise evidence-based tools, endorsed by NICE or the National Quality Board (NQB), that allow for medical and social complexity, training,		JL	No further action	Nursing and Medical workforce planning tools used. BR+ Report in date. Also work with regional Leads
			18	Aligned local and national strategies supporting recruitment to those vacant posts identified through workforce planning		JL	No further action	No specific work done with Rebirth report – review of same. Clear choices and information is in place including the updated/revamped website. Continue to work with MNVP re equity and equality to ensure all people receive information they understand.
	Objective 5: Value and retain our workforce	Our maternity and neonatal staff perform critical, life-changing work every day. We must ensure they are valued and have a fulfilling and sustainable career within the NHS. We need to do more to improve the experience of all our staff, to retain them within the NHS	**19**	Staff feel valued at all stages of their career. This includes support to get off to a good start, opportunities for progression and flexible working, and support when approaching retirement age to allow staff to continue to use their skills and experience.		JL	No further action	
			20	All staff are included and have equality of opportunity		JL	No further action	
			21	A safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination		JL/NP/MS/SR	30/6/24	Score survey to be undertaken in Maternity and Neonates
	Objective 6:	Staff feel valued when they are supported to develop. We are investing in our staff by ensuring they have ongoing training and	**22**	All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development		JL	No further action	Evidence collated for Ockenden improvement plan

	Invest in skills	career development opportunities. Effective training of frontline clinicians in technical and non-technical skills has been shown to	**23**	All staff have regular training to maintain and develop their skills in line with their roles, career aspirations, and national standards. Training is multi-disciplinary wherever practical to optimise teamworking		JL	No further action	TNA in place and reviewed annually
	Theme 3: Developing and sustaining a culture of safety, learning and support				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 7: Developing a positive safety culture		**24**	All staff working in and overseeing maternity and neonatal services: -Are supported to work with professionalism, kindness, compassion, and respect. Are psychologically safe to voice their thoughts and are open to constructive challenge. -Receive constructive appraisals and support with their development. -Work, learn and train together as a multi-disciplinary team across maternity and neonatal care.		JL	No further action	MDT training in place. TNA supports training requirements incl psychological safety. Appraisal process in place with good compliance monitored at Board level.
			25	Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.		JL	No further action	Training in place to support
			26	There is a shared commitment to safety and improvement at all levels, including the trust board, and attention is given to 'how' things are implemented not just 'what'		JL	No further action	Evidenced through safety champions meetings; Newly formed divisional MatNeo Assurance Board
			27	Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.		JL	No further action	Trust training and policies support professional behaviour/s. Disciplinary processes support appropriate action when needed
			28	Systems and processes enable effective coordination, rapid mobilisation, and supportive communication based on agreed principles. The team can escalate concerns and, should there be a disagreement between healthcare professionals, they will be supported by a conflict of clinical opinion policy.		JL	No further action	Policy in place – provided for Ockenden evidence
			29	Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief		JL/MD	No further action	Training in place for staff and this is reviewed and provided by the Trust Governance team
	Objective 8: Learning and Improving	Staff working in maternity and neonatal services have an appreciation and understanding of 'what good looks like.' To promote safer care for all, we must actively learn from when things go well and when they do not. To do this, we need a continuous learning and	**30**	Our ambition is framed by the patient safety incident response framework (PSIRF) which provides a consistent approach across clinical specialties, including for maternity and neonatal services		JL/MD	31/3/24	Work is ongoing to ensure Trust processes meet the requirements of PSIRF
			31	The Healthcare Safety Investigation Branch undertake investigations of incidents which meet their criteria		JL/MD	No further action	HSIB quarterly meetings take place and Trust evidenced 100% reporting by the Trust
	Objective 9: Support and oversight	While some trusts and ICSs do effectively support their maternity and neonatal services to improve and change; others do not. Good oversight is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise	**32**	Robust oversight through the perinatal quality surveillance model (PQSM) that ensures concerns are identified early, addressed, and escalated where appropriate		JL	No further action	Evidence Monthly PQSM report to Board with quarterly detailed maternity /neonatal reports presented
			33	Well led services, with additional resources channelled to where they are most needed		JL	No further action	CQC visit supported well led service at last inspection. Other evidence / outcomes also support
			34	Leadership for change, with a focus on ensuring new service models have the right building blocks for high quality care, especially the workforce.		JL/NP/MS/SR	31/12/24	Leadership training in place and underway x various programmes for Senior Leaders, Quad perinatal leadership programme
	Theme 4: Standards and structures that underpin safer, more personalised and more equitable care				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 10: Standards to ensure best practice	Advances in clinical practice have been crucial in the improvement in maternity and neonatal outcomes over the last decade. Better Births also identified that variation in protocols, policies, and standards between services creates additional burden and hinders the ability to work together to provide effective care.	**35**	Consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities		JL/MS/MD	31/3/24	MIS year 5 and SBLv3 to be implemented following publications as of 31/5/23
			36	Healthcare professionals have access to shared standards and guidelines, including transfer, transport, and referral protocols, so that clinical teams across the ICS work to the same definitions of best practice		JL	31/7/24	Ongoing work with ICB; timeframes to be set
			37	Where local policy varies from national standards, this is subject to careful local scrutiny through governance processes. The whole multidisciplinary team is involved when developing local guidance			No further action	Processes in place to ensure MDT are involved with developing local policy
			38	Policies and guidelines recognise women as the decision-makers in their maternity care and are not used to prevent women from seeking care that is outside these guidelines			No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
			39	Neonatal care is provided in units with clear designation of the level of care to be provided. Units work together across ODNs to optimise capacity and ensure care can be provided in the right place for very pre-term or very sick babies			No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
	Objective 11: Data to inform learning	The Kirkup report highlighted the need for accurate, up to date data to highlight safety issues promptly. Such data enables providers to learn and act. Work is underway to review what data is needed for monitoring, and in the meantime, the NHS should continue to use the data it already collects	**40**	Standardised data is collected in a consistent way, primarily through the Maternity Services Data Set. Additional data collections are minimised, to focus on gathering the right data to drive insights, understanding and assurances.			No further action	MSDS submitted in addition to completion of a local and regional dashboard
			41	Monitoring trends at both national and local level is enabled by analysing data from different sources alongside themes from MBRRACE-UK , and the national clinical audits patient outcome programme reports			No further action	LMNS support in leading on monitoring trends regionally. Outlier reports are presented to Board quarterly; Improvement plans are developed to address any outlier reports
			42	The national maternity dashboard provides demographic data, clinical quality improvement metrics and national maternity indicators enabling trusts and LMNSs to benchmark their services and inform continuing quality improvement work			No further action	Data submitted to national dashboard; Given limited metrics the national dashboard is not currently reviewed – work to be identified to address an improvement moving forwards.
	Objective 12: Make better use of digital technology	Digital technology will make it easier for women to access the information they need and for services to offer safe and personalised care. There is currently significant variation in the use of digital technology. While some maternity services remain almost entirely paper-based, others support personalised care with apps and benefit from an integrated electronic patient record (EPR).	**43**	Women can access their records and interact with their digital plans and information to support informed decision-making. Parents can access neonatal and early years health information to support their child's health and development. Information meets accessibility standards, with non-digital alternatives available for those who require or prefer them		JL/NP	31/12/24	Processes in place for women to access their records electronically – work to progress to roll out patient portal.
			44	All clinicians are supposed to make best use of digital technology with sufficient computer hardware, reliable Wi-Fi, securing networks and training			No further action	Full IT system in place and supported with equipment
			45	Organisation's enable access to key information held elsewhere internally or by partner organisations, such as other trusts and GP practices			No further action	Work across Wirral with the introduction of the single care record is supporting this

Wirral University Teaching Hospital NHS Foundation Trust

Arrowe Park Hospital

Inspection report

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Wirral
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Tel: 01516785111
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Date of inspection visit: 24 and 25 April 2023
Date of publication: 10/08/2023

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Arrowe Park Hospital

Requires Improvement 

Pages 1 and 2 of this report relate to the hospital and the ratings of that location. From page 3 the ratings and information relate to maternity services based at Arrowe Park Hospital.

We inspected the maternity service at Arrowe Park Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out an announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

We did not review the rating of the location therefore our rating of this hospital stayed the same.

Wirral University Teaching Hospital NHS Trust is rated requires improvement.

We also inspected 1 other maternity service run by Wirral University Teaching Hospitals NHS Trust. Our reports are here:

Wirral University Teaching Hospital NHS Trust (also known as Seacombe Birth Centre) – https://www.cqc.org.uk/location/RBL18

How we carried out the inspection

During our inspection of maternity services at Wirral University Teaching Hospital NHS Foundation Trust we spoke with 20 staff including leaders, obstetricians, midwives, and maternity support workers.

We visited all areas of the unit including the antenatal clinic, maternity triage, labour ward, birth centre, day assessment, antenatal and postnatal ward. We reviewed the environment, maternity policies and 3 maternity records. We also looked at a wide range of documents including standard operating procedures, meeting minutes, risk assessments, recent reported incidents as well as audits and audit actions. Following the inspection, we reviewed data we had requested from the service to inform our judgements.

We ran a poster campaign during our inspection to encourage pregnant women, birthing people who had used the service to give us feedback regarding care. We analysed the results of the eight responses we had back to identify themes and trends. These reflected a mixed response describing a kind and caring workforce but with some people experiencing delays to treatment and support during their stay in the maternity unit.

The trust provided maternity services at hospital and local community services and 2,975 babies were born at the trust during 2022.

Our findings

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Good ➔➔

Our rating of this service stayed the same. We rated it as good because:

Staff completed multidisciplinary training in key skills and responding to emergencies and worked well together for the benefit of women and birthing people. Staff understood how to protect women and birthing people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.

Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment. All staff were committed to continually improving services.

However:

The service did not always have enough midwifery staff in triage. This was because the staffing model in triage required 2 midwives, but when acuity was low 1 midwife could be moved to a busier department. Because the acuity in triage was changeable and unpredictable, sometimes triage could become very busy and outside of office hours there could be delays bringing a second midwife back to triage.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Most midwifery staff received and kept up to date with their mandatory training. Eighty seven percent of inpatient midwifery staff had completed all 13 mandatory training courses.

Most medical staff received and kept up to date with their mandatory training. Eighty one percent of medical staff had completed all mandatory training courses. Although the trust did not provide a target for mandatory training, they used a red, amber, green system to monitor compliance and when training was due. Managers monitored mandatory training and alerted staff when they needed to update their training.

The alongside midwifery led unit (MLU) had birthing rooms with pools. All staff who worked in the birthing centre had received up to date training in how to support a woman or birthing person in a pool evacuation emergency.

Maternity

The service provided staff with multi-professional simulated obstetric emergency training. Some staff had yet to complete this training, but 80% of midwives, 79% of consultant doctors and 92% of rotational doctors had completed the course. This training was themed around known risks and incidents within maternity services. For example, staff had emergency pool evacuation training and skills practice with a compliance rate of 90% for midwifery staff.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training, and neo-natal life support. Ninety two percent of midwives and 86% of medical staff had completed CTG training and competency assessment.

The trust employed a practice development midwife and carried out a training needs analysis. This outlined training required for each role and frequency. A clinical preceptorship midwife supported band 5 newly qualified midwives through their preceptorship training programme.

Staff were supported to access and complete training by the practice development midwife. They organised regular skills and drills training based on themes and learning from incidents. Specialist midwives also provided short practice update sessions for staff.

The majority of staff we spoke with including newly trained midwives, experienced midwives and medical staff told us they were able to access the training they required and were positive about the training and support they received. A newly qualified midwife told us they felt very supported by all the band 6 and 7 staff and felt valued. However, some medical staff told they did not always have time to complete their training.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff completed protecting vulnerable people (PVP) training level 3 and level 4. Training records showed staff had completed both level 3 safeguarding adults and level 3 safeguarding children training as set out in the trust's policy and in the intercollegiate guidelines. Ninety eight percent of midwifery staff and 88% of medical staff had completed this training.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. For example, community links had been established with faith leaders from different religions. To help with safeguarding concerns, staff had access to and used interpreter services and language line for people whose first language was not English.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse and this was a mandatory field to be completed in the patients' electronic records system. Where safeguarding concerns were identified, women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals, and how to access advice. They gave us an example of a recent safeguarding concern and how this had been dealt with following all the guidance and protocols.

Maternity

The service employed a safeguarding specialist midwife and a safeguarding team who staff could turn to when they had concerns. The safeguarding specialist midwife had won a national award for outstanding leadership in safeguarding. Care records detailed where safeguarding concerns had been escalated in line with local procedures. The safeguarding lead worked closely with other professionals in the local area and attended monthly multiagency meetings.

One area of concern which was recognised was a risk of omission or inability to document the checking of child protection information sharing. This had been identified on the trust's risk register due to the current electronic records system not having comprehensive fields for documenting this information. To resolve this, an additional field was added to the system to ensure midwives had checked child protection information sharing systems.

Staff followed the baby abduction policy and undertook baby abduction drills. A baby abduction drill had taken place a week before our site visit to test the system and staff response. When we looked further into the process, we found the system for exiting the maternity ward was reliant on a staff member observing people if they left during office hours. We were concerned this system was not safe enough. The trust took immediate action and changed the exiting system so women, birthing people, and all visitors had to be let out by a staff member when leaving the ward at all times.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They kept equipment and the premises visibly clean.

Maternity service areas were visibly clean and had suitable furnishings which were visibly clean and well-maintained. Cleaning records were up to date and demonstrated all areas were cleaned regularly.

The service generally performed well in cleanliness checks. Cleanliness audits were carried out daily on all maternity wards and departments. Audit results showed a high compliance rate of 92% and above for April 2023 and 96.1% for hand hygiene and housekeeping audits carried out in the previous 3 months.

Staff followed infection control principles including the use of personal protective equipment. Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The environment was designed and fit for purpose. There was a day assessment unit, antenatal clinic area and triage area. Triage was open 24 hours a day with a dedicated phone line. There was a waiting area with comfortable seating and assessment rooms. Women we spoke with told us they were happy with this environment and found it comfortable.

Maternity

There was an alongside midwife led delivery suite and a consultant led delivery suite including an induction of labour suite. A maternity ward provided antenatal and post-natal care. A shared bay was used to care for postoperative women and birthing people and all other beds were in single rooms. One dedicated operating theatre was used for emergency surgery and 3 further operating theatres were available.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

The design of the environment followed national guidance. The maternity unit was secure with a monitored entry and exit system.

There was a bereavement suite which was sound proofed and sensitively decorated and furnished. This provided bereaved women, birthing people and their families with the necessary space and distance from the rest of the department.

Staff carried out daily safety checks of specialist equipment. Records showed resuscitation equipment outside maternity theatres was checked daily. Records for February to April 2023 and resuscitaire checklist audits showed staff checked resuscitaires at every shift. However, we did see some gaps in daily checking records for resusitaires in triage and on the maternity ward.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there was pool evacuation equipment and on the day assessment and triage unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment. Leaders told us centralised CTG monitoring was being installed later in the year.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration

Risk was assessed at each maternity contact/appointment. We reviewed 3 maternity care records. In each record, risk factors had been defined and identified at the booking appointment and risk assessments were completed at each maternity contact. This enabled women and birthing people to be allocated to the right pathway, so the correct team were involved in leading and planning their care.

Maternity

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. This included the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. We reviewed 3 MEOWS records and found staff correctly completed them and, where indicated, had escalated concerns to senior staff. Staff completed a quarterly audit of records to check they were fully completed and escalated appropriately. Audits for March and April 2023 scored 100%.

Staff completed risk assessments for women and birthing people on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised risk assessment tool for maternity triage. The maternity triage waiting times for review audit for January to March 2023 showed midwives reviewed 100% of women and birthing people within 15 minutes of arrival.

Staff knew about and dealt with any specific risk issues. Staff reviewed care records from antenatal services for any individual risks. There was a fetal surveillance lead and staff used the fresh eyes approach to safely and effectively carry out fetal monitoring. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The January to March 2023 audit showed clear interpretation and management plans following CTG and staff did 'fresh eyes' at each hourly assessment in 72% of cases. Compliance with CTG and 'fresh eyes' was monitored monthly.

Audits were carried out to check risk assessments and other key areas. For example, maternity harm prevention audits, sisters' audits, care metric audits and surgical safety checklist audits were carried out monthly. Compliance rates were high and where issues were identified, action was taken to increase safety and compliance.

Women and birthing people had access to the scans they required and there were enough sonographers and scanning equipment available. Additional scanning appointments were made available if required.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. Specialist mental health midwives and support workers were part of the team. They attended multiagency meetings with mental health professionals and supported women and birthing people across a range of mental health needs.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was held on a secure electronic system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information with multidisciplinary teams.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up to date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation (known as S-BAR) for each person.

Staff completed new-born risk assessments when babies were born using recognised tools and reviewed this regularly. New-born and infant physical examination clinics were held daily on the maternity ward and staffed with midwives who had additional training to carry out these checks.

Maternity

The service provided transitional care for babies who had additional needs. Four rooms on the maternity ward were used for transitional care and these were staffed with neo natal trained staff.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third party organisations were informed of the discharge.

Women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. Staff completed risk assessments for women and birthing people on arrival to the triage department. They used a recognised tool, and reviewed this regularly, including after any incident. Staff used an evidence-based, standardised risk assessment tool for maternity triage. The maternity triage waiting times for review audit for January to March 2023 showed midwives reviewed 100% of women and birthing people within 15 minutes of arrival.

Midwifery Staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service had no current risks with recruitment, retention and staff sickness. Staffing levels usually achieved the planned numbers. At times when staffing numbers were short, an escalation pathway was followed to make leaders aware of staffing needs in each area and to organise appropriate cover. Some staff were moved from their usual working areas to cover staff shortages in other areas. When the triage area was not busy, the second midwife was moved to support busier departments, However, this left one midwife and a ward clerk to deal with incoming calls and to assess women and birthing people as they arrived. This had not led to any known delays in assessment, but some staff told us they felt it was not always safe.

Midwifery staff were organised into continuity of carer teams (where women and birthing people received dedicated support from the same midwifery team throughout their pregnancy) and core teams of midwifes based within maternity wards and departments. Six teams were embedded and established. The teams were based in localities which supported harder to reach and vulnerable communities. The service had plans to reach 100% continuity of carer by September 2024. Staffing needs were assessed daily against the clinical and other needs of the women and birthing people (acuity) expected.

The service last completed a staffing and acuity review in December 2022. It said the service met acuity needs 78% of the time against a trust target of 85%. To respond to this, a recruitment and retention midwife had been recruited to attract new staff and support existing staff within maternity services. There were proactive succession plans to address any shortfalls in numbers or skill mix to provide safe care to people who used the service. The vacancy rate for midwifery, nursing and medical staff was comparably low.

Staff turnover rates were low and were decreasing. For example, the staff turnover rate in November 2022 was at 15.3% and this had reduced to 11.8% in April 2023. The service did not routinely use agency staff. NHS bank staff who were familiar with the service were used as required.

Maternity

There had been 6 red flag events in the last 6 months. A red flag event is a warning sign that something may need attention in midwifery staffing numbers or skill mix. We saw how the red flags were recorded and managed to consider themes or areas where staffing had dropped below the required level (2 occasions). Other red flags recorded in the last 6 months included a delay in administering antibiotics and a delay in carrying out a new-born screening check.

We looked at the most recent staffing report sent to the trust's board which reported staffing and absence and planned versus actual staffing in the maternity departments. It showed no reported trends of any staffing issues within maternity services.

There were supernumerary shift coordinators on duty 24 hours a day who had oversight of the staffing, acuity, and capacity. The labour ward coordinators were also supernumerary.

Managers requested bank staff familiar with the service and made sure all bank and agency staff, if used, had a full induction and understood the service.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. The staff appraisal compliance was at 100%. A practice development team supported midwives. They were responsible for ensuring the required levels of training attendance and competence were achieved. They had an escalation process for any staff who did not attend planned training. The practice development team had been recognised and won an award for the practical obstetric multi professional training delivered in 2022. Incidents and events were used within the training to provide practical learning opportunities.

There were a number of specialist midwives to support different aspects of the service such as surveillance, mental health and bereavement. Managers made sure staff received any specialist training for their role. As well as supporting the staff, specialist midwives also provided practice update training sessions for staff.

The service had specialist midwifery services and clear guidelines for the care of women with mental health problems, teenage pregnancies, substance misuse, bereavement services and infant feeding.

Ten midwifes had completed additional training in enhanced critical care to support the 2 high dependency beds on the delivery suite.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff on duty achieved the planned number. The service had comparably low vacancy, turnover and sickness rates for medical staff.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings, nights and weekends.

Medical ward rounds were carried out twice a day so women and birthing people could be assessed, and their care reviewed. Medical staff involved woman and birthing people in decision making about the plan of care. Ward rounds were comprehensive and women and birthing people were given the time they required to ask questions or raise concerns.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff told us they felt supported to do their job through clinical supervision and were given the opportunities to develop. Consultant rotas included allocated time for supporting professional activities as well as direct clinical care.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Women and birthing people's clinical records were comprehensive and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 3 sets of patient records, 3 of which were in the electronic system and 3 which were the linked paper records. We found the records were clear and complete.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. Electronically stored records could be accessed throughout the hospital so staff in different departments could access this information. To support this, the trust had recruited a midwife to lead on the digital role. There was an information technology (IT) steering group and transformation group with plans in place to upgrade IT systems and record keeping. Women and birthing people did not have direct access to their digital records, but development was underway for access to these to be provided from summer 2023. However, women and birthing people did have handheld notes.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

The service used systems and processes to safely prescribe, administer, record medicines. However, staff did not always ensure all stock medicines were within expiry dates.

Staff followed systems and processes to prescribe and administer medicines safely. The service used an electronic prescribing system. Women and birthing people had electronic charts for medicines to be administered during their admission. We reviewed 3 prescription charts and found staff had correctly completed them.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. These checks were recorded in the prescription charts we checked.

Staff completed medicines records accurately and kept them up to date. Medicines records were clear and up to date. Midwives could access the full list of midwives' exemptions for medicine prescribing, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were stored at the correct temperature. Staff checked controlled drug stocks daily. There was central monitoring for fridge temperatures and staff would be alerted and knew how to act if there was any variation to safe temperatures.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Medicines recorded on both paper and digital systems for the 3 sets of records we looked at were fully completed, accurate and up to date.

However, we found some medicines had passed their expiry dates in three areas. Leaders took immediate action and carried out a full check of all medicine stocks in all maternity departments. As well as this, as a result of our feedback, the frequency of audits of all medicine cupboards and fridges was increased from monthly to fortnightly.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 3 incidents reported in the 3 months before our inspection and found them to be reported correctly.

In the last 3 months, 2 incidents had been referred to the Healthcare Safety Investigation Branch (HSIB) for investigation under the guidance for referring certain events. The investigation into these incidents was ongoing. However, a rapid review had been carried out by the trust and additional training had already been implemented in response to one incident.

The service had no ‘never’ events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Managers reviewed incidents on a regular basis so they could identify potential immediate actions. Weekly care improvement meetings took place to review incidents. Any identified learning or care improvements were shared with staff. Incident reporting was encouraged and used as an opportunity to learn and improve services.

Staff understood duty of candour requirements. They were open and transparent and gave women and birthing people and families a full explanation if and when a notifiable safety incident occurred. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed. All incidents were reviewed by the clinical governance team and with a 10-day target to complete duty of candour and provide a written explanation.

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations as our review of 3 serious incident investigations showed. In these 3 investigations, managers offered an apology and explanation under duty of candour regulations, and shared draft reports with the families for comment.

Maternity

Managers reviewed incidents potentially related to health inequalities through the incident investigation process. Leaders acknowledged this could be strengthened and improved and had plans to do this when changing to the new NHS patient safety incident response framework (PSIRF) for incident reporting.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff discussed a serious incident and shared learning at an obstetric clinical governance meeting in January 2023. As a result of this incident, leaders ensured staff had access to carbon monoxide (CO) monitors and reminded midwifery staff that CO readings must be completed at each contact/appointment with women and birthing people.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people. There was evidence that changes had been made following feedback. Managers debriefed and supported staff after any serious incident.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

There was a clearly defined management and leadership structure. The service was led by a divisional director, midwifery director, and associate medical director for obstetrics, gynaecology and neonatology – often referred to as 'the triumvirate'. They were supported through clear professional arrangements. There was joint working between leaders within maternity, the wider trust, and external agencies and bodies to maximise care provision for women, birthing people and babies.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us the director and head of midwifery were approachable and accessible. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

The service was supported by the Board via the maternity safety champions which included the Chief Nurse and a non-executive director. Safety champions carried out 'walkabouts' within maternity services to speak with women and birthing people and with staff.

Leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in leadership and development programmes to help all staff progress.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a maternity vision and a set of core commitments which underpinned the trust's 5 year maternity clinical services strategy**.** Leaders had developed the vision and strategy in consultation with staff at all levels. Further work had commenced to increase staff knowledge and involvement with the maternity vision and this was displayed in the maternity departments.

Leaders had considered the recommendations from the NHS Ockenden 2020 and 2022 reports on the review of maternity services. They had developed and implemented essential actions as well as revising their vision and strategy to include these recommendations.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. These led to continuity of care teams being well established and being developed further. Also, woman and birthing people had a choice of birth location depending on risk assessment.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff were positive about the department and its leadership team and felt able to speak to leaders about difficulties and when issues arose.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture placing people's care at the heart of the service. They recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and demonstrated by all staff we observed and spoke with. Feedback from women and birthing people following was mostly positive during our site visit and following this inspection. Two women told us they had to wait a long time for pain relief to be given.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. The 2022 maternity survey results showed the general level of care reported for this trust was positive.

Maternity

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service initially used the most informal approach applicable to deal with complaints. Complaints and the response to complaints was a standard agenda item at monthly clinical governance meetings.

We reviewed 2 responses to complaints received and found these were thorough and responded to well.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff. Following any incidents or shortcomings in care or processes, action plans were developed with clear timescales and responsibilities.

There was clear oversight of the service with appropriate lines of reporting to various meetings. For example, there were monthly clinical governance meetings which had oversight of all known or emerging risks. There was a clear line of communication between the service and the trust board. A monthly maternity report was presented to the board of directors providing an update for quality and safety metrics within maternity services and identifying any key risks or required actions.

Maternity

There was a learning culture when incidents occurred or something went wrong. Staff were encouraged to use the electronic reporting system to report any incidents so they could be analysed and used to learn and improve. A midwife leading on risk held weekly meetings to increase learning from incidents.

Staff followed current policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were current and followed the latest guidance.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes. The Ockenden assurance visit of August 2022 found compliance with the 7 immediate and essential actions to improve care and safety in maternity services.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits. Care improvement meetings were held weekly and reviewed incidents across the trust including maternity services.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make changes where risks were identified.

The maternity risk register, perinatal mortality review reports and healthcare safety investigation reports, clinical incidents and audits were a standing item at monthly clinical governance meetings for review and action planning. These were used to identify and manage known risks and were reviewed at monthly trust board meetings and presented to the board of directors every quarter by the director of midwifery. There was a team of safety champions (including a non-executive director and the director of midwifery) who attended monthly meetings and completed walk abouts withing maternity services to speak with women, birthing people and staff.

There were plans to cope with unexpected events. The service had a detailed local business continuity plan. Leaders worked closely with other local maternity departments to support each other when maternity services were busy.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. Listening events and team meetings routinely took place and staff told us they were asked for their feedback and input.

Information Management

Maternity

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it**.** The service had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations to compare performance. Clinical governance reports with statistics on quality, safety and performance were published and displayed in all the maternity areas for all staff to see.

The hospital trust provided staff with the systems and data to access the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

At the time of this inspection woman and birthing people did not have personal access to their clinical records through the hospital's system but changes planned to the IT system would enable this to happen. However, women and birthing people had maternity handheld notes**.** Development was underway for digital access to be provided from summer 2023".

The information systems were integrated and secure**.** Electronic records were protected by security access and only those staff with authorisation were able to see medical records.

Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

The voices of women and birthing people were considered within key decisions. Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. The trust were supportive of the MNVP, met with them frequently and involved them in key decisions affecting maternity services. This included, for example, the recruitment of new leaders.

Leaders understood the needs of the local population. Listening events took place within the local community and in multicultural centres to promote inclusion to all people.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity. The experience of woman and birthing people of using interpreter services was discussed and explored so changes could be made to meet needs. Discussions were underway to further develop antenatal education into other languages and the translation of maternity information to include cultural differences. Staff also used a telephone interpretation service when required, which was available 24 hours a day, every day. Information on social media was also available in other languages.

Social media was used to engage with the local community. This included live-streamed tours of the service and women and birthing people were able to make comments and ask questions. Changes were made in response to what people said or asked for. For example, the décor was changing in the birth centre to make it more welcoming in response to people's feedback. Important antenatal education messages such as 'what to do if fetal movements are reduced' were recorded by staff who could speak other languages and put on social media for people to access.

Listening events and staff meetings took place to engage with staff, communicate changes and listen to their views and experience. For example, listening events had covered topics such as staff work life balance and managing finances.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service was committed to improving by learning when things went well or not so well and promoted training and innovation. Learning was shared with staff through monthly clinical governance newsletters and staff social media platforms. These contained information about recognised risks and incidents; learning from care improvements meetings; complaints; staff and patient feedback; and nationally produced healthcare safety investigation branch reports. Staff were remined how to report incidents and about governance issues such as 'duty of candour.' The newsletter was also used to recognise staff achievements and good practice.

The trust was the only service within the local maternity services network to offer 4 birth choices to woman and birthing people.

The service had a quality improvement training programme and a quality improvement champion who coordinated development of quality improvement initiatives.

There were a team of enhanced care trained midwives with at least one enhanced care trained midwife working on the delivery suite at all times. This was planned to reduce the need to transfer woman and birthing people to intensive care or high dependency units.

Designated infant feeding support staff were available on every shift to provide support to woman and birthing people.

Funding had been secured for an application and new IT software to improve communication in other languages and antenatal education.

There was a team of 3 midwives with a specialist role in mental health support. Midwifery mental health services were being devolved to provide increased support with anxiety and mental health wellbeing. For example, weekly 'singing mammas' groups were offered to antenatal woman (singing mammas groups are designed to improve mood, reduce stress and promote connections). Mental health midwives were attending training so hypnobirthing and a technique known as 'emotional freedom' could be offered. Virtual reality headsets were available for relaxation and medication sessions.

The midwifery team had been awarded a team excellence award by the trust.

Maternity

Outstanding practice

We found the following outstanding practice:

The Maternity and Neonatal Voices Partnership (MNVP) Chair was well supported and received 16 hours per week funding. The relationship between the MNVP chair and leaders was strong and inclusive. The MNVP chair had access to leaders at all times and they responded quickly and efficiently to any concerns raised. The MNVP chair was involved in the recruitment of leaders and encouraged to attend regular meetings to feedback the voices of woman, birthing people and pregnant people. They were involved in a number of initiatives designed to reach out to all groups within the local community.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

Location/core service

- The service should ensure the staffing model and deployment used in triage does not delay access to assessment and treatment.
- The service should ensure there are no out of date medicines within medicine stocks.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, other CQC inspectors and 3 specialist advisors including a consultant and midwives. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.

Wirral University Teaching Hospital NHS Foundation Trust

Wirral University Teaching Hospital NHS Foundation Trust

Inspection report

St. Pauls Road
Wallasey
CH44 7AN
Tel: 01516045431

Date of inspection visit: 24 and 25 April 2023
Date of publication: 10/08/2023

Ratings

Overall rating for this service	Good
Are services safe?	**Good**
Are services well-led?	**Good**

Our findings

Overall summary of services at Wirral University Teaching Hospital NHS Foundation Trust

Good

Pages 1 and 2 of this report relate to the hospital and the ratings of that location. From page 3 the ratings and information relate to maternity services based at Wirral University Teaching Hospital NHS Foundation Trust, also known as Seacombe Birth Centre.

We inspected the maternity service at Wirral University Teaching Hospital NHS Foundation Trust, also known as Seacombe Birth Centre, as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out an announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

The inspection was carried out using a pre-inspection data submission and an on-site inspection where we observed the environment, observed care, conducted interviews with patients and staff, reviewed policies, care records, medicines charts and documentation.

Following the site visit, we conducted interviews with senior leaders, specialist staff and stakeholders. We held focus groups for staff of all grades and roles and reviewed feedback from women and families about the trust. We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We analysed the results to identify themes and trends.

Wirral University Teaching Hospital NHS Foundation Trust, also known as Seacombe Birth Centre is 1 of 2 sites for maternity services for the trust. It is a stand-alone midwifery led unit within Seacombe Children's Centre in Wirral, Merseyside. The birth centre has 1 ensuite birthing room with a birthing pool. It is the base for the 'Highfield' maternity continuity of carer team who provide a continuity of carer community birth service to women and birthing people in Wirral, as well as staffing the birth centre. Between January and December 2022 there were 15 births at Seacombe Birth Centre and the Highfield team also supported 77 home births.

The local maternity population come from areas of higher levels of deprivation than the national average with 26% in the most deprived decile compared to 14% nationally. A higher proportion of mothers (91%) were White compared to the national averages.

The trust offers 4 birth options to women and birthing people including hospital setting, alongside midwifery led unit, freestanding midwifery led unit and home births.

Seacombe Birth Centre was registered with CQC in August 2022 and this is the first time this location has been inspected. We rated it as good because we rated safe and well-led as good.

Our findings

We also inspected 1 other maternity service run by Wirral University Teaching Hospital NHS Foundation Trust. Our reports are here:

Arrowe Park Hospital – https://www.cqc.org.uk/location/RBL14

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Good

We have not previously rated this service. We rated it as good because:

Staff had training in key skills and worked well together for the benefit of women and birthing people. Staff understood how to protect women and birthing people from abuse.

The service controlled infection risk well. Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well.

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. The service managed safety incidents well and learned lessons from them.

Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.

Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities.

The service engaged well with women and birthing people and the community to plan and manage services People could access the services when they needed it and did not have to wait too long for treatment. All staff were committed to improving services continually.

However:

There were gaps in the provision and checks of resuscitation equipment, although these were addressed during and shortly after our visit.

Is the service safe?

Good

We have not previously rated safe. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Most nursing and midwifery staff received and kept up-to-date with their mandatory training. Eighty-eight per cent of continuity of care midwifery staff had completed all 9 mandatory training courses. Managers monitored mandatory training and alerted staff when they needed to update their training.

Maternity

The service provided staff with multi-professional simulated obstetric emergency training. Eighty-six per cent of community midwives and 75% of continuity of carer midwives had completed Practical Obstetric Multi-Professional Training (PrOMPT). This training was themed around known risks and incidents within maternity services.

The birth centre had a pool in the birthing room. All staff had received up to date training in how to support a woman or birthing person in a pool evacuation emergency. Drills specifically relating to the birth centre started in 2023 additional to the annual updates relating to birth centre and home birth.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included skills and drills training and neo-natal life support. Training was up-to-date and reviewed regularly. Eighty-six per cent of midwives based at Seacombe Birth Centre had completed neo-natal life support. There was only 1 midwife who had not yet completed it, as they were a new starter, and they were booked onto training.

The trust employed a practice development midwife and carried out training needs analysis. This outlined training required for each role and frequency. A clinical preceptorship midwife supported band 5 newly qualified midwives through their preceptorship training programme.

Staff were supported to access and complete training by the practice development midwife. They organised regular skills and drills training based on themes and learning from incidents. Specialist midwives also provided short practice update sessions for staff.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff completed protecting vulnerable people (PVP) training level 4. In this service, level 4 PVP training equated to intercollegiate guidance level 3 safeguarding adults and children training. Training records showed staff had completed both level 3 safeguarding adults and level 3 safeguarding children training as set out in the trust's policy and in the intercollegiate guidelines. Ninety-three per cent of continuity of carer midwifery staff had completed this training.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics, for example by arranging interpreter services.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of developing individualised birth plans with relevant agencies and staff for women and birthing people where safeguarding risks had been identified.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service employed a safeguarding specialist midwife and a safeguarding team who staff could turn to when they had concerns. The safeguarding specialist midwife had won a national award for outstanding leadership in safeguarding. The safeguarding lead worked closely with other professionals in the local area and attended monthly multiagency meetings.

Maternity

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They kept equipment and the premises visibly clean.

The birth centre was visibly clean and had suitable furnishings which were visibly clean and well-maintained. General cleaning was provided by the cleaners for the children's centre.

Staff cleaned equipment after contact with women and birthing people and labelled with green 'I am clean' stickers to indicate it was ready for use. Midwives were responsible for ensuring equipment was clean and ready for use and for cleaning the room and equipment after a birth. Maternity support workers carried out a weekly deep clean of the birthing room. This was monitored through monthly matron's audits.

Staff followed infection control principles including the use of personal protective equipment. Leaders completed regular infection prevention and control and hand hygiene audits. The most recent hand hygiene audit from March 2023 showed compliance was 100%.

Waste water from the birthing pool was discarded safely using a single use hose. Staff regularly checked pool cleanliness and there was standard operating procedure for cleaning the pool after use.

Staff followed policies and procedures for the transportation and disposal of soiled linen and placenta. Staff in the Highfield had a people safe device for lone working as an additional security measure following best practice.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. However, there were gaps in the provision and checks of resuscitation equipment, although these were urgently addressed following our visit.

The environment was designed and fit for purpose. The design of the environment followed national guidance. The birth centre was fully secure with a monitored entry and exit system. Access to the birth centre during the day was through the reception for the children's centre, which was staffed. Out of hours midwives met women and birthing people at the centre and admitted them through either the main entrance or the side entrance direct into the birth centre. Staff followed a lone working policy when attending the centre out of hours and it was monitored by CCTV and a community patrol.

Staff carried out weekly safety checks of this specialist resuscitation equipment. This had changed in April from monthly checks and assessment visit by the trust resuscitation officer. However, during our inspection we found an out of date airway in the home birth resuscitation bag.

The service had suitable facilities to meet the needs of women and birthing people's families. T

There was access to a range of birthing equipment including birth balls, a birth stool and couches, as well as a birthing pool used for pain relief during delivery.

The standard operating procedures clearly outlined the arrangements for birth partners of women and birthing people to attend the birth and provide support. Following the birth, women and birthing people and their birth partners could

stay in the room until they were ready to go home. Midwives told us they did not place a time limit on this, but it was usually between 2 and 4 hours. There were no facilities for overnight stays or postnatal care at the birth centre. If a woman or birthing person required additional postnatal care, above that given by a community midwife, they would be transferred to the main maternity unit at Arrowe Park Hospital.

With the exception of the resuscitaire discussed below, the service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, there was equipment to assist staff to evacuate a woman or birthing person from the pool in case of emergency. Staff completed skills and drills training on emergency pool evacuation.

Equipment maintenance was carried out by the trust's maintenance department, and we saw them on site during our inspection ensuring all relevant equipment had an up to date portable electrical appliance test.

The service had carried out ligature risk assessments of the environment in line with NHS England National Patient Safety Alert/2020/001/NHSPS.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored clinical waste in bins in a locked compound outside the building while waiting for removal.

The birth centre was equipped with emergency equipment in line with best practice for home birth. This meant it did not have a resuscitaire. A resuscitaire is a large standing device used by midwives if a baby requires some additional support with their breathing when they are born. If a new-born required resuscitation, staff had access to a home birth resuscitation equipment bag. Following our inspection, the service confirmed they had sourced a resuscitaire for the birth centre. During our inspection, we saw a trolley set up with the equipment in preparation to be transferred to an appropriate flat stable surface should a new-born require resuscitation. Though staff told us they had been instructed to use a flat stable surface this was a risk as in an emergency midwives may transfer new-borns into the trolley to perform resuscitation and this was not a stable base on which to perform this. The service confirmed following the resuscitation officer's visit in April 2023, midwives had been instructed to no longer use the trolley for resuscitation. Following our inspection, they organised for it to be immediately removed and a resuscitation station to be installed.

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

Risk was assessed at each maternity contact/appointment. We reviewed 3 maternity care records. In each record, risk factors had been defined and identified at the booking appointment, and risk assessments were completed at each maternity contact. This ensured women and birthing people were allocated to the right pathway so the correct team were involved in leading and planning their care.

The service had clear criteria for staff to assess if women and birthing people would be suitable to give birth at the birth centre. The standard operating procedure for the birth centre and 'guidelines for women who give birth outside of a hospital setting' gave clear guidance to staff which supported women and birthing people's choice and outlined the risk assessment process.

The service achieved 100% compliance with provision of one to one care in labour.

Maternity

There were clear criteria and processes to follow if a woman or birthing person required transfer to the obstetric-led unit at Arrowe Park Hospital. Transfer times were approximately 8 minutes but could be longer dependent on traffic. Women and birthing people were made aware of the transfer times to Arrowe Park Hospital and that this would take place by ambulance.

Staff shared key information to keep women and birthing people safe when handing over their care to others. Staff used a situation, background, assessment and recommendation (SBAR) tool to hand over care to staff at the obstetric led unit.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. This included the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. Staff completed a quarterly audit of records to check they were fully completed and escalated appropriately. Audits for March and April 2023 scored 100%.

Audits were caried out to check risk assessments and safety checks were carried out. For example, matron's audits and team leader's audits were carried out monthly. Compliance rates were high and where issues were identified, action was taken to improve safety and compliance.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide. Specialist mental health midwives and support workers were part of the team. They attended multiagency meetings with mental health professionals and supported women and birthing people across a range of mental health needs.

The care record was held on a secure electronic system used by all staff involved in the woman or birthing person's care. Each episode of care was recorded by health professionals and was used to share information with multidisciplinary teams.

Staff completed new-born risk assessments using recognised tools and reviewed this regularly. New-born and infant physical examinations were carried out by the named community midwife at the postnatal visit following a birth at the birth centre.

Leaders monitored waiting times and made sure women and birthing people could access services when needed and received treatment within agreed timeframes and national targets. The birth centre and home birth service had remained open at all times between September 2022 and March 2023.

Staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

Maternity

The service had enough nursing and midwifery staff to keep women and babies safe. The birth centre was opened and staffed by a midwife when a woman or birthing person attended in labour. This was arranged directly with the home birth midwife and, out of hours, there was a home birth midwife on call. A second midwife would then attend from the 'Highfield' home birth team or, out of hours, the community on-call midwife would attend as second midwife.

Managers accurately calculated and reviewed the number and grade of midwives, maternity support workers needed for each shift in accordance with national guidance. The service had completed a maternity safe staffing review in March 2023 due to a decrease in births and increase in midwifery staffing. They had confirmed the staffing required to continue the roll out of continuity of carer. Managers reviewed staffing each day using a nationally recognised tool and had escalation processes, using redeployment of midwives, in line with NICE Guideline 4 Safe Midwifery staffing for maternity settings.

The service had no vacancies for midwives. In March 2023, the sickness absence rate for community midwifery staff was 0.9% and for continuity of carer midwives was 5.2%. The service did not use agency staff.

The service had specialist midwifery services and guidelines for the care of women with mental health problems, teenage pregnancies, substance misuse, bereavement services and infant feeding.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The service was delivered by midwives from the 'Highfield' continuity of carer team who also provided the home birth service. This meant all staff were experienced community and home birth midwives and maternity support workers.

Managers supported staff to develop through yearly, constructive appraisals of their work. The staff appraisal rate was at 100%. A practice development team supported midwives. They were responsible for ensuring the required levels of training attendance and competence was achieved. They had an escalation process for any staff who did not attend planned training. The practice development team had been recognised and won an award for the practical obstetric multi professional training delivered in 2022. Events were used within the training to provide practical learning opportunities.

There were a number of specialist midwives to support different aspects of the service such as fetal surveillance, mental health and bereavement. Managers made sure staff received any specialist training for their role. As well as supporting the staff, specialist midwifes also provided practice update training sessions for staff.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women and birthing people's clinical records were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records. We reviewed 3 sets of patient records, 3 of which were in the electronic system and 3 which were the linked paper records. We found the records were clear and complete.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. To support this, the trust had recruited a midwife to lead on the digital role. There was an information technology (IT) steering group and transformation group with plans in place to upgrade IT systems and record keeping. Women and birthing people did not have direct access to their digital records, but development was underway for access to these to be provided from summer 2023. However, women and birthing people did have handheld notes.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had paper prescription charts for medicines to be administered during their admission. The medicines management process was clearly outlined in the standard operating procedure for the birth centre. Pharmacy cover was provided by the trust pharmacy department.

Staff completed medicines records accurately and kept them up-to-date. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely although one oxygen cylinder was out of date for safe use. The birthing room where the medicines and intravenous fluids were stored was locked and could only be accessed by authorised staff. Staff explained a woman or birthing person would never be left unattended in the birthing room. Medicines for internal use were kept in a wall mounted locked medicines cupboard and there was a process to regularly change the digital code. Staff could access medicines from sealed home birth and anaphylaxis medicines kits.

Medicines were in date and stored at the correct temperature. Staff monitored and recorded room temperatures and knew to take action if there was variation. Medical gases were stored in line with risk assessments completed by the trust's fire safety and health and safety officer.

There were 2 cylinders of medical gases, one nitrous oxide and one oxygen, on a secure trolley for use in the birthing room. The oxygen cylinder was out of date for safe use. We escalated our concerns to leaders who took immediate action to remove and replace the out of date oxygen.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed an incident reported in the 3 months before inspection and found it to be reported correctly.

Maternity

The birth centre had no 'never' events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Managers reviewed incidents on a regular basis so they could identify potential immediate actions. Weekly care improvement meetings took place to review incidents. Any identified learning or care improvements were shared with staff. Incident reporting was encouraged and used as an opportunity to learn and improve services.

Staff understood the duty of candour requirements. They were open and transparent and gave women and birthing people and families a full explanation if and when a notifiable safety incident occurred. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed. All incidents were reviewed by the clinical governance team and with a 10-day target to complete the duty of candour process and provide a written explanation.

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations as our review of the rapid review for the 1 serious incident showed. In this example, managers offered an apology and explanation under duty of candour regulations.

Managers reviewed incidents potentially related to health inequalities through the incident investigation process. Leaders acknowledged this could be strengthened and improved and had plans to do this when changing to the new NHS patient safety incident response framework (PSIRF) for incident reporting.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff we spoke with were aware of the recent serious incident and immediate learning and action taken. There was evidence changes had been made following feedback. For example, the resuscitation officer had carried out a full review and additional new-born resuscitation equipment had been ordered.

Is the service well-led?

Good

We have not previously rated well-led. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

There was a clearly defined management and leadership structure for maternity services. The service was led by a divisional director, midwifery director, and associate medical director for obstetrics, gynaecology and neonatology – often referred to as 'the triumvirate'. The triumvirate were supported through clear professional arrangements. There was joint working between leaders within maternity, the wider trust, and external agencies and bodies to maximise care provision for women, birthing people and babies.

Maternity

Locally, staff at Seacombe Birth Centre were supported by the maternity matron and community midwifery team leaders.

The matron had lead responsibility for the birth centre and the consultant midwife supported the team by attending the centre and having a clinical presence regularly.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

Both senior and local leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, matron and the head of midwifery. The matron and head of midwifery visited the birth centre on a regular basis. Staff spoke of how accessible and encouraging senior leaders and the executive team were.

The service was supported by maternity safety champions which includes the chief nurse and a non-executive directors.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders and which included services delivered at Seacombe Birth Centre.

The maternity clinical service strategy for all maternity services was updated in April 2023 to reflect relevant learning from both the Ockenden Review and East Kent 'Reading the Signals' reports. This had been developed in consultation with staff at all levels in the women's and children's division and ensured it aligned with the trust's strategic objectives. Staff could explain the vision and what it meant for women and birthing people and babies.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. For example, one of the clinical service priorities was to 'provide seamless care working with our partners'. This described strategic partnerships and collaboration with other NHS providers, user groups and the Maternity Voices Partnership and universities. The strategy was underpinned by bespoke strategies for some areas such as the maternity digital strategy.

Leaders and staff understood and knew how to apply the strategy and monitor progress. The strategy included an accountability performance framework which included quarterly monitoring of progress toward achieving the strategic priorities.

Culture

Maternity

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff felt respected, supported, and valued**.** Staff were positive about the birth centre and the choice it offered women and birthing people. Staff told us they felt able to speak to leaders about difficulties and when issues arose.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture placing care at the heart of the service. They recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and described by staff we spoke with.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. The 2022 maternity survey results showed the general level of care reported for this trust was positive.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service initially used the most informal approach applicable to deal with complaints. Complaints and the response to complaints about all maternity services was a standard agenda item at monthly clinical governance meetings.

The service clearly displayed information about how to raise a concern in public areas. Staff understood the policy on complaints and knew how to handle them.

There had been no complaints received in the last 6 months about services at Seacombe Birth Centre

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders operated effective governance processes, throughout the service and with partner organisations. There was clear oversight of the service with appropriate lines of reporting to various meetings. For example, there were monthly clinical governance meetings which had oversight of all known or emerging risks. The governance process for the whole maternity service included reporting and oversight of service delivery and outcomes at Seacombe Birth Centre.

There was a clear line of communication between the birth centre, maternity service as a whole, and the trust board. A monthly maternity report was presented to the board of directors providing an update for quality and safety metrics within maternity services and identifying any key risks or required actions. Following any incidents or shortcomings in care or processes, action plans were developed with clear timescales and responsibilities.

Maternity

There was a learning culture and staff were encouraged to use the electronic reporting system to report any incidents so they could be analysed and used to learn and improve. A midwife leading on risk held weekly meetings to increase learning from incidents.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Staff followed up to date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were current and followed the latest guidance..

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Maternity services participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent and met expectations, such as national standards.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits. Care improvement meetings were held weekly and reviewed incidents across the trust including maternity services.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

The maternity risk register, perinatal mortality review tool and Healthcare Safety Investigation Branch reports, clinical incidents and audits were a standing item at monthly clinical governance meetings for review and action planning. These were used to identify and manage known risks and were reviewed at monthly trust board meetings and presented to the board of directors every quarter by the director of midwifery.

There were plans to cope with unexpected events. Maternity services had a detailed local business continuity plan, which included Seacombe Birth Centre. Leaders worked closely with other local maternity departments to support each other when maternity services were busy.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. Listening events and team meetings routinely took place and staff told us they were asked for their feedback and input.

Information Management

Maternity

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it**.** The service had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations to compare performance. Clinical governance reports with statistics on quality, safety and performance were published and displayed in all the maternity areas for all staff to see.

Key performance indicators were displayed for review and managers could see other locations to compare performance. At the time of this inspection woman and birthing people did not have personal access to their clinical records through the hospital's system but changes planned to the IT system would enable this to happen. However, women and birthing people had maternity handheld notes**.** Development was underway for digital access to be provided from summer 2023.

The information systems were integrated and secure**.** Electronic records were protected by security access and only those staff with authorisation were able to see medical records.

Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

The voices of women and birthing people were considered within key decisions. Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. The trust were supportive of the MNVP, met with them frequently and involved them in key decisions affecting maternity services. This included, for example, the recruitment of new leaders.

The MNVP completed a '15 steps' visit of the birth centre in early 2023 and staff were able to describe the feedback and actions they were taking to make changes based on the recommendations. The MNVP report included consideration of the needs of women and birthing people with seldom heard voices.

The service held regular coffee mornings to promote the support available and build relationships between women, birthing people and the continuity of carer midwives.

Staff promoted choice for women and birthing people. Women and birthing people with complex social needs were not excluded from delivering in the birth centre, with protocols in place to ensure the involvement of specialist midwives and the consultant midwife as required.

Leaders understood the needs of the local population. Listening events took place within the local community and in multicultural centres to promote inclusion to all people.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity. The experience of woman and birthing people of using interpreter services was discussed and explored so

changes could be made to meet needs. Discussions were underway to further develop antenatal education into other languages and the translation of maternity information to include cultural differences. Staff also used a telephone interpretation service when required, which was available 24 hours a day, every day. Information on social media was also available in other languages.

Social media was used to engage with the local community. This included live streamed tours of the service and women and birthing people were able to make comments and ask questions. Changes were made in response to what people said or asked for. For example, the service had plans to change the décor to make it more welcoming in response to people's feedback. Important antenatal education messages such as 'what to do if fetal movements are reduced' were recorded by staff who could speak other languages and put on social media for people to access.

Listening events and staff meetings took place to engage with staff, communicate changes and listen to their views and experience. For example, listening events had covered topics such as staff work life balance and managing finances.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service was committed to improving by learning when things went well or not so well and promoted training and innovation. Learning was shared with staff through monthly clinical governance newsletters and staff social media platforms. These contained information about recognised risks and incidents; learning from care improvements meetings; complaints; staff and patient feedback; and nationally produced healthcare safety investigation branch reports. Staff were remined how to report incidents and about governance issues such as 'duty of candour.' The newsletter was also used to recognise staff achievements and good practice.

The trust was the only service within the local maternity services network to offer 4 birth choices to woman and birthing people.

The service had a quality improvement training programme and a quality improvement champion who coordinated development of quality improvement initiatives.

Funding had been secured for an application and new IT software to improve communication in other languages and antenatal education.

Midwifery mental health services were being devolved to provide increased support with anxiety and mental health wellbeing. For example, weekly 'singing mammas' groups were offered to antenatal woman (singing mammas groups are designed to improve mood, reduce stress and promote connections). Mental health midwives were attending training so hypnobirthing and a technique known as 'emotional freedom' could be offered. Virtual reality headsets were available for relaxation and meditation sessions.

The midwifery team had been awarded a team excellence award by the trust.

Maternity

Outstanding practice

The Maternity and Neonatal Voices Partnership (MNVP) Chair was well supported and received 16 hours per week funding. The relationship between the MNVP chair and leaders was strong and inclusive. The MNVP chair had access to leaders at all times and they responded quickly and efficiently to any concerns raised. The MNVP chair was involved in the recruitment of leaders and encouraged to attend regular meetings to feedback the voices of woman, birthing people and pregnant people. They were involved in a number of initiatives designed to reach out to all groups within the local community.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust SHOULD take to improve:

Maternity

- The service should ensure staff carry out regular checks of specialist resuscitation equipment and that resuscitation equipment used is suitable and properly used.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, other CQC inspectors and 3 specialist advisors including a consultant and midwives. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	no	No escalation from SCN / LMNS on outlier report
	Outlier for rates of neonatal deaths as a proportion of birth	no	No escalation from SCN / LMNS on outlier report
	Rates of HIE where improvements in care may have made a difference to the outcome	no	Very low rates of HIE, sitting way below the lower control limit for the region. No current cases
	Number of SI's	no	No serious incidents reported in June 2023
	Progress on SBL care bundle V2	no	SBLCBV2 has been fully implemented at WUTH with progress monitored using audits which are registered on the FAAP. SBLv3 launched and will continue to be a key safety action of MIS Year 5 with an additional element 6: mgt of pre-existing diabetes
	Outlier for rates of term admissions to the NNU	no	The rate of avoidable term admissions remains low. Regular multi-disciplinary reviews of care take place
Service user and st	MVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints; to date all complaints have been addressed for maternity in the target timeframesand there is nil to escalate
	Trainee survey	no	No update this month
	Staff survey	no	Trust Staff Survey completed and divisional response has included staff engagement and continuation with the Pulse surveys
	CQC National survey	no	Nil to report this month
	Feedback via Deanery, GMC, NMC	no	Nil to report this month
	Poor staffing levels	no	All vacacnies have been recruited into for Band 5 and Band 6 midwives; further retirements anticipated later and in the year. New starters anticipated start date Sept/Oct 2023
	Delivery Suite Coordinator not super nummary	no	Super nummary status is maintained for all shifts
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	Nil of note; full establishment
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams /Directorates
	False declaration of CNST MIS	no	Externally audited by MIAA. MIS Year 4 submission and declaration submitted by 12 noon on 2nd February 2023; MIS Year 5 published 31/5/2023 and submission cycle will be Feb 2024
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil to report this month
Safety and learning culture	Lack of engagement in HSIB or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead. Quarterly regional meetings arranged with excellent MDT attendance. Quarterly meeting held in Feb 2023; site visit May 2023; nil to escalate
	Lack of transparency	no	Being open conversations are regularly had and 100% compliance with duty of candour evident
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all SI's, local reviews, rapid reviews, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress. Trust wide lessons learnt forum has commenced reviewing themes from SI's, complaints and audits
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations. No exceptions to report. Three year single delivery plan for maternity and neonatal services published 31th March 2023 - gap analysis in progress and will monitored via WUTH CG structure and BoD
Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Regular training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture
	Delays in reporting a SI where criteria have been met	no	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework
	Never Events which are not reported	no	No maternity or neonatal never events in May 2023
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales
Governanc e processes	Unclear governance processes		Clear governance processes in place that follow the SI framework - Within division there is maternity and neonatal review of governance processes: 3 separate meetings. Staff are informed of top risks and incident themes. Governance notice boards updated and newsletters disseminated. Additional quality assurance framework agreed with effect from June 2023 to give the BoD addiitonal assurances in monitoring of MIS, Three year delivery plan etc.
	Business continuity plans not in place	no	Business continuity plans in place
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	Nil to report this month
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Nil to report this month
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	N/a
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
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	Rates of HIE where improvements in care may have made a difference to the outcome	no	Very low rates of HIE, sitting way below the lower control limit for the region. No current cases
	Number of SI's	no	No serious incidents reported in July 2023
	Progress on SBL care bundle V2	no	SBLCBV2 has been fully implemented at WUTH with progress monitored using audits which are registered on the FAAP. SBLv3 launched and will continue to be a key safety action of MIS Year 5 with an additional element 6: mgt of pre-existing diabetes; nataional toolkit available and quarterley meetings with ICB to monitor to be set up
	Outlier for rates of term admissions to the NNU	no	The rate of avoidable term admissions seen an increase in July; all reviewed and appropriate admissions; Regular multi-disciplinary reviews of care take place
Service user and st	MVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints; to date all complaints have been addressed for maternity in the target timeframesand there is nil to escalate
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	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil to report this month
Safety and learning culture	Lack of engagement in HSIB or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead. Quarterly regional meetings arranged with excellent MDT attendance. Quarterly meeting held in Feb 2023; site visit May 2023; nil to escalate
	Lack of transparency	no	Being open conversations are regularly had and 100% compliance with duty of candour evident
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all SI's, local reviews, rapid reviews, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress. Trust wide lessons learnt forum has commenced reviewing themes from SI's, complaints and audits
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations
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Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Regular training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture
	Delays in reporting a SI where criteria have been met	no	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework
	Never Events which are not reported	no	No maternity or neonatal never events in July 2023
	Recurring Never Events indicating that learning is not taking place	no	N/a
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	Business continuity plans not in place	no	Business continuity plans in place
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	Nil to report this month
CQC Inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Nil to report this month
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	CQC reports published for maternity sites Seacombe Birth Centre and APH site for the domains Safe and Well led; both sites were rated 'GOOD'
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

Publication reference: PRN00610

Newborn and infant physical examination: training requirements

July 2023, Version 1

Guidance for NHS providers of maternity and neonatal services on training requirements regarding newborn and infant physical examination (NIPE).

Introduction

NHS England is committed to ensuring everyone using maternity and neonatal services receive high quality care throughout their perinatal journey. An important part of that care is the delivery of the newborn and infant physical examination (NIPE) screening programme, which is integral to identifying health issues early and effectively to help reduce morbidity and mortality alongside other screening programmes. This is achieved as part of the holistic assessment of the newborn.

To best achieve this, the programme stipulates that the NIPE newborn screening examination must be completed by a "…trained practitioner who is competent to undertake all elements of the newborn screening examination and who has undergone relevant training and a locally agreed competency assessment by a practising NIPE examiner. This can be a midwife, nurse or health visitor who has successfully completed a university accredited 'examination of the newborn' programme of study or a doctor…",[1] or who has completed a midwifery education programme under the Nursing and Midwifery Council Standards (2019).

Purpose

This guidance seeks to clarify the NIPE screening programme requirements, to ensure only trained and competent individuals who meet the requirements of the NHS England NIPE clinical guidance (section 12) undertake examination of the newborn (including NIPE newborn screening for eyes, heart, hips and testes).

[1] Newborn and infant physical examination (NIPE) screening programme handbook - GOV.UK (www.gov.uk)

The information is presented through six possible scenarios to help providers assure themselves that midwives within their current workforce have the required level of training to be deemed as a NIPE trained practitioner:

Scenarios

1. Midwives joining the NMC register completing programmes approved on the Standards of proficiency for midwives (2019):
    - All students successfully completing and exiting a programme approved against the 2019 NMC Education Standards should have completed both theory and practice requirements of the systematic physical examination of the newborn.
    - In England, this would meet NIPE screening programme requirements and assuming both theory and practice has been included in the training these midwives are, therefore, able to carry out NIPE newborn screening examinations as newly qualified midwives (NIPE trained).

2. Pre-registration midwifery programmes (Approved against the NMC Standards of proficiency for midwives (2009):
    - There will still be some third year, and potentially second year student midwives on education programmes approved against the 2009 Standards. Some of these students may have:
        - not completed any examination of the newborn training (including NIPE screening)
        - completed theory only
        - completed full (theory and practice) elements (NIPE trained).

This will depend on the curriculum at their approved education institution and can be ascertained by a discussion with the individual midwife and liaising with the relevant lead midwife for education. These colleagues therefore may not be considered NIPE trained.

3. Internationally educated midwives:
    - Internationally educated midwives (IEMs) undertake a systematic physical examination of the newborn (SEN) NMC OSCE as part of their test of competence (ToC). While the OSCE has some principles and elements of a newborn NIPE examination via the simulated assessment, the OSCE standards and marking criteria are for SEN.
    - This means that successful SEN OSCE completion would not constitute examination of the newborn and NIPE university accredited training or assessment and therefore would not meet the NIPE screening programme training requirements.

4. Return to Practice (RTP) midwives through a RTP programme or completion of the ToC:
    - Where a midwife is returning to practice through a university RTP programme the midwife will have achieved both theory and practice elements of the examination of the newborn and NIPE screening training and would meet the NIPE screening programme requirements upon successful completion of the programme.
    - Those returners completing the ToC route may have previously undertaken NIPE newborn screening university accredited training and undertook examination of the newborn and NIPE screening prior to leaving the NMC register.
        - In line with the NIPE screening programme requirements these individuals could recommence examination, but trusts/employers would need to ensure that there are local processes in place to assess their competence (ideally using the NIPE screening annual learning framework and peer review assessment tools).
    - Those returners completing the ToC route that have not previously completed NIPE newborn screening accredited training will need to complete a university accredited programme to complete NIPE examinations.

5. All midwives completing the ToC without previous examination of the newborn training (including NIPE screening):
    - Completion of a ToC does not equate to NIPE accreditation. All midwives who complete the ToC will have achieved some of the theory or practice elements of the NIPE screening programme requirements, but not all.
        - You will need to consider this with the local HEI along with the support they need while in employment to fully achieve the NIPE screening programme requirements to safely carry out formal examination of the newborn examinations (including NIPE screening).

Registrants who do not fall into one of the categories in the scenarios above should refer to the guidance provided in the NIPE Handbook: Newborn and infant physical examination (NIPE) screening programme handbook - GOV.UK (www.gov.uk)

Further support

Please consider this guidance when identifying and determining whether your colleagues are considered trained practitioners for the NHS NIPE screening programme. To help provide clarity around the training requirements, we ask that you proactively share this information within your systems and midwifery workforce.

Should you have any further queries, do not hesitate to contact us via england.screeninghelpdesk@nhs.net and england.nursingworkforce@nhs.net.