Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 19 January 2022

TB2022.07

Title:	**Maternity Incentive Scheme Update Report**

Status:	**For Discussion**
History:	

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

Executive Summary

1. The purpose of this paper is to provide an update on the status of OUH compliance with the NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year Four.
2. It is also intended to highlight to the Board areas of risk to compliance, facilitating discussion as to how the Trust Board could most effectively support the Maternity and Neonatal units with proposed mitigations.
3. The Trust were notified on the 23 December 2021 that in recognition of the current pressure on the NHS and maternity services, the majority of reporting requirements relating to demonstrating achievement of the maternity incentive scheme (MIS) 10 safety actions are paused with immediate effect **for a minimum of 3 months**. This will be kept under review.

Recommendations

4. The Trust Board is asked to:
   - Receive and note the contents of the update report.
   - Discuss how the Board could support the Divisional Teams with overcoming the challenges to compliance which have been identified.
5. The deadline for the Board declaration to reach NHSR is now provisionally **12 noon on Thursday 30 June 2022**.

Contents

1. Purpose

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

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

2. Background

2.1. The ten safety actions for year four of the scheme were first published by NHSR on 9th August 2021, however, were subject to changes to extend deadlines and support trusts. The revised document was released on 12th October 2021.

2.2. The Oxford University Hospitals NHS Trust were informed on the 23 December 2021 that the majority of the **reporting requirements** relating to demonstrating achievement of the Maternity Incentive Scheme have been paused for a **minimum of 3 months** due to the current pressure on the NHS and maternity services.

2.3. The deadline for the Board declaration of compliance with all ten standards to reach NHSR is **12 noon on Thursday 30 June 2022.**

2.4. This paper outlines the required standards for each of the ten safety actions along with the current evaluation of the compliance status and perceived level of risk for each standard (see appendix 1 below), however timeframes may change when the scheme is relaunched.

3. Pause in Reporting December 2021

3.1. The Trust was informed on the 23 December 2021 that there would be a pause in reporting for a minimum of 3 months.

3.2. Trusts have been asked to continue to apply the principles of the 10 safety actions, given that the aim of the MIS is to support the delivery of safer maternity care. Examples of continuing to apply the principles include undertaking midwifery workforce reviews, ensuring that as far as possible the oversight provided by the maternity, neonatal and board level safety champions continue, as well as using available online training resources.

3.3. Trusts have been asked to continue to report to MBRRACE-UK and report eligible cases to the Health Safety Investigation Branch (HSIB). In addition, every reasonable effort should be made to make the Maternity Services Data Set submissions to NHS Digital.

3.4. In the current challenging circumstances, in descending order of priority for reporting to MBRRACE-UK as follows:

3.4.1. **Notify all perinatal and maternal deaths:**

- Complete the surveillance information for COVID-19 related perinatal deaths where either the mother and or baby is infected with SARS-CoV-2.
- Continue to complete the perinatal surveillance information for all other deaths, whilst there is capacity to do so.
- Continue to complete reviews using the Perinatal Mortality Review Tool, whilst there is capacity to do so.

4. Conclusion

4.1. This paper outlines the Trust's current level of compliance all ten safety actions for Year 4 of the MIS.

4.2. The paper brings to the attention of the Board recent national level changes in relation to reporting requirements, which have been noted and acted upon.

4.3. The Board are asked to note areas of risk to compliance, facilitating discussion as to how the Trust Board could most effectively support the Maternity and Neonatal units with proposed mitigations.

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

5. Recommendations

The Trust Board is asked to:

- Receive and note the contents of the update report.
- Discuss how the Board could support the Divisional teams with overcoming the challenges that have been identified.

Appendix 1: Year 4 Safety Actions: Detail of Current Status and Risk Level

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

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
a) i. All perinatal deaths eligible to be notified to MBRRACE- UK from 1 September 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.	**Expecting to be compliant** Recruited a 1.0 whole time equivalent (WTE) perinatal mortality review (PMR) coordinator at band 6 to ensure the surveillances are completed within the one-month period whilst also providing women-centred and personalised care. Three members of the Neonatal team Child Mortality Team have been trained on how to complete the surveillance part of the Tool.	Copy of the job description for the Perinatal Mortality Review (PMR) Coordinator. Copy of the reporting Standard Operating Procedure (SOP). Clinical Negligence Scheme for Trusts (CNST) will check our Perinatal Mortality Review Tool (PMRT) data.
a) ii. ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.	**Expecting to be compliant** PMR meeting takes place every Monday afternoon. The PMR coordinator will monitor the timescales.	
b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 8 August 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.	**Expecting to be compliant** PMR coordinator and perinatal mortality lead to monitor this.	

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
c) For at least 95% of all deaths of babies who died in your Trust from 8 August 2021, the parents will have been told that a review of their baby's death will take place, and that parents' perspectives and any questions and/or concerns they have about their care and that of their babies will be sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.	**Expecting to be compliant** There is a Standard Operating Procedure (SOP) describing parental involvement in the PMR process. Also included as part of the maternity and neonatal checklists. Parental perspectives are recorded on the PMR tool.	Copy of the SOP included as part of the evidence.
d) Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	**Expecting to be compliant** Quarterly reported is submitted to the confidential Trust Board – Quarter 2 submitted in November 2021. This was also presented at MCGC in October.	Papers submitted to Confidential Trust Boards in November for quarter 2.

Safety Action 2: Maternity Services Data Set (MSDS)

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. It will help trusts understand the improvements needed in advance of the assessment months. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met. Criteria 1-13 will be assessed by NHS Digital and included in the scorecard.		
1) Trust Boards to confirm that they have either: • already procured a Maternity Information System complying with the forthcoming framework (to be published by NHSX) and are complying with Information Standard Notices DCB1513 and DCB3066 ○ or • have a fully funded plan to procure a Maternity Information System from the forthcoming commercial framework and comply with the above Information Standard Notices and attend at least one engagement session organised by NHSX.	**Moderate risk of non-compliance** This standard is to be amended to: By 31 March 2022, every Trust should have an up to date digital strategy for its maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the NHSX What Good Looks Like Framework. The strategy must be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place and have engaged with the NHSX Digital Child Health and Maternity Programme by 31 March 2022. **Trusts' declaration of meeting this is due by end of June 2022.** OUHT currently have a dedicated digital lead midwife in maternity. Benchmarking of the current maternity digital strategy against the Trust digital strategy and the NHSX 'What good looks like' framework is in progress.	NHS England and Improvement will cross-reference self-certification of criteria 2-5 (inclusive) against NHS Digital data.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
2) Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria on the national Maternity Services Dashboard for data submissions relating to activity in January 2022. The data for January 2022 will be available on the dashboard during April 2022.	**Moderate risk of non-compliance** August 2021 – 2/11 CQIM's passed the associated data quality criteria on the MSDS. The information team confirm that they are on track to meet the standard.	
3) January 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 14+1 weeks gestation for 90% of women reaching 14+1 weeks gestation in the month.	**Moderate risk of non-compliance** The information team are in discussion with NHSX about the correct reporting methods as we are submitting data, but it is still showing as not achieved. To be reported April 2022	
4) January 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month.	**Moderate risk of non-compliance** The information team are in discussion with NHSX about the correct reporting methods as we are submitting data, but it is still showing as not achieved. To be reported April 2022	
5) Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria on the national Maternity Services Dashboard for data submissions relating to activity in January 2022 for the following 5 metrics: **Continuity of carer (CoC)**	**Moderate risk of non-compliance** We currently meet one of the 5 components for this standard. Work continues to increase this however the data quality tool has been and will continue to be submitted as per NHSX guidance which will allow us to pass this component.	

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
1. The proportion (%) of women placed on a CoC pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation 2. The proportion (%) of women receiving CoC **Personalised Care and Support Planning** **Important note:** A woman's Personalised Care and Support Plan is a live document that should be reviewed at each appointment. The below timescales indicate the point at which a plan for the relevant phase should have been **started** in discussion with the woman and recorded in MSDS. Please see the technical guidance section for further information on the type of information that should be included within plans by these timescales. 3. The proportion (%) of women who have an antenatal care plan by 16+1 weeks gestation age (119 days) which is part of a personalised care and support plan. 4. The proportion (%) of women who have a birth care which is part of a personalised care and support plan. 5. The proportion (%) of women who have a postpartum care plan by 36+1 weeks gestation age (259 days) which is part of a personalised care and support plan. The data for January 2022 will be available on the dashboard during April 2022. If the data quality for criteria 5 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information).		

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

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Expected Evidence
a) Pathways of care into transitional care 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.	**Expecting to be compliant** Guideline for Admission and Community Referral to Newborn Care Services (attached) – next review due 01/10/2023. In this guideline there is an audit section, but it is for yearly audits whereas the scheme says quarterly audits. The neonatal team are currently updating the audit section. Declared compliance in year 3.	Guideline for Admission and Community Referral to Newborn Care Services – next review due 01/10/2023.
b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.	**High risk of non-compliance** Naso-gastric (NG) tube feeding has not been fully implemented on the ward where Transitional care is provided at the time of the report. This has been due to the closure of beds on Level 7 due to Covid and staffing pressures and as a result the beds on level 5 were used for postnatal care. **The Neonatal Unit has been on red alert for a number of months** and as a result there has not been staff available to do teaching. Audit results presented at the Safety Champion meeting in December 2021. **There is a plan to achieve compliance** which involves neonatal staff and the practice development team.	A copy of the audit report. Evidence of training attendance and competency completion Confirmation that NG feeding has commenced on level 5 (Transitional Care).
c) A data recording process for capturing existing transitional care activity, (regardless of place – which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity	**Expecting to be compliant** This exists via BADGERNET data capture system. TC activity is captured using HRG XA05 codes. The criteria could be extended to include all babies born 34 to 36 weeks who did not have supplemental oxygen are classed as special care (HRG XA04)	

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Expected Evidence
management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.		
d) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), Local Maternity and Neonatal System (LMNS) and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.	**Expecting to be compliant** The Clinical Director for neonates as requested that the monthly report on care categories is sent to the Maternity Clinical Governance team as evidence.	d) Copy of the email requesting the monthly report is sent to Maternity Incentive Scheme lead.
e) Reviews of term admissions to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. The reviews should report on: a. the number of admissions to the neonatal unit that would have met current TC admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues. b. The review should also record the number of babies that were admitted to or remained on Neonatal Units because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there.	**Expecting to be compliant** Quarterly audit undertaken for quarter 2. These results have been shared with the neonatal safety champion on the 30/11/2021 and the maternity safety champion on the 01/12/2021. Discussed at the Safety Champion meeting on the 16/12/2021. In the three months of Q2, 45 late preterm babies were admitted to the neonatal unit. With a fully functioning Transitional Care 5 of these admissions could have been avoided. A further 15 babies could have been reunited with their mothers on Transitional Care to receive NGT feeding following recovery of their acute condition (requiring medical support).	e) Copy of the audit reports. Agenda and minutes of the safety champion meeting from the 16/12/2021.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Expected Evidence
Findings of the review have been shared with the maternity, neonatal and Board level safety	Therefore 20/45 babies could benefit from a reduction in separation by provision of NGT feeding alongside their mothers.	
f) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions into Neonatal units (ATAIN) reviews (point e) has been agreed with the maternity and neonatal safety champions and Board level champion.	**Moderate risk of non-compliance** Action plan required to address the findings of point b) in relation to providing NG feeding on the postnatal ward. ATAIN meeting held on the 08/12/2021 – action plan to be developed and presented at MCGC in January 2022 prior to it being agreed by the maternity and neonatal safety champions and Board level champion.	Copy of the action plan to address point b Copy of the action plan to address point e Copy of the agenda and minutes from the safety champions meeting where they have been agreed. Copy of the action plan Agenda and minutes of the Safety Champion meeting Copy of the email to send it to the local maternity and neonatal services (LMNS) Copy of agenda and minutes from LMNS and integrated care system (ICS) quality surveillance meeting.
g) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.	**Expecting to be compliant** ATAIN meeting held on the 08/12/2021 – action plan to be presented at the Maternity Clinical Governance Committee (MCGC) in January 2022 and then will be shared with the safety champions, LMNS and ICS quality surveillance meeting.	

Safety Action 4: Clinical Workforce Planning

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
a) Obstetric Medical Workforce 1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined 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/ 2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document 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. Trust requirement should be shared with the Trust board, the board-level safety champions as well as LMS.	**Moderate Risk of non-compliance** Confirmation from the Clinical Director (CD) that the unit would be adopting the RCOG guidance – email received on the 24/11/2021 following the consultant meeting on the 23/11/2021. The relevant guidelines will be updated in December 2021 and the CD will also create a document with the list for a quick way to refer to it. Monthly audit to be commenced from the 1st of January 2022. Further work to be undertaken to look at how this will be undertaken.	Email from the Clinical Director (CD) that the unit would be adopting the guidance – email received on the 24/11/2021 following the consultant meeting on the 23/11/2021. A list of the guidelines that have been updated. Communication to staff about the change – copy of the email to inform staff. Audits to be reported monthly at MCGC. Minutes of MCGC.
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. (ACSA standard 1.7.2.1)	**Expecting to be compliant** At OUH there is a resident obstetric anaesthetist 24 hours a day with responsibilities solely for obstetric anaesthesia. This anaesthetist is always supervised by one of the 14 consultant obstetric anaesthetists who cover the Delivery Suite. The consultants have daytime and twilight sessions on Delivery Suite and participate in the out of hours obstetric anaesthetic consultant on call rota.	Copy of the rosters with names redacted. Report provided with

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
c) Neonatal Medical Workforce The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies.	**Compliant** Confirmation from the Clinical lead for Neonatal Intensive Care that the neonatal medical doctor numbers have been fully recruited (there are no vacancies) and they are fully compliant.	Copy of the email from neonatal clinical lead.
d) Neonatal Nursing Workforce The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead.	**Moderate risk of non-compliance** Confirmation received from the Divisional Director of Nursing that work continues against the action plan. Current vacancies for December 2021 • Band 7 – 2.66 wte, • Band 6 – 7.67 wte, • Band 5 - +2 wte • Band 4 – 2.28 wte Current recruitment is **ahead of the target** for the first year of the 5-year business plan.	Copy of the business case from year 3 with the 5-year plan that was presented to Trust Management Executive Meeting on 01 July 2021.

Safety Action 5: Midwifery Workforce Planning

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	**Compliant** Currently use Birth Rate Plus. This is currently being refreshed.	This action plan will be included in the Safe Staffing paper that will be presented to Trust Board in March 2022.
b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.	**Expecting to be compliant** Supernumerary coordinator allocated to Delivery Suite (DS) and there is also a second band 7 allocated to Delivery Suite (DS). Escalated to the bleep holder (and manager on call out of hours) if there is a risk that they would not be able to remain supernumerary.	
c) All women in active labour receive one-to-one midwifery care.	**High risk of non-compliance** There has been one episode of in November Reported in safe staffing paper that went to MCGC in December. The technical guidance related to this safety action, asks for an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour and this has to be signed off by the Trust board and it needs to include a timeline for when it will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.	
d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the MIS Year Four reporting period.	**Expecting to be compliant** Safe Staffing paper to be submitted with an action plan if unable to provide one to one midwifery care in labour.	

Safety Action 6: Saving Babies Lives Care Bundle Version Two (SBLCBv2)

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.	**See below**	
2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network. 3. Suspension of the quarterly care bundle surveys until January 2022.The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from January 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.	**High Risk of Non-compliance with each element, please see detail below**	Quarterly survey will be undertaken.
The following rows outline the assurance required to assess compliance with each element of the care bundle		
Element One Process indicators: A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. B. Percentage of women where CO measurement at 36 weeks is recorded. Note: The relevant data items for these process indicators should be recorded on the providers Maternity Information System (MIS) and included in the MSDS submissions to NHS	**High Risk of Non-compliance** NHS Resolutions (NHSR) have confirmed that monthly audits need to be carried out for all women at booking and at 36 weeks. It is not possible to carry out an audit of consecutive notes for each month. The NHSR were contacted on 23/11/2021 to clarify the following points to assist with	Weekly Audits to assess CO screening compliance Audit to assess referral to smoking cessation services

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing an average of 80% compliance over a six-month period. If there is a delay in the provider trust's ability to submit these data to MSDS then compliance can be determined using their interim data recording method. The denominator should still be the total number of women at booking or 36 weeks gestation, as appropriate for each process indicator. A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. In addition, the Trust board should specifically confirm that within their organisation they: 1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' CQIM. 2) Have a referral pathway to smoking cessation services (in house or external). 3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service. 4) Have generated and reviewed the following outcome indicators within the Trust for January-April 2022: • Percentage of women with CO measurement ≥4ppm at booking. • Percentage of women with a CO measurement ≥4ppm at 36 weeks.	evidencing this element: A reply was received on 22/12/2021 and the response are being implemented.	Review of outcome indicators Jan – April 2022 as per schedule Action plan if process indicator scores are ≤ 95%

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
• Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at 36-week appointment. Additional information If your Trust is planning on using the maternity dashboard to evidence an average of 80% compliance over six months, please be advised that there is a three-month delay with MSDSv2 data. The last month to be included in this will be February 2022. If your Trust does not have an in house stop smoking service or a pathway to an external service, please contact your local authority stop smoking service or escalate to your local maternity system to enable the Trust to ensure provision is in place.		

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Element Two Process indicator: 1) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20-week scan (e.g., Appendix D). Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If there is a delay in the provider Trust MIS's ability to record these data at the time of submission an in-house audit of 40 consecutive cases of women having a 20-week scan using locally available data or case records should have been undertaken to assess compliance with this indicator. A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. In addition, the Trust board should specifically confirm that within their organisation: 2) Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards	This is recorded at the 20-week scan which is in notes and uploaded to the electronic patient record (EPR). Compliance is >98% There is currently no search set up to be able to obtain this information from EPR. The risk status for fetal growth restriction (FGR) is produced at booking but there is currently no way of obtaining the data electronically. There may be a way of obtaining the 20-week information from the USS department. More work is needed to capture this information accurately going forward. It is a robust system indicating good compliance, but evidence needs capturing.	To be evidenced by Audit
	Expecting to be compliant For the Year 2 and Year 3 MIS, an exception report was submitted to and agreed by local governance, Trust Board, CCG and Clinical Network in relation to an alternative to offering ultrasound assessment from 32 weeks' gestation for women with BMI>35kg/m2	Copy of the Exception report and submit to Trust board

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation.	**Expecting to be compliant** Uterine artery doppler flow is measured in all pregnancies at the 20-week anomaly scan.	Audit report
4) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.	**Expecting to be compliant** EPR currently doesn't record centiles which appears to be a gap. Going forward it would be useful to add this as a searchable field. An audit will need to be undertaken of term small for gestation age.	Audit report
5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT).	**Expecting to be compliant** PMRT intrauterine growth restriction (IUGR) theme.	To be included as part of the PMR report after quarter 4 as it is a review of mortality cases in 2021.
6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network.	**Expecting to be compliant** NICE guidelines indicate a 24/40-week ultrasound scan (USS) for multiple pregnancies. A variant has been agreed. Monochorionic twins and higher order multiples are scanned every 2 weeks (from 16/40) and Dichorionic twins at 28, 32 and 36 weeks (minimum). Includes optimum gestation for delivery.	Multiple pregnancy and Birth Guideline (23/11/2020)

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
7) They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile .37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g., components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above-mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if the staffing is critical and this directly frees up staff for the provision of clinical care.	**Expecting to be compliant** Quarter 3 Audit omitted to free up staff for clinical care. Re-start in Quarter 4 2021/2022 to allow time for quality improvement initiatives to be reported/implemented	Audit of term small for gestational age (SGA) – **this audit to be paused at this time due to high clinical demand (in accordance with extension of MIS reporting deadline)** Re-start in Quarter 4 2021/2022 (Report March 2022)
Element Three Process indicators: A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. B. B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short-term variation). Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators. A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.	**Expecting to be compliant** Tommy's Reduced Fetal Movement (RFM) Leaflet is in all the maternity handheld records. An in-house audit of 20 consecutive cases is currently being carried out by Maternity Assessment Unit (MAU) to evidence compliance with A and B of this element.	Audit report to be presented at Maternity Clinical governance Committee (MCGC) when completed.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Element Four There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include intermittent auscultation, electronic fetal monitoring with system level issues e.g., human factors, escalation, and situational awareness. The Trust board should specifically confirm that within their organisation: • 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above. • A dedicated Lead Midwife (0.4 WTE) and Lead Obstetrician (0.1 WTE) per consultant led unit have been appointed by the end of 2021 at the latest. Please refer to safety action 8 for updates re training.	**Moderate Risk of Non-compliance** Moderate risk of non-compliance in relation to fetal monitoring training. There is a lead midwife in post (0.4wte and a lead obstetrician (0.1 wte). **See Safety Action 8 for training update**	Include training trajectories as evidence Confirmation email received from clinical director that the Trust employs a lead consultant (0.1 wte) for fetal wellbeing. Copy of appointment letter for one of the band 7 fetal wellbeing lead midwives already received. The second band 7 has commenced in post in December 2021.
Element Five Process indicators: A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).	**Moderate risk of non-compliance** Currently results are lower than expected. Current results for August, September, October for : Point A – between 18 to 42% Point B – 14 to 18% Point C - >85% Audit to be undertaken and action plan produced if scores less than 80%. When there was a regional audit, it showed similar numbers. Manual data collection was necessary - Orbit will only give those prescribed in EPR and at the John Radcliffe (JR).	Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention Funding has now been secured for a Band 7 midwife who will support preterm labour service here and also support care in the network,

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Note: The relevant data items for these process indicators should be recorded on the provider's MIS and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. If there is a delay in the provider Trust MIS's ability to record these data, then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%. In addition, the Trust board should specifically confirm that within their organisation: • They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife. Further guidance/information on preterm birth clinics can be found on https://www.tommys.org/sites/default/files/2021-03/reducing%20preterm%20birth%20guidance%2019.pdf • Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner	In some instances, the time frame of <7 days (and <24 hours) may mean that in many instances steroids have been as an earlier intervention that has not been captured (perhaps due to previous quality improvement initiatives). There is a MatNeoSIP improvement programme for antenatal steroid administration in progress. This was launched on the 01 November 2021.	including facilitating referrals. Recruitment has not yet started for this post. Copy of the job description (JD) when available. Copy of the poster for the MatNeo SIP improvement programme.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
(CCG) and that their Clinical Network has agreed is acceptable clinical practice. • An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate, and high-risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway. The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local CCGs following advice from the Clinical Network. • Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network.		

Safety Action 7: Maternity Voices Partnership (MVP)

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership local maternity services?	See below for details of evidence required.	
Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems.	**Expecting to be compliant** Terms of Reference	
Minutes of MVP meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff.	**Expecting to be compliant** Details of collaboration and co-production through Facebook Live, PILs, CoC Pathways Table of Evidence	
Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes.	**Expecting to be compliant**	
The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMS board that ratified it	**Expecting to be compliant**	
Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including childcare costs in a timely way.	**Expecting to be compliant** Childcare costs is extra inclusion this year	
Evidence that the MVP is prioritising hearing the voices of women from Black, Asian, and Minority Ethnic backgrounds and women living in areas with high levels of deprivation,	**Expecting to be compliant**	

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.		

Safety Action 8: Training

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
a) A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4 in August 2021.	**Moderate Risk of Non-Compliance** More staff have been booked onto the training days. The Training Plan has been produced to ensure that all six modules of the Core Competency Framework are included in the training programme over the next three years commencing from August 2021. This plan includes the six Core modules of the Core Competency Framework: • Saving Babies Lives Care Bundle • Fetal surveillance in labour • Maternity emergencies and multi-professional training • Personalised care * • Care during labour and the immediate postnatal period* • Neonatal life support Also included each year of the plan are two additional modules (*) which have been tailored to identified unit priorities, audit report findings and locally identified learning. For the reporting year 2021-2022, uterine rupture and group B streptococcus (GBS) will be covered	Copy of the training plan and training trajectories

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
b) 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi- professional training day, to include maternity emergencies starting from the launch of MIS year four on 8 August 2021?	**Moderate Risk of Non-Compliance** Extra training dates have been factored in to ensure that this training target is met. This is reliant on staff being able to attend the training sessions due to the impact of Covid related service pressures.	Copy of training data to be provided
c) 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi- professional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four on 8 August 2021.	**Moderate Risk of Non-Compliance** Extra training dates have been factored in to ensure that this training target is met. This is reliant on staff being able to attend the training sessions due to the impact of Covid related service pressures.	Copy of training data to be provided
d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four on 8 August 2021.	**Risk of non-compliance** Staff in maternity are given the time as part of their training week. However, at OUH resuscitation compliance is set at 2 yearly in My Learning Hub (MLH) and the Maternity Incentive Scheme (MIS) asks for compliance within specific dates. If staff are already compliant in MLH and they complete the NLS again when they are still compliant then MLH does not update. This may be a reporting issue and steps are being taken to properly capture the training data	Minutes of meeting with representatives of MyLearning Hub Copy of training data to be provided

Safety Action 9: Safety Champions

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
a) The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-qualitysurveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.	**Compliant** Pathway was visible to and shared with staff by the 10/01/2022 deadline	Copy of Pathway
b) Board level safety champions present a locally agreed dashboard to the Board on a quarterly basis, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 31 October 2021. NB, the training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 31 December 2021.	**Expecting to be Compliant** Perinatal Quality Surveillance report (PQSR) has been presented at Trust Board since July 2021. A Bimonthly paper has been sent to the BOB LMNS since July 2021. The paper is presented monthly at the Maternity Clinical Governance Committee (MCGC). The training plan is included in the January paper (December data) and has been seen by the Board Safety Champion on the 23 December 2021. The monthly maternity and neonatal feedback sessions were paused in June 2021, and they restarted in September 2021. There was no meeting held in October and November due to staffing and covid. There was a meeting held on the 31 December 2021. The minutes from the December meeting will be discussed with the Safety Champions on the 11 January 2022. Action logs are discussed at meetings.	Minutes of Maternity and Neonatal feedback sessions. Copy of Perinatal Quality Surveillance Report. Action Log & minutes from Safety Champions Meeting

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2023, prioritising those most likely to experience poor outcomes.	**Risk of Non-compliance** There will be an action plan submitted to the Board level safety champion by the 31 March 2022 however Continuity of Carer will not be the default model of care offered to all women by March 2023.	Paper to be presented to MCGC in January
d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)	**Expecting to be compliant** Regional Perinatal Governance meeting: September 24, 2021 – 6 OUH staff attended Regional Maternity Clinical Network Meeting (Maternity & Neonatal network): 8 December 2021 – 4 OUH staff attended. <u>Future meetings</u> Regional Perinatal Governance meeting: 28 January 2022 Patient Safety Network meeting: 08 February 2022 Peer review undertaken in October and November 2021. December 2021 – Maternity and neonatal services have commissioned an external benchmarking Culture Review within Maternity Services to gain a deeper understanding of the current culture and staff experience. Ibex Gale commenced	Email received from Academic Health Science Network (AHSN) confirming attendance at the Regional Perinatal Governance meeting in September. Agenda and minutes to be used as evidence for the meeting. Copy of the minutes from the December “Regional Maternity Clinical Network Meeting (Maternity & Neonatal network)” received.

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
	discussions with staff during the week commencing 11 January 2022.	

Safety Action 10: NHSR Early Notification Scheme

Required Standards following re-launch of MIS	Update on status & RAG rating for risk of non-compliance	Evidence
A) Reporting of all qualifying cases to HSIB for 2021/22.	**Expecting to be compliant** All qualifying cases have been reported to HSIB so for 2021/22.	Ulysses incident reporting system data Health Safety Investigation Branch (HSIB) Case Log
B) For qualifying cases which have occurred during the period 1 April 2021 to 31 March 2022 the Trust Board are assured that: 3. 1. the family have received information on the role of HSIB and the EN scheme; and 4. 2. 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.	**Expecting to be compliant**	Ulysses incident reporting system data HSIB Case Log Copy of letter